

## **KHN's 'What the Health?'**

**Episode Title:** A World Without 'Roe'

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**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 30, at 10:30 a.m., making sure we get in that very last Supreme Court case for the session. But 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.

**Margot Sanger-Katz:** Good morning.

**Rovner:** Sarah Karlin-Smith of the Pink Sheet.

**Sarah Karlin-Smith:** Hi, Julie.

**Rovner:** And my KHN colleague Victoria Knight.

**Victoria Knight:** Hi. Thank you for having me.

**Rovner:** Later in this episode, we'll have my interview with KHN's Angela Hart, who wrote the latest KHN-NPR "Bill of the Month" story about a pair of identical eye surgeries with not very identical price tags. But first, this week's news. We're actually not going to start with abortion this week, although we will get to it momentarily. The Supreme Court, just before we sat down to tape, decided its final cases of the term, including one that limits the ability of the Environmental Protection Agency to address climate change and possibly constrains what else government agencies can regulate. But it is a long and complicated decision, and we will save that discussion for a later time. So we *will* move on to abortion. We are coming to the end of our first week without *Roe v. Wade* since Richard Nixon was still president. It's hard to put into words just how much has changed, how fast. But we're going to try. Margot, why don't you start — and I know this is changing by the hour, but as of now, where in general is abortion still legal? Where is it illegal and where is it about to become illegal or at least sharply restricted? We have sort of buckets of states, right?

**Sanger-Katz:** There are buckets of states. So, there are 13 states that have these laws that are known as trigger bans. So these were laws that were passed before the decision came down and they were designed to be activated if *Roe* was overturned — then abortion would be banned in those states. And some of them have already gone into effect. Others are on a time lag. So we can expect them to start kicking in sometime in the next month or two. It turns out there's never been trigger bans before. This is a new legal way of doing things, and it turns out that there is some ambiguity in the wording of these laws, where it's not clear if the 30-day period begins when the court issues its opinion, like it did last week, or when a more official version of the decision is

finalized and printed. So different states are interpreting that differently. That's one chunk of states. Then there's a bunch of states that had laws that banned abortion from way back before *Roe v. Wade* was decided — some of them dating back to the 19th century. And those laws have just been hanging around on the books. And there's some ambiguity about the degree to which they can be reactivated and enforced. But in a bunch of states, they have been, and abortion providers have stopped providing abortions because they are concerned that they could be prosecuted under those old laws. And then there's a bunch of states that had laws that didn't totally ban abortion but that banned most abortions. So there are a chunk of states that have these six-week limits. So you can have an abortion within the first six weeks of pregnancy, but not afterwards. So some of those are in effect. And I would say all three of these categories of laws are getting tied up in the courts right now. There are legal challenges to all of them, to the trigger laws, because they're unusual and because it's such a big change to the old laws, because it's unclear whether a law that has been dormant for so long is still in effect — to these six-week bans because, you know, for other reasons. And then also, I do think in some of these states, there's a question about whether there is a state constitutional right to abortion. So there's no longer a federal constitutional right to abortion. But there might be some state supreme courts have found a right to abortion in their state constitution. So anyway, a lot of litigation happening right now. And so I'm almost reluctant to list the states that have switched off abortion because it's so fast-moving.

**Rovner:** And I'm reluctant to have you, for that same ... exact reason.

**Sanger-Katz:** But I think it is reasonable to assume that most of these states are going to ban abortion, whether it takes them a couple of weeks or a couple of months to fight through the court battles. Even if they lose, I think a lot of these states have legislatures that are committed to doing this. And so I think they'll just go back and pass another law that addresses whatever issue the court has identified as problematic about their current law. And, you know, estimates vary a little bit about what the landscape will look like when all the dust has settled. But people who really track state laws and the political climate in these states estimate that we're looking at somewhere between 21 and 26 states that are likely to largely or entirely ban abortion in the coming months, in a year or two.

**Rovner:** And I feel like it's important to add, because we keep seeing headlines about abortion rights groups are going to court in all of these states, and in many cases they are actually getting stays of these laws. But most of these stays are for 10 days or two weeks. I mean, these are not permanent injunctions on these laws yet. These are just brief stays while the court finishes whatever it is that the court is going to do. So even though you see these headlines that say abortions have resumed in Texas or abortion — I believe there was one this morning — abortions have resumed or can resume in Kentucky, we're also seeing a lot of providers just close up shop or close up shop and move to other states where they perceive they will be more welcome, right?

