KHN's 'What the Health?'
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Julie Rovner: Hello, Happy New Year, 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, Jan. 5, 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 Joanne Kenen of the Johns Hopkins Bloomberg School of Public Health and Politico.

Joanne Kenen: Hi, everybody. Welcome back.

Rovner: Rachel Cohrs of Stat News.

Rachel Cohrs: Hi, Julie.

Rovner: And we welcome to the podcast panel this week Rachel Roubein of The Washington Post.

Rachel Roubein: Thanks for having me.

Rovner: So I plan to call you guys "Rachel C." and "Rachel R." since I have you both today. Later in this episode, we'll have my "Bill of the Month" interview with Mark Kreidler. This month's patient got a bill for care that was actually delivered to someone else and eventually had that bill sent to collections. We will try to sort this all out in far less time than it took her. But first, the news. And there's plenty with what happened over the break. So we're going to start with the bill that ended the 117th Congress. That huge omnibus spending bill that included all 12 of the annual appropriations that fund much of the government through the end of the fiscal year. That bill also served as a vehicle for a lot of other bills, including an array of health legislation. Rachel C., why don't you start us off with what the bill did for Medicare and Medicaid? Both of which are pretty significant.

Cohrs: Sure. For Medicare, I think, doctors had been worried that they were going to see pay cuts at the end of the year, and they had been asking Congress to make sure they were budget-neutral there. Congress didn't quite meet their demands all the way. They blunted the effect of the cuts. So a little bit of cuts will go into effect this year, and then those cuts will increase a little bit next year as well. So it's some of what they asked for, not all of it. On Medicaid, there was a really big change to what we call in D.C. the redetermination process. Basically, to get extra money from the federal government during the pandemic, states had to agree not to kick people off Medicaid — even if they were no longer eligible. But starting in April, states are going to be able to start kicking people off Medicaid if they are no longer eligible. And there's a phase-out of that extra money that states were getting to treat these people as well.

Rovner: This has been the big concern about the public health emergency and why everybody's cared whether or not when it ends, because when it ended, states were going to start being able to basically kick off the program people who weren't eligible. And there was a whole lot of concern about how they would do it and how long it would take. And this basically sets up a process, right?

Cohrs: Right. It provides a lot more certainty. And states and CMS [the Centers for Medicare & Medicaid Services] have been preparing for this for months. There's resources. But I think the ultimate question is whether these people are going to transition from Medicaid onto another form of coverage or whether there's going to become uninsured. And, I think KFF estimates about ... between maybe 5 million and 14 million people will lose Medicaid coverage. And if there's not a smooth transition, that could have really big implications for coverage. So those were the two big things. There were many other smaller policies that this paid for, though, because it saved money based on all the congressional budget magic that CBO [the

Congressional Budget Office] uses. So I think there's more protections for children on Medicaid as well. It extends CHIP [the Children's Health Insurance Program] until 2029, makes permanent maternal health programs. So there were improvements that Congress decided to make to the Medicaid program with this money. But I think it does ... it's a little bit of a tighter timeline than some people were expecting.

Rovner: They basically are, to some extent, divorcing the Medicaid unwinding from the end of the public health emergency, which people expect will be sometime this year. But we've expected that public health emergency to end for a while. Joanne, you want to add something.

Kenen: And I think this is the time to point out, yet again, they'll probably be a certain amount of chaos and disruption. But *most* people in *most* states who are leaving this enhanced Medicaid will in fact be eligible for Affordable Care Act coverage with good subsidies, if they're low-income. But we still have the Medicaid gap, so there are about a dozen states — it might be down to 11 now — but there are about a dozen, 11 or 12 states where people who won't have enhanced Medicaid won't have anything.

Rovner: Yeah.

Kenen: And that's just political reality.

Rovner: That was something that the Democratic Congress tried very hard to fix last year and it ended up on the cutting-room floor. It didn't make it into the Inflation Reduction Act ...

Kenen: Yes, it was in Build Back Better. It was sent ...

Rovner: Right. It was in Build Back Better and it didn't pass.

Kenen: An *attempt* to fix it was in Build Back Better and it did not make it into the final what did pass, which was the so-called Inflation Reduction Act.

