

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

**Episode Title:** A Big Week for Biden

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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, Aug. 11, at 10 a.m. As always, news happens fast, even in August, and things might have changed by the time you hear this. So here we go. Today we are joined via video conference by Rachel Cohrs of Stat News.

**Rachel Cohrs** Good morning.

**Rovner:** Alice Miranda Ollstein of Politico.

**Alice Miranda Ollstein** Hi, Julie.

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

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

**Rovner:** So, no interview today, but more than enough news, so we will get right to it. It's been a very big week for the Biden administration. The president finally tested negative for covid following his rebound infection and managed to have signing ceremonies at the White House for the "chips" bill to address the semiconductor shortage and authorize funding for research. Plus, the PACT Act that will finally provide health benefits to veterans who got sick from exposure to toxic burn pits overseas. And, barring something unforeseen, next week he'll get to sign the Inflation Reduction Act, which most experts say won't really do that much to reduce inflation, but which does represent some major steps forward on health and climate change. The bill passed the Senate in a rare Sunday session, and it's scheduled for a House vote on Friday. Rachel, we have talked at length about what's in this bill for health care — some provisions that would allow Medicare to negotiate prices of some drugs and limit out-of-pocket costs for Medicare patients and to extend for three years those expanded subsidies for premiums under the Affordable Care Act. But not every health provision made it into the final bill. So catch us up on how this thing finally made it across the Senate finish line and what we can expect in the House.

**Cohrs:** Sure. There was some chaos, I think, as we kind of expected with the Senate parliamentarian. I have been waiting for this ruling on the commercial market, essentially, side of the drug pricing. And Alice had, too, since like November, December time, because I think everyone expected that there might be some challenges there.

**Rovner:** I'm going to give my little reconciliation lecture, because nobody understands it, about the budget process, which is: The budget process consists of the appropriations, which are the spending bills, and taxes. And the way the budget works: There's mandatory spending that is not touched by the appropriations. So what reconciliation is, it's a way to reconcile the budget

document, the budget resolution that Congress passes, with mandatory spending and taxes. So therefore, if it's not mandatory spending, it generally can't go in reconciliation. OK, Rachel, pick up where you were.

**Cohrs:** Sure. So I think there were two big provisions that — like, Medicare is mandatory spending. So that is pretty baseline. Everyone expected that those policies would continue.

**Rovner:** Right. You can pretty much do anything you want to Medicare in reconciliation, anything you want to. Medicaid in reconciliation.

**Cohrs:** Yes. Right. But there were a couple provisions Democrats were trying to advance that would have affected employer-sponsored insurance, people who use, I think, the ACA markets as well. So just non-Medicare patients is kind of how they're described. And one of them would have applied to a policy that penalizes drugmakers for hiking their prices faster than inflation. So the formula they used to calculate those penalties had Medicare units and private-market units of drugs in the formula initially. But the parliamentarian said they couldn't count the commercial units. So the Democrats just took it out when she ruled against it. The parliamentarian also ruled against a second policy that would have capped costs for insulin for patients in the private market insurance at \$35 a month. That she also ruled against. But Democrats decided to just stick it in the bill anyway and make Republicans vote to strike it out, which they did. There were a lot of headlines that were negative: The Republicans Vote Against Insulin Cap. And it's true. If Republicans had given it 60 votes, then it could have passed into law.

**Rovner:** That's right. I mean, the other thing to remember about reconciliation is that you can have things that don't technically belong in reconciliation by, quote-unquote, "waiving the budget act." But you need 60 votes to waive the budget act. I've seen it happen.

**Ollstein:** And if they had 60 votes, they wouldn't have done a reconciliation bill in the first place.

**Rovner:** Exactly. Well, there was all this I wanted to talk about insulin, because insulin had been moving on a separate track, right? Because there was a bipartisan bill that they thought they had 60 votes for. Is it possible that, I mean — we should say: This bill will cap insulin costs for Medicare patients at \$35 a month, but it won't cap insulin costs for anybody who's not on Medicare. Medicaid is a whole different thing. I mean, they're already protected. But for people in the private market, it won't affect them. Could there still be legislation coming to cap insulin costs for everybody else?