**Sanger-Katz:** Yeah, I think there are two things that are happening simultaneously here. One is there's just these debates about technically what is legal. Can this law be enforced? What does it mean? How does it match up with various other legal intricacies? And that is important. And I think, in the long run, it will be important for all of these laws to work their way through the court

system and for the courts to rule, OK, you as a state can or can't do this or that. But then there's facts on the ground. And so there are some of these states where the law really is ambiguous. And I think if you were a law professor, you could have a really smart conversation about why that law probably can't be enforced. But the reality is that the abortion providers are facing felony charges if they provide abortions, and they are wrong in their legal interpretation. And so, we see in states like Wisconsin and Arizona — these are states where there are these old laws, kind of ambiguous. I think there are smart people who think maybe they won't hold up in the end, but those providers have stopped providing abortion because they really just can't take the legal risk. And so if you're a woman living in one of those states and you want or need an abortion right now ... it doesn't really matter to you what the legal intricacies are. What really matters [is] where abortions are being provided that is near to you. And so, for me, when I look at the map, I'm trying to think about where are there still abortion providers. Less so than where is there a law.

**Rovner:** Right. So the Biden administration is managing to do something I did not think was possible in this very polarized abortion debate — irritate both sides. On the one hand, from the president to the secretaries of Health and Human Services, Treasury, Labor, and the attorney general, they've said very strong things in favor of the right to abortion and expressed anger, disappointment, and frustration with the Supreme Court's decision striking down *Roe* and its successor case, *Planned Parenthood [of Southeastern Pennsylvania] v. Casey*. But at the same time, we've all known this was coming for months. We've been talking about it here, and we've known it pretty certainly since the draft opinion leaked in May. Yet the administration still seems to be trying to figure out what it can and cannot do to ensure women's rights to birth control, much less abortion. Victoria, you were at HHS Secretary Becerra's press conference on Tuesday. He didn't seem to have much to offer in the way of specifics, did he?

**Knight:** He definitely did not. And there was a sense of frustration among the reporters, I think. And he really wouldn't give us much details on things that they've talked about that they want to do. But when we asked for more specifics, he really couldn't give much more than, "Yes, we're going to expand access to medication abortion. Yes, we're going to do everything we can to protect women who might travel to other states to get abortions." But when you try to dig in and get more info, he really wouldn't give a lot and kept referring to the president and saying it's a conversation we're having with President Biden. And as you said, they've had a lot of months to prepare for this, so it's not clear why they're still having those conversations.

**Rovner:** So a lot of progressives have been pushing this idea of building abortion clinics on federal property. But that's not as easy as it seems, is it?

**Knight:** No. That's actually what I asked him about at the press conference, asked Secretary Becerra. And he would not say that they definitely weren't going to do it. He left it ambiguous, so as a possibility potentially. But as you all have seen this week, it seems that the Biden administration, it's not something they really want to pursue. They're saying that it would leave providers up to potentially be criminalized for providing abortions even if they did it on federal land. It seems like that's up in the air for a legal interpretation, if that's actually true. But that's the line they're taking at least this week right now.

**Rovner:** And Margot is sending me a note ... something I was going to mention anyway, which is I have covered the Hyde Amendment in all of its various iterations since the 1980s, and I think people don't appreciate how embedded it is into federal law. It's not just you can't spend federal money for abortions for women on Medicaid, it's buried in all of these appropriations bills, things that you can't do. In the military, women can't use military medical facilities to get abortions even if they pay for it themselves. That's a fight that's been going on for 20 or 30 years. So I think it would be harder than it looks to just ... There was a piece I saw ... "Let's go to Yellowstone Park and open up a quickie clinic." It's not that easy. And even though it's federal property, there are all kinds of other constraints on it. The other thing the administration has done this week is put out information on how to protect your privacy for your reproductive health records. That is something that the administration can do and that women can do, right?

**Knight:** Yeah, absolutely. That is one thing that is definitely within women's power to somewhat try to control. It's difficult because your phone, you take it everywhere with you, and you probably need it if you are going to navigate to an abortion provider. But there are some certain steps that you can take to reduce the amount of data that you might have on your phone if you do need to go seek an abortion. And they did release some guidance on that.

**Rovner:** Well, now that *Roe* is formally kaput, to use a legal term, and abortion rights supporters are mostly pointing fingers, the anti-abortion movement isn't missing a beat on its momentum. I have not seen efforts to declare personhood for embryos yet, although I still think that's coming at some point. But, meanwhile, there are model state laws being written that would allow people to sue anyone who helps a woman get an abortion across state lines. Former Vice President Mike Pence has already called for a national abortion ban, and many of the bans going into place include exceptions only for the life of the pregnant woman, not for rape or incest or her health. This is a lot more draconian a lot faster than I think even I imagined. Is there any chance that they're pushing too far too fast, that there could be a backlash from this?

