

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

**Episode Title:** Finally Fixing the 'Family Glitch'

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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, Oct. 13, at 10:30 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today we are joined via video conference by Margot Sanger-Katz of The New York Times.

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

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

**Rachel Cohrs:** Hi, everybody.

**Rovner:** And Joanne Kenen of the Johns Hopkins Bloomberg School of Public Health and Politico.

**Joanne Kenen:** Hi, everyone.

**Rovner:** So, no interview this week, but plenty of news. So we will get right to it. We're going to start this week with the Affordable Care Act. Open enrollment for people with ACA plans this year begins Nov. 1, runs to Jan. 15. This is the only chance for people to change or enroll in plans unless they have a specific triggering life change like moving or getting married. And the big news of the week is the Biden administration's announcement that it's going to take care of something called the "family glitch" to make more people eligible for government premium subsidies. Someone, explain to us what the family glitch is.

**Sanger-Katz:** Oh, this is a fun one. Basically, the Affordable Care Act was trying to patch up holes in the health coverage system. So, if you get employer coverage, you get these benefits. If you have Medicare, you get these benefits. If you are poor enough, you can qualify for Medicaid in most states. And if you buy your own insurance, you can qualify for subsidies based on your income. And the family glitch basically happens to people who are in between those categories. So, if you get coverage that is offered by your employer and it's considered affordable, given your income, then you are not allowed to also get subsidies on the exchange because Congress didn't want people to just leave their employer coverage and flood the exchange and get these public subsidies. They wanted to keep people in employer coverage who could stay there. But Congress didn't really think about what was going to happen to the family members of those people who get employer plans. And more and more employers will offer an affordable plan to their worker, but maybe not to their spouse or children. And until very recently, the spouse and children in that situation could not get subsidies on the exchange. So they would have to get insurance some other way, either through the spouse having another job, which is a very common way that this happens, or by paying the full price of insurance on the exchange, which can be quite expensive,

depending on how big your family is and where you live. So, what the Obama administration said was: "Nothing we can do about this. This is just the way the law is written. Sorry, it's a problem. Congress should fix it." The Trump administration had basically the same opinion, except they didn't really want to fix it. And the Biden administration has come along and said, "Oh, no, no, we can just fix this with a regulation." And so now if you are such a person, if your spouse gets affordable employer coverage but you cannot get it according to the affordability standard, you can now go to the exchange and buy insurance with subsidies. So this is one of the big gaps in coverage that remains due to the Affordable Care Act. And there are people who are definitely going to benefit from this. But I think ... What's interesting to me about it is it turns out that actually a lot of people in this situation have other ways of getting coverage. And so I think it could shift around where people get insurance. So it will reduce the number of uninsured people a little bit, but it might actually change the kind of insurance currently insured people have quite a bit as well.

**Rovner:** One thing I will add is that Congress actually did know that they were doing this when they did it. There were people who complained right as the law was being passed. And the bottom line was it was too expensive for them to fix it at the time. It was going to go over the amount that they were willing to pay. So they recognized that there was a problem, but they let it happen anyway and vowed to come back and fix it and have never been able to come back and fix it. But, Margot, as you said, I and a whole lot of other people thought this was something that could only be fixed by Congress. How is the administration justifying doing this on their own when no other administration said they could do it by regulation?

**Kenen:** I assume there's going to be a suit. Has anyone filed suit yet? It's been more than 24 hours, but I have not yet seen one. But I'm assuming someone is drafting one right now.

**Sanger-Katz:** I think there is like a serious answer and a snarky answer. And I think the snarky answer a little bit is that this is the kind of issue where even if it turns out that what they have done is totally illegal, I think it's actually pretty hard to sue and fix it because, generally speaking, our legal system requires that if you want to sue to overturn a law, you have to demonstrate that you have been harmed by that law. And I think in this case it's very hard to understand who is the harmed party here. The person basically who is harmed by this is the taxpayer because what's going to happen is that more people are going to get the subsidized coverage who might have paid the full price themselves before or whose employer might have paid a substantial share of their coverage price before. But you don't really get to sue as a taxpayer in general. The courts don't usually consider those to be valid grounds for lawsuits. And so I think there is an element of, like, "we dare you" in this strategy. I also think that there are people in the Biden administration who always thought that the Obama administration's interpretation was wrong, and they do think that they are on more solid legal ground than a lot of other analysts do. But I can't help but think about the Trump years as really influencing the thinking of regulators in this space, where I do think that there were a lot of areas where regulators in the Trump administration just kind of shot for the moon and did a lot of things that all of us would have said: "No, the law doesn't say that. Previous analysis has said that that's not legal." And many of them, as I wrote about at the time, many of them were overturned by the courts. I mean, there were ... The Trump administration's record in the courts with some of these regulations was quite poor relative to previous administrations. But

some stuff did get through. And the kind of stuff that tends to get through is this kind of thing, where there's not an obvious person with what's called "standing" to sue.

**Rovner:** Which is ... It's the same for the student loan thing. The question is: Does the Biden administration have the authority to waive these student loans? And the answer is: "Probably not, but it's going to be hard." Although there have been a few lawsuits filed. People are going to try.

