

KHN's 'What the Health?'

Episode Title: Washington's Slow Churn

Episode Number: 249

Published: June 2, 2022

Julie Rovner: Hello and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent at Kaiser Health News. And I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, June 2, at 10:30 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today we are joined via video conference by Margot Sanger-Katz of The New York Times. Welcome back, Margot.

Margot Sanger-Katz: Good morning, guys.

Rovner: Rachel Cohrs of Stat News.

Rachel Cohrs: Hi, everyone.

Rovner: And Sandhya Raman of CQ Roll Call.

Sandhya Raman: Good morning, everybody.

Rovner: Later in this episode will have my interview with KHN's Michelle Andrews, who reported and wrote [the latest KHN-NPR "Bill of the Month,"](#) about a way-too-common trap in the Affordable Care Act's guaranteed preventive coverage that lots of people fall into. This time, at least, the patient came out on top. But first, this week's news.

We're going to start with Medicare. We haven't said that very much this year. By the time you hear this, the news will be out about the latest trustees' report and Medicare's financial future. But that hasn't happened as of our taping, so we will get to that next week. This week, though, we learned that the Department of Health and Human Services will not be reducing the Part B premium for the remainder of the year. So back in January, HHS Secretary Xavier Becerra ordered Medicare officials to reevaluate the premium hike in light of a cut in the price of that controversial Alzheimer's disease drug, Aduhelm. Now, this was before Medicare decided mostly not to cover the drug and before the drug's maker decided not even to promote it after Medicare decided not to really cover it. But back last year, when it seemed that the use of the very expensive drug could be high among Medicare beneficiaries, actuaries preemptively raised the Medicare premium by a record \$12 a month. So fast-forward to last Friday afternoon, right before the holiday weekend, when HHS puts out a press release announcing it will not lower premiums in 2022 after all, but will lower them starting in 2023. Of course, that lowering could be swallowed up by other health care inflation, so beneficiaries could end up with an increase that's just smaller than it otherwise would have been. Why did HHS decide to do it this way? I mean, it's like five months after they could have just said, OK, we're taking this 10 bucks of this \$12 increase off.

Cohrs: Right. So I think ... there was some pressure from Capitol Hill because I think lawmakers weren't thrilled that there was this big increase in Medicare premiums and there was pressure on HHS to do something. And I think Secretary Becerra wanted to be responsive to that. And, you know, he's a lawyer. He, I think, is well versed in what's possible under ... legally, potentially. I think he wanted to explore that. But as, I think, Medicare officials said — I think they really tried to make it work is the thing. And that's why it took so long, because, you are right that it was January when they kind of gave ... a draft idea of how they were going to cover this drug. And I think it was operationalizing just the logistics of a midyear premium adjustment. It had never been done before. It would have been really difficult, and I think they just came down on the fact that there's never a perfect estimate [of] what the premium number is going to be versus what costs are. And this year just had a particularly big difference because of a particularly unusual situation with Aduhelm.

Rovner: I feel like the administration was both very lucky and very unlucky in this. Had it not been for, you know, so much other bigger health care news, this would have been a huge deal. On the other hand, a lot of people are paying a lot more in their Part B premium. And it just adds to the “Oh, my God, everything is getting more expensive. Can't this administration run the economy?” part of the debate. I'm just wondering, you know, there's nothing like angering old people in a midterm election year when they are more likely to vote.

Sanger-Katz: I think the one small bit of silver lining in that is that Social Security payments were increased by basically a record amount this year. So, a lot of older people obviously have fixed incomes. A lot of them rely almost exclusively or entirely exclusively on Social Security for their income. So that means when Medicare premiums go up, they're feeling the squeeze. But at least in this year, they did get an increase in the Social Security payments that are going to more than compensate for this increase in the Medicare pay.

Rovner: Yes, and it's true, they would have been. But next year's decrease may be smaller than otherwise. But I guess this year's increase being smaller, at least there *was* an increase for most people.