**Sanger-Katz:** I think that is very much the hope of Democratic politicians and, of course, abortion rights activists, that the very fast and extreme nature of these legal changes might activate voters who had not been paying a lot of attention to this issue before. We know in public opinion polling about abortion that there is some ambivalence among the public about abortion. I think people have complicated and relatively nuanced views about it, but two-thirds of Americans support a legal right to abortion in at least some form. And fewer than 10% of Americans support total abortion bans. And I think, again, I was talking about this landscape of states and what they're doing. What we're seeing for the most part is really a pretty binary choice between preserving the current legal standard that we've enjoyed under *Roe* for the last 50 years, which is abortion is very easily accessible to women until relatively late in their pregnancies, and then states that really are going for bans that approach total bans. As you said, all of them have some exception to save the life of the mother. Some have exceptions to protect the victims of rape and incest. But those are kind of narrow exceptions. And I think in an environment where (a) all of the abortion clinics have closed and (b) providers are facing really substantial criminal legal liability if they make a misjudgment or if a prosecutor or a jury or a judge disagrees with their judgment, I think we really are looking at laws where very few abortions are going to take place, even if they technically fit

into these exceptions. And that is not really where the American public seems to be. So I think it will be very interesting to see how this plays out politically. There are a lot of Democratic politicians and activists who are hoping that this will be an issue that will bring Democrats to the polls in the coming midterm elections. But I do think for the most part, policy around abortion is likely going to be determined at a state-by-state level. And it is a little bit hard for me to imagine the politics of some of these states changing radically enough for there to be majorities to overturn these laws even if they turn out to be pretty unpopular in those states.

**Rovner:** Yeah. Well, it looks like one of the biggest fights is going to be over the future of the abortion pill, mifepristone, which is how a majority of abortions are now conducted in the U.S. There was no abortion pill in 1973 when *Roe* was decided, and pills can be sent through the mail, although that's not always legal. So how do abortion opponents plan to stop this, and how do abortion rights proponents plan to keep those pills available? Victoria, you've been looking at this whole federal preemption versus state ban question, right?

**Knight:** Yeah, absolutely. And I think it's somewhat still to be determined what states are going to do about abortion pills specifically. As Margot has pointed out, there's these trigger bans going into place. If they're outright banning abortion, it seems likely that pills are involved in that. But because these just are being implemented, it's still kind of playing out how they're going to be enforced and what all that involves. But the Biden administration took a really strong stance last week, on Friday when the opinion came out, saying states are not allowed to ban these abortion pills. Attorney General Merrick Garland came out with a statement outright saying that and saying we are not going to let states stop the use of these pills, which have been approved by the FDA. They are safe. Since 2000, they've been approved by the FDA, so it's been awhile. And so basically it all comes back to this preemption argument, which is that if the federal government has authority over certain things, more than a state does. So because the argument in this case is that because the FDA has approved this medication, that authority preempts a state's authority to try to ban the use of this medication. And there really is not much legal precedent for this argument. There's been, as far as we're aware of, just one case in Massachusetts a couple of years ago — the state tried to ban the use of an opioid, and that was not allowed to happen. It was found that the state could not ban the use because of this preemption argument. But it seems likely if the [Department of Justice] tries to pursue that and sues states that try to ban the use, it's going to be tied up in courts. And we're not really sure what's going to happen. But it sounds like the Biden administration really strongly is going for this.

**Rovner:** And the makers of the abortion pill are going for this too, are suing in Mississippi.

**Knight:** Yes, there is a case in Mississippi that's been ongoing for a couple of years, I believe, and that's the argument they're using, this preemption argument.

**Rovner:** So there's another problem, a potential problem, with the abortion pill. It is safe and effective, says the FDA, but only when taken exactly as directed and with available surgical backup if the method fails, which it sometimes does. Women getting pills in the mail and taking them without medical supervision could result in a far higher complication rate, according to a [new article](#) in the journal *Health Services Research*. Quoting from the article, which comes from an

abortion-rights-supporting doctor in Canada, “Treatment failure will inevitably occur for a meaningful number of patients, and some of the adverse outcomes we currently view as rare may become more prevalent when patients are suddenly left without personalized access to providers and essential supportive care. In short, the medication abortion of the future may not be the same procedure responsible for generating such reassuring statistics.” We were talking about how going too far too fast could backfire on abortion opponents — this could backfire on abortion rights supporters, couldn’t it?

**Knight:** I think that's certainly possible. I know in states where abortion is getting banned, places like Planned Parenthood are planning to serve as a resource if someone takes an abortion pill and is having complications. So they can maybe safely go to a Planned Parenthood and get care if they're worried about going to an ER and running into legal trouble. So, I don't know. But I know there's going to be safeguards in place. I think there's going to be underground networks of people, I believe. So, I don't know.

