

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

**Episode Title:** On Government Spending, Congress Decides Not to Decide

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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, Sept. 29, at 10 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today we are joined via video conference by Alice [Miranda] Ollstein of Politico.

**Alice Miranda Ollstein:** Good morning.

**Rovner:** Rachel Cohrs of Stat News.

**Rachel Cohrs:** Hi, everybody.

**Rovner:** And we welcome formally to the podcast Victoria Knight, lately of KHN but now covering the health beat for Axios.

**Victoria Knight:** Hey, y'all.

**Rovner:** Later in this episode, we'll play my interview with documentarian Cynthia Lowen, whose new movie, "Battleground," opens in theaters Oct. 7. The film takes an inside look at three anti-abortion leaders and how they played the very long game to achieve the overturn of *Roe v. Wade*. But first, this week's news. So, as we speak, Congress is rushing to pass a temporary spending bill to keep the government open past the Sept. 30 end of the fiscal year. Now, in the olden days, literally in the last century, Congress would pass 12 separate spending bills by Oct. 1. They would get signed or vetoed individually by the president and somehow all settled by the start of the fiscal year. But now Congress just — I won't even say kicked the can down the road, it's more like a dog pushing a rock, just a little ways. So this latest continuing resolution, as it's called, will bundle together all of those appropriations bills and keep the government funded, this time until mid-December, at which time Congress will either get its act together and pass spending bills for the remainder of the fiscal year, until next Oct. 1, or more likely, push funding out a few more months to give lawmakers more time to negotiate. But one thing that can and does happen here is that other bills catch a ride, so to speak, on this big, must-pass spending bill. And that's what's happened with the FDA user fees that also expire Oct. 1. We've been talking about this pretty much since the spring. Victoria, you were one of the people who figured out that they were going to compromise on this and stick it on this bill. What did they do?

**Knight:** Well, that was actually Rachel. But I was on the Hill asking lawmakers about it. Basically, Mitch McConnell said, "I want this to be a clean bill." And Democrats were hoping that they could maybe still tack some things on. But in the end, they weren't successful with that except for some ... Rachel, where there some very minimal things tacked on, but very small?

**Cohrs:** Yeah, the actual user fee agreements between the drug industry and the FDA, those all are reauthorized for five years. So the fight's over, and that was most of their leverage. But there were some smaller reauthorizations, like Victoria said, that aren't technically user fee agreements but are usually considered part of the package. It's like, you know, regulations around safety inspections and reporting for pediatric patients, that kind of stuff. So they did try to only reauthorize a couple of those until December to try and create a new kind of mechanism where they have to come back to the table in December to talk about the FDA. Obviously, the user fees were a lot bigger leverage because that caused pink slips and delays in approvals, all of that. But nobody wants these programs to expire either. So I think they are hoping to revive this conversation in December.

**Rovner:** And Rachel, remind us: What are some of the other things that lawmakers are looking to do [other than] that every-five-year renewal of the user fees? And for those who don't remember, these are fees that drug manufacturers pay to basically pay the salaries of drug reviewers at the FDA to keep them from getting backed up and taking years to actually get products reviewed. But Congress has been using this sort of every-five-year renewal as a chance to take a look at other programs at the FDA, because as you point out, it's a must-pass bill. If you don't pass it, these people actually get fired. So what else might this sort of new December deadline give them a chance to talk about?

**Cohrs:** Well, I think what Democrats would really like to do — and just because it is every five years, you know, Democrats don't have a trifecta in government very often, so this was what I think Scott Gottlieb called a once-in-a-generation chance to reform the FDA. And they were talking about reforms to how the FDA might regulate cosmetics or dietary supplements or the accelerated approval process that gives people access to experimental drugs. And I think also, like, clinical lab tests, how some of those are regulated as well. So I think there were just several packages that have been languishing for a very long time that they were hoping to get. Like, this was their chance, but they just weren't able to get Republicans on board.

**Rovner:** So, user fees are in. But the money that the Biden administration really wanted to continue to fight covid and monkeypox is *not* in. Is this the last we've seen of this fight, Alice, or will the administration try again in December or after the elections when they have to come back and finish this work, basically?