Sanger-Katz: But I do agree with you, Julie, that sometimes these price increases are really politically salient, even if people are overall coming out on top. You know, we see a lot of that in the discussion of inflation and the economy, generally, where there are a lot of workers who are actually making higher incomes than they were before, but they still are staggered by increasing prices for things that they buy because you just notice those every day and they feel more alarming, even if they are in the context of an overall higher ability to pay.

Rovner: Yeah, it's funny. I'm used to gas prices going up and down, but the idea that a gallon of milk is about to cost \$5 — it's kind of horrifying to me, that is a first. So ... I think everybody is noticing this. All right. Well, we will definitely have more to say about Medicare next week when we hear what the trustees have to say. But now to gun violence. It appears that the latest mass slaughter of elementary school students in Texas has again jump-started talks on Capitol Hill about potential gun regulation. Obviously, there is yet another mass shooting this week in Oklahoma. But forgive me, we have seen this movie before. After Columbine, after Sandy Hook, and now

after Uvalde and, I guess, after Tulsa. Any chance that there's a different ending this time, or is this just another effort by the gun lobby to look like it's trying to negotiate something other than just running out the legislative clock?

Raman: It's a really difficult topic to approach. I know that some of the Senate Republicans have said they were open to some form of gun control legislation before the Memorial Day recess. You know, something that could be bipartisan, like some of these red-flag laws or which would ... flag, you know, if you have a family member that might be a danger to themselves or others. But I think some of the issues that could be bipartisan are low-hanging fruit; the things that the Democrats want are not.

Rovner: The gun-show loophole!

Raman: Yeah, those things are not really coming to the table. Even something like in 2020 when Democrats have pushed a study [on] gun violence prevention, that was like the first time that they had done that. And this has been an issue for so many years that it's hard to make more than just a little nudge forward on this.

Sanger-Katz: I would say, though, just talking to some people on the Hill this week that, you know, never say never. I think there has been a long history of very little bipartisan action on gun-safety legislation over certainly the last 20 years. And I think that there is a certain cynicism that people have about it, that it's just impossible to legislate in this area. And it may indeed be the case that nothing passes now. But I do think that there are some good-faith, bipartisan conversations that are happening in the Senate. Sen. [John] Cornyn, a key member of the Republican leadership, is part of negotiations over some gun package.

Rovner: [He's] from Texas. So someone who's having a lot of pressure put on him by both sides.

Sanger-Katz: But, you know, that doesn't guarantee that they'll come to consensus. And, of course, for gun legislation to advance in the Senate without eliminating the legislative filibuster, you need 10 Republicans and all Democrats to sign on. So that's pretty hard. But, we will see, certainly in the House, the Democrats are passing a lot of stuff. They're going to mark up a package of bills today. They are hoping to bring those to the floor next week and they have a couple of gun bills that they've already passed through the House. So, it will be interesting to watch. I would not, as you guys have said, I would not imagine that the Senate has an appetite for some really expansive form of gun regulation. But I do think that some of these measures that we might — that we didn't see before, that there has been unwillingness to consider before — are on the table and perhaps in a more serious way right now.

Rovner: Well, speaking of things that Congress is talking about, but not actually getting done. West Virginia Democratic Sen. Joe Manchin was home this week talking to a local AARP chapter about how much he wants to lower prescription drug prices. Now, this suggests there still could be a deal out there to renew the expiring subsidies of the Affordable Care Act and possibly lower some prescription drug costs. Of course, we've been saying this pretty much every week for the better part of a year now: Which is more likely? Getting some deal like this done with just Democrats, or getting a bipartisan deal done on guns — or neither?

Cohrs: Well, I think, as someone who's listened to a lot of what Joe Manchin has said on drug prices over the past year or so, the comments that he made this week were a marked change in rhetoric for him. I think he's always supported some form of prescription drug pricing reform. He kind of alluded to the fact that there is unanimous Democratic support for an actual package of legislation that's written, which is not the case for so many other issues that Democrats are talking about right now. And he did kind of say that if nothing else gets done, then maybe he would agree to this. So I think it's a difficult thing. Things change, dynamics change week to week. Things can go south and sour very quickly. So I think it's difficult to predict right now, but I think there is a sense of wait-and-see that we've had for a long time. But things — I think the tenor has definitely changed over the past week publicly in the rhetoric that the negotiators are using, and I think ... the Democrats are feeling the pressure of the election coming, front-liners are feeling pressure, and I think there's a desire to just get something done, so you don't waste this mechanism, which I think as we've talked about often, expires at the end of September. So I think that the clock is ticking and it's possible. It's not definite, but it's possible.