**Cohrs:** Yes.

**Ollstein:** There could be. But I think that it will mirror what we just saw, where the purpose is to put the bill on the floor and hold a big, splashy vote so they can show Republicans voting against it and run ads about Republicans voting against it. If there was sufficient Republican support to get it across the finish line, it would have happened months ago. I mean, we all remember when [Senate Majority Leader Chuck] Schumer promised to vote on that around Easter, and that never happened. And so this is the [Republican Maine Sen. Susan] Collins [and Democratic New Hampshire Sen. Jeanne] Shaheen bipartisan effort that really never went anywhere because of a

lack of support on the GOP side. That said, the other thing I've been hearing from patient advocacy groups saying, yes, we understand that Republicans are the ones that blocked putting the cap on out-of-pocket costs in the commercial market, where most people get their insurance, and limiting it just to Medicare. However, they do fault Democrats for not including in the reconciliation bill itself, what was in the House version, which specifically told Medicare to negotiate insulin prices. They said that wouldn't have been a parliamentary problem because it just involved Medicare. We don't understand why they didn't do it. Yes, it's good to cap out-of-pocket costs, but that doesn't get at the underlying costs of the drug. And they're a bit baffled as to why that didn't go in the bill itself.

**Rovner:** One of the issues here is that when you only deal with Medicare, you get this, what we call, "cost shifting." Usually cost shifting has to do with hospitals. They don't make enough for Medicare. They raise their prices for the privately insured. There's concern that the same thing could happen in the drug market, right?

**Karlin-Smith:** Yes. So there has been some concern about that. But actually, a lot of the people that analyze and follow this market have basically said they think there's probably fairly little wiggle room for that because, basically, the idea that drug companies can raise the prices more in the private market because of this Medicare negotiation implies they're leaving something on the table now, when they do their negotiations in the private sector. And there's no reason to think drug companies are being nicer to the private commercial markets in the U.S. just because they get more money potentially from Medicare now than they'll be getting under the bill. So I think people really, on all sides of this debate, don't see that as a huge threat. I mean, there are other ways the drug companies may be able to offset the threats in this bill and some of them probably more than others. One thing CBO [the Congressional Budget Office] looked at, which was, do they just raise their initial launch prices of the drug? Because this bill doesn't do anything to prevent them from launching their initial prices higher to deal with not being able to raise them as much year over year, or to deal with negotiations down the line. And CBO seems to think there'd be some kind of minimal impact, although eventually that would be made up for with negotiations. And actually, Medicaid might be the hardest hit by that based on how their rebates work, and then Part D and probably the commercial market would actually be less impacted in some ways by that happening.

**Rovner:** In many ways, the drug provisions of this bill remind me of the Affordable Care Act. It was much less than it started out to be and much, much less than most Democrats wanted. But still, as [President Joe] Biden once so famously put it, "a BFD." So where does this rank in the pantheon of efforts to control prescription drug prices? Obviously, the drug industry didn't want this to happen. If you've turned on cable TV in the last two weeks, you've seen all of these "the world's going to end" ads.

**Ollstein:** Some progressives have said all along that the drug industry is going to fight this tooth and nail and say the sky is falling. Whether we pass H.R. 3, which was much, much more sweeping, or this much narrower version. And so they were bringing that up to argue for the much more sweeping version. Of course, all along they knew they were going to be hampered by their narrow margins in the House and Senate. And in both the House and Senate, there were more industry-

friendly Democratic members who demanded concessions and demanded things get watered down and fewer drugs, longer delays until negotiation starts. So that's what we end up with now. But I think, like the Affordable Care Act, like Medicare and Medicaid itself, this is likely to grow in the years ahead. I was talking to some experts who were predicting that next time they need a little "pay-for" here and there, they can just add a couple of drugs. They can just shorten the delay until negotiations start, they can sort of dig away at it, dig away at it to make it expand over time. So we'll have to see. Of course, it depends on which party controls Congress.

**Rovner:** But this is literally the camel's nose under the tent, right? As far as the drug industry is concerned.

**Ollstein:** Yes, exactly. It's changing this precedent that has been in place for decades to not allow negotiation. And so it could really be a tipping point. The biggest challenge is that it won't start for so long that not only will people not feel the effects, Democrats are going to go out and campaign and say, "We lowered your drug prices," and people are going to say, "No, you didn't. I'm paying the same. What are you talking about?"