**Kenen:** Commercial lenders.

**Rovner:** Yeah.

**Kenen:** I mean, there's standing. It's a different issue. They already modified the policy because of that.

**Rovner:** But I will say that this is not the first time I have seen this. I remember in the '90s there was an effort to allow Medicare patients to participate in clinical trials and have the clinical trial pay their medical expenses. And for complicated reasons, that wasn't allowed. And Congress had tried to change the law and come close and hadn't done it. And then finally the Clinton administration just did it. And I remember asking one of the Clinton aides, "If you could just do this, why have we been fighting about it in Congress?" And he said, "Well, we couldn't just do it until we got legal counsel opinion that we could do it."

**Kenen:** No, I mean, also, we've seen prolonged legal fights over standing. So, if you get a sympathetic lower court, you can still have some kind of stay or delay or lower court ruling that gets overturned later or a temporary stay. I mean, if somebody decides to sue — I suspect someone will — it could be thrown out really fast on standing, or it could be thrown out in three years on standing, with lots of delays in between. I mean, basically nothing major in health care happens without a lawsuit. So, yes.

**Sanger-Katz:** I also think this policy fits into one of my favorite/least favorite themes in Washington coverage, which is just one of these things that we see all the time here but that I never once thought about before I covered health policy here. Which is, as you said, Julie, Congress knew that if they made it clear that this was allowed in the law, the CBO [Congressional Budget Office] would have said it was really expensive and that would have affected the score for the Affordable Care Act. Democrats really cared about the Affordable Care Act lowering the deficit on net. That was politically important for them. So as a result, they didn't do it. Now, if the Biden administration comes and does this through regulation, it still costs the same amount of money, but it doesn't count toward any scorekeeping that people have to go back to their districts and defend. It still has the exact same impact on the deficit. And we see this all the time. This is a problem. It's called the "family glitch" by many Democrats. They believe it is a glitch. It is a hole in the Affordable Care Act that they want to fix. They just passed a whole bunch of legislation, including legislation that touched on the Affordable Care Act. They could have fixed this in a different way. They didn't want to because they did not want to be on the hook for the price tag. They again wanted to pass legislation that was perceived as lowering the deficit. And that's why we see this policy being enacted in this way, where it has more legal vulnerability, not because the

effect is different, not because the actual cost is different, but because the way that the cost is accounted for has a different political valence.

**Kenen:** But I also think it was simply that they needed to keep their CBO score under \$1 trillion for it to get the moderates to vote for it. And it could be 99999 — a whole lot of 9s — but it couldn't have that headline: Obamacare costs \$1 trillion. And this was one of the things that they jettisoned to keep it under. So, Margot, I agree with her, but there was also this compressed version of that, not just, “well, is it scored as deficit reduction” or is it ... just what's the headline? And that would have been a headline.

**Sanger-Katz:** But it's also just scored at all. It's scored as a cost.

**Rovner:** Right. We will move on because we will clearly be coming back to this.

**Kenen:** I'm surprised how little coverage it got, though.

**Sanger-Katz:** It's because it's so hard to explain, I think. No one wants to write that sentence about what the family glitch is.

**Kenen:** No, I think it's also because of other things in the news this week, including the elections in Ukraine. I mean, it's been a nonhealth ... other than abortion. Those are the dominant stories.

**Rovner:** Yes. It's been busy. All right. Well, I want to talk about another story that's gotten some coverage, thanks to Margot, but not as much as maybe it should, which is Medicare. Which I hasten to add is still the big kahuna of health programs. It's much bigger than the Affordable Care Act. It accounts for 12% of the federal budget and 20% of all health spending. Medicare open enrollment begins Oct. 15 — so, soon — and runs until Dec. 7. So, open enrollment in Medicare is very different from open enrollment for the Affordable Care Act and employer plans. Generally, you enroll in Medicare when you turn 65 or when you stop receiving employer insurance, whichever comes later. Open enrollment is when Medicare enrollees can join or change prescription drug plans, or join or change private health plans that may offer more benefits than traditional Medicare. Those plans, called Medicare Advantage, are getting so popular that they're about to enroll more than half of all Medicare beneficiaries. But they're not always that advantageous, particularly to taxpayers who help fund them, right, Margot?

**Sanger-Katz:** Yeah. This is a very interesting, complicated machine that Congress has created where they have a system by which these private plans can compete. They can offer slightly different benefits than traditional Medicare, and they can offer lower cost sharing and lower premiums than traditional Medicare. And I think they also can spend a lot of money on marketing. If you watch any cable news, for example, you're probably seeing commercials for these plans constantly. There are lots of them. And these are companies that are better at marketing probably than the federal government.

**Rovner:** Network news, too. The commercials are ubiquitous.

**Sanger-Katz:** I think there's two sets of questions. One is: Are they better or worse than traditional Medicare? And I think the answer to that question is kind of complicated, a little bit unclear. It seems like on average they are about as good and maybe a little bit better in some ways. There

are a lot of people who choose them who prefer them. I think a crucial reason is because the traditional Medicare benefit is not very affordable, has relatively high premiums. Really importantly, it has extremely high cost sharing, traditional Medicare benefit. You're on the hook for like 20% of your medical bills, with no cap. So that means if you're really sick, you could be just paying and paying and paying. Traditional Medicare does not include benefits like dental and vision and hearing services, which are services that a lot of senior citizens need. So I think it's not a total surprise that Medicare Advantage has become a popular alternative. If you're a middle-class person and you don't want to have uncapped liability, you want to have access to these additional benefits, and you see a great commercial on television that's telling you that this plan can solve all your problems, I think people sign up. So Medicare Advantage is poised to become the majority of Medicare by next year. So it's just swallowing up the government program very slowly, which is a surprise even to me.