Sanger-Katz: The clock is ticking in another way, too, which is the expiring enhanced subsidies for people who purchase Affordable Care Act marketplace plans. Obviously, Congress is going to get to these things when it gets to them, but those rates for next year are already being calculated. They're being submitted to regulators. They are getting approved by regulators. This is a process that takes many months before open enrollment begins, and actuaries have to make certain assumptions about who is going to buy insurance and how much it's going to cost to take care of them. Those numbers are going to differ quite a lot, depending on whether or not these enhanced subsidies are available. And, if Congress waits until the eleventh hour, as they often like to do, you could end up in a situation in which premiums go up a lot and there aren't any subsidies. Acting sooner really would make this policy have a larger impact in the context of the election because, you know, it's complicated, but it's not ... of course, the policy itself affects the subsidies. So that affects how much if you are paying for a subsidized premium, how much you have to pay. But it also affects what is the total premium. And there are still people out there who pay the full price of their insurance and those people will be affected by the increases in premiums.

Raman: And at the same time, there's so many other things on their health laundry list just for this year. We still need to go through the appropriations cycle. And at least three of the top people related to the health appropriations process are retiring at the end of this year, meaning that they are more likely to want to get a few things done to just put their mark.

Rovner: Legacy issues.

Raman: Yes, legacy issues. And I can see that also complicating it. And if they want to do that faster rather than, you know, going through several continuing resolutions, which has been the pattern in the past. So that puts another thorn in what can all get done before the end of the fiscal year.

Rovner: Once upon a time, June and July were the busiest parts of the federal legislative calendar. They like to get stuff done before the August recess. I feel like in recent years it's like, "Let's load everything into September" and then it's like, "Let's put it off and do it later." But, yeah, Margot

has a point. I mean, premium estimates are due in May, aren't they? They've already been submitted, I would imagine, for most of the Affordable Care Act plans. I think that the rest of the summer is ironing out with regulators exactly what those are going to be. And without knowing whether these increased subsidies are going to continue, they're kind of flying blind. But Congress is going to do what Congress is going to do *when* Congress is going to do it, which I suspect at this point is mostly up to Joe Manchin. OK, let us talk about covid, which is still with us, still bad, still getting worse in lots of places in the U.S. and around the world. In fact, we learned this week from the CDC [Centers for Disease Control and Prevention] that while the general perception has been that the omicron version of covid has generally been milder than those versions that preceded it, almost as many older people died of omicron than died of the much more severe delta variant, and that older people are again dying at much higher rates than younger people. A lot of this is due to waning immunity variants that can infect even those who had previous versions of covid and previous vaccinations. Meanwhile, the Biden administration is formally appealing that federal judge's ruling that struck down the mask mandate on public transportation, although that's more about the next pandemic than it is about this one, right? Rachel, you're nodding.

Cohrs: Sure. I think there is definitely this long-term perspective of some of these lawsuits. And I think they are choosing their battles in terms of what they would like to be able to have the flexibility to do immediately versus the legacy of public health in the country, which I think we've talked about over the weeks as, you know, trust, and different states are doing different things. So I think this is definitely something that's on their mind for the long term, even if a lot of states and localities have lifted their mask mandates for now.

Rovner: The CDC and other public health officials are discovering that when they told people that they could take their masks off but they should put them back on when things get bad again ... now things are getting bad again and nobody seems to want to put their masks back on. Have we lost our — I don't want to say faith in public health — but lost our desire to follow public health recommendations?