**Rovner:** And we saw that — it's funny. We saw that both with the Affordable Care Act, which legitimately took years to get up and running, and with the Medicare drug bill that the Republicans passed in 2003 that didn't start until 2006. Partly it doesn't start, the negotiation part, doesn't start until 2026 because it's literally going to take them that long.

**Cohrs:** Right. And I think it just depends where you sit, too, as to how big of a deal this is. If you're sitting looking from the H.R. 3 angle and how much bigger this started out, it looks kind of small, but if you're looking, sitting in the pharma-almost-never-loses side, this is a really big deal. And I think the last big loss that they had was the doughnut hole. You know, they had a little bit more liability in one phase of the Medicare Part D drug benefit. And I think it's just important to keep that larger perspective that this was the third rail. This was something they fought for a long time. They've just taken a scorched-earth approach to any even minor change to what prices they can charge. So obviously, just wanted to put that out there that it's a big deal in that sense.

**Rovner:** And I think it can't go without mentioning that this is a 50-50 Senate, that they had to wait, gosh, it was like a half an hour for the vice president to show up, to break the tie. It's like, didn't she know they were going to need her? But I mean, that's — this was not a small thing to get this done, considering they had Bernie Sanders on the one hand pounding the desk saying it didn't go far enough, and Joe Manchin and Kyrsten Sinema, you know, saying that it went too far. I feel like we need to stop and say, "Wow, this was kind of impressive, just an impressive political feat to get this done."

**Karlin-Smith:** And it almost seemed like it was going to collapse. I mean, as we know, many things do, it's not like this is unique. But it almost seemed like it was going to collapse many, many times. And it came back.

**Rovner:** Many, many times.

**Karlin-Smith:** It's still alive. I mean, the White House seems pretty confident they're not going to have any troubles in the House. They're already planning how they're going to communicate this victory. And I think the other thing we didn't talk about is there are some elements of this bill that people are going to feel fairly fast, like the Medicare redesign, which I think is a bigger deal than most people have focused on, and perhaps ...

**Rovner:** The Part D cap.

**Karlin-Smith:** Right. So that seniors will have a maximum amount they can spend each year. And that's a really big deal for people that go above that cap. And that's kind of an industry-friendly thing. Pharma doesn't necessarily mind that, though they're paying a little bit more to have that in there. I think there are things in here that people are going to feel, and Democrats will get credit for, pretty fast.

**Rovner:** Eventually. As Nancy Pelosi also once famously said about another bill: They'll have to read it to find out what's in it. All right. Well, let us move on to abortion. Alice, you were in Kansas last week when voters there resoundingly protected abortion rights in the state. What was that like? I take it it was as unexpected to those of you who were there as it was to those of us who were outside looking in, right?

**Ollstein:** Absolutely. I was there at the watch party in Kansas City when the results were called, and everybody was screaming and crying for joy. This was the progressive side, the "vote no" campaign. And what really shocked people was not that they won — they had been working very hard, they got a lot of big donations from Planned Parenthood and other national groups, they had been canvassing in 100-degree heat. But the real shocker was that it wasn't even close. It was a 20-point difference in a very red state, very conservative state. The "no" campaign didn't only do well in the urban areas and suburbs, where they expected to do well. But they did well even in pretty red, pretty rural counties, such as along the Colorado border. These ballot initiatives are going to be so revealing in this and other states going into the fall because for a while we keep hearing claims about how many Democrats might oppose abortion, how many Republicans might actually support abortion, how the split among voters doesn't necessarily reflect the split among lawmakers and people in power. But now we can really see that for the first time because voters are able to vote separately on the policy itself and the candidate they want to be in office. This is really changing a lot of people's calculus. We have several states that are already set to have their own abortion referendum this fall, in November. And there are already talks of trying to get things on the ballot in other states in 2023, 2024, whenever they can. I will say this is a tactic that is not possible in every state. Not every state even allows people to put something on the ballot like this. Even the states that do, some of them are moving right now to make it harder to get on the ballot, raising the signature threshold, etc. And so this won't be possible everywhere. But I think the results in Kansas are making people reconsider where and when it could be possible in the future.