**Rovner:** It's going to wither on the vine, as Newt Gingrich once suggested of these private plans. It used to be that people would buy [an] insurance supplement to go with Medicare, which just covered their cost sharing, but it didn't give any of these extra benefits. There was one that gave a tiny drug benefit. This was before there were drug plans in Medicare. But now we have these big fancy plans, and you have to stay in network, which can catch some people off-guard. When they first started what is now Medicare Advantage — it was called Medicare Plus Choice; it had yet another name at the beginning, which I can't remember — they only paid the plans 95% of the average Medicare beneficiary's costs, because the theory was this is managed care. They could make up that 5% in more efficient care and still make a profit. That's not how they're paying them anymore, right, Margot?

**Sanger-Katz:** No, they're paying them in lots of different ways. So, one thing is that they pay them, even for apples to apples, a similar customer, similar package of benefits, they pay them according to a benchmark formula that is more than 100% of what Medicare would get for a similar patient. Then they have all of these other bonus programs that they have for them, including additional payments if they exceed certain measures of quality. Which I think the quality metric system is maybe imperfect, but they're trying. And then the other thing that they did — and this was, I think, born out of a good instinct — is that Medicare pays the plans a higher price to take care of sicker people than healthier people. So if you are a 65-year-old, just joined Medicare, you go running every day, you have no health problems, you don't take any medicines, no diagnoses in your health record, a Medicare managed plan doesn't get that much money for you. If you're someone who has diabetes with related renal failure and a previous stroke and a mental health problem, the plan gets paid a lot more. And that makes sense because you are going to cost a lot more in insurance claims. You're going to use more medical services on average than the really healthy 65-year-old. But what [our story](#) showed is that the plans have become just like incredibly adept at gaming the system, at finding methods that allow them to harvest as many diagnoses as possible from their patients. And in many cases those efforts have crossed the line into fraud, according to lawsuits brought by whistleblowers and by the Justice Department and, in some cases, lawsuits that have been settled by the companies themselves. Just this huge financial incentive to make the patients look really sick. The plans are optimizing for that, and it's costing

taxpayers a lot of money in a program that is expensive and that is experiencing some financial strain.

**Rovner:** We've known this generically for some time, but you found cases where these plans were actually pushing doctors to mine medical records to find the possibility that years ago somebody had some ailment that they could now collect for.

**Sanger-Katz:** Yeah. I mean, one thing that I thought was interesting and the reason that we decided to do the story in part is that Kaiser Permanente — not associated with Kaiser Health News — Kaiser Permanente, I think, is often seen as this model health system. They run the insurance company, but they also employ the doctors and hospitals. And people often talk about them, they're so great at integrated care because they do all of the things. They are ... The whole idea of Medicare Advantage is: "Well, if you do this managed care, you're going to be able to keep people healthier. And the company has a profit incentive to keep people out of the hospital, keep people from having very expensive care. And they can do that by figuring out how to keep them healthy on the way in and prevent problems." And Kaiser [Permanente] was always seen as the kind of institution that was optimized to deliver on that promise. And what we found is that actually when the insurance company employs the doctors directly, they just have way more leverage over them to force them to do all this scammy stuff. And Kaiser [Permanente], in fact, according to several whistleblower suits, put enormous pressure on doctors to add diagnoses to patients' records and often gave them financial incentives, champagne, and other prizes if they hit certain targets that allowed them to reach their financial goals. And Kaiser [Permanente] is the subject of multiple whistleblower lawsuits, and the government has joined that suit so that ... They obviously deny that they've done anything wrong. And that case has not been concluded yet. But it is ongoing, and I think it is, to me, a real sign that like even Kaiser [Permanente], that this is a very widespread practice throughout the industry. And, again, that's what we found in our story. We read through basically every single lawsuit related to this kind of fraud, of which there were like 20 or 25. And there's just very few major players that have escaped these kinds of serious allegations of fraud.

**Rovner:** Yeah.

**Sanger-Katz:** And there are also just like numerous other indications that the plans are being overpaid by these formulas, which is not necessarily fraud, but it is overpayment by taxpayers.

**Rovner:** This was a classic case of fixing one problem and causing another, because it used to be that these plans wouldn't enroll sicker people and they would have these mischievous ways of doing that by ... You had to sign up for them. You had to go to the second floor of a building that didn't have an elevator. The extra benefits were things like gym memberships. I mean, they were designed to attract only the healthy people. So this was an effort to make sure that they also were welcoming to sicker people. And as we've seen, when there's money on the table, people will find ways to claim it.

**Kenen:** But briefly ... I mean, Margot's story is great, but there's also gaming the system in traditional Medicare. There's upcoding in traditional Medicare. There's unnecessary ... You give people stuff they don't really need. The whole health care system lends itself to this. And it's a

problem. I may have told this story. I know someone, a Medicare recipient on fee-for-service at the time, who went to her dermatologist for an annual screen. And the doctor wanted to do one-half of her body. She had to come back for the other half. Because they pay twice. And it's ... America.