Sanger-Katz: I think it's ... somewhat complicated by what you mean by “getting bad again.” I think the versions of covid that are circulating now are, on average, less severe, less likely to result in hospitalization, less likely to result in death. So even though we are seeing covid spreading around a lot, most people who are getting it are having relatively mild illness. There are a lot of Americans who got omicron in the winter. And so they do have some immunity, even if they have waning vaccine immunity from the older strains of covid. And so, I do think that there is less of a sense of fear and urgency about covid risk among many Americans. Doesn't mean that everyone is making rational decisions about that. Of course, I do think there is a lot of fatigue and people are just sick of masks and want to go back to regular life. But I do think that there is some rationality in the behavior, just given the dangerousness of the form of covid that is circulating now and the kinds of population immunity that people have that may not prevent them from getting covid. But for people who do not have high health risks, their risk of getting really sick from covid right now, if they're vaccinated or if they've had a previous infection or both, is a lot lower than it was before.

Rovner: Yeah, we're at this point where there's sort of willful ignorance in the ... and then, you're right. There's been a lot of this advice that you need to make your own personal risk decisions. You know, I'm still wearing a mask indoors most places.

Sanger-Katz: I think there's a huge philosophical tension about how we should approach a disease like covid. Should it be something that individuals assess their own risk, their own tolerance for risk? Should it be something where we feel more of a societal obligation to protect the most vulnerable people who really can't make that assessment very easily? And, I think that's just an ongoing debate that we have in our culture. But I think when you think about why is it that lots of Americans seem to have shed their masks and not put it back on, I think it's because there are a lot who are in that first camp who just are thinking about their own risk, their own concern about covid, and they just are less worried than they were before.

Rovner: And we still ... I should say, we don't we don't have any moms of little kids here today, I don't think. But the 0-to-5s are still not eligible for vaccine. Pfizer has just applied to the FDA for approval. I mean ... all of my friends with little kids hope that will come in the next couple of weeks and that maybe ... the smallest kids will be able to be fully vaccinated by the fall. But that, I know, has been a continuing frustration.

Sanger-Katz: Well, it's been it's been going on for so long that we're now considering the approval of a vaccine for a strain that's like five generations old, right? That we know does not protect adults from getting omicron very well. It is a very weird and long process that we've gone through that we're now going to have this vaccine finally approved for young kids that probably isn't really going to work that well.

Rovner: I know. It's ... all a huge frustration at this point. Meanwhile, Rachel, you had [an interesting story this week](#) about hospitals finding creative ways to get paid for treating covid patients, even in the absence of formal federal funding, which has mostly run out. Tell us what they're doing.

Cohrs: Yeah. So I think there are definitely some hospitals who were looking for creative solutions after HHS shut down their mechanism ... to pay for claims for covid-19 care for the uninsured, and that included vaccinations and testing and also treatment costs. And there were some facilities that use that program a whole lot — they were submitting their claims — some facilities didn't. But for the facilities that did, I think there has been a quiet exploration of what other options there might be, because kind of how these federal programs have worked is that the government will pay if nobody else is going to pay. So once one option shuts down, then I think hospitals are looking to, now, FEMA [Federal Emergency Management Agency] funding to see if there is another avenue to pay for some of the care for the uninsured that they may not be paid for otherwise. And it's much more limited than the HRSA [Health Resources and Services Administration] program; it's much more complicated, because it's only available for nonprofit facilities. And just the way that FEMA processes expenses that they would pay is different than generally how the health care reimbursement claims system works. So I think there are definitely some details to be worked out. And obviously there's another potential for inequality, because the facilities that have the resources to hire external consultants, and have time to dedicate on their staff to figuring all this

stuff out, are more likely to be able to take advantage of that mechanism. Whereas some of the smaller facilities or teams that are stretched thin or may not have that. So I think that'll be interesting to see how that plays out and if that creates an extra stress on the FEMA program as well. Because as pots of money come down to zero across the government, then extra demand gets placed elsewhere. So I think this is just another example of that dynamic working out.