**Rovner:** And as I said last week, I was in South Dakota in both 2006 and 2008, where they also, another extremely red state where they defeated abortion bans. Again, voters got a chance to vote yes/no on ... It was a very strict ban in 2006, and then they tried to make it a little bit less strict, thinking that would help pass, in 2008, and both times it lost also convincingly. I went back

and looked it was like 55-45. So, yeah, we've got a number of states that we will see in November whether voters are going to go the same way. Meanwhile, Congress wasn't the only legislature that was busy legislating last weekend. The Indiana legislature late Friday made Indiana the first state to pass an abortion ban since the overturn of *Roe v. Wade* in June. Those other states' bans had been passed prior to the Supreme Court's ruling. And the Republican governor signed it just hours later. It's set to take effect next month. Alice, it's a pretty strict ban, right?

**Ollstein:** Yes. What we've been reporting on is — it's fascinating that there are these very strict bans that states are passing. Indiana's the first, but West Virginia could be right behind them. And yet a lot of anti-abortion advocates in these states and lawmakers that are on the far right are really dissatisfied with where they are ending up and saying, "It's not strict enough, and there are too many exemptions for things like rape and incest, and the penalties for doctors violating the laws are not harsh enough." And so there's some real angst going on. It's just fascinating that, like we've seen on so many fronts, like we've seen with Republicans pledging to repeal and replace Obamacare, it's so different, too, when you're out of power, or not able to do something because of the courts, to make these sweeping promises and saying we're going to ban all abortion. And then when it actually comes time to do it, all of the scrutiny is on you. It's a lot harder, and there are a lot more fights and disagreements about how to move forward. And I think we're likely to see a lot of that.

**Rovner:** I think I wasn't expecting how much further particularly state lawmakers were prepared to go when the court overturned *Roe*. I mean they obviously ... A lot of these states had trigger laws that they've passed. Some of them obviously go back 100 years or more. But many of them go back just two or three years, in the anticipation that the court would soon overturn *Roe* and that they would be ready. And I get those. But I think I'm surprised that states like Indiana and West Virginia are jumping in and saying, "let's double down on this," even though there seems to be a backlash. I mean, it seems like the sides are getting further apart rather than closer together, which is, I think, not what the Supreme Court had in mind.

**Ollstein:** Well, we always knew that the argument that returning this issue to the states would calm everything down and solve all the problems was always a fantasy. And instead of having one big federal fight over this, we are now having 50-plus individual state fights about this, and that's only going to continue.

**Rovner:** So we've talked also at length about how private companies are reacting to these state bans. In Indiana, Eli Lilly, the Indianapolis-based drug company that gave us, among other things, [President Donald] Trump's Health and Human Services Secretary Alex Azar, put out a statement Saturday criticizing the ban, suggesting that they would be looking to expand their workforce outside the state. But it turns out that Lilly and another big Indiana-based tech company, Cummins Inc., both issued their statements after the bill was signed. And both firms have given considerable contributions to the lawmakers that passed and the governor who signed the ban. Companies trying to have it both ways here?

**Ollstein:** I think companies are trying to have it both ways. And I think that this is what I was saying about separating the policy from the candidate. Because when people vote for a very conservative

Republican candidate, you don't necessarily know if you're voting for their abortion beliefs or if you're voting for their tax cut beliefs or whatnot. And that is true of voters, and that is true of companies that give these big donations. And so now they are forced to reckon with the repercussions of that. And they are finding that while they might love their tax cut positions, on other issues, they are either inadvertently or on purpose supporting policies that are could impact their business in a negative way and their employees. So I think that we're really seeing some companies wrestle with this, and we are seeing them take measures that don't really get at their underlying support and their role in bringing about these laws in the first place. Instead of saying, "we won't support any lawmaker who is for these laws," instead they're saying, "oh, we are just going to shield our own workers from the impacts of them," rather than protecting all people in these states from them.

**Rovner:** I remember after Jan. 6, there were a number of companies that in the wake of the insurrection said, "we're not going to give money to the Republicans." And that lasted all of about two weeks, if I remember correctly. I think companies just like to hedge their bets. It's like, whoever's in charge we want to have given them money so that they will listen to us. But it does feel a little bit like they could have weighed in before the bill passed because, as we said, they've been fighting about it. All right.