**Ollstein:** Yes. Everyone expects them to keep trying again, to try again in December. What was really notable to me was that Republicans have not wavered for months in their position. They've pretty much across the board said we don't think they actually need this money. We think they still have unspent money. We're not convinced. And of course, [President Joe] Biden going on TV and declaring the pandemic over did not exactly help matters. We heard endless references in the hallway interviews to that comment, and Republicans citing it.

**Rovner:** As you point out, the Republican position was long before Biden declared the pandemic prematurely over.

**Ollstein:** Oh, absolutely. But this gave them a lot of fuel to say, “Why should we spend more than \$20 billion on something that is over?” Of course, it's been a difficult message for Democrats and the administration all along to both say, “Look at all this amazing progress we've made, and aren't things so much better than before? But we still need money because it's still not over and we have to stay vigilant, etc.” That's always been a tough message, and it just did not win over Republicans. But what was notable to me is Republicans have been very consistent. But the difference we saw more recently, it was Democrats just not willing to go to the mat for it and not really drawing a line, fighting for that funding. And so it did not make it in. And I thought it was interesting that the Democratic appropriations chair, Pat Leahy, did not even mention covid in his statement about the temporary spending bill. He mentioned a few other things that he was disappointed were left out, but no mention of covid. So I think that really is telling.

**Rovner:** I'm curious, over the years, the appropriations bills have been the forum for fights over abortion, the hottest political issue of the year. And I have heard nary a peep. I mean, is there anything that anybody's working on? Obviously, there have been efforts to get rid of the “Hyde Amendment.” That's where it lives, in the spending bills; it has to be renewed every year. But ... there are, probably, we know there are the votes to get rid of it in the House, but there aren't the votes to get rid of it in the Senate. Did they just leave this fight for another day?

**Ollstein:** Yes, I think longer ago than giving up on the covid fight, Democrats pretty much gave up on the Hyde Amendment fight and indicated that they were willing to let these spending bills go through. They cared more about keeping the government open and funded than making this fight. They know that Republicans are not going to change their position there and they need their votes to get this passed. This has to be bipartisan.

**Rovner:** All right. Well, as we've noted, once or twice or at least a dozen times every week, the midterms are approaching. I believe we're six weeks away. And President Biden had an unlikely chance to take something of a victory lap on Medicare earlier this week, noting the drug price changes passed by Congress in August, bashing Republicans for some of their proposals to sunset the Medicare program, and advertising the very latest news, an actual drop in Medicare premiums and deductibles for 2023. But that drop is actually due to an extenuating circumstance with the high price of just one drug, right, Rachel?

**Cohrs:** Yeah, I think CMS [the Centers for Medicare & Medicaid Services], even in their press release, said this was why premiums were lower this year because they were so much drastically higher the year before. And I think it's also worth noting that just hours after President Biden made this speech, Biogen released some results from trials from another drug that look better than Aduhelm's. So I think, obviously, there's a long road to go, but I think there will be hard questions about what if there ... it may not be Aduhelm, but this problem isn't going away where there's these huge fluctuations when we have really expensive drugs that come on the market.

**Rovner:** And let's back up for people who forget what happened, which is that the FDA preliminarily approved Aduhelm, this supposedly breakthrough drug to treat people with Alzheimer's, which obviously would be a big deal and a big expense for Medicare. And then, basically, Medicare said, no, we're not going to cover it. That was in January, right? By that time,

they had already raised premiums in anticipation of people starting to use this drug that now people aren't going to use. So basically, Medicare has been collecting too much money this entire year of 2022 and they're rebating it back, basically, in 2023. Is that where we are? But that enabled President Biden to get up in the Rose Garden to say, look, Medicare premiums are going down.

**Knight:** Now, I think we should also keep it in context. So it was a huge jump last year, it was about \$170. And this year, it's dropped to about \$165, \$164.90.

**Rovner:** That's the Medicare Part B premium.

**Knight:** The Medicare Part B premium.

**Rovner:** It didn't go up by \$170. It went up to \$170 a month.

**Knight:** Yes, yes. But if you look at 2021, it was \$148.50. So it's because it went up so much last year that there is a drop this year, but it's still higher than it was in 2021. And I think it's really important to keep that in context when President Biden is kind of boasting about this.