Rovner: And there were a bunch of things that members had tried to get into this last-minute package, this year-end package, that didn't make it either, right? Like the child tax credit. Yeah.

Kenen: I mean, there's some mental health provisions and substance abuse provisions, but many of them didn't make it.

Rovner: The covid money didn't make it. Rachel R., you would like to add something?

Roubein: I think there's a lot of under-the-radar provisions that people had championed for a long time that did make it. And obviously covid money didn't. There was some pandemic preparedness that didn't. But a bipartisan independent commission to study covid did not make it into the package, but some kind of interesting under-the-radar provisions, I think, included like a longer-term funding fix for the Indian Health Service, which Native Americans have been championing for a long time. And there was a pretty big funding boost for the 988 mental health crisis hotline, like a $400 million increase.

Kenen: Another thing is — this is a little obscure — but normally Medicare drug coverage does not include something that would be under an emergency authorization. My understanding is — right? You're shaking your heads — that they did fix that so that as the covid money didn't get in, some of these drugs and therapeutics, and shots, and everything else that was not going to be subsidized by the government, they're not gonna be free. And there was a problem with Paxlovid, which is the outpatient oral drug that you can get at a drugstore. Very important for the senior population that that was going to be really expensive, hundreds of dollars, because it's an emergency authorization. So Medicare wasn't going to be able to cover it. They did fix that. So seniors who do get covid, which is — may we repeat it yet again — still here and still spreading and yet another subvariant, can in fact get that under their drug coverage. They don't have to put

out hundreds of dollars out-of-pocket, which would have really been an impediment to some people. And it's a really good drug. It's one of the few things we have that really works.

Rovner: And before we move away from this, it also included the pandemic preparedness bill that had been pushed by Sen. [Patty] Murray and retiring Sen. [Richard] Burr, the bipartisan bill, right?

Cohrs: It's not in its full form, but it's pretty close to what they introduced. And a couple pieces to highlight there is that now the future CDC [Centers for Disease Control and Prevention] directors will have to be Senate-confirmed. And there's a new pandemic office at the White House, which I think it'll be really interesting to see how the infrastructure there shifts to instead of having, you know, a czar for covid and monkeypox and Ebola, you know, there's going to be some sort of permanent infrastructure there. There's also some public health data provisions and, like, recruitment for infectious disease doctors. There's a lot in that package, but I think it's definitely worth highlighting, as you said. The one other item that I think we haven't touched on is that pandemic-era telehealth flexibilities have been extended for two years, which provides a lot of certainty with something that the health care industry really wanted. So that'll continue with business as usual for another couple of years as Congress figures out what they would actually want to make permanent.

Kenen: And the longer that goes on, right, the harder it is to take it away.

Rovner: That was another thing that people were worried about when the public health emergency ended is that that freedom to do telehealth was going to end. Sorry, Joanne.

Kenen: No, I mean, and the longer people have access to telehealth, the harder it will be for Congress to change it in two years. I mean, it's probably here to stay.

Rovner: Yeah.

Kenen: They may tinker how they pay, or formulas, or certain limits. I mean, who knows what they'll do in two years? It might not be exactly with the way it is right now, but the idea that telehealth is going to go away? It's not going to happen.

Rovner: Yeah, I think it's ... I also think it's here to stay. All right. Let us turn to abortion. There has been a lot of news since we last talked about this in mid-December. But some of the biggest news that's happened just came in the last few days from the Biden administration, which is taking some pretty significant actions, particularly by the Food and Drug Administration and the Justice Department, to make the abortion pill more widely available. Rachel R., tell us what they did.

Roubein: On Tuesday night, and not with a ton of fanfare, there wasn't a huge press release. But the Food and Drug Administration said that they will permit some retail pharmacies to dispense abortion pills for the first time. So that's potentially a major step towards easing access to medication abortion — I should say, in states where it is legal. I think the really big question was what will major retail pharmacy chains do? On Tuesday night, they said they were still looking at it. But yesterday, CVS and Walgreens did say they planned to seek certification to do that. There's a few steps they have to go through. The expectation is those two major retailers deciding to do that could have implications for other pharmacy use decisions. They may follow suit as well.