Well, finally, from the "I told you so file": more stories this week from Wisconsin and Texas, among others, of women pregnant with wanted pregnancies experiencing complications and having their health and lives endangered because doctors are caught between conflicting bans and medical ethics, and more cases of women who can't get drugs like methotrexate for rheumatoid arthritis and other conditions because pharmacists fear that it might be used for abortion. Anti-abortion groups say doctors and pharmacists are overreacting and that these things are not illegal under their bans. But lawyers seem not so sure. Alice, do you think we're going to see clarifications here in any of these states? Or are we just going to continue to have this trickle of sad stories about women who basically can't get health care because their providers are worried about losing their licenses and being thrown in jail?

**Ollstein:** I think the pressure would really have to mount even more than it already has to get some of these state legislatures to backtrack. Already we are seeing ... In the creation of new laws when there are proposals for more exemptions for rape and incest, moderating the criminal penalties on doctors, we are seeing that leading to accusations and finger-pointing. And so I think people will be really hesitant to give any fodder to that kind of behavior. And so I think for now they are just continuing to insist that this is not their fault, that this is a misinterpretation, that these people could get the treatment they need. But I think that they are reckoning with it's one thing to put something on paper, but it's another thing to consider the chilling effect and to consider that a doctor is not going to risk their livelihood and their freedom in order to make even what they think is a perfectly legal and ethically correct medical decision. And so this is what advocates on the other side were warning about before this. We got a sneak preview of this in Texas, which implemented its ban before the Supreme Court ruling. And I think these cases are only going to continue. It's just also shining a light on something that ... Pregnancy loss, pregnancy challenges are really, really common. And we don't like to talk about it. We don't like to think

about it. But losing a wanted pregnancy because of a medical emergency, even later in pregnancy, it happens — and it happens kind of a lot. And other things that are uncomfortable and horrifying to talk about, like children being raped and getting pregnant, [are] more common than we thought. So, these cases, while they might seem like extreme outliers, are not as extreme and are not as far outside what happens as we thought. And whether laws will change to reflect that remains to be seen.

**Rovner:** Yeah. I'm finding an awful lot of men getting an awful lot of education in biology really fast this year. All right. Well, let us move onto this week in infectious diseases. We will start with monkeypox, for which the government seems every bit as disorganized as it was with covid. Or is that my imagination? Sarah, can you explain what's happening with the monkeypox vaccine and with the monkeypox treatments for that matter?

**Karlin-Smith:** Sure. So I'll start with the monkeypox vaccines because there's more, I would say a little more government action there. This week, the health and human services secretary formally did another public health declaration that is separate from the one they did last week. This one allows the FDA to issue emergency use authorizations. He did this very narrowly. So it's only for vaccines in this case for monkeypox. And as I think a lot of our readers know from covid, it's sort of a lower standard to get a drug or device or vaccine approved. So you end up with a little less data or a little less confidence about the product. The idea is “but it's an emergency and we need to help people now, so we are willing to take that little bit of a higher risk.” And what they did was — we have the vaccine that's already approved for monkeypox, but we don't have a lot of it. So there was a study done in 2015 that showed that if you administered the vaccine a different way — intradermally, instead of what they now do is subcutaneously. — you can give a fifth of the dose and it produces the same immune response in people. So they decided, “this seems like a good plan — let's allow that to go forward.”

**Rovner:** So, basically, we're going to have five times as many vaccines as we did otherwise.

**Karlin-Smith:** Right. Exactly. You can divide it by five. Now, I've asked the government some questions like because it's actually not so easy to administer the other way, less people are trained and know how to do this. You have to be a bit more careful to make sure you don't accidentally underdose people. The [Centers for Disease Control and Prevention] says they're going to do trainings and so forth, but it'll be interesting to track and see how quickly do they switch over, how many of the doses actually go out through this new administration just because there are so many implementation challenges. I assume states and localities are incentivized to learn how to do this because the more people they can serve, the happier you would think their people will be. But it's not like flipping on a light switch. And there's been some backlash to this plan, which I find interesting because people have been so critical of FDA for moving too slowly and being too conservative in covid in some cases. And here they are being willing to say, “OK, we don't have perfect information, but we're pretty happy with it and will be” — I don't want to say experimental — “but we'll make a good guess and we think the benefits outweigh the risks here.” But some people are pointing out this is based on one study — we don't even know ... actually backtracking a bit ... if this vaccine, what the effectiveness is in humans overall. So the vaccine was actually approved for smallpox and monkeypox a while back. Monkeypox is not very common in