**Rovner:** Yes, fair point. It's been really hard to figure out what's going on with Medicare spending because of the pandemic. We'll talk about hospitals a little bit later, but the people who set the premiums are doing the best they can. But health care spending, as we know, has been all over the place. And as you point out, Rachel, we've got this new Alzheimer's drug on the horizon. I mean, it looks like it works the same way. I mean, the same mechanism as Aduhelm, but it seems more promising? Or is it just still really early?

**Cohrs:** I think the big question is what ... Aduhelm — they were able to show that it did clear these amyloid plaques in your brain that scientists and experts have long thought caused Alzheimer's or worsened your symptoms, that kind of thing. That there was some relationship there. But I think the big elusive question is whether any of these companies can prove that these drugs that clear these plaques actually have clinical benefits for patients, whether they actually reduce or slow the symptoms of the progression of disease. I think that is what these two companies are trying to do right now that they weren't able to do with Aduhelm yet. Again, studies are ongoing, but that's the big question that's loomed over this whole space.

**Rovner:** So definitely watch that space. So you might have missed this, but the Republicans in the House last week put out their legislative agenda in the event that they do win back the majority in November, which is still more likely than not, if only for redistricting reasons. But their "[Commitment to America](#)," as they're calling it, is a far cry from the specific bills that Republicans promised to pass back when they last tried this stunt in 1994 in the "Contract with America." And it's really, really light on health care promises. Here's the entirety of what it proposes on health: "personalized care to provide affordable options and better quality delivered by trusted doctors and lower prices through transparency, choice, and competition; invest in lifesaving cures; and improve access to telemedicine." What does any of that even mean? That's literally the entirety of the Republican platform on health.

**Ollstein:** I mean, I think it's a clear reflection of them feeling like they touched the health care hot stove a few years ago and don't want to do that again, and making very specific promises, like “we're going to repeal Obamacare and replace it with something amazing” can come back to bite you when you don't really agree on what that something amazing should be. And so, yes, you have a lot of platitudes about choice, and competition, and personal, and all of that, rather than specific bills. Now, totally separate from that, we have gotten some indications of what they want to pursue if they win back a majority. And a lot of it is undoing things that Democrats and the Biden administration have done, such as they want to get rid of the new drug pricing provisions that just passed. They feel that it will impede. They echo the drug industry's arguments that it will prevent the development of new cures and drugs. And so they have ... Both Republicans in the House and Senate have expressed a desire to try to get rid of what was just passed. Of course, Democrats are making hay of that politically, as well. And then, of course, the other specifics we've seen are on the abortion front, as always, wanting to implement national restrictions even though a lot of Republican lawmakers are hesitant about that and think it should be left to the states. And so we have gotten some specifics, but not on the core questions of Medicare, Medicaid, employer insurance — some of the bread-and-butter health care stuff.

**Rovner:** Yes, the Republicans discovered that the one thing that they're unified on is that they don't like what the Democrats do. Then when we get to the point of deciding what they're going to do instead, not so much unity there. The Democrats aren't all that unified on a lot of these things either, but at least they're unified on some. Well, the other thing in this one-page Commitment to America — I keep forgetting the name of it. There is a reference to protecting the lives of unborn children and their mothers, which suggests that the Republicans are a little bit squirmy when it comes to the abortion issue. And apparently it's not just House Republicans. Republicans everywhere are kind of ducking this issue, right, Alice?

**Ollstein:** Yeah, definitely. Like you said, there's just a lot of internal divisions over ... They spent so long saying *Roe v. Wade* had to go because it prevented states from deciding what was best for their residents on the abortion issue. Of course, now you have [South Carolina Sen.] Lindsey Graham and his allies trying to argue for national restrictions on abortion even in states that are supportive of abortion rights. So I think you're going to see, and are already seeing, some similar dynamics of the Obamacare repeal fight from 2017, where when you're in the minority, it's very easy to make sweeping declarations and promises and say, “we're for protecting babies and banning abortion.” And then when it comes time to get into the nitty-gritty of exactly what circumstances would be banned and allowed ... We're seeing that in states, too. A lot of infighting on the right over that. So that is only likely to continue if they're put in power again.