**Rovner:** America's health system.

**Sanger-Katz:** But the other thing I just want to say again that, in doing the reporting for this story, was surprising to me and feels notable is some of the lawsuits that we wrote about are like 10 years old, and some of the behavior is even older. This is something that has been going on since this program started operating under these rules in the early 2000s and has been ... MedPAC [Medicare Payment Advisory Commission] has written about it. The GAO [Government Accountability Office] has written about it. The inspector general has written about it. Academics have done analysis of these. There's all these lawsuits. One of the things that was surprising to me is how little CMS [the U.S. Centers for Medicare & Medicaid Services] has done about it. The reasons for that are somewhat complicated, but I think that there is a lot of political pressure to protect Medicare Advantage because it has become so popular. When you're talking out about a program that enrolls now about half of Medicare beneficiaries, is about to be the majority, that's a lot of voting constituents in the congressional districts of lawmakers. And if you look at the map of where these plans are the most popular, they tend to have really high saturation in areas where Democrats are the political leaders, and they tend to have more ideological affinity among Republicans, who like the idea of privatizing Medicare more and giving consumers more choice in insurance. And so what that means is that this is a program that has enormous political support across the bipartisan spectrum. There was a letter that was recently written to CMS, was signed by 80% of House members, basically saying, "Don't you touch this program. Don't you take money away from them. Our constituents are counting on them. We don't want you to take money out of the pockets of our very happy voters." And you can see across multiple, multiple administrations, even though there's pretty substantial evidence of fraud and gaming in this program, that there has just not been a lot of effort to change the regulations or to stamp it out.

**Rovner:** Well, obviously, Medicare is a big political issue, and the Democratic Congress tried to make their stamp on it earlier this summer with the drug negotiation and out-of-pocket cap and insulin provisions of the bill that they passed. But we're not seeing that much on the campaign trail. I'm surprised that Democrats aren't touting this more because the seniors are a big voting bloc, and this is something that seniors had very much wanted and that they're very much going to get. Why has this fallen aside as a campaign issue?

**Cohrs:** Just, quickly, I want to touch on open enrollment on this issue as well. When seniors are looking at their plans, they're not going to see a lot of difference this year. Obviously, the insulin copay cap at \$35 a month is going into effect this year. But seniors already had options to have plans that already did that before this went into effect. And the out-of-pocket cap of \$2,000 a year doesn't go into effect until 2025. So this is a little bit down the road. And that doesn't mean that Democrats are doing a good job getting it out there. There was a Kaiser Family Foundation poll that found that the issue wasn't really breaking through and that only about 36% of voters that they polled showed that this issue was breaking through, that they even knew that this new

authority existed. And I think it is just a different landscape than earlier this year. And it's a question of which health issue is going to be the winning issue to talk about and what can really move the needle for people. And, yeah, I mean, it's a big problem if people aren't seeing the pocketbook impacts quite yet and they don't have an awareness of what this really big bill did. And I think part of the argument for this was the political salience besides the savings, like Margot was talking about earlier with the Congressional Budget Office — always a big factor. But I think it is a problem for Democrats. They're going to have to figure out how to message this to people if they want to benefit from it this election cycle and not kick it down the road to 2025, 2026 when this actually goes into effect.

**Rovner:** Although they will benefit from the overcollection of premiums last year for Aduhelm that's now basically being rebated next year. So Medicare Part B premiums are going down. And just this morning they announced the largest Social Security cost-of-living increase in 40 years. Thank you, high inflation. So at least seniors will see some pocketbook relief right away, though neither of them are because of anything that Congress did. So sometimes you're the windshield, and sometimes you're the bug.

**Kenen:** But I also think there's like part of a long history of the Democrats being unable to sell what they have achieved on health care. The ACA had a lot of benefits for people who were not in the exchange. I mean, preventive care, well-baby visits, a lot of cancer screenings.

**Rovner:** Kids under 26 on their parents' plan.

**Kenen:** Right. Lots and lots and lots of things — protections for preexisting conditions, all these things that people didn't understand because if they weren't in an ACA exchange plan, they just thought, "Oh, look, the health care gods gave me this stuff." And the Democrats never said, "We're the health care gods." The amount of confusion. I mean, Obamacare was harder than the Inflation Reduction Act because it had so many moving pieces. It was controversial, and it was very confusing. But people getting a benefit and not knowing where it came from in a political year is not new to the Democrats.

**Sanger-Katz:** There's a lot of other salient stuff. [I] think that abortion is just such a huge and motivating issue, and we're going to talk about that more. But it seems like the public opinion polling is basically telling Democrats "this is the issue that you should be talking about." And I think if we did not have this Supreme Court decision and all these states changing their abortion laws, I think we would be hearing about these prescription drug price reforms a lot more. Going into the summer, this was an issue that Democrats thought was going to be a huge winner, and I think in the last few campaign cycles we have seen Democrats messaging about their desire to fix this problem quite successfully. I just think things change and campaigns have to decide what their priorities are.

**Kenen:** I think the Democrats are missing an opportunity because you create the priorities that the polls reflect. If you say, "Yeah, we're fighting inflation. Here's one way: We just saved Medicare patients from having to pay X." And they're not doing it. And I don't think they even tried. It's not like they did it and it didn't resonate. I mean, we all know the messaging patterns. We've seen it. We've seen it for a lot of years.