the U.S. and even globally. So they had some studies in animals that showed it was effective. And then they did a similar study to what they've used to allow this dose bearing, which is they look at an immune response: Does your body produce a response? But that doesn't necessarily tell us what's going to happen. Are you going to get sick if you're exposed to monkeypox or be prevented from getting sick? Are you going to get sick but not as well? So there's been some criticism just about the overall data gaps here. Even in Stat News, in Rachel's publication, there was an op-ed from two former prominent FDA officials basically saying, like: "This isn't a great idea. We already don't know as much as we want to know about this vaccine. This is going to make it even harder to get the information we need." So we'll see what happens there. Like I mentioned early on, on the therapeutics side, the interesting thing is that the HHS secretary made that public health emergency declaration for the FDA authority on emergency use so narrow that it doesn't apply to therapeutics. And this is another thing where, like, I'm still trying to press government people to be more clear about what their thinking is and why they didn't make it more widely accessible — because it's not that there isn't a treatment need or there aren't people that would want to maybe have this lower authority to get more treatment out there. And, in fact, there's one antiviral drug that was approved in the U.S. under, again, the animal rule for smallpox that we have been making use of for some people with monkeypox through what's known as "expanded access" or "compassionate use." And that's a complicated pathway where doctors can get people some access to this drug through the strategic national stockpile. But they have to fill out a lot of paperwork. And as part of that commitment, they have to track people's outcomes more closely than they might otherwise so that the government can collect some data on what's happening.

**Rovner:** It's a burden on the providers, in other words.

**Karlin-Smith:** Right, and even sometimes on the patients. And because of some of the follow-up visits that government wants now, HHS, CDC, and FDA are trying to make that burden smaller to let more people get access this way. But if, in theory, FDA was willing to give an emergency use authorization for this drug TPOXX, it would really open the floodgates, and probably potentially any monkeypox patient who wanted it could get access. Now, FDA, [National Institutes of Health], and CDC leaders in this space wrote in the New England Journal of Medicine last week, before we really even had the sense that there was going to be a public health emergency formally declared overall, that they really wanted randomized controlled clinical trial data with this drug to know if it works in monkeypox patients with this version of monkeypox in humans. And it seems like they were less willing to be flexible on the therapeutics side. So maybe that's why HHS Secretary Becerra didn't put them in that awkward situation of having the option to do an EUA but not. I don't know what's going to happen here, but I love covering these issues because there's such a fascinating tension in our society between "we want things fast, we want things faster." And then when you start telling people, well, but here are the data gaps, then they get criticized on that end. So FDA is getting pushed and pulled both places here. They didn't move fast enough during covid. They're trying to move faster here. But then once they do, there's criticism on that end. So it's hard for them to win these days.

**Rovner:** Yes The American public is ... We want it, and we want it fully tested. We want to make sure it's safe, but we want you to test it in five minutes because we want it right now. I guess

that's the continual tension in public health. Well, meanwhile, covid is most definitely still with us. Alice, you had a really interesting piece this week about what lawmakers are not doing about long covid, which I have seen described as a "mass disabling event," which is kind of ominous. Why such inaction? Is it one of those things like pregnancy complications that we just don't want to think about?

**Ollstein:** I think that's part of it for sure. So, yeah, and I wrote most of the piece months ago and we only finally published it this week, and I didn't have to update it that much because Congress has not done anything in the last few months related to long covid. So all my previous reporting was still relevant. Look, there's a lot going on. So, the main barrier is that there is just not a lot of Republican interest and support for spending a lot of money to increase access to treatment for people with long covid. And there's really not a lot of support to meet demands from the growing long covid community for financial support. They're saying, "Look, the research that NIH has begun is great and needed, but how are we going to survive until the research comes up with something for us? How are we supposed to pay our rent?" A lot of these people can't work. There is new data out about just the large and growing number of people who can't work because their long covid symptoms are so debilitating. They also have trouble qualifying for existing programs like Social Security disability.

**Rovner:** Which has a 24-month waiting period.

**Ollstein:** Exactly. Exactly. And so there are also all of these demands that Congress look into making those programs more easily accessible for people with long covid. And there's just really not a lot of action. So, yes, no Republican has co-sponsored any of the bills that have been introduced to deal with long covid, but also Democratic leadership has not really thrown their weight behind these bills and moved them forward for hearings and markups in the House or the Senate really. In the Senate, some provisions were included in the bipartisan pandemic preparedness bill, which passed out of committee and is now in a big shruggly position that we ... Yeah. Not sure if and when that is going to move.