Kenen: But to be clear, this still requires a prescription. This is not over-the-counter access. The so-called quote “morning-after” pill is over-the-counter. The abortion pill, which is [for] the first, I believe, 10 weeks of pregnancy, will still require a prescription, but it'll be easier to fulfill that prescription. And there are time pressures when you can take that drug. It's going to be easier to go to a neighborhood pharmacy and pick it up once you have the prescription.

Roubein: Exactly.

Rovner: When it first got approved, there were a lot of restrictions, including for a long time — and now in some states — that the doctor has to actually hand the pill to the pregnant person who has to then take it in the doctor's presence. That obviously is starting to be relaxed because we now have 20 years of data that shows that this is a pretty safe way to end a pregnancy. But let's not skip ... what did the Justice Department do? They added to this, right?

Roubein: Yes. So the Justice Department essentially cleared the U.S. Postal Service to deliver abortion pills to women in states that have banned or restricted the medication to terminate a pregnancy. Basically, the gist is that Postal Service had requested an opinion from the office. And the legal opinion issued Tuesday basically concluded that mailing the drugs doesn't violate a nearly 150-year-old statute.

Rovner: The Comstock law, for people who have covered the ...

Roubein: Yes, the Comstock law.

Rovner: ... the early history of birth control, that was what was used to ban the distribution of birth control until the 1960s. So I imagine that this is going to make the anti-abortion movement very angry because they seem to be honing in on the abortion pill, because they're worried that in places where you ban abortion and you don't have any more abortion clinics, people are going to turn to the abortion pill, which more than half of people are anyway, even in sort of the pre-end of *Roe v. Wade* world, when abortion was legal.

Roubein: There was a lot of backlash from the anti-abortion movement in the past few days. And we've already seen a major conservative group file a lawsuit even over the approval of the pills from the FDA.

Rovner: From the year 2000. The original approval, which seems a long time to wait, but I imagine that this will end up being maybe the biggest deal of anything the Biden administration has done. Because I can see ...

Kenen: On abortion.

Rovner: Yeah, on abortion. Excuse me. Yes. When President [Joe] Biden said, after *Roe v. Wade* got overturned, that they were going to do everything they could to make abortion accessible and available, and they hadn't done very much, all of a sudden, they seem to do a lot — at the last minute at the end of the year. Actually, there was one more thing that we should add to this last week in the middle of the break between Christmas and New Year, the Biden administration formally moved to reverse the Trump administration's so-called conscience rules, which had been blocked by federal courts anyway. But that's a fight that's been going on since 2008, at the very tail end of the George W Bush administration, trying to balance the rights of individual health care workers to opt out of providing services that violate their conscience and balance that with the rights of patients to actually obtain care. The Biden administration signaled they were going to rewrite those rules in March of 2021. Does anybody have any idea what took them so long or is this just really hard to balance?

Kenen: And one more quick thing that happened over the break is the FDA came out and formally stated, or restated more publicly and explicitly, that the so-called morning-after pill does not cause abortion.

Rovner: That's my extra credit. So we'll get to that.

Kenen: All right.

Rovner: That's another thing that I've been covering pretty much forever. All right. Well, let us move on. Also over the break, there was an unusually large amount of news between Christmas and New Year this year. We got a very juicy report from a congressional committee on its investigation into how Aduhelm, that

promising, expensive, and ultimately mostly ineffective drug for Alzheimer's disease, was approved by the FDA. Rachel C., you wrote about the report, and I know it's very long, but what are a couple of the highlights here?

Cohrs: The most interesting findings fell into two buckets for me. The first was looking behind the curtain at how Biogen priced this drug. The initial price was around $56,000 a year, which is really expensive. They later dropped that. But, I mean, it caused a great upheaval in the Medicare program. It caused a dramatic spike in premiums and then a drop the next year. I mean, it really impacted people's lives. And the documents that the committee uncovered showed that Biogen was well aware of the impact that this drug could have on the Medicare program. They knew that if they priced this drug above around $20,000 a year, that some patients wouldn't be able to access it. And they chose a really high price point anyway. And I think it just offers some interesting graphs to show that they saw the breakdown and they understood all the finances and they just wanted to make it the biggest drug launch in history. They wanted the blockbuster; they wanted the glory. And it definitely was historic, but not for the reasons that they quite wanted.