**Sanger-Katz:** And there's some history in other countries. So, the United States is not the only country where abortion has become illegal. There are other parts of the world where abortions have been banned for some time or where abortion care is like technically illegal but not very accessible. And these pills have been sort of distributed and used through underground networks in a number of countries in South America, in Africa, in Mexico until recently. And when you talk to the workers who have been involved in those efforts and the researchers who have studied them, they actually have found better efficacy numbers than what we saw in clinical trials in the United States. And I think the reasons for that are complicated and worth investigating. I think it's not entirely obvious who is right about this, but I do think that there is some precedent for the use of these pills without the kind of medical supervision that the FDA has asked for. And certainly we're going to see — I think there's no doubt that many more women are going to obtain these pills through legal channels, through telemedicine. But they might be pretty far from the provider or pretty far from a surgical provider if things go south. And I think it also seems entirely clear that a lot of women are also going to purchase these pills through a kind of extralegal methods by ordering them from internet pharmacies overseas and administering them themselves. And I guess we'll see what the effectiveness profile looks like.

**Rovner:** We're going to run this enormous clinical trial whether we want to or not. It's sort of a naturally occurring clinical trial. Speaking of confusion, things are getting really messy out there. In Missouri, one hospital chain briefly stopped providing emergency contraception, which is not the abortion pill and does not end an established pregnancy, before reversing itself later in the day. Employers are vowing to help workers leave ban states for abortions in other states. But it's confusing how that could work. Do you go to your boss and say, “Hey, I need to take a few days off next week to go get an abortion?” That feels a tad awkward. Do we have any feel for how this might actually play out?

**Sanger-Katz:** There is just an environment of real uncertainty right now about what is legal and illegal, and there are not the same rules that existed before. So, under *Roe v. Wade* — I think there are a lot of people who disagreed with what the finding of the court was, but there was this relatively clear standard about what was legal and illegal at various stages of pregnancy. And in

these state laws you see standards for a definition of pregnancy that seem to be fertilization. That's very early in the reproductive process. And I think that is just a stage where a lot of medical providers really aren't sure whether the care that they routinely deliver is on the right or the wrong side of that limit. Are certain kinds of contraception potentially going to expose them to legal risk? Is IVF and other forms of fertility treatments going to place them on the wrong side of that risk? And so, for a lot of medical providers who don't want to go to prison, I think we're going to see them potentially correcting and in some cases overcorrecting and denying women care that is allowed or that should be allowed. I do think in the case of contraception, this is another area where you see the federal government shouting from the rooftops, "No, this is all FDA-approved. Insurance has to cover it. Medicaid has to cover it. Hospitals should provide it." But at the same time, if you're a doctor and you're looking at a 10- or 15-year prison sentence if you make the wrong decision, it is really hard to know who you should listen to. Should you listen to your state official, to your local cops, to your local prosecutor, or to what the FDA or the Health and Human Services secretary is saying in a press conference?

**Rovner:** This is obviously just the very beginning of this conversation, and we will all see how it plays out in the coming weeks and months and possibly years.

Well, in other news and, yes, there is other news this week, we got a gun bill. You might have missed it partly because President Biden signed it on Saturday morning just before leaving for his European trip and partly because it came right after the Supreme Court effectively struck down several other states' gun laws. But while this gun bill, the federal one, might not do a ton to actually regulate guns, it does include a lot of money to beef up mental health care, right?

**Knight:** Yeah, I actually am working on a story on this right now, but it does a lot to beef up mental health care — or it appears that it's going to. Most of the funding is actually allocated toward a bunch of different mental health programs that are already existing; it's just going to beef up that funding for them. And so a lot of them are school-based. So, to get more counselors into schools or to connect students with resources inside schools. Also, a lot of telehealth for kids in rural areas where it might be difficult to access a provider, a mental health provider. There's a lot of different things in the bill, actually, that are mental health-related. Oh, and another big thing is the ability for states to get a certified community behavioral health clinic, which is a pilot Medicaid program that is in 10 states. And there's an option for states to get that program if they don't already have one right now. And so those clinics provide 24/7 behavioral health care. Anyone can show up and be treated. So that's a potential option also.

**Rovner:** Yeah. I mean, we obviously — and we've talked about this at great length, that mass shooters aren't necessarily diagnosed with mental illness prior to their mass shooting. But that doesn't mean that we don't have a mental health crisis. So whether or not this does anything about gun violence, it could at least address the mental health crisis that's going on, right?

**Knight:** Well, and one big thing, when I talk to researchers, they said it definitely has the potential to reduce the number of suicides, for sure, because behavioral health interventions can help prevent suicidal ideations, but also the potential for states to implement red flag laws if they don't have those already. Red flag laws are shown to take away guns from people who may be having

suicidal thoughts. And so it definitely has the potential for that. But as you said, there is a very low percentage of people with serious mental illness that commit violent crimes. And so it may not do as much to prevent mass shootings in that way.