**Rovner:** All right. Well, I want to pivot to something that seems more obviously political and something that, instead of being aimed at older voters, is something that is aimed at younger voters: marijuana. President [Joe] Biden last week — of course, right after we taped last week's podcast — issued pardons for anyone convicted of the federal crime of simple possession. Basically, people caught on federal land like national parks or in the District of Columbia. And the president urged state governors to do the same for those convicted of simple possession on state charges, which is obviously the majority of people. The president also ordered the administration to review whether marijuana should remain on the list of Schedule 1 controlled substances, which are those that technically have no medicinal uses. But he stopped short of calling for federal decriminalization. Is this a play for the youth and stoner vote? Is that literally why he did this in early October before a key midterm?

**Sanger-Katz:** I think not only ... I think there's broader political support for decriminalizing and legalizing marijuana than I think anyone thought even a few years ago. And I don't think it's just young people who want it. We've seen it decriminalized in so many states, legal sales, either for medical purposes or for recreational purposes. And it really is a political winner. I think not everywhere and not among every voting demographic. But I think it's not as risky a move as it might seem on first look.

**Rovner:** Also, Congress is looking at this, right? On my list, I had seen a story that Congress was about to pass a medical marijuana law, but I guess it didn't happen before the break. So there must be some hold up. Anybody tracking this?

**Cohrs:** Not tracking much, but I know there's been a whole lot of stops and starts on a whole lot of issues. And [Senate Majority Leader] Chuck Schumer's made a lot of promises that haven't come true. But they've done a lot. There's a lot they haven't done, too. So I think this just falls into that category.

**Rovner:** And may yet get tucked into something before the end of the year.

**Cohrs:** Who knows?

**Rovner:** We'll have to watch. Well, we're going to talk about abortion. But first I want to talk about John Fetterman and the race in Pennsylvania for the Senate because there's been a lot of talk about the Democratic candidate's health. He had a stroke in May, around the time of the primary. And he was off the campaign trail for a good long time recovering, and they were fairly transparent about that. He's been back on the campaign trail, but he's using what we call an accommodation. He's still having trouble processing the spoken word. It's easier for him to read it. And there's been a lot of "oh, my God, will people vote for him? Is he incompetent to hold office?" And then there was this huge backlash on social media from the disabled community about "how dare you suggest that someone who's just using a fairly simple accommodation." And Fetterman's been doing a lot of media. He spoke for over an hour to one of the Pennsylvania editorial boards this week. I'm wondering maybe this is showing a lesson about people with disabilities. We certainly have had disabled members of Congress before, people in wheelchairs. [President Franklin D. Roosevelt] was in a wheelchair. How is this different?

**Kenen:** He hid it.

**Rovner:** That's true. He did. I guess my question is: What are we to make of this fight over Fetterman's fitness for office?

**Sanger-Katz:** I think there are two things that seem salient to me. One is that it does seem like voters are pretty comfortable voting for members of Congress who have physical disabilities now. I think it may still be a disadvantage, but we do have a number of members of Congress who use wheelchairs or use other kinds of physical accommodations. I do think part of what is politically unknown about this is that he does have a brain injury and he has some cognitive deficits. And I think the question is: Do those just affect whether he can hear speech as well as he can read it? Which I think is what the Fetterman campaign is saying. Or is there something more fundamental in his cognitive abilities that we don't know about? And there are, of course, many people who have disabilities of this type who are really tremendous people and they just need reasonable accommodation and they can work in all kinds of capacities. And I think that is why we see this backlash is that if he just needs this easy little tool that helps him and he's everything else that we want in a senator, who cares? But I also think this is an injury that he suffered during the time of his campaign. And he hasn't been doing a lot of public appearances, and he hasn't provided a lot of transparency about his health until very recently. And I think voters just, like, don't know. And they're going to have to decide how they feel about it. I think it's obviously something that voters are curious about and are going to consider. And it's hard to pretend that it is not happening.

**Kenen:** But it's also a really, really bitter campaign going on in Pennsylvania. And the control of the Senate may come down to Pennsylvania. And if he were a sitting senator ... There are other sitting senators who've had strokes and who have had various needs or temporarily ... Some of them have recovered more fully than others. Others have ended up retiring. But there are senators who get sick and there are senators who need accommodations, and some of them stay well past their expire date, right? We've all been on the Hill and seen over the years senators who are not as cognitively alert in their 99th year as they were in their 50th.

**Sanger-Katz:** And that's different, right? Because it's not just someone who needs a tool. It's someone who actually maybe doesn't have the full capabilities to do the job. I mean, I think we've all seen that in Congress.

**Kenen:** Right. But if he wasn't a candidate, if he was a serving senator, if he was in the Senate now, no one would be saying, "Oh, he's using this closed caption reader. We need to get rid of him right away. Let's impeach him." I mean, it's because he's a candidate in a tight race. So it is being manufactured to a certain extent. The question Margot brought up, which is the transparency. And, yeah, he should be really transparent. He should say, "This is what my doctors know and we're sharing with you. It should have been done at the very beginning." Right? I mean, we're all for transparency across the board. We all, all of us on this podcast, believe in that.