**Rovner:** So, meanwhile, in a segment I'm calling “it's not just abortion that's being affected here,” let us turn first to Idaho, where a trigger ban on abortion took effect late in August. In light of that ban, the general counsel of the University of Idaho issued guidance halting the distribution of birth control and advising university employees that if they speak about, promote, counsel, or refer a student for abortion, they could face a felony conviction and be permanently barred from future state employment. Apparently, that has since been clarified to allow the distribution of condoms, but only for the prevention of sexually transmitted diseases, not for prevention of pregnancy.

Now, this pretty clearly feels like an overreaction to an abortion ban, and it's apparently because the Idaho abortion law is vaguer than most. But could we start to see this at other universities, too? And what kind of backlash are we expecting? I can see that there's a lot of states now that have abortion bans. And if suddenly "abortion" is becoming a word you cannot mention on campus, I expect that would be a big deal.

**Ollstein:** I mean, there's a few threads going on here that we are seeing in other states. One is this conflation of contraception and abortion. You have a lot of groups on the right who consider some forms of contraception as abortion, even though it's not medically the case, and saying that because they believe they are, that should count. You also are seeing ... This has definitely been a longtime struggle between big universities in these more conservative states. The universities tend to be more progressive than their home states. And there have been long conflicts in the state government trying to crack down on policies at the university level that is outside of health care, outside of abortion. That's just like a bigger trend. So I definitely think we will see a lot of this going forward. And it's just interesting that it's coming amid complaints of restrictions on free speech on the right. But this is compartmentalized, I guess, out of that bigger debate.

**Rovner:** If you carefully read the stories about Idaho, it's not that the general counsel is being ideological about this. It's that he's being careful about this. I mean, he's worried that somebody could come in and try to prosecute people. Not that he thinks they shouldn't do it, it's that he's worried that the law is so vague that somebody could. And, eventually, I think we're going to start to see cases. I think everybody is frozen in place right now. All right.

Well, the next stop on our "It's Not Just Abortion" story. It's from our friends at Stat News. And it's actually [a story by a CEO from a biotech firm](#) who's worried that the requirement that women in clinical trials who have to take regular pregnancy tests could potentially end up in trouble even if they subsequently have a miscarriage, which is more common than people realize. Rachel, this is kind of a big deal for people who do research, right? I mean, you do pregnancy tests because, first of all, you want to protect pregnant women from things that are being tested, but also you don't want that to confuse your results. So, generally, if you're in a clinical trial, you have to continue to prove that you're not pregnant.

**Cohrs:** Right. Yeah, I think that's a really great point. And I think we've seen also like routine testing before, like, surgeries or other procedures, any routine pregnancy testing. I mean, even for some medications you have to be on, you're supposed to be testing regularly. So I think certainly this is one of those gray areas where it's, like, how much data is protected. And I think there's just liability issues for practitioners, as well. It's definitely something to be aware of and to know going in when you're taking these tests.

**Rovner:** Yeah. We've talked about how this could chill things like IVF because you're making embryos, basically. But the idea that this could also chill research, I think this was the first time I had seen that. And in this case, it was a specific case of a woman who tested as pregnant. And then obviously she must have been early. She didn't know she was pregnant, and she must have had a miscarriage and basically didn't know that either, because then she tested as not pregnant.

But in today's atmosphere, that could cause raised eyebrows and investigations into, "well, how did she become not pregnant?" The world is a different place than it was three months ago.

Well, Alice, you've got [a story this week](#) about patients still having trouble getting drugs for chronic diseases again unless they can prove that those drugs are not for the purpose of ending a pregnancy. When we first started seeing these anecdotes, we had people in these states where abortion was banned saying, "No, no, no, it doesn't apply to these things." But it's still happening.