Rovner: I was gonna say, they succeeded at making it a really big deal!

Cohrs: And I think the other aspect that was really interesting as we got a little bit more insight into the FDA's reflection on this whole process. And there was an internal review that the agency conducted that was made public in part for the first time, and they decided to exonerate themselves. They thought that communications were appropriate and that was kind of their top-line takeaway. But they did go through and admit that there were some problems. And I think one big issue was that Biogen and some FDA officials were working together to prepare presentations for FDA advisers. But there were other parts of the FDA that were a little bit more skeptical of the drug that were almost entirely left out of that process. They said the skeptical division didn't know that this report was happening. They didn't know they were working with Biogen, and they only hav, like, two days to comment. And then ultimately, that dispute wasn't resolved before advisers got this presentation that was supposed to represent this "unity FDA perspective" that didn't really exist. And I think there was some reflection there. But we still have some unanswered questions. We don't know if there's been any discipline within the agency. We saw no reference to it. But again, with personnel issues that can be sensitive. We don't know what progress exactly they've made toward any of the committee's recommendations or any of the internal review findings or suggestions there. But I think there are some big questions about the agency's decision-making and how badly they wanted this drug approved and what they were willing to do to make it happen.

Kenen: And ... beyond the $56,000 [annual price] and beyond this whole controversy about the process within the FDA, there's also the fact that this big controversial drug, expensive drug ... there's big questions about whether it works, how well it works, and how safe it is. I mean, it's not like the hepatitis C drugs, which had these huge launches — eight? $84,000, you know, 10 years ago was a lot of money, or 12 years ago, whenever it was. They work. They cure hepatitis. I'm not defending the price point. But there's a whole other thing. It's this whole saga about this drug and, like, it's not even a clear-cut, useful drug.

Rovner: Well, and that ... it looks like history might be about to repeat itself. We're expected to hear possibly by the end of this week, FDA's decision on a similar drug, lecanemab, which seems to work somewhat better than Aduhelm, but which also has dangerous side effects. Do we assume the FDA is going to be more careful with this one?

Cohrs: I mean, I think there's definitely a sensitivity by FDA as to how rebuilding public trust in the agency, because I think there was so much skepticism. Again, this is a different drug with the different data behind it that showing it maybe could be more clinically effective. But I think the agency is ... I mean, we'll see over time, but hopefully going to document and their decision-making process more clearly and being more accountable. But I think that there are going to be these lingering questions about this new drug, both for

FDA and for Medicare, ultimately in deciding how they're going to give Medicare beneficiaries access to this drug or not, because the parameters were based on this other drug, which is a strange situation. But that's how these things work.

Rovner: Yeah, but I mean, but to be clear, though, I mean, finding a cure for ... an effective treatment for Alzheimer's would be an enormous medical breakthrough that people, scientists, have been working towards for a couple of generations now. So at least it feels like they're getting closer, but perhaps they're not there yet.

Cohrs: I think, yeah, there's a little bit of a gap sometimes between, I think, what some people wish these drugs were and what they actually are.

Rovner: Yeah.

Kenen: So it's sort of this first-draft phenomenon, like a drug will come out and it's not great. But down the road — we've seen this with cancer, too — I mean, you have a certain kind of drug that's the first of its kind and in the in the years to come, they'll be a better version. I don't think there's a consensus on that with Alzheimer's, though. I mean, they still don't agree on what causes it.

Rovner: Yeah, So we may not be there yet. All right. Well, moving on, Jan. 1 brought us another step in the government quest to help patients figure out how much medical care might cost *before* they get it. In addition to hospitals and insurers having to post prices, insurers will have to give their clients access to a cost estimate or that takes into account out-of-pocket costs like copays and deductibles. The goal is to make 500 different nonemergency services, quote, "shoppable." Joanne, price transparency is one of the few reforms to the health care system that Democrats and Republicans actually agree on. Why is that? What makes ... yeah, to a point ... what makes transparency something that transcends the partisan disagreements about health care?