**Rovner:** We're journalists. It's our job.

**Kenen:** But there's also: How is he being portrayed? And he is being portrayed as mentally deficient, incompetent, questioning basic abilities. That is not a match. Needing an

accommodation does not mean you cannot be a senator. We don't even know how long he'll need this accommodation. Maybe for the rest of his life. Maybe for a few more months. We don't know. But doctors probably don't know. I mean, people recover from strokes, but they recover [to] different degrees. So I don't think you can totally ... Yes, there are ugly things about how people perceive people who do have a disability and need an accommodation. But I also think this is about the Senate.

**Rovner:** I do think it has prompted a useful conversation even though there's a lot of people angry at each other.

**Kenen:** Yes.

**Sanger-Katz:** I'm reminded that during the 2016 presidential campaign, when President [Donald] Trump was running against Hillary Clinton and there were a lot of questions about both of their health that there was kind of ... We all talked about, there were these discussions about, like, should political candidates have to go to some kind of third-party, neutral auditing of their health. When it comes to the Senate, obviously, this is not the person with the nuclear codes, but I still think, generally speaking, voters want people who have some minimum amount of health and mental capabilities. And we just have limited transparency into how all these people are functioning in their jobs. And I think as people who are in Washington and interact with lawmakers, we probably have a little bit more visibility into some of the deficiencies that especially older members tend to have over time than maybe the average voter does. I think when you have the power of incumbency, there's just less scrutiny on these things because you have a track record of things that you've delivered for people and you have some name recognition. But I do wonder whether our political system needs some better way of evaluating the health of people who want to be our political leaders in general.

**Rovner:** Another conversation that I'm sure will continue. Well, let us turn to abortion policy. We will start where we just left off, which is how this issue is moving voters or not. We've seen a bunch of polls that cut both ways. Abortion is either waning as a voting issue, being lapped by the economy and inflation, or it's motivating mostly Democrats, which could be decisive in some of these close races that we've just been talking about for the House and Senate and governor. So which do you guys think it is? Is it ebbing or flowing or about the same as it's been?

**Kenen:** I think that this race is so close in so many states. If they all break the same way, if every single close race goes Democratic or five out of the six close races go Democratic, then we'll know abortion was a huge issue. And if the Republicans run the table, we'll know that abortion fell short for the Democrats. Do I have this feeling right now that it's a little less intense than it was a few months ago? Yes. But I don't know. I don't know that we know until ... I mean, you can look at what's going on in Nevada, right?

**Rovner:** It'll be easier to tell in hindsight.

**Kenen:** I mean, we know it's a factor. Whether it's the decisive factor in things. The fact that the Nevada race is now ... You have a woman who is a pro-choice Democrat and a Latina, and she was ahead, and she's now not. So there are multiple factors going on there. But, clearly, abortion is not

the magic bullet for a victory for every Democrat. In some of the close races, I don't think it's even necessarily the defining issue. It's an issue in every single race. But there are other issues. I mean, obviously, the Republicans are running on inflation and crime. And every time you go into the supermarket, you are reminded of inflation. And if you're poor, the food prices are a really big deal.

**Sanger-Katz:** I feel like the cliché, right? It's the economy, stupid. I feel like the economy is the No. 1 issue in every election. It's the No. 1 issue in this election. And I think the president and Congress don't have a lot of control over what happens with the economy in this short period between now and the end of the election. Six months ago, the economy was looking really bad, and inflation was high, and things were unaffordable, and gas prices were through the roof, etc. That was a really favorable political climate for Republicans who are running a campaign about those problems. The abortion issue was helpful for Democrats, but I feel like part of the reason why it's been rising in salience is because a lot of these issues in the economy actually have gotten a little bit better in the last few months. Gas prices have come down a lot. Inflation is not as high as it was before, etc. That could change again. I mean, there's a war going on between Ukraine and Russia that's affecting global energy markets. There are a lot of things that could change. And I think the rising and falling salience of these issues includes issues that politicians have control over, like whether they talk about prescription drug prices. That's something that they can control. They actually have done something on that, and they can talk about it or not talk about it. But I think these economic issues really override a lot of other things. And these politicians are just either lucky or unlucky as to whether or not it helps or hurts them.

**Rovner:** Well, also this week, the Supreme Court declined to hear a case out of Rhode Island that sought to have the justices rule that unborn fetuses are persons in the eyes of the Constitution from conception, which would effectively outlaw abortion and lots of other things, too, like in vitro fertilization. I got the feeling that the court didn't want to take this question up so close to when they struck down *Roe [v. Wade]* but they might in the future. This is the next on the agenda for a lot of anti-abortion advocates, right? We're going to see more about this whole personhood thing.

**Kenen:** Which just five or six years ago was considered so fringe that even Republicans didn't really talk about it very much. And now it's mainstream. Not all Republicans are for it, but it is part of the Republican dialogue.

**Sanger-Katz:** I think there's some evidence the Supreme Court is not ready for this issue yet. Justice [Brett] Kavanaugh in the oral arguments on the *Dobbs [v. Jackson Women's Health Organization]* case made it pretty clear that he did not want to cross that line, at least in the *Dobbs* case. Anything can change, and you'll need five Supreme Court justices to sign on to a new legal doctrine. But they have gone extremely far on abortion extremely fast since Justice Amy Coney Barrett joined the court. And I think personhood is probably a slower percolating issue if it does percolate its way to the court at all.