**Ollstein:** Absolutely. And I think it's an example of what you said. Of course, it matters what the letter of the law is and, of course, it matters ... State officials are interpreting the laws and whether anyone is actually getting prosecuted. But I think even more than that, just putting out these very broad and vague laws and creating an atmosphere of fear creates a chilling effect. And so you have people maybe being overly cautious or going far beyond what is actually required because they're so afraid of getting hit with a felony charge, losing their medical license. The stakes are really high for them. And even though it's causing delays and in some cases the inability of patients to access medication completely unrelated to abortion. I talked to a bunch of pharmacy groups who are saying, "Look, in order to protect our members, we are implementing these policies where we have to verify the diagnosis when it comes to certain drugs and certain patients." And so they're getting this extra scrutiny. And so I talked to anti-abortion groups who are backing these laws who say, "Oh, this is an overreaction. They don't have to do this. This is so overblown." But, look, it's happening. There is this atmosphere of fear, and they feel the stakes are too high. And I also think what's interesting is that pharmacists say they're trapped between federal and state law. You have the states saying "if you dispense medication that could be used for abortion, you could be part of a crime." At the same time, you have the federal government saying "if you deny medication, you might be in violation of federal law." But it's clear that these pharmacists are much more afraid of the states taking action than the federal government based on their behavior.

**Rovner:** And we're seeing the same thing this week at the VA, where we're hearing about, I guess, the first abortion on someone with VA insurance, not sure whether it was a veteran or a family member. But the secretary of the Department of Veterans Affairs says, "Oh, the federal government will defend any doctor who does an abortion under this new policy even if the state attorney general in that state wants to come after them because it's a violation of state law." I don't think I would want to be the doctor. I mean, thank you, federal government, for saying you've got my back, but I'm the one that's going to get thrown in jail. I mean, I could see how that could be kind of uncomfortable for doctors in this position and, as you say, Alice, for pharmacists, too. I mean, you've got federal and state law or federal and state policy conflicting. But there's also the possibility that you're going to be charged with a crime and at the very least have to go get a lawyer.

**Ollstein:** Absolutely. And these physician groups and pharmacists groups have pointed out to me that if someone is charged with a crime, even if they're eventually exonerated, they still have to disclose that they've been charged when renewing their license in the future and things. And so there can be real repercussions even if they're completely cleared in the future and defended by the federal government. And so the medical field is very cautious. They're very small "c"

conservative. And so it was really notable to me that these groups that are not leftists, they're not activists in any sense if they're raising the alarm that these patient denials of accessing medication are really widespread, that really caught my attention.

**Rovner:** This has been sort of an underplayed part of this story that we're going to see more of. All right. Well, I'm calling this last segment this week "Hospitals in the News and the News Is Not Great." We will begin in Renton, Washington, where, according to a front-page [story in the Sunday New York Times](#), a nonprofit hospital system instituted a program designed to pressure patients into making payments, even those patients whose low incomes entitle them to free care, and sent those patients who didn't pay to collections all while taking a \$1 billion-a-year tax credit for providing "community benefit." Meanwhile, in [a companion story](#), a Catholic health system based in Richmond, Virginia, used the funding it got from the 340B discount program for one of its hospitals in a low-income part of town to invest not back in that low-income hospital, but in wealthier, whiter neighborhoods. While these stories were dramatic and maddening, nothing in them was really new, right? These things are things we've known about what hospitals are doing?

**Cohrs:** Right. I think both of these were just really good examples of trends that we've seen going on. And I think both of the systems actually were Catholic, as well — Providence is too. And I think there's just that extra level of question, with mission and how they were founded when it comes to these profit-seeking activities that we're seeing. Certainly the 340B program, there's been concerns about this happening for many years. The program is growing a lot. And, certainly, I think this was a very egregious example of people not getting the charity care that they're promised in a state where there actually are legal protections at the state level for who is supposed to be offered charity care, which a lot of states don't even have. So I think this was just an egregious example. You have McKinsey involved, too, with this "Rev-Up." They put together this whole program, and I think the system, Providence, did say that the tone of this doesn't reflect our values, this presentation that they're giving to their staff about how to collect from these patients.

**Rovner:** Basically, I mean, part of it was "don't ask them for money if they're going to pay, ask them how they're going to pay."

**Cohrs:** Exactly. But, yeah, I think these ongoing issues, it's important to still highlight them and show they're still going on and just build out that public awareness that these things are happening.