Kenen: Well, I think that it's hard to be against transparency. You know, you're supposed to be for consumers not knowing anything? That politically is not great, right? So everybody's for transparency. I think that the partisan difference is how *much* you think it matters. Like, the Democrats are for transparency, they're not going to say, "No, consumers shouldn't have tools" and that insurers and hospitals and everybody else shouldn't empower us with more information that's actually usable. The Republicans tend to think that this is much more of a cure-all for health care costs than the Democrats. Generally speaking, you'll ... it's not 100%, but generally speaking, the Republicans have more faith in this as something that'll really, really empower consumers and bring down prices and spur more competition. You know, I can see this provider charges this, this provider charges that; I'm going to go to the cheaper one. But that's actually not how it always works in the real world. Sometimes people think in health care there's two phenomena. One is like Hospital A can see that Hospital B is getting away with charging more and they raise their prices, or that people think the more expensive care is, the better care is, which is not true. So, yes, transparency is good. Yes, transparency is bipartisan. But how well this tool works in the real world? Health care is complicated, as we've all heard people say. It might be easier to find out, OK, you know, I need a mammogram. It's going to be, you know, $30 here out-of-pocket and $90 there. That might be an easier call. But some of these really complicated conditions people have and treatments ... and things go wrong. An insurer said that it's going to cost $90. But then something happened and it cost $900. I mean, I just don't see it as like, OK, we fixed health care.

Rovner: And plus, what we've discovered from the transparency that we have is that people don't shop even when they can.

Kenen: Right.

Rovner: You know, if their doctor says you should go to this place, that's where they go. So it's been hard to get them to use the transparency that's available. Rachel R., you wanted to say something?

Roubein: I think I found one of the interesting things about some of these debates over surprise bills and transparencies is sometimes it doesn't always fall under ideological lines. Sometimes it is — at least in the surprise billing debate — lawmakers who are more hospital- or provider-friendly will stick together, whether they're Republicans and Democrats. And then seven or more insurer-friendly will stick together. We saw some real fights between just committees in general on this.

Cohrs: There was one more item I wanted to add on this, and I think when I first saw this kicked in, I was like, oh, I'm curious, does my health plan have this? So I poked around, couldn't really find ... it wasn't on the homepage, you know, we have this flashy new feature. So I called the number on my card and they didn't know anything about it, couldn't help me. And so then I asked the media line, and then I finally figured out ... like, they taught me how to do it. But I think there's a big possibility that people just don't know about this. And if they're not asking the media line, it's possible customer service reps aren't trained in how to help people find it. And I think there's just this disconnect sometimes, as things are rolling out. So I'm curious to see how many people use it, and it shows kind of generally what your plan allows, like generally what you might be expected to pay. But it wasn't necessarily, like, here's your bill, like what that's going to be at one provider versus another. So I think I'll be curious to see, once the reports and once academics do their wonderful work on really evaluating compliance over the next couple of months, what the results of that are and how that compares with what we've seen from hospitals.

Rovner: I was already going to ask my next question: that politicians want this, but there's been a lot of resistance from both health care providers and insurers who are loath to release what they consider proprietary information. And, Rachel C., as you pointed out, we have seen less than stellar showings for the information that's supposed to be available already. We've also seen a lot of hospitals simply not post the information that they were supposed to post. Do we think that Congress might go back to this or is there some good way to nudge them to comply?

Cohrs: I think there are some signals that the oversight could be a priority for ... especially the Energy and Commerce Committee, I believe? The chair and ranking member, I think, last Congress wrote a joint letter, which is sort of unusual for Democrats and Republicans to join together in that way, saying that it's an area of interest for them and that they would like to check into that more. So I think there are not a whole lot of things that Democrats and Republicans will be agreeing on this session. So I think this is a really ripe area for oversight.

Rovner: Yes. Rachel R.

Roubein: Off of what the other Rachel is saying, I think another place to watch here is the Centers for Medicare & Medicaid Services, because over the summer they had done the first warning shot and fined two hospitals for flouting federal price transparency rules. So if they kick up more fines, etc., that could put pressure on other hospitals.