**Rovner:** Well, our podcast-mate Alice Ollstein isn't here this week, but she's left us an interesting [story about how doctors](#) in Pennsylvania and some other states are hitting the campaign trail, mostly for Democrats and supporters of abortion rights, arguing that more restrictions would jeopardize the state's huge health care industry and prevent medical students and residents from

wanting to locate there. Doctors are also worried about their own professional autonomy, but I'm interested that they're pursuing this business aspect, too. I don't remember ever seeing that before, doctors coming out and saying, "This could hurt the health industry in our state."

**Cohrs:** Yeah. That's a really fascinating story from Alice, just because there are certain places where hospitals are such large employers. Pennsylvania is certainly one of them. It's a huge industry and certainly one that the lawmakers in D.C. are very sensitive to. It doesn't happen everywhere, but certainly a dynamic at play here. And I think the business and the recruiting has just become such a salient issue for hospitals that when you talk to them about their staffing issues, that's the No. 1 thing that comes up. And it's not something that's really easy to solve. So I think they're just nervous about anything that's going to tip the scales on this issue. There are arguments about "should they be paying their regular staff more" versus "the changing dynamics in the temporary staffing market." And I think that definitely is an interesting point to highlight. And, yeah, Alice's story is really great and shows how big business really can have sway at the state level, as well.

**Rovner:** There's a [CNN story](#) out that suggests we might not be hearing as much from doctors as we otherwise would because these big hospital systems for which they work are telling them not to talk to the media and that doctors are frustrated that they're not being allowed to, that sometimes they can talk but they can't say where they work. They have to hide where they work. Are we not getting the whole picture of how these bans in some of these states are actually affecting pregnant women?

**Kenen:** I think that story, which was doctors, many of whom actually specialize in high-risk pregnancies and maternal and fetal medicine and some who work on maternal mortality issues, and they were talking about not being able to talk about ... wasn't so much just abortion in general. But there are times when women's lives are in danger and that it is becoming increasingly difficult for them to take care of those women in a timely manner. And their life becomes more at risk when their job as physicians is to prevent and reduce that risk, and that they were disturbed that they were really not allowed to talk about medical crises because of the politics, that they were not able to talk about lifesaving issues that involve both women. And many of these are wanted pregnancies with women who want to have a baby. And it wasn't just "we need *Dobbs* back." It was they're being suppressed, according to the story, when they're talking about, "I was not able to treat this woman until she was really on the brink of death and everything, and she was sick or it was more dangerous, it was more harmful."

**Rovner:** And I will point out that this is not something new. When I was covering the partial-birth abortion ban in 2003, there was a medical journal piece that suggested that it actually was a useful procedure in some women with high-risk pregnancies that had gone wrong. And I finally got to interview one of the authors of the study, but I had to get on a train and go to New York and sit in his office with the ACLU [American Civil Liberties Union] lawyer sitting there with us. I mean, it was such a big deal to get this one interview. So a lot of these institutions, and the CNN story says this, are frightened of jeopardizing their political standing and are trying to tell their workers to please be careful on this extraordinarily divisive issue. But I think it is truly frustrating, particularly [for] doctors who take care of women with high-risk pregnancies.

**Sanger-Katz:** Well, can I just make a more general point, which is I remember being a newspaper reporter at the Concord Monitor in New Hampshire 10, 15 years ago, and I wanted to interview local doctors about flu season. And the hospital would not let me talk to those people. I do think that, in general, it is true that this is an issue about which there is extraordinary political challenge and risk. And also when you're talking about doctors talking about experiencing not being able to help patients who have life-threatening conditions, you can see why that might be bad press for the hospital or might have liability-related issues. I think there are issues specific to the abortion issue that make it worse. But I also think, in general, you should just never underestimate the fear of hospitals of letting doctors talk to journalists. And we see this, of course, not just doctors and hospitals, but in government. We can't talk to the regulators about the work that they're doing without being babysat. And I think there's just a growing corporate anxiety about letting ordinary people doing their jobs talk about those jobs to journalists in a straightforward way. And it's frustrating on all kinds of stories. And it does prevent all of us, in many cases, from being able to tell the public everything that they ought to know about important issues in the news.

**Cohrs:** I think there is this sense in the hospital industry, especially children's hospitals right now, who've been facing threats of violence over whether they ...

**Kenen:** Trans care.

**Cohrs:** Right. Gender-affirming care. So I think there's this new dynamic. Certainly, like Margot said, they're always a little bit skittish. But I think with something this controversial, it's definitely something that's playing out in the space in a new way. We weren't necessarily seeing bomb threats, that kind of thing, at hospitals. So I think that's just another dynamic that's playing out. And they've seen how this can really affect the safety of their facilities and their staff.

**Kenen:** I had the same thought as Rachel. The CNN article didn't talk about that. But I mean there have been these online mobs. Some of the hospitals. Vanderbilt is the one that's gotten the most attention, I think, that do provide affirming care ...

**Rovner:** And Boston Children's Hospital, I think is the other one.

**Kenen:** They've really had this online onslaught, and they've changed what they publicly say.

**Rovner:** All right. Well, I think that's as much news as we have time for this week. Now it is time for our extra credit segment, where we each recommend a story we've 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. Margot, why don't you go first this week?