**Rovner:** Yeah, I mean, there's been some ... We've talked about the 340B program here a lot. It's where hospitals and other facilities that serve low-income patients get big drug discounts and they're allowed to keep the difference, on the theory that they're going to spend it back on those low-income patients. So the idea that Bon Secours was taking this, that the hospital system was taking this money and instead of funneling it back into the hospital, the reason they were eligible for it, but funneling it into other facilities in more affluent areas is definitely not in the spirit of program, whether or not it's within the legal limit of the program. Well, also on the hospital front, [the latest in our KHN series](#) on medical debt found that some of the markets with the most patient debt also have some of the most profitable hospitals. At the top of that list is the Dallas-Fort Worth area, which averages more patients with debt and patients with larger amounts owed while



at the same time home to a series of hospitals with higher-than-average operating margins. Hospitals have a lot to complain about right now: labor shortages, rising prices for supplies. But they're coming to Washington asking for more relief. But at some point, somebody's got to start asking about what's happening with their patients. I mean, are we seeing any evidence of that? Or is the health arm of Congress busy with other things?

**Knight:** It's getting pushed off again to the end of the year [is] what's going to happen. And that's something my colleagues have been reporting on, what the providers, hospitals, different groups are asking. And, again, it's to be seen what will happen. There was one thing in the [continuing resolution], in the stopgap spending bill, about continuing the, extending the Medicare programs for rural hospitals. And there is evidence that those hospitals really are struggling. But as for the other hospitals, I'm not sure there is as much evidence. But it's not stopping them from going to Congress and asking for help. So it's still to be seen how that's going to play out at the end of the year.

**Rovner:** Hospitals are always, they always have something that they need from Congress. And they're always involved in these end-of-the-year negotiations. I think a lot of stuff is being pushed off to the "lame duck." And well, obviously, that will play out depending on who wins a majority for next year, how much they're going to want to get done. But we will come back to this in future weeks.

OK, that is the news for this week. Now we will play my interview with documentarian Cynthia Lowen about her new film on the abortion debate. Then we will come back and do our extra credits.

I am pleased to welcome to the podcast Cynthia Lowen, director and producer of the new documentary "Battleground: The Fight for the Future of Abortion in America," coming in October to a theater near you at literally what could not be a more opportune moment, news-wise. Cynthia Lowen, thank you so much for joining us.

**Cynthia Lowen:** Thank you so much for having me, Julie.

**Rovner:** So I have seen a lot of documentaries over the years about the abortion debate, but this is the first one that's really delved deeply into the organizational strategies of the anti-abortion side. I feel like the subtitle of this could be "How They Did It." First, congratulations for getting such intimate access to these groups and their daily activities. But tell me why you chose this particular lens through which to showcase the abortion debate.

**Lowen:** I was really curious to understand how it was possible that so many anti-abortion policies were being put in place, how so much anti-abortion legislation was being passed, when 7 in 10 Americans — the number varies, but when the vast majority of Americans support access to abortion. And so the approach to get behind the scenes with the antis and see how they were strategizing and organizing and doing what they were doing was really out of curiosity of, "How are they doing this when they are so vastly outnumbered?" So that question was really what led to the lens that the film takes and trying to understand who these folks are and what they're doing.

**Rovner:** How did you get permission to do all of this? I mean, I've covered both sides of the abortion debate for a long time, and I find both sides are pretty private about their actual strategies.

**Lowen:** The thing that I said to the three anti-abortion women who are at the center of the film is: "Putting aside one's personal perspective or personal opinion about abortion, the power and influence of the anti-abortion movement over American policy, legislation, and culture is a fact. And it's a fact that I think is worth exploring and understanding." And so the pledge that I made to them was that I would depict them and their perspectives and their actions as accurately and completely as I could. And I think that that's the approach that you see coming through in the final film is that we're very editorially restrained and just present them and what they're doing and what they've done as "this is what it is" and just laying it out there. The film does not in any way caricature them or treat them disrespectfully. It presents them and who they are and what they believe as it is.

**Rovner:** So you feature two unquestioned leaders of the anti-abortion movement, Marjorie Dannenfelser of the Susan B. Anthony List, who we had on the podcast back in January, and Kristan Hawkins of Students for Life. But you also include a much lesser-known anti-choice representative, Terrisa Bukovinac, who calls herself a progressive, pro-life atheist. At first, I thought she was going to be your token pro-life Democrat, but that's really not the case. Who is she there to represent?

