KHN's 'What the Health?'

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Julie Rovner: Hello and welcome back to "What the Health?" I'm Julie Rovner, chief Washington correspondent for Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, Aug. 12, 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 videoconference by Mary Ellen McIntire of CQ Roll Call.

Mary Ellen McIntire: Good morning.

Rovner: Joanne Kenen of Politico.

Joanne Kenen: Good morning.

Rovner: And we welcome to the podcast panel this week Yasmeen Abutaleb of The Washington Post. Glad to have you here.

Yasmeen Abutaleb: Glad to be here.

Rovner: So, the Senate actually passed something this week. Two things, in fact. First, the "hard infrastructure bill." That's the bipartisan bill that would spend money for roads, bridges, airports and broadband, among other things. It doesn't include any health spending per se. But one of the pay-fors — to the tune of $51 billion over 10 years, per the Congressional Budget Office — is a delay of the Medicare Part D rebate rule. Can somebody take a stab at what this is and why it saves so much money by not doing it?

Abutaleb: Sure, I can give it a try. So, this was a health care policy that was sort of forced through at the end of the Trump administration. It was this really tortured effort. But the idea was that drugmakers would stop giving rebates to what they call insurance middlemen, pharmacy benefit managers, in Medicare with the idea that the savings that come from those rebates would go to consumers instead. But what ended up happening

in the analysis of that rule is that the CMS analysts determined that instead of savings being passed on to consumers, drug prices would probably just be higher and it would actually end up, because there wouldn't be the rebates meant negotiation between drugmakers and the pharmacy benefit managers. So, it was actually going to cost the government. There were a couple of different analyses, but it usually ended up around $180 billion, $190 billion over 10 years. So that's where they're saying the savings will come from. It's a little bit of funny money because that has not actually gone into effect. The Biden administration delayed that rule. It hasn't happened, probably won't happen. But you can use that analysis to say, you know, you'll save about $200 billion a year. I don't know if that was a great explanation.

Rovner: That was actually a very good explanation! One of the fun parts of budgeting is that, you know, Congress can take money that never actually existed and spend it on something else. And it comes out even on the balance sheets. And I imagine we're going to see much more of this as we go on.

OK, so, if you thought the hard infrastructure bill, the bipartisan bill, was hard enough, now comes the really hard part. After the Senate approved the infrastructure bill, it took up and passed the budget resolution for fiscal 2022, which starts Oct. 1. This Oct. 1. You might remember Congress already did a budget resolution this year in order to do the covid relief bill. But that was actually last year's budget resolution, because the last Congress didn't bother to do one. This year's budget resolution includes what are called reconciliation instructions, which are orders to House and Senate committees to write a bill that meets certain budget targets. They're actually reconciling current spending to the terms of the budget resolution. That's where the word comes from. And this does include a lot of health programs. So, Mel, what actually made the cut in terms of health in the budget resolution?

Kenen: The whole wish list.

McIntire: Almost everything Democrats have talked about doing for the last couple of years, with the exception of the public option, have made it into this wish list. We all know that that does not mean that everything that they have talked about doing will actually end up in law, by far. But, you know, the Budget Committee, led by Sen. [Bernie] Sanders, he really kind of put everything in there. An expansion of Medicare benefits to cover vision, dental and hearing. He is proposing to lower the eligibility age, although he has not said exactly to what the eligibility age he would like to see it lowered under this process. There is the extending the advanced premium tax credits, the expansion of those that we saw in the earlier reconciliation bill. There is a push for

home health care for seniors. Gosh, what else? Lowering prescription drug prices by allowing Medicare to negotiate drug prices. Although no one has really waded into, you know, the policy parameters of what this would look like. I'm probably forgetting something. Money for pandemic preparedness, for future pandemics beyond covid. Those are a lot of different things. And there's probably a few more that you guys can remind me of if I'm forgetting them. But really, we've got a wish list here.

Rovner: Yeah, I think it's important. I mean, people who keep misdescribing the budget resolution, which doesn't actually do anything; it's a resolution. It doesn't go to the president. It's basically a blueprint. And the important part of the blueprint is for, is the orders for these committees to actually sit down and write this. And they have been given a deadline in this budget resolution of Sept. 15. That feels pretty ambitious, right? For all these committees to do all of this?