**Sanger-Katz:** I want to recommend an article by Rae Ellen Bichell from Kaiser Health News called "[Routine Births Are Turning Into Moneymaking 'Emergency' Events at Hospitals That Work With Private Equity-Backed Staffing Companies](#)," which was published in Fortune online this week. And it's like a maddening article, fascinating, about how there are growing number of hospitals that have basically set up special triage areas in their labor-and-delivery room where when women come to the hospital in labor expecting to deliver, they are triaged at that place. And then in addition to getting their bill for labor, delivery, and the care associated with a newborn infant,

they are also getting an additional bill for going to the emergency room on their way in the door. And this article spoke to a number of women this has happened to, including a number of health care professionals who I think really were like sharp to understand that this was a weird thing that was happening and then spoke to the hospitals and companies that have been creating these obstetric emergency rooms, which is a growing trend. And it does seem like, as with many of these very expensive new services, that there is a private equity connection in many cases, that the obstetrical staffing companies that are owned by private equity are encouraging the hospitals that they work with to set up these obstetrical emergency rooms as a way to bill for more money. So I just was fascinated by this practice. Seems like it's happening a little bit more in the West. This reporter is based in Colorado, where it seems like it's becoming very widespread. And I would not be surprised to see it proliferate throughout the rest of the country, too.

**Rovner:** There was a [Bill of the Month about exactly this](#), about a pregnant woman who went to the hospital to deliver and got this mysterious emergency “obstetrical emergency room” charge. I'll throw that in when I post your story.

**Kenen:** But when I was pregnant with Ilan, which was 22 years ago, I had a high-risk pregnancy, and I was hospitalized at one point, and I was in and out of hospitals for briefer visits. Off-hours, I would have to go through the emergency room. And there was a community hospital — privately, locally owned hospital at that time. And they made it very explicit: “You need to check in at the emergency room, but tell them you're coming up to the fifth floor and that we know you're coming.” Because they didn't want me to go ... So they had a system for me that you had to walk into the emergency room, because it was 2 in the morning or whatever, but they wouldn't process you there and you would get to the care you needed with the experts faster and you wouldn't get that extra bill.

**Rovner:** Pre-private equity.

**Kenen:** Pre-private equity.

**Rovner:** Rachel, why don't you go next.

**Cohrs:** The story I chose is by my new colleague Sarah Owerhohle, and the headline is “[A Miniscule New HHS Office Has a Mammoth Goal: Tackling Environmental Justice](#).” It's kind of a follow-up on the big fanfare in May about the new [Department of Health and Human Services] Office of Environmental Justice. But it doesn't really have any funding and only has two staff right now, and one of them is leaving. So I think it's a study in both the seriousness and just the scope of what work there is to do in this space and the desperate desire by advocates at the state level for involvement in all of these huge range of issues and just the lack of actual tangible support for this office. And I think it raises important questions. Obviously, we're going through a new appropriation cycle now, so who knows, maybe there'll be some positive developments here. But I think it was a really important accountability story to show that it's more than just a press release. This actually affects people's lives, and shedding light on the fact that there hasn't been really meaning[ful] action here. And certainly the staff are working very hard. So, a lot to do. But, yeah, I just thought it was a great spotlight and just follow-up on what's actually happening here.

**Rovner:** Yeah, I feel like we don't do enough follow-ups. We write about these things happening, and then we just sort of let them go on autopilot and sometimes they don't happen, as this story pointed out. Joanne.

**Kenen:** So my story is from FERN, the Food & Environment Reporting Network. It came out a few weeks ago, although I didn't see it until yesterday, and it's called "[For One Historically Black California Town, a Century of Water Access Denied.](#)" It's about a town called Allensworth, and it is written by Teresa Cotsirilos. And it's a story about a Black community in the Central Valley of California, where it was settled by about a century ago. They had all these dreams of making it this model community, and they have not been able to get water despite various contracts that were abrogated. Or the white town next door got the water, and the Black town didn't get the water. And recently they've had water. And this is what makes it a health care story, not just an economics story, is in addition to water for cooking and cleaning and drinking, in addition to supply problems, they also have arsenic in their water. So the difference between the surrounding white neighborhoods and this Black city are very ... data and history ... And there are also some solutions. There is an experimental ... There's some work with solar panels to actually pull water out of the air. That's not enough, to pull the moisture out of the air, that won't meet the city's needs. But it is sort of a stopgap because there's no arsenic in the water in the air. And then there's another experimental program going on to try to remove arsenic from ground ... They're using groundwater. And as the water tables are changed and climate change and drought and all sorts of other things, it's gotten worse. Other communities are going to face changing water table levels. And if they can figure out how to remove the arsenic and make the water clean and safe, it does have application beyond what is also a story of discrimination and racism involving something as basic as water for a century. It was a really good read.

**Rovner:** I expect we'll see a lot more stories about water, both too much and not enough. Well, my story is also an environmental story. It's from my KHN colleague Bernard Wolfson, and it's called "[If You're Worried About the Environment, Consider Being Composted When You Die.](#)" And, honestly, I thought being cremated was the environmentally sensitive thing to do. But it turns out, nope, that emits pollution and carbon dioxide into the atmosphere. So if you really want to love the land when you die, you might want to consider what they call natural organic reduction. And you really can help grow a tree.

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 tireless 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 — [@kff.org](mailto:@kff.org). Or you can tweet me. I'm at [@jrovner](https://twitter.com/jrovner). Margot.

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