Rovner: And finally, this week, while we're talking about price transparency, there's a new study from the U.S. Public Interest Research Group that finds that half of ambulance rides result in an out-of-network balance bill. Yet — we've talked about this before — air ambulances were covered in the surprise bill law, but ground ambulances were not. Any chance that might change?

Roubein: You're right. Ground ambulances were not. Basically, what Congress had [done] was said that they were going to require that an advisory committee begin, and that advisory committee work is going to start in January. CMS released the names of the people who are going to be part of it, and they will essentially have to issue a report to Congress within, like, 180 days of their first meeting, which I think is mid-January.

Rovner: So stay tuned for that one. Obviously, more to come on this. All right. Well, that's as much news as we have time for. Now we're going to play my interview for the "Bill of the Month" with Mark Kreidler, and then we will be back with our extra credits.

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

Mark Kreidler: Hi, Julie. Nice to be with you.

Rovner: So this month's patient definitely got an outrageous bill, although the outrageous part was not so much the amount. It was the fact that she got a bill at all. Tell us who the patient is and what happened.

Kreidler: Well, if we're really getting serious about it, there were two patients. They're both named Grace Elliott and that lies at the heart of the confusion. Our patient, the woman that we first interviewed to talk to about this story, is Grace E. Elliott. She's 31 years old. She's a preschool teacher now living in San Francisco, California. There's another Grace Elliott. She's 81 years old, a retiree living in Venice, Florida. Younger Grace, for lack of a better way to put it, once used a hospital in Venice, Florida. It was in 2013. She was a kid home from college on break. Younger Grace was taken to the hospital in Venice, which at that time was really just called Venice Hospital or Venice Regional Hospital. She was treated, held overnight for a kidney infection, received a prescription for antibiotics the next morning, and sent on her way. She remembers that it cost her about 100 bucks, which as a college kid, struck her as exorbitant. Those were the good old days. And that was the last time that Grace Elliott, the younger, ever used the hospital in Venice. In fact, it apparently was the first and last time. But that doesn't mean her name wasn't still in their records system. It was. And about this time one year ago, her mother, still living in Venice, received a letter from the hospital, now owned by a hospital corporation called ShorePoint, with her daughter's name on it. She got a bad feeling about that letter, called her daughter in California. Younger Grace Elliott asked her mother to please open it, and what she found inside was a bill for $1,170 for hospital services at Venice, rendered over a six-day period the previous September. So Grace was a little bit confused.

Rovner: So September of 2021.

Kreidler: We're now talking about nearly 10 years after she'd been to the hospital, she received a bill for services that she'd obviously never had.

Rovner: So she actually must have started to go after to figure out what it was, right?

Kreidler: Her first reaction was to do what any of us would do and say, "Oh, this is a case of mistaken identity." Called the hospital, explained it very nicely: "Oh, you've got the wrong person." The hospital basically at that point said, "We don't think so. We're pretty sure we have the right person." And so this young woman was basically plunged into the medical billing system nightmare in which she has been misidentified. We now know because we reported the story, we know what happened. We know that when Grace Ann Elliott, an 81-year-old, as I mentioned earlier, living in Venice, needed a shoulder replacement, she went to the Venice hospital, she was checked in, and a registration clerk typed in her name, Grace Elliott. Clearly errantly retrieved the file of a 50-year-younger person, and then didn't verify — and that's where the story breaks down — the registration desk employee simply never confirmed via birth date or photo ID or anything like that. And at that point, two medical patients' records functionally become one. That's what younger Grace Elliott, the woman we spent most of our time with, wound up having to deal with.

Rovner: I mean, this should have been easy to sort out. You call the hospital and say, "No, these are two different people. This is not my bill. I have not been to Venice, Florida. Obviously, this is not me." And they take care of it. That's what would usually happen in this situation. But that's not what happened in this situation, was it?