**Sanger-Katz:** I just feel like we always end up dismissing that as like a side effect of these policies, but I just want to say out loud that mass shootings represent like less than 1% of the deaths from gun violence in this country and suicides represent about two-thirds. So suicide is a huge public health problem. Suicides by gun is a huge public health problem. And policies that reduce the likelihood of suicide death could save a lot of lives.

**Rovner:** Yeah. I feel like in some ways this gun bill is like the Affordable Care Act. It doesn't "solve the problem," but that doesn't mean it doesn't do a lot of important things.

**Karlin-Smith:** I think the worry among people pushing for stronger gun reform is just that because the bill is so mental health-focused, people come away with the impression we addressed the cause of mass shootings, we addressed these big events like the ones we've been so focused [on]. And that's where people say, "Wait a second — mental health isn't really going to solve that problem. And we didn't probably do enough to solve that problem." I think that's the point — yes, this bill probably does a lot of good for certain populations and certain public health and gun problems, but it doesn't actually really address the core one that sparked this latest attempt to get something done in Congress.

**Rovner:** Exactly. But they got something done in Congress.

All right. Well now let us turn to covid, which, yes, is still with us. While just about everybody else in Washington was watching the Jan. 6 hearing on Tuesday, Sarah, you were watching the FDA advisory committee meeting on the next covid vaccine. What did we learn?

**Karlin-Smith:** Right. And so actually, we delayed our podcast for the Supreme Court, but it actually helped because the FDA also took some late action this morning, deciding to go with their advisory committee recommendation from early in the week and recommend that covid vaccine manufacturers update their vaccines for the fall so that people can get boosters with a new what they would call a bivalent vaccine, or two-strain vaccine, where you essentially include the old vaccine component, which targets the original or wild-type Wuhan strain of the virus that causes covid, as well as adding in a component directed at omicron. In this case, they went with the BA.4 and BA.5 sublineage of omicron, which is the latest variant that's really impacting or expected to be impacting the U.S. going forward. The original omicron is on the downfall at this point. So it's interesting because what this means is that we're probably going to get updated vaccines in the U.S. that come to patients without any actual clinical trial data in humans. So it's going to be based — their approvals essentially at this point because of this opinion, I mean, that companies just don't have time to do this clinical trial work. They've been focused on the older omicron variant, but this virus is moving so fast that by the time you get those studies done and ready for FDA, what we've seen now is the committee is saying, well, this is going to be outdated. We need a different approach. And another thing is it's going to be a huge manufacturing challenge for them to switch in the fall. And we've heard all along that one of the great things about mRNA vaccines,

which is the two main vaccines we've been using in the U.S., is that it allows companies to pivot and make manufacturing changes and so forth faster. That is true, but it still takes a number of months. So it's going to be a crunch, if you think about the timing right now. We'll see what happens as this moves forward over the next few months. But people should be able to expect, at least for a certain population of Americans, that there may be an updated booster that gets people a little bit more protection.

**Rovner:** There was some talk last year of trying to combine the covid booster with the flu shot, the annual flu shot. I take it that's not happening this year.

**Karlin-Smith:** I know there are some companies working on that, but as far as I'm aware, nobody again is going to have that ready in time for this season.

**Rovner:** So is this booster going to be for everybody? I mean, I got a fourth shot because I'm old.

**Karlin-Smith:** So even at the FDA advisory committee meeting, the folks who — and it was the majority of the panel, 19-to-2, that voted to update the vaccines in this way — a lot of people are saying we think we need to move in this direction and update the vaccines, but we're not entirely sure when we should pull the trigger on using them and then who we should use them [on]. And so some of that is going to come down to CDC [the Centers for Disease Control and Prevention]. Also, again, just a caveat, FDA saying telling the companies to update their vaccines in preparation to submit them to them and hopefully get authorization in the fall. They still have to actually give FDA what data they have, and FDA has to authorize them. And then CDC, as we've seen with these vaccines, takes the reins. And they'll probably provide more guidance as to who they think in the U.S. should get it. And it's possible they might just say people above a certain age, people with certain illnesses should get it. And part of the reason why that might happen is, actually, I know as much as people are frustrated with the vaccines, to some extent, they are still really, really good at preventing severe disease, death, hospitalization. You know, they're not as good at preventing people with the new variants from getting infected. So people are getting sick who are vaccinated, and that's frustrating. But for the most part, they're not having really terrible outcomes. So that's one reason we may see less people recommended. It's also been quite publicly reported that it's not clear how much money the Biden administration has to purchase these new vaccines. So another problem we might just run into is logistics around supply, both, like I said, from the manufacturing side of how fast they can come out there. But also in terms of the U.S. government of how much they would even have, whether they could give one to everyone who wanted it.