Kenen: Funny money and a funny resolution and a funny deadline. But basically, this kept the process going. This did, nothing got chopped out means … everything's on the table. There's going to be a lot of negotiating going on. There's going to be a lot of horse trading going on. None of us expect this to actually, everything in here to make it through. But at this point, nothing was kicked out, which means that the progressives and the moderates and the budget hawks and the spend-it-all people, “This is the only chance we got” camp. This conversation is going to go on. It's complicated. Somebody likened it to the ACA in 2010. I think it's a little different than that, because there's more room to compromise on this. You know, it's got trillions of dollars’ worth of stuff. You could end up with a lot of it, but not all of it, and still have something that Democrats can agree on and get through. It's not totally a make-it-or-break-it kind of thing. That's right. I mean, it's a heavy lift.

Rovner: Although, I mean, these two bills are really very much tied together politically, if not actually, because you've got the progressives in the House saying, “We're not going to vote for the bipartisan bill until you give us this bigger bill.” And you've got moderates in the Senate already saying this bigger bill is too big, and the House is coming back early from its August recess — which, boy, in all my years of covering Congress, I have never seen that before. I've seen them go out late like the Senate did this year. I've seen them work into the August recess, but I've never seen them come back early. I mean, what are the chances at this point, you know, I guess with everything on the table, of them actually getting a deal that all the moderates and all the progressives are going to be able to hold hands and say, yeah, let's do this?

McIntire: I think we're sort of in a wait-and-see mode. You know, it was just earlier this week that [Rep. Steny] Hoyer said they were going to come back early, on the 23rd. It's sort of unclear, you know, exactly how long they're going to be, going to be there. But the plan is to vote on some voting rights legislation, and the Senate passed a budget resolution. We've seen a lot of back-and-forth from members. You know, I saw yesterday [Rep.] Stephanie Murphy — she's the leader of the Blue Dogs, one of the more moderate groups of Democrats in the House — say on Twitter that, you know, she thinks that they should vote with the budget resolution on the infrastructure bill like the Senate did, something that, you know, more moderates have sort of talked about doing in the past couple of weeks. And then the first response to her tweet was, and I'm blanking on his name. He's a progressive Democrat from California. And he just said, "Respectfully, no." So I think we're going to see a lot of posturing on this.

Abutaleb: It was [Rep.] Jared Huffman, by the way.

Rovner: Oh, thank you.

McIntire: Thank you. Yeah. Yeah.

Rovner: The moderates and the progressives are not on the same page yet.

McIntire: But we've got about a week and a half before they actually come back, and that is a lot of time to figure this out. And, you know, no one really seems to be drawing, at least on the moderate side, drawing really clear red lines yet. So I think it's, we're still in sort of a wait-and-see. And a week and a half is a lot of time in these cases.

Kenen: And we don't think this will be done by Sept. 15. I mean, Mel's right. We'll have a better sense of where things stand when the House comes back. We're not going to have the end game until we get to the end game. At the end of the day, no Democrat wants this all to collapse and go home with nothing. I mean, that's just not in their interest. This is a historic opportunity to get a lot of their agenda enacted. How much of the agenda and what gets kicked off the table is the issue here. But the idea of not doing any of this, having it all go up in smoke, I don't see that.

Rovner: Before we leave the budget, President Biden, even as we speak, is reminding Congress that he wants them to do something about prescription drug prices. There

doesn't seem to be anything new in what the president is talking about. Why is he sort of coming out and, you know, beating this drum now? Is it just to sort of keep it on the front burner?

McIntire: I think what's almost most notable about this, sort of, as this came out this morning and sort of seeing some of the talk about it, is that if you think back to the spring, there were a lot of Democrats on the Hill who weren't exactly thrilled with Biden leaving a lot of the health care stuff out of his, you know, big budget plan. This almost seems, you know, as this is starting, Democrats were never going to allow this bill to go through with no health care being talked about. It seems notable to me that he's talking about it and is making the push for it now, you know, at this moment. He's obviously not going to try to get ahead of the negotiations in Congress about, OK, how exactly do we set up a Medicare price negotiation process? That's really tricky. He's not going to try to wade into that. But it seems notable to me that at this point he is making a point of talking about this and dedicating a day to it. He'll have the news coverage around it and everything.