**Lowen:** What I think Terrisa represents is that the anti-abortion movement is seeking to really expand their base. And what I found really interesting that comes through both Terrisa's story and I think the approach that Kristan Hawkins is using with Students for Life is that they are cultivating single-issue voters. And they understand that many young people, in general, they tend to be more progressive. They don't tend to be conservative. And they also tend to be interested in things that they think are fighting the good fight. They tend to be interested in social justice. And so in Terrisa's corner of the anti-abortion movement and to some degree some of the folks who are involved in Students for Life, it's like they may be progressive, they may be liberal, on many other things. And yet the thing that they are centering in how they vote are anti-abortion policies. And I was really curious to see how this would play out when Justice [Ruth Bader] Ginsburg passed away and when you had someone like Amy Coney Barrett who was being nominated. I was very curious to see how someone like Terrisa would respond to that because Amy Coney Barrett is anti-abortion and conservative on many, many, many other issues that impact the kind of policies that left-leaning people tend to support, such as gun control, such as advancing universal health care, such as advancing environmental issues. And yet for Terrisa, and I think for others — and this is part of what the antis have been really doing — is that they are willing to put aside environmental issues, educational issues, health care issues to say, "Oh, no, this is the thing that I care the most about. And so even if a conservative like Amy Coney Barrett is going to vote against the policies that I support on these other things, she's anti-abortion, and so I'm going to get behind her for this."

**Rovner:** So one of the major criticisms of the pro-life movement over many, many years is that it's been mostly led by older white men. You've made it a point to highlight women in the movement, particularly, as you just said, young women. Was there a specific reason for that?

**Lowen:** I think that I went into this project with a lot of those preconceived notions about who anti-abortion folks are. And I think I had that idea that, "oh, it's all old white men." And I was totally surprised myself, once I started looking and getting more inside the movement, to discover so many women, so many young women. And, again, I think it really speaks to the strategy and some of the forward-looking things that the antis are doing, which is to be building up the next generation of people. It's something that Kristan Hawkins says: "Young people drive cultural change, and if we don't get the young people on our side, then the things that perhaps were started by the old white men are going to be lost" — from their point of view. You also have individuals like Phyllis Schlafly, who has a brief cameo in the film, and I think that it would be a failure to ignore or underestimate the anti-abortion conservative women and to assume that all women are in favor of choice and in favor of abortion access, because there are a lot of women who aren't. And I think it's important to look at that because when you try to understand why in places like Alabama, which is one of the main places where I started filming, there is so much stigma against speaking up about abortion. It also comes from the fact that there are many women who are anti-abortion. There are many women who will not share their own experiences about abortion for fear that their own communities will turn on them. And that includes women in those communities.

**Rovner:** So how do you hope this film can advance what's already an extremely heated — nay, overheated — debate about abortion?

**Lowen:** I think that there was Alexis McGill Johnson, who participates in the film and who also ... She's the president and CEO of Planned Parenthood Federation of America ... She participated in our Q&A at the premiere at the Tribeca Film Festival, and she said what the pro-choice movement has been confronting is a believability gap and the ability to really understand that the threat to abortion rights, and the threat to abortion access, is very real. And I think that this film does a lot to open audiences' eyes to how formidable the anti-abortion movement is, that these are people who have a lot of organizing power. They have a direct line to the most powerful people in the country. You see a direct line to [Senate Minority Leader] Mitch McConnell, to [former] Vice President [Mike] Pence, and, of course, to former President [Donald] Trump, who was very willing to put in hundreds of federal judges and others in the federal government, and that there's this very coordinated strategy to manipulate the levers of power to advance their agenda because they know that they're outnumbered. And so there is a clear understanding, and we saw this in Kansas, that when the matter is put through a democratic process, that people will vote for abortion access. But what is happening behind the scenes is that the antis' agendas are being advanced through undemocratic means. And understanding how that's working, understanding how they're manipulating the levers of power in our democracy, I think are very important. And to not underestimate the tactics and the abilities of the antis to have their agendas become law.

**Rovner:** And it speaks to, obviously, more than just abortion, right?

**Lowen:** Absolutely. Absolutely. I think that as we've seen in the wake of *Roe*, that many of the other rights that we enjoy as Americans are hinging on the kind of rights that abortion provided. And once that's chipped away at, there is a vulnerability to many of our other rights.