**Rovner:** One broader covid question this week, [Ed Yong over at The Atlantic writes](#) that we're now in the, quote, "Figure it out yourself," quote, phase of the pandemic. First, the public and now the policymakers all seem to have moved on, except, as we've said, covid is still with us, still infecting people. People are still dying. This line from Ed's piece really struck me, quote, "America's recurring mistake is to create such technofixes at warp speed, while neglecting the systems that actually deploy those tools." Are we too far gone to regain any trust in our public health system? Because that's what it's going to take at this point to get these things out. I mean, it's amazing and magical that we have these vaccines that they can pivot and then they can, you know, adjust to some of these new variants. But if people have literally moved on, what is the point?

**Karlin-Smith:** I think it is a precarious time because you have different groups of people with different philosophies that are frustrated with the government and the pandemic response. You have people that initially thought the government overhyped covid and the threat of covid and didn't take it seriously and didn't want to mask and was not very interested in vaccines. And you also have a lot of people now that are frustrated with how public health agencies are responding and issuing guidance to the virus. That sometimes seems like it's based more on trying to keep the U.S. economy intact than necessarily control covid and keep people's public health at stake. So you have people that are inclined to trust public health authorities, like FDA, like CDC, that are not really sure when they should or shouldn't trust them now. You see tons of scientists like Eric Topol constantly [garble] the CDC for still not updating its isolation guidance and quarantine guidance related to how long you're likely infectious. They say after five days, you can probably leave your house. And people are saying, no, no, a lot of people are quite infectious after that. So I think that's a big problem. And even, you know, I'm curious to see what happens with these updated vaccines, because, again, they're going to be likely cleared with a lot less data than we would expect for fairly new vaccine platforms and some very, again, prominent champions of vaccines and members of the FDA committee like Paul Offit, I think, raised some of those concerns about how much safety data we'll have on these products and so forth going forward. So I think they're in a really tricky situation because they've frustrated so many different groups of people.

**Rovner:** Yes, I think frustration is the watchword of the week. All right. Well, that is the news for this week. Now we will play my "Bill of the Month" interview with KHN's Angela Hart, and then we will come back for our extra-credit segment.

We are pleased to welcome to the podcast, my KHN colleague Angela Hart, who reported and wrote the latest KHN-NPR "Bill of the Month." Angela, welcome to "What the Health?"

**Angela Hart:** Thank you.

**Rovner:** This month's patient had one of the most common surgical procedures adults get — so common that his wife actually had the same procedure within months of his surgery. Tell us who they are and what brought them to the medical system.

**Hart:** Yeah, this is a couple from Fresno, California. His name is Danilo Manimtim. And his wife is Marilou Manimtim. He is in his early 70s. She is in her late 60s. And what you might consider as you get a little bit older, having a little bit of blurred vision, both knew that they were going to need cataract surgery. And Danilo, the primary focus of my piece, decided "It's the end of the year. I've already met my deductible for the year. May as well get it done, pull the trigger." And he was expecting to pay some bill, a few hundred dollars, perhaps, but he got slammed with a much bigger bill than he was expecting.

**Rovner:** He's a retired surgeon, right? This guy is a doctor.

**Hart:** Yeah, this is someone who knows the health care system, who has worked in the health care system. He even did more than, I think, what many other people would do. He actually called his insurance company to inquire about his deductible to make sure he met it. And there were some other questions that didn't get answered that he didn't know to ask. This is someone, again, who

even ... someone who knows the health care system. So imagine how difficult this maze must be for someone who isn't as familiar.

**Rovner:** That's right. And he went to an in-network hospital and he still got a really big bill. How much was his bill?

**Hart:** His bill was over \$4,000. And that's just what he was being charged. His overall bill was over \$9,000. And that's a lot for any cataract surgery. As several experts told me, really, I think what it amounts to is this health care provider charging essentially what they can, what they could charge.

**Rovner:** And when his wife got virtually the same surgery with the same insurance, but at an outpatient center rather than a hospital, just a few months later, she was billed how much less?

**Hart:** She was billed a little over \$200. So, I mean, his was in the thousands, hers was in the low hundreds. And these two different provider offices — one is a hospital and one is an outpatient surgery eye clinic located less than a mile from each other in Fresno. And because ... the couple had already met their insurance deductible for the error, they thought, no harm, no foul, let's go where we want to go without really thinking twice about it. And they turned out to just lead to dramatically different experiences.