Kreidler: No. One of the things that happened to younger Grace Elliott was that she simply had been straight-up identified as the patient. The hospital was at that point simply trying to collect a bill. And so, in the early stages, Grace is calling this hospital. And then at a later point, she's calling the medical system, you know, the owner of the hospital. But at each step, she's just getting someone who never had anything to do with the case in the first place. And it's simply part of the bill collection process. They're just doing billing and records. And so even though Grace at one point was really able to definitively establish that she was not the person in question, and even though the hospital, at least one person in this hospital food chain, did say to her, "You're right, we've got the wrong person." Again, she made — I don't even want to call it a mistake; she reacted the way most of us would. She exhaled a little bit and thought, "Well, good, this will be taken care of." The next thing that she knew, she was being sent a letter from a collection agency because the hospital had done — hospitals do this all the time — if they have trouble collecting a bill, they'll eventually pass it over to a collection agency. Now, Grace had a collection agency after her, so that's got two problems.

Rovner: So the whole thing sounds funny. The younger Grace Elliott got a bill for someone else's care and got it sent to collections. The older Grace Elliott got her private medical records sent to the younger Grace Elliott, right?

Kreidler: Yeah.

Rovner: So how did this all get sorted out?

Kreidler: Well, that is the really stunning thing that happened. And yes, she received, essentially as she appealed to the collection agency, in their denial of her appeal, they furnished medical records, which they thought was proof that they had the right person. In fact, they were sending her the records of Grace Elliott, this 81-year-old retiree who was obviously terribly upset to learn that her medical information had been shared. Luckily for her, I would say, it was shared with a very responsible younger person who not only started acting on her own behalf, but acting on older Grace Elliott's behalf. The takeaway is that Grace was denied her appeal. She was denied a second time. She contacted us, and I'm not even really sure how she knew to do that. But I'm happy that she did because after we made a few phone inquiries, Grace began to see action. The hospital acknowledged that it had made a mistake. The hospital then went back and corrected its electronic records and took her out of the database of the collection agency. So they say, I mean, I think she's being careful. She wants to see that this actually all happens the way it's said that it would have happened. But yeah, they did eventually. And they acknowledged the mistake so that it was a straight-up human error. And that's where the problem started. But for Grace, the nightmare was that once the problem started, even though as we sit here talking about it, Julie, it seems like such an easy fix. It took her one year to get this done. And really only journalists getting involved to really moved the needle on it.

Rovner: What's the takeaway here for other people? I mean, obviously, clerical errors do happen. Should either of these women have done something that would have avoided this or that would have cleaned it up faster?

Kreidler: One of the big takeaways for medical patients is your information can be incorrectly entered and once it's there, unless you forcefully push back, and I mean early and hard, it can be very difficult for that information to get removed. You know, database information lives on for generations. It can be hard to fix. So one big takeaway for anyone who's using a hospital system, who sees a doctor regularly and has a health plan: Get online, look at your medical profile. Look at what your own profile says about you. And I have personal experience with this from a person very close to me who found a mistake in her medical record that took much pushback to eliminate. And it can be something as basic as a medication you never took. It can be a procedure you never had done. Sometimes things get eerily entered. So big takeaway is: Check your profile. Know what your medical record says about you so that if you need to push back on any aspect of it, you have your forces ready to be marshaled.

Rovner: And obviously you can always complain to us, but there are other places that you can complain to, right?

Kreidler: You certainly can. And you can go to the Better Business Bureau. These are, on some levels, consumer protection and consumer rights issues. So there are consumer agencies, federal agencies and state agencies, that can get involved on your behalf. In this case, the best defense is a good offense. Be very aggressive. Know what your profile says about you. Check your records often and do all the grunt work that we normally don't want to do. But in a case like this, it becomes obvious pretty quickly how important it is.

Rovner: Good advice. Glad this worked out for both of the Grace Elliotts. And Mark Kreidler, thank you very much.

Kreidler: You bet. Thank you.

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

Cohrs: Sure. The piece I chose is headlined "'Major Trustee, Please Prioritize': How NYU's E.R. Favors the Rich," in The New York Times by Sarah Kliff and Jessica Silver-Greenberg. And I think this piece is the last installment in the Times' series on nonprofit hospitals. And this one really stood out to me because it seemed like it was a new phenomenon. Like, I hadn't really read a whole lot of stories about a case like NYU's ER, where the reporters describe this dynamic where — theoretically in an ER, everyone comes in, you know, the urgency of your medical issue, the severity determines what priority you get. But they showed here that children of donors, politicians, family members were getting special treatment. There was even a special room that they typically went to that could have negatively impacted other patients' care. And I think it was remarkable how many doctors that used to work there, they got on the record saying that this was morally questionable. And yeah, it was just really well done, really comprehensively documented. And I thought it was interesting as well how the hospital chose to engage with them by calling into question the integrity of the doctors that spoke with the Times. And it was just really not something that we see every day from hospitals' emergency departments.