Abutaleb: I think he also, he has to talk about it. I mean, drug pricing has always polled as a top voter concern. Whether they're really serious about it, it doesn't seem like it, at least from the White House point of view. I mean, I think — Julie, you know better than anyone — if you're going to do drug pricing, it has to be your top political priority. You have to be willing to expend all your political capital on it. That's definitely not what they're doing. At the very least, you have to talk about it and address it or else it looks like you're just overlooking a massive voter concern.

Rovner: Yeah, I'm still dubious about how much drug pricing they're going to get into this, although they need to do something on it because that's how they're going to pay for a lot of these benefit expansions.

McIntire: And how long they can have these benefit expansions going.

Rovner: Yes, that's right. And how long they could … yeah, I think the thing, the two are tied. It's not just that it's popular, though it's really popular and people really want them to do something about it. But it's also that it's going to be a source of money for the other things that we mentioned, like expanded benefits and expanded home care and expanded tax credits for the Affordable Care Act. So we will see. All right.

Well, we should move on to covid. Things are getting worse again, particularly in undervaccinated parts of the country like Texas and Florida and Arkansas and Mississippi. And now school is starting just when it appears that the delta variant affects kids more than earlier iterations of covid did. My polling colleagues over the firewall at KFF this week found that a significant majority of parents nationwide, 63%, favor mask mandates for unvaccinated kids and school staff. Any chance some of these governors that have banned mask mandates are going to back off? We're starting to see some pushback, and particularly in Florida and starting in Texas, too.

Kenen: It might come down to the courts. I mean, I don't think we know yet. Some of the governors have really made no mandates their signature political identity, you know, in Florida and Texas. You know, in Arkansas, Asa Hutchinson had signed a bill last, I think it was April or May, when things were looking a lot better.

Rovner: Yeah, it was in the spring.

Kenen: And he said, you know, he has said several times he now regrets it, but there's a court battle going on. So rather than seeing governors say “Oops, I was wrong” — and you may see some of them, you may see “I was against them in old covid. But delta's a new ballgame and I am for them now.” It does sort of give them an out. We're fighting a different battle with kids. You could say that.

Rovner: It's also true.

Kenen: It's true. But I also think that for some of them who are so dug in and who don't want to face primary challenges from the “covid isn't real” crowd, you might end up seeing courts say yes, its local school board can decide. A city can decide, a county can decide. I mean, however that shakes out, none of us know. But it might turn out to be a legal fight rather than an “oops!” fight, which was the last couple of Texas governors ago. Not the current one [garbled]. Right.

Rovner: Well, the same survey found that parents do not favor vaccine mandates for kids, primarily because they're uncertain about any long-term effects from the vaccine. But we're learning that more and more kids are getting long covid, too. Could that change the equation? I mean, are parents maybe going to come around faster than some of the politicians?

Abutaleb: I feel like for parents and deciding whether to get especially their young kids vaccinated, it's not as clear-cut, I think, in a lot of cases as, as an adult, because there are sort of questions about the doses, and even though the complications are rare, it is, I think it's a bit more of a risk assessment than it is in adults. And I've heard a lot of medical experts and epidemiologists talking about this now, that we need to have an honest conversation about it. But I do think because of prevalence of long covid in some kids, the fact that delta, we don't really know why or to what degree, but does seem to behave differently in kids, might change the calculus. I mean, I think delta's kind of changed everything for everyone. And I think even for some of the Republican governors, it might become politically untenable to strongly oppose mask mandates. Maybe they won't impose statewide mask mandates. But I think at some point, some of them, depending on how outbreaks evolve in their states, are going to at least have to get out of the way of local officials who want to impose them. I mean, you don't want to have that responsibility on your hands. And I think there is a growing awareness that the more you kind of stand in the way of some of these safety measures, the more, you know, the worsening outbreaks will get pinned on you.