**Rovner:** Now, a big part of this was going to the hospital rather than the outpatient center, right? I assume there was a big facility fee attached to this.

**Hart:** Yeah, the hospital definitely charged the bigger amount.

**Rovner:** But there's also something involved in this called "reference pricing" ... I think that's what you were alluding ... that he didn't know that he needed to ask about. So what is that and how do you know if your insurer has it?

**Hart:** Yeah. And this is, I think, one bigger point that I heard from several experts talking to them about this bill and the quandary that this patient found himself in, is you get sticker shock more than one place in the health care system, right? It's not only about your deductible. You also have to ask about things, about your coinsurance. And yeah, reference pricing comes into play. Essentially, this is when a purchaser is setting the price on what they're willing to pay for a specific procedure or type of health care service. And this patient's case has a limit for cataract surgery — \$2,000 — and that's \$2,000 that he didn't know about. So that's foul one. Foul two, I think, is the provider's side, where the doctor could have offered this patient an exemption to get out of this maximum payment that they would allow. And that didn't happen, either. So this patient got a double whammy there.

**Rovner:** I mean, the irony here is that reference pricing is supposed to encourage patients to shop for the best price.

**Hart:** Exactly.

**Rovner:** Isn't that the idea behind it?

**Hart:** Yeah, that's definitely part of it. But what actually happens, in reality, sometimes it's much different.

**Rovner:** So what eventually happened with this bill?

**Hart:** So we contacted the insurance company, Anthem, and we also contacted the hospital and the provider and they put their heads together and retrospectively they went through the exemption form for this patient. And he did have also something called coinsurance. So he had a coinsurance payment of about \$750 that when, all is said and done, that's all he essentially was charged.

**Rovner:** Still a lot more than his wife.

**Hart:** Still a lot more. And the hospital still got paid that big chunk. It was the insurance company paying it, not the actual patient.

**Rovner:** How do you prevent this from happening to you? This is yet one more of these traps that it looks like anybody can fall into.

**Hart:** And there are several of these sort of pricing traps in the system. I think the one thing that I heard from everybody loud and clear is: Ask questions, understand your plan, do your best job you can advocating for your own understanding of what you're actually being billed. Don't just pay it. If you have questions, you can ask questions and you can even ask questions after you've had a certain bill or certain procedure done. And I think also just understanding on a higher level that there are several ways that patients are slammed with charges. And their coverage — and that's not only looking at your health insurance premium, which ... this patient was really focused on his premium and having met his deductible. But there are all these other hidden costs that might not be as obvious. So it's very important to contact your health plan, your provider, and find out not only if there are things available, for example, for low-income patients for charity care, but maybe there are exemptions that your health plan would allow you to actually pay less.

**Rovner:** Good.

**Hart:** It doesn't say anything about driving up the costs of the health care system overall. Someone's still picking up that price tag, but it's not this patient this time.

**Rovner:** Yeah, well, that's a bigger problem. Fixing the health care system overall. At least for here, we're trying to allow patients to not have it fall on them to the extent they can.

**Hart:** And I think it does highlight another thing that I think we all know, but in stark examples like this, it really highlights that you can, in this health care system, get the exact, essentially the exact same care at Point A and Point B with no difference in the quality yet pay such dramatically different prices. It really makes you question, as some experts also question, it really makes you wonder what the rationale is for any of the prices that doctors are setting, hospitals are setting, insurers are setting.

**Rovner:** Well, it looks like both members of this couple can now see better in different ways.

**Hart:** Definitely.

**Rovner:** Angela Hart, thank you so much.

**Hart:** Thank you.

**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](http://khn.org) and in our show notes on your phone or other mobile device. Sarah, why don't you go first this week?

**Karlin-Smith:** Sure. So I took a look at a piece called "[Why Should You Stop Frolicking in Miami-Dade Floodwater? It's Probably Full of Poop](#)," by Alex Harris at The Miami Herald. And it's about the ever-increasing flooding of South Florida streets and the quite gross and potentially dangerous-to-your-health products and bacteria and everything else that could be in it.

**Rovner:** It's not just your average fountain, right?

**Karlin-Smith:** Right. I mean, the sewage and all the just disgusting and unhealthy stuff getting in it. And despite that, I guess, people are blissfully unaware and it's normal for them to try and kayak or paddle board in the streams that regularly go down their streets. And the story is really interesting because it goes through, you know, I think some really big gaps in our public health and water monitoring systems in that a lot of this floodwater is not being really accurately and scientifically tracked. And we need to do a better job because, the piece points out, things are only going to get worse due to climate change, particularly in this area. And it's a bit scary. You almost start to think, should people be living in some of these areas given the degree of problems that are described and also just the lack of preparation to help keep people healthy there?