Rovner: Yeah, it was a very interesting story.

Cohrs: It was wild, great, well done, highly recommend.

Rovner: Rachel R.

Roubein: The piece I chose was titled "Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours?" And it was by Noam N. Levey, and this was part of a long-running series, I believe all year, a partnership between Kaiser Health News and NPR. And I just think they've been doing really interesting, impactful journalism on this. What really stood out to me here was reading the numbers, and I feel like the data tells a powerful story. So some snapshots of the numbers from KHN's analysis was more than two-thirds of hospitals sue patients or take other legal action against them, such as garnishing wages or placing liens on their home or property. And about 1 in 5 deny nonemergency care to people with outstanding debt.

Rovner: Yeah, which is quite a number. Joanne.

Kenen: This is a story I wrote and I spent many months talking to people for it, and I wrote it with a physician in California who's also a hospital executive in a poor neighborhood of L.A. And it was called "Racist Doctors and Organ Thieves: Why So Many Black People Distrust the Health Care System." I think the

takeaways of that is, you know, I think we tend — or at least white people tend — to blame the distrust on historical atrocities like Tuskegee. And there are many others that are not as famous. But ... and I wrote about them, and people recalled them and told me about them.

Rovner: Henrietta Lacks.

Kenen: Henrietta Lacks, but ... I mean, one person I talked about growing up poor and Black in the South and a kid in the neighborhood cut himself — a Black child, a poor Black child — and the doctor stitched his hand up. And when they found out he couldn't pay, he took the stitches out. And this was in our lifetimes, right? At least, Julie, in my lifetime. So, you know, it's not just a historical legacy. It's today. It's subtler today. It may be implicit and unintentional, but it exists. And the other thing, it's not income-related. It's not just poor people. It's just pervasive. It was a really eye-opening story for me. And I have some follow-ups I'm working on. And the organ thieves. There was a heart transplant in Richmond, Virginia. A Black laborer. His family didn't find out. It's one of the first heart transplants in the country, and the family didn't find out about it until the funeral home called and asked where his heart was or said they didn't know where his heart was.

Rovner: It is quite a story, and I think everybody really needs to read it. Well, as Joanne teased earlier, my story this week is from The New York Times by Pam Belluck. It's called "The F.D.A. Now Says It Plainly: Morning-After Pills Are Not Abortion Pills." And this is a story that I've been tracking personally for more than a decade. In 2012, Pam Belluck wrote the first story of the studies that found that, contrary to previous belief, the morning-after pill does not work by preventing the implantation of a fertilized egg. It only works by preventing ovulation, meaning there's not an egg available to be fertilized. It was the possibility that the morning-after pill might prevent implantation that led many abortion opponents to oppose the pill. This ... remember the morning-after pill, not the abortion pill. But they call preventing implantation a very early abortion, even though that's not the medical definition of pregnancy or abortion. I was surprised at the time that Pam's story didn't seem to get a lot of traction. So I did my own version of it the next year for NPR, which also didn't get a whole lot of traction, which is another story that I have found out the reason for. But one of the things that I uncovered is that European drug regulators had already changed their labels to say that morning-after pills only work by preventing ovulation. Yet the FDA didn't get around to changing the label here until last week. Maybe now some of this confusion will stop.

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 producer, Francis Ying, who makes the weekly magic happen. As always, you can email us your comments or questions. We're at what the health — all one word — @kff.org. Or you can tweet me. I'm still on Twitter: @jrovner. Joanne?

Kenen: I'm marginally still on Twitter: @JoanneKenen

Rovner: Rachel C.

Cohrs: I'm @rachelcohrs

Rovner: Rachel R.

Roubein: @rachel_roubein

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