Rovner: I can't help feeling like, you know, last year when there was no vaccine, when there was basically no school, we were dealing with a far less contagious version of this disease. And now, you know, there's certainly universal "We gotta send kids back to school." And yet, in many ways, it's more dangerous to send kids back to school this year than it was last year.

Kenen: Well, we also might see kids back to school on and off. Right? There's a difference between keeping kids home for an entire year, another entire year and a half, versus starting in September. You know, it may depend on the virus doesn't spread in every community at the same speed at the same time. You might have, also you can be outside more. You can eat your lunch outside in some climates and some days. And you can't in other, you know, obviously, if there's a blizzard in upstate New York, the kids are not going to be eating lunch outside. So you might just see a, yes, schools are open, but with weeks that kids are home or months that kids are home or hopefully just weeks. I don't know that they're in school every day from now until next June. But there's clearly a consensus that kids need to be in school. And we do know that there's data on ways of keeping them safe. Now, delta is different and, you know, maybe there are going to be half the kids in school, you know, these kids will be here one week and the other kids will be the other week so you can social-distance, whatever. I don't know what it's going to look like. I don't know how, you know, how much open windows and ventilation is going to help. We know masks help. This is changing fast. It seems to be

worse every day, but people want kids, I mean, we know that it really wasn't good for kids not to be in school.

Rovner: I know. I'm just sort of curious that a lot of companies are delaying return to work for adults who are, by and large, vaccinated in a lot of places, but not delaying return of kids to school who are, by and large, unvaccinated.

Kenen: I'm skeptical about every kid being in school all year. I think that many kids will have some time to be in school and that will be a healthier thing for them. My son is a camp counselor and things change every single day. You know, which kids get home, which groups are down. I mean, it's a day camp; they're mostly outside. [garble] They're not vaccinated. Nobody's gotten really sick. But every day it's a new set of calculations. But they have managed to find safe ways of doing things. And it has, there have been isolated cases, but there hasn't been a calamitous spread. So it's harder in school, because you're indoors. Day camp, you're mostly outdoors.

Abutaleb: I think the added challenge is that it's going to be so confusing to sort through what's covid, what's flu, what's normal seasonal illness. Like we saw this rise in kids getting colds this summer and spreading them to adults. I mean, I got a cold this summer and after I was fully vaccinated for a while and worried it was covid; it wasn't. But, you know, that's really confusing, especially because I think still, in the majority of kids, the symptoms are relatively mild or resemble a cold or flu. I mean, it's going to be a minefield, I think. And I hope that we learn from last year that we should learn from the different districts, see which schools and states are doing well, which ones are not, and maybe learn to implement those lessons in real time, because I think they're all going to have drastically different experiences.

Rovner: Yeah. And I think it's going to matter a lot how many, I mean, we're starting to see this already in some of the data, in places where more adults are vaccinated, fewer kids are getting it because there's just less of the virus around. But that's a public health message that I think the CDC is trying, but having difficulty, saying, that you know, the best way to protect kids who can't be vaccinated is for adults who can be vaccinated to get vaccinated. But it doesn't seem to be happening. Well, meanwhile …

Kenen: Right, and for the people who don't believe the vaccines are safe for themselves are not going to get them to protect their kids, because there's a section of

the population that is not where most of the population is. And I don't, I don't know that a message to protect your kids works when you think the vaccine itself is dangerous.

Rovner: Or that the whole thing is a hoax. So meanwhile, in the on-again-off-again court fight over vaccine mandate bans, a federal judge has ruled that cruise ships can so require passengers to be vaccinated. In fact, we're seeing more and more vaccine mandates even in the absence of full formal FDA approval of the vaccine. Actually, as we were talking, I saw on my screen that HHS Secretary Becerra is going to require all HHS workers — although, I guess, weren't they already covered by Biden's federal worker mandate? — to be vaccinated. Are we looking at a case where we're going to pretty much see people have to be vaccinated in blue states and pretty much not in red states, or are, like. national companies like United and, I just saw, Amtrak going to make requirements broad enough that almost everybody will be touched?