**Rovner:** Right. We'll take it up when we come back in September, in that long list of things that they will take up when they come back in September. Sarah, I wonder is the focus on monkeypox taking away from some of the focus on covid? I mean, obviously, covid is still here. We're about to start another school year. I see all these angst-ridden tweets from parents who don't know what to do with their kids going back to school. I feel like the federal government has kind of washed its hands of covid, too, if you will.

**Karlin-Smith:** I think there's a lot of people in the infectious disease space that have been burned out from covid, both at the federal government level and in hospitals and clinics and so forth. So I think this second whammy is going to be hard for sure. Obviously, we know CDC is supposedly working on updating some of their covid guidance. It's for schools. FDA is still working very closely on how to update covid vaccines for this fall. So we should, I think, in September probably see some more news on that front. So certainly the government has people to move on both tracks and so forth. But I do sort of worry again about some of the exhaustion ... Are the same people at FDA who again are working on covid vaccines going to need to use some energy to think about this

monkeypox response and how do we track the data on the safety of altering these vaccines and so forth. So I think there is some challenges. And the other thing I've been looking at is there is this sense that covid's in a stable place in the U.S., but it's not necessarily a good stable place, right?

**Rovner:** It's like 100,000-cases-a-day stable, right?

**Karlin-Smith:** Right. So we're at like 400-500 deaths a day. It seems like it ranges — like sometimes it gets closer to 300; sometimes it's past 400. So it's not great. I guess maybe I shouldn't say stable, but the government is trying to treat it like it's not this big crisis anymore. One of the things I noticed in some of my reporting is, for both long covid and then just covid in general, it's meant there hasn't been a lot of effort, it seems like, from the government end to continue funding new treatments for covid and figuring out how to develop new treatments for long covid. And I think that's something people are worried about because, again, our habit in the U.S. is to kind of wait and react, instead of preemptively preparing. And we probably need some preemptive preparing for things like Paxlovid to potentially no longer work as well. Can we develop drugs that will prevent people from getting long covid, instead of actually getting long covid? And they're certainly like academics and people working on some of this stuff, but they need more funding. They need more guidance from the government around clinical trial design and so forth. And, of course, some of this is not the Biden administration's fault. Congress has decided it doesn't really want to fund covid anymore. And so the Biden administration has their hands tied to some degree, and they've decided, "OK, well, we have to get these new vaccines." So that's meant pulling money from testing or maybe therapeutic work and so forth.

**Cohrs:** Just one quick thing to add. I think in the spirit of covid becoming more of a stable thing, I think there is a conversation about addressing some of our covid funding through the regular appropriations process this cycle and not having it be a big separate emergency bill. I think a lot of times that's just not an option now for covid or for monkeypox really. So I think that will be interesting ... trying to watch whether Republicans get on board with Democrats' push with that. Obviously, it probably isn't going to be at the levels that the White House would prefer. But I think there is this potential path forward by the end of the year where we could maybe get some support. Obviously, prioritizing that funding is going to be a difficult decision for the Biden White House too.

**Rovner:** Well, hopefully Congress will get some rest over its August recess and come back in September ready to work. All right. Well, that is the news for this week. Now it is 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:** My extra credit, the headline is "[Conservatives Skeptical of Coronavirus Vaccines Battle to Lead a Hospital](#)," by Tim Craig in The Washington Post. And I think this is just a really fascinating, kind of scary microcosm of the political leanings of different candidates to lead this hospital system in Florida and the idea that facilities could become politicized almost. And it's hard for me to imagine if there were political leadership at a hospital — like, what would the mask policy be? — if that could bleed into the policies and if there is this really deepening conservative distrust of

hospitals themselves. I think there's been this transition to distrust of public health, and we've been talking about that for a very long time on here. But I think this was just a very scary politicization of a seemingly mundane leadership election where a lot of times it's ... the focus is on academic qualifications or experience in clinical setting or even like business acumen, as opposed to the politics being a big selling point. So I think it was a wake-up call for me and I think a really fascinating read.