Rovner: Leave it to hospitals to figure out creative ways to continue to get paid. All right. Well, let us turn to abortion. We are still waiting for the Supreme Court. That decision could come anytime starting next week, or it might not come until early July. The court has more than 30 cases still pending, which is a lot for the beginning of June. But meanwhile, things in the states are getting, if anything, even more confused. In some red states, local prosecutors in blue cities and counties are announcing they won't enforce abortion bans or trigger laws. While in some red states, it seems that state constitutions could end up guaranteeing a right to abortion, even in the absence of *Roe [v. Wade]*. Margot, I know you're trying to keep track of this. It's not going to be as simple as red states, no abortion; blue states, abortion still legal. Right?

Sanger-Katz: I think it is and it isn't. So, I think when it comes to what the effect is going to be on the ground of *Roe* being overturned, I think there are these technical legal questions of, like, what is a court going to say when a case comes before them? What is the likelihood that a prosecutor is going to bring a case if they can? And then there's the real-life decisions about whether abortion is going to be available. And a lot of that really comes down to how ... what kind of risk are clinics willing to take? If you're an abortion clinic in a red state that's going to ban abortion and your local prosecutor says, don't worry, I won't prosecute you, I think it's a pretty tough call. And I really think from the reporting I've done so far, most of these clinics don't have the stomach for that kind of risk. A lot of these providers, they don't want to face felony charges and maybe go to prison for 10 years. And so they're not going to roll the dice, even if maybe there are some signs of a favorable legal environment. And I think, similarly, there may be state constitutions that will protect the right to abortion. But while that is being litigated again, I think the providers are probably reluctant to face down a lot of legal risk on the possibility that they might lose those cases. And so I do think that there is going to be a lot of ongoing litigation and political wrangling around all of this. But I do think when we think about the short-term effects of *Roe* being overturned, a lot of states are going to lose abortion access because the providers are going to err on the side of caution. And so we may really see ... the states that we think are going to ban abortion, we may see access to abortion really precipitously go away pretty quickly, even if there are ongoing cases and it might come back in some more limited fashion in the future. And I think ... I keep looking at what's been happening in Texas. Texas has had this very restrictive abortion law that is technically in violation of the *Roe* standard but has been allowed to go into effect. That's been in place for more than six months now.

Rovner: Since Sept. 1.

Sanger-Katz: Since Sept. 1. So I think it's like a little bit of a good guide. And what we saw in Texas is the very day that that law went into effect, the clinics started complying with the rules under that law, even though they believed, and I think they had a very good reason for believing, that the law was unconstitutional and ought to have been overturned. And in conversations with

abortion providers in other states that are treating Texas patients, they say that they are also seeing a lot of patients who want abortions and who have life-threatening health conditions. So these are women who should be able to continue to have access to abortion in Texas under the SB 8, which says, in general, you cannot have an abortion after a certain developmental milestone has been reached. But then if there is a threat to the health of the mother, then there are exceptions later. But ... there is no one in Texas who is willing to provide abortions to those women because they are scared of that ambiguity and about legal risk. And so that is forcing these women into other states. And I think, again, that's just a good preview.

Rovner: And now the same thing has happened next door in Oklahoma, as of last week, which I think has been very under-covered compared to Texas. But a lot of women in Texas were going to Oklahoma and now they can't do that either because Oklahoma providers are having exactly the same concerns that the providers in Texas were having — also in a law that technically violates *Roe*, which hasn't officially been overturned yet.

Raman: Yeah, and Oklahoma's law is even stricter than Texas'. It's banning essentially all abortions regardless of the time, with very limited exceptions, from the point of fertilization.

Rovner: Fertilization.

Raman: And they were supposed to have their hearing this week to look at this law. And that has been moved to August, which is after we're going to get the *Roe* decision anyway. So that's going to likely stay in effect, possibly permanently. But I think you guys make a good point that the states are really the place to be watching right now. When I was ... especially the state constitutions and how looking at the nuances there is really going to be important. Like this week, Florida's 15-week ban is getting sued because they have a very uniquely broad privacy clause in their state constitution, which has made it historically more difficult to implement a lot of these abortion laws compared to other Southern states. And I think the interesting thing there is that that individual privacy liberty thing is also something that's supported by a lot of Republicans for other types of things outside of abortion. So it's not something that they would try to override because it has other ramifications. So I think that ...

Rovner: Yeah, let's be careful at amending the Florida Constitution, in other words.