**Rovner:** Well, Cynthia Lowen, thank you very much. Congratulations on the film.

**Lowen:** Thank you.

**Rovner:** "Battleground" is in theaters starting Oct. 7.

**Lowen:** Thank you so much, Julie.

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

**Ollstein:** Sure. I have [a piece](#) by my former co-worker and now your current co-worker, Darius Tahir, about medical bias in medical records. And it's a really interesting piece in how doctors put loaded language into people's medical records. It can be something as small as putting scare quotes around a word or two, or putting language about how they're dressed, or things that imply class or their behavior, and that that can follow people around just for years and years and years and impacts the quality of care they get. So. Smart story there that I recommend.

**Rovner:** Yeah, it was really terrifying. Victoria.

**Knight:** This week, I read [a profile of Mark Cuban](#) in Forbes, and it's about his Cost Plus Drugs company, which launched in January 2022. But it was kind of in the works beforehand by some doctors. It was a nonprofit, and he took it over and invested a bunch of funding in it. Basically, in this company, he's offering drugs for very cheap generics because he's bypassing the pharmacy middlemen. And so he's buying directly from the drug manufacturers. Then he's putting a 15% upcharge on the drug and then slapping the shipping charge on there and then sending it out to people. And so there are some stats in the story where some of these drugs cost hundreds of dollars and he's selling them for like \$4 or something like that. So it's so much cheaper. One thing is he doesn't take insurance and doesn't sell drugs that have patents on them. So it is a limited set of drugs that are available through his company. But according to this story, it's pretty successful so far. They're seeing lots of customers. I think it was something a million customers. They're growing pretty rapidly, hoping to be profitable in 2023. So it's just another company that is trying to fill a need in the American health care system that is messed up and has people paying lots for drugs.

**Rovner:** So Mark Cuban, whom people know from "Shark Tank," has been thinking clearly about the health care system for a long time and apparently wants to see what he can do from the capitalist point of view to actually make things better. He's making the effort. That's, I guess, what we need.

**Knight:** And he said he may even leave "Shark Tank" for it. So he is very passionate about it.

**Rovner:** Yes. Rachel.

**Cohrs:** So I chose a story in The New York Times. The headline is "[Arbitration Has Come to Senior Living. You Don't Have to Sign Up](#)," by Paula Span. And I just thought this was a really great deep dive on arbitration in senior living facilities, nursing homes, because I remember back when we were having fights over covid funding and Republicans really wanted a liability shield for providers. And I think a lot of states do have state shield laws for senior living facilities. And I think it's fascinating — and very practical knowledge — that if your loved one is in one of these facilities that they may be signing papers. The intake papers may include an arbitration clause, and that may limit your legal options. And also from a journalist's perspective, these lawsuits aren't actually getting filed in court. There are less public documents available, and it's harder for us to see which facilities are attracting an outrageous number of lawsuits or an unusual number. So I thought this was just a really great rundown and had some very practical implications for patients.

**Rovner:** Well, my story is also about senior living, and it's also about private equity. It's happening abroad. It's a KHN story by our former executive editor Christine Spolar called "[Britain's Hard Lessons From Handing Elder Care Over to Private Equity](#)." And it's about how even in a country with a government-run national health service, paying for long-term care continues to be a problem, and a problem that privatizing the sector hasn't helped, at least not so far. To quote from the story about a survey done in Britain, more than a dozen staff members who weren't identified by name or facility said companies were "cutting corners" to curb costs because their priority was profit. Staffers said these changes meant residents sometimes went without the appropriate care, timely medication, or sufficient sanitary supplies. Someone really needs to figure out how to deliver adequate long-term care at an affordable price. Apparently, it is not going to be private equity. Obviously, no matter what your health system looks like, this is something that we're all going to continue to struggle with.

So 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 producer, Francis Ying, who makes the weekly magic happen. As always, you can email us your comments or questions; we're at [whatthehealth](mailto:whatthehealth@kff.org) — all one word — at [kff.org](http://kff.org). Or you can tweet me. I'm @jrovner. Victoria.

**Knight:** @victoriaregisk

**Rovner:** Alice.

**Ollstein:** @AliceOllstein

**Rovner:** Rachel.

**Cohrs:** @rachelcohrs

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