**Rovner:** Yeah. Victoria.

**Knight:** The article that I read this week is called "[2,000 Leaked Documents and Employees Say Silicon Valley Healthcare Startup Cerebral Harmed Hundreds of Patients and Prescribed Serious Medication With Abandon](#)." And it is by Shelby Livingston and Blake Dodge of Insider. This continues Insider's really amazing investigative coverage of Cerebral, which is a health care startup. It started right before the covid pandemic, and they basically took advantage of a federal regulation which allowed prescribers to prescribe certain really serious medications remotely via telemedicine rather than having to have an in-person meeting before prescribing the medication, which was the rule before covid. So, basically, this startup was aimed at helping improve access to mental health care, and it took on patients with different mental illnesses and then prescribed them medications. But basically this reporting found that they were really just prescribing; the providers who were prescribing things weren't necessarily always qualified to be treating patients with really serious mental illnesses. It's another case of a startup that sounds like it was just moving too quickly, growing too quickly, and it was reaching a lot of patients that needed mental health care and hadn't had treatment before, but it wasn't always treating them well. So, specifically, they were sometimes giving medications to patients that they didn't necessarily need or co-prescribing things that maybe would have interactions and could really harm patients. There

were accounts of patients going to the ER or different things because they weren't prescribed accurately or they hadn't looked. It was just a lot of carelessness, it seems, on the part of some of these providers. And also the company was just always trying to get as many people signed up and also get as many providers signed up to prescribe things, is what it appeared. And so the story really relied a lot on internal documents that they got access to and employee interviews. And so, earlier this year, it actually was announced that the company is under investigation by the Drug Enforcement Administration because of all of this that we just talked about. So it's a really excellent look at how this startup is not ...

**Rovner:** Yet another example of good ideas gone wrong in health care. Alas, we've seen many of those.

**Knight:** Exactly.

**Rovner:** But this is a particularly good example. Margot.

**Sanger-Katz:** I wanted to draw everyone's attention to a really wonderful story from about 10 days ago in The Washington Post called "[This Texas Teen Wanted an Abortion. She Now Has Twins.](#)" It was written by Caroline Kitchener. And it is a portrait of a young woman who wanted to get an abortion right around the time that Texas imposed its six-week abortion ban. So that was last fall. And so she has young infant twins that she had not planned on having. And it's just a very close and beautiful portrait of what her experience has been like, both the real challenges, I think, that she faces with her family situation, with poverty, with interruption of her education and some of her plans. But also, I think, her real joy in motherhood and love for her babies. And I think it's just a very sensitive portrait of a person whose story, you know, we're likely to see replicated around the country again and again as abortion access goes away. What's going to happen to some of these women who would have had abortions in the past and now don't? And I think it also raises some interesting questions about where the pro-life movement might go from here and what kinds of obligations they have to try to help these women and their children that are now going to come into this world and wouldn't have before. This story features a crisis pregnancy center, which advised her against traveling out of state for an abortion. I think, you know, these kinds of organizations are very prolific already and I think are going to become very important in some of these states that ban abortion. It's very ... it will be interesting to see what role they're going to play in advising women and also in helping them with what comes next.

**Rovner:** Yeah, it's a really well-done piece. I was sort of taken with it. It was on the front page of the Post. Mine is also from The Washington Post. It's by Erin Blakemore and it's called "[Women Are Still Underrepresented in Clinical Trials.](#)" And it's about a study in the journal Contemporary Clinical Trials that found between 2016 and 2019, researchers continued to find gaps in female participation in trials of treatments for cardiovascular disease, psychiatric disorders, and cancer. This topic is particularly personal for me as a female health policy journalist. I covered the debate in 1993 when Congress mandated for the first time that women be included in clinical trials. They had been excluded for generations because they were worried that their reproductive abilities would confuse the results of the trials. I won an award for a story I did in 2015 that showed that NIH [the National Institutes of Health], despite orders to do so, wasn't making clinical trial data

available in a way that allowed the results to be analyzed by sex, which kind of defeats the purpose of having women in your clinical trials. And now it seems that women still aren't being included the way they were supposed to 30 years ago. End of lecture. Good story.

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, as always, to our crack producer, Francis Ying, without whom there would be no podcast. And while we're handing out thanks, this week marks the fifth anniversary of our “What the Health?” podcast. I want to thank Margot, who was there at the beginning, and all of our panelists over the years. Such smart women reporters all. But mostly I want to thank our loyal and *mostly* supportive audience, even if you haven't heard every episode. As always, you can email us your comments or questions. We're at [whatthehealth](http://whatthehealth.org) — all one word — [@kff.org](mailto:kff.org). Or you can tweet me. I'm [@jrovner](https://twitter.com/jrovner). Victoria?

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