Raman: Yes. Yes. So I think that case will be really interesting to watch. And because the 15-week [ban] is pretty similar, almost identical to the Mississippi law and *Dobbs [v. Jackson Women's Health Organization]*. But I think two other places to watch are Kentucky and Kansas that both have on the ballot this year. They want to change their state constitutions to say that there's not a right to abortion. And so what those will do and, in Kansas in particular, given that, you know, a couple of years ago, the state Supreme Court had decided that there was a right to abortion in the state constitution, which had kind of prompted people that oppose abortion to say no, we need to make that clear that it's not. So I think that one in particular is going to be interesting to watch as this year goes on.

Rovner: Yes, I think lots, many, many, many more balls in the air ... there are now and will continue to be. All right. Well, a couple of more smaller items that I thought were interesting this

week. First, the Department of Health and Human Services has established an Office of Environmental Justice, headed by a former CDC official whose job is to look explicitly at how environmental issues like lead exposure and inadequate wastewater treatment disproportionately impact lower income communities and communities of color. But, as Politico reports, the office is to be housed in an Office of Climate Change and Health Equity that still hasn't yet been funded. So both offices are to be staffed for the moment by detailees from elsewhere in the department. But this has the potential to do something that until now has been mostly lip service from elected officials and administrations about doing something about environment and health equity, which has been a big problem, well documented over the past decade or so. Could this office actually have some impact here?

Raman: I think it depends if it gets funded. I mean, the House Energy and Commerce Committee had an appropriations hearing earlier this year and a point that a lot of Republicans had made was about not wanting to look at health through a climate equity lens, that there was some pushback on what that meant. And I think in order to get something funded, you're going to need to make it broader and get that broader support. So I think it might be difficult for to get this unless they ...

Rovner: Unless it's one of the legacy issues for retiring appropriators!

Raman: Yes.

Rovner: Well, so basically, it's going to matter who's going to push it, right?

Raman: Yeah, I think that it's tricky. And it's also some things that ... it hasn't been done before. It's hard to see who might be especially interested in pursuing this kind of thing through the health lens rather than one of the other committees.

Rovner: Yeah, it is an interesting sort of expansion. I think we've talked more in recent years about the impact of climate change on health in particular, particularly on disadvantaged communities. And I think this is an effort to actually put some of that into action. But you're right, it hasn't been done before. And it is it is still controversial. All right. Well, finally this week, the Department of Health and Human Services formally withdrew the Trump administration's last-minute, quote-unquote, "SUNSET [Securing Updated and Necessary Statutory Evaluations Timely] rule," which would have required the administration to formally renew just about every rule issued by HHS or else those rules would terminate. Had this gone into effect, it could have thrown a lot of programs into chaos, right? Challenging the rule, the review called, quote, "an unprecedented and infeasible task." So why did it take the administration a year and a half to make this go away?

Raman: Well, last year they had delayed it by one year because Trump had finalized the rule the last day of that he was in office.

Rovner: Right. It was, like, Jan. 19 of 2021.

Raman: Yeah. And then by the fall, I think, was when they had proposed initially doing it and then now they completed the process of withdrawing it altogether. But I think a lot of it [was] just, like, logistical and planning how they would get it done.

Sanger-Katz: The regulatory wheels turn slowly. I think this is the theme of our episode. It is not different from what we were discussing when it came to the Medicare premiums. You know, you would think that they could just recalculate and change, but they cannot.

Rovner: Yeah, although in this case, it was making this go away. I'm still sort of and ... I am tracking how long it's taking some of these rules that we assumed would be wiped off the books pretty quick ... I noticed this during the Obama administration, how long it took the Obama administration to undo some of the things that we assumed would be undone very quickly. And it took a couple of years. And I guess it's just a matter of what their priorities are and when they get to these things. But this obviously was — *could have been* a really big deal. It could have basically eliminated lots and lots of health and safety rules simply because there was no way to renew them, to go back through and run through the entire regulatory process on every major rule. It was done for the purpose of getting rid of these rules, not for the purpose, really, of reviewing them. But it is, at the moment, it is gone. And we'll see if it ever comes back again.