**Rovner:** Yeah, I thought so, too. I was just ... This is the next step after conservatives try to run for school board. It's ,like, let's run for the local hospital board. OK. There we go. Alice?

**Ollstein:** Mine is a bit terrifying as well. So I have a piece from the [Associated Press] by Seth Borenstein about [how much climate change is worsening infectious diseases](#). Turns out, a lot. This found that more than half of the human infectious diseases that we know of are made worse by things related to climate change. That includes flooding, that includes droughts, that includes warming oceans. And these can be food-borne pathogens. These can be animal-borne pathogens. And it feels like covid's never going to end, and it feels like there's always some new scary thing on the horizon. And this does not ameliorate those feelings.

**Rovner:** Awesome. Sarah?

**Karlin-Smith:** So I took a look at a piece by my colleague Sue Sutter at the Pink Sheet called the ["US FDA Commissioner Califf Takes on Misinformation, Starting With 'Rumor Control.'"](#) [Califf] came into his second term as commissioner saying that combating misinformation in science was going to be a big focus. I think he was thinking about covid and some of the vaccine hesitancy and so forth, but other things as well. His initial website ... which, you know, there's a lot of interesting things to think about here, like the name "rumor control," whether that really sends the message he wants in terms of how serious this is. Obviously, people sometimes don't like thinking about the government in control of their life. So there's lots of interesting things to look at. Their initial down payment webpage focuses very much on covid vaccines and misinformation out there. I think it's an interesting effort. But, you know, probably I've seen lots of good efforts at this over the past two years, so I'm not sure they're really filling a gap. He says he's going to basically take a year, though, to develop a more thorough misinformation plan and how the FDA would play a part in this. And it'll be interesting to see what he does because some of his sentiments, I think, come from a time and a place where doctors had more control in a sense of what their patients were hearing — right? — because they had less information. So he talked about ... He said, like in the good old days when I was a cardiologist, there was a hierarchy of information, and companies developed products, the FDA adjudicated, and people learned things from their doctors. It does worry me a little bit if that's how he's thinking about this because I think that the internet exists. We have all these resources to educate ourselves. And I started thinking about back in the day when people couldn't read the Bible for themselves — right? — because they couldn't either read or it was in Latin. We don't want to go back to a time where people are just supposed to take information and not think about it and process it. What we want to do is help people learn — right? — how to discern what information is good, what's bad. People should be able to think and form opinions, and we have to teach them how to deal with information, not necessarily think about controlling what information or who they get it from. So I don't know. I'm just really

fascinated to see how he can take this on from an FDA perspective, from a government perspective, and also to see the philosophy he approaches it from.

**Rovner:** Yeah. I mean, obviously, disinformation is a big issue in a lot of realms, but certainly no more so than in health care. Well, my extra credit this week is a piece of accountability journalism from a former KHN editor — Laurie McGinley is now at The Washington Post — and is called “[For Sleep Apnea Patients With Recalled CPAP Machines, Restless Nights.](#)” And it's really reminiscent of the recall we had of all those air bags a few years ago when people knew they were driving around with air bags that could literally blow up in their faces. But there weren't enough new air bags nor technicians to get to all of them in a timely way. Well, now we are experiencing basically that same thing with CPAP machines, those air blowers that help people with sleep apnea continue to breathe through the night. Royal Philips, the Dutch conglomerate that makes the majority of machines used in the United States, discovered that the foam that's used to muffle the noise of the machine's motor could disintegrate and the particles could be inhaled by patients. Not a good thing. But while the machines were recalled more than a year ago, the company has repaired or replaced only about half of the 2.8 million recalled products. Now the company and FDA are arguing about how dangerous the machines really are and how hard the company has tried to reach customers. Not hard enough, says the FDA. And of course, as usual, patients are caught in the middle. It's a really good story.

All right. That is our show for this week. As always, if you enjoy the podcasts, 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 producer, Francis Ying, who makes the weekly magic happen. As always, you can email us your comment or question. We're at whatthehealth — all one word — @kff.org. Or you can tweet me. I'm @jrovner. Sarah.

**Karlin-Smith:** I'm @SarahKarlin

**Rovner:** Alice.

**Ollstein:** @AliceOllstein

**Rovner:** Rachel.

**Cohrs:** @rachelcohrs

**Rovner:** We will be back in your feed next week. Until then, be healthy.