All right. Well, that's the news for this week. Now we will play my “Bill of the Month” interview with Michelle Andrews, and we will come back and do our extra credits.

Rovner: We are pleased to welcome to the podcast my KHN colleague Michelle Andrews, who reported and wrote [the latest KHN-NPR “Bill of the Month.”](#) Michelle, welcome to “What the Health?”

Michelle Andrews: Thanks! Thanks for having me.

Rovner: So, this month's patient fell into a loophole that happens way too often in trying to navigate that guaranteed, quote, “no out-of-pocket cost,” quote, for preventive coverage provisions of the Affordable Care Act. Tell us who she is, where she's from, and what she had done.

Andrews: The patient that I talked with was Elizabeth Melville, and she's a 59-year-old part-time ski instructor who lives in the vacation town of Sunapee, New Hampshire. She had to get a screening colonoscopy, as people in their 50s are often recommended to do, and that's what she did.

Rovner: Now, under the Affordable Care Act, preventive care like colonoscopies are supposed to be free — well, not free, but free to the patient — but she got a bill for this one. How much?

Andrews: The bill was nearly \$2,200.

Rovner: Ouch.

Andrews: No kidding. She's covered under insurance that her husband has through his job, and that amount is a far cry from free.

Rovner: Now, she'd had an earlier colonoscopy where she wasn't charged anything, right? So, what happened when she questioned this \$2,000 bill?

Andrews: Well, what they told her multiple times was that because they had discovered a polyp — a little cluster of cells — during the test and removed it, that that made it a diagnostic test and not a preventive test, and that therefore she had to pay for part of it.

Rovner: But that was the same thing that happened with her first colonoscopy, right?

Andrews: The very same thing, almost six years before. And they snipped out a little polyp and they didn't charge her a thing. So, what's different? Why the change?

Rovner: Yes, that's my question for you. What's different?

Andrews: Well, it was a mistake. There shouldn't have been that charge, because the federal government has made clear for a very long time that under the Affordable Care Act, if someone has a polyp removed during the process of a screening colonoscopy, that that's just an essential part of the procedure and no one should be charged because of that.

Rovner: And, technically, it's preventive because it's preventing the polyp from becoming cancerous, right?

Andrews: Exactly. Exactly.

Rovner: So what eventually happened with the bill?

Andrews: Eventually, after she contacted KHN and said this doesn't seem right, they looked into it and reprocessed the claims and said, "Oh! It was a mistake. You don't owe anything."

Rovner: So how does someone prevent this? As you point out in the story, 40% of adults will end up with a finding of benign polyps when they have what should be a screening colonoscopy. So this obviously happens a lot. You go in for your screening colonoscopy, they find a polyp, they snip it out, you're not supposed to get a bill. How do you make sure you're not wrongly charged?

Andrews: Well, alas, you can't make sure, but there are a few things you can do. And what I would suggest — what experts suggest — is to call your insurance company, first of all, and just go over the basics and say, Look, do you have this as preventive and not diagnostic? And under the law, you might want to just say, I'm not supposed to have to pay if something happens, like a polyp is discovered. Just point that out and help them remember that. And then ask them to see any paperwork upfront. Because one of the things that — I should say, *before* the exam — because one of the things that this woman found was that when she arrived at the hospital, she signed a bunch of paperwork. And then after the fact, they said, Oh, well, you signed something that said you agree to pay if we took out a polyp, that it would become diagnostic. She doesn't remember that. And who knows if she actually signed that. But if you get that paperwork upfront, then you can avoid that happening.

Rovner: So basically ... like everything else here, it's on you to basically know your rights and make sure that they don't try to take them away from you.

Andrews: Exactly. Alas, that's true.

Rovner: And if you have trouble, you can come to us.

Andrews: Yes.

Rovner: Michelle Andrews, thank you very much.

Andrews: Thanks, Julie.

Rovner: OK, we're back. It's time for our extra-credit segment, where we each recommend a story we read this week we think you should read, too. Don't worry if you miss it; we will post the links on the podcast page at khn.org and in our show notes on your phone or other mobile device. Rachel, why don't you go first this week?

Cohrs: Sure. So my extra credit is headlined "[Baby-Formula Shortage Worsened by Drop in Breast-Feeding Rates](#)." And this is in The Wall Street Journal by Jennifer Maloney. And I just ... it explains how, because of pandemic restrictions on how long new moms are in the hospital, that there's less time to adjust to breastfeeding, which has led to this transition over the past couple of years to fewer new moms breastfeeding and higher demand for formula. And then all of these issues that we've seen and talked about in the news have been exacerbated. So I thought it was really interesting to look at some of these — the root causes for how the market has changed. And certainly there's a lot of things unrelated — the factories and oversight, all of that. But I just thought this tie between the dynamics that we've seen in covid was just a really interesting idea and just made me wonder how many of these other downstream effects we're going to see down the road.

Rovner: So, Margot, your extra credit is related to Rachel's extra credit. Why don't you go next?

Sanger-Katz: Yeah, I was really interested in this project that Alyssa Rosenberg, an opinion columnist at The Washington Post, did with some colleagues to try to calculate the cost of breastfeeding. I think in this period in which formula has been in a shortage, it's been a kind of easy thing for people to say, "Well, like, why don't you just breastfeed, breastfeeding is free and then you don't have to deal with these shortages of formula?" And what she noted is that breastfeeding is only free if you assume that women's time has no value, and if you pay them for the time that they — or you assign some wage or some value to the time that they spend breastfeeding — actually breastfeeding can be quite expensive. Now, lots of people are likely to disagree about whether or not we should be assigning monetary value to this or whether there are other reasons why women should breastfeed. But I did think that it was a very nice way of thinking about this debate. There are lots of reasons why women choose to feed their babies in different ways, and breastfeeding is quite time-consuming. It does make very large demands on women throughout the day for long periods of time. It affects their ability to work and to do other things. And it is worth thinking about those costs as well.

Rovner: Yeah, I feel like a lot of women breastfeed anyway because it's good for the baby and if you can, you should. But it's certainly not something that's quote-unquote "free" or quote-unquote "easy." I mean, ... I think people, I won't say men in general, but people in general

underestimate what a chore that actually is since they don't have to do it. Sandhya, why don't you go next?

Raman: My extra credit this week is from News From the States. It's called "[From Skepticism to Insurance Denials, Long COVID Patients Face More Than Only Health Challenges.](#)" It's from Annmarie Timmins, and it looks at long covid in a way that I have never really thought about, which I think was super interesting. You know, the different obstacles that someone suffering from long covid faces, since you can't always clinically diagnose long covid in the same way as other diseases that you might have. So it's harder to get approval for medications for symptoms you have [with] long covid, or roadblocks to getting those covered by insurance, or having your employer understand that you're having some challenges with long covid. And not everyone even has proof that they had covid if they got it during a time when there were testing shortages. So I think it's a really interesting piece looking at some of those things.

Rovner: Yeah, I think there's way more to come on that. All right. Well, for the second week in a row, I'm going to recommend another podcast. This one is an episode of NPR's history podcast Throughline, and it's called, quote, "[Before Roe: The Physicians' Crusade.](#)" It's about how abortion was not illegal in the U.S. until the middle of the 19th century and how the effort to restrict it was made primarily by doctors, in many cases trying to drive midwives and other lay practitioners out of the medical market. Now, I know a fair bit about this history, but there are some interesting details in this podcast that were new even to me. It is quite a story and quite well-told, and there will be a Part 2, although they haven't released that yet.

OK. That is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review — that helps other people find us, too. Special thanks this week to our producer, Lydia Zuraw, filling in for Francis [Ying], who's taking some well-deserved time off. Also, as always, you can email us your comments or questions. We're at: whatthehealth — all one word — @kff.org. Or you can tweet me. I'm @jrovner. Sandhya?

Raman: @SandhyaWrites

Rovner: Margot?

Sanger-Katz: @sangerkatz

Rovner: Rachel.

Cohrs: @rachelcohrs

Rovner: We will be back in your feed next week. In the meantime, be healthy.