Kenen: I don't think almost everybody will be touched, because not almost everybody works for a large corporation or a school system or, I mean, it's not going to be universal. But as large national companies do require, more and more people will be required throughout the country, including in states that don't have limitations. But it's not going to be anything. I mean, right now it's, you know, it's blue states, a bunch of big companies, household-name companies that do have national reach. They're still giving people the option of vaccine or test. And testing once a week is not enough. You can be negative on Monday and positive on Tuesday. And you don't get tested again until the following Monday. So even some of these mandates, there's a difference between daily testing or every-other-day testing and once-a-week testing. Different companies are doing it different ways. But the people who really don't want to get vaccinated are going to opt for the test — many of them, not 100%. I think we're in mandate 1.0 and we'll see how that develops.

Abutaleb: I feel like when you have companies like Walmart and United requiring them, that reaches a much broader swath of the population than maybe like a Google or Facebook, you know, probably reaches more people who might have — it's just a more diverse population; they're massive companies. So I think that makes a big difference. And it does seem like the travel ones would probably have the biggest impact, because even in focus groups, I mean, they clearly work. People want to travel; they want to live their lives. They will probably get it if it's required. But it does seem like, for it to touch almost everyone, it would need to be required and a bit more everyday things, whether it's restaurants or, you know, sending your kid back to school or going to the gym or whatever it is — these things that touch people's everyday lives. Otherwise, I think, like

Joanne said, the people who really don't want to get it will not get it. And they'll probably still be able to live their lives mostly as they want to.

Kenen: And there's also no great way of verifying right now. Right? I mean, there's a huge amount of forgery; these cards are available online. Some of them are just attestations. You don't even have to give your card. It's porous. And also, you know, I don't think they know what the level now — they were guessing that 70% was enough. You know, I don't think any of us think 70% is enough anymore.

Rovner: No. I mean, even the experts are saying 70% isn't enough. I'm curious to watch what's going on in France, where there is a pretty tough requirement. I mean, you basically can't go into any public place without proof of vaccination. And there is a backlash. I mean, there are demonstrations and, you know, people calling [President Emmanuel] Macron, you know, a dictator. But there's also, apparently, it's working for the vaccine hesitant, because, again, they would like to be able to live their lives. And this is the only way. I can't imagine doing that here, although I could see a state or a city trying to do it. And it would be, I'm curious to see whether it would work. I mean, is there any place where we could sort of go as far as France is going?

Kenen: We should watch and see what happens in Takoma Park [Maryland, a liberal Washington, D.C., suburb].

Abutaleb: Well, New York City will sort of be a good test case, too.

McIntire: Yeah, New York I don't think goes quite as far as France but sort of tried to move in that direction. But I haven't heard of any other U.S. cities. It sounds like in D.C. the mayor is very much not trying to go that route — yet, at least. She seems very tied to what the CDC has said.

Rovner: Yes. And I notice that the House Republicans are going after the House physician for putting back a mask mandate, because they said it was not science based. So D.C. is full of its own issues.

All right. Well, let's move on. I want to talk about Medicaid. We learned this week that as of this spring, nearly 1 in 4 Americans is covered by Medicaid, which kind of makes you wonder if the health care industry push against a public option or lowering the eligibility age for Medicare is taking on the wrong target. But I digress. The big news this week is

out of Missouri, where last August voters approved a ballot measure to expand Medicaid to the working poor under the Affordable Care Act. Then the Republican legislature refused to fund it. The Republican governor refused to start it without legislative funding. And then the Missouri Supreme Court said, sorry, the voters spoke; you have to expand. Now, we have another court ruling from a state judge saying you have to expand Medicaid right now. And as of Wednesday, the governor agreed. So now can we add Missouri to this list of expansion states, or do we think there might be yet another twist in this whole saga?

Kenen: I don't think anyone knows if somebody in the state legislature or a private group is going to appeal this. I mean, it's not at the Supreme Court. It was state. So, the governor is signaling, OK, you know, the voters did it and the court said, listen to the voters. Other red states that resisted eventually did. I mean, they tried ways around it in other states that had voter initiatives and they hemmed and hawed and said this and that and the other thing and they all ended up doing it. So my hunch is that Missouri now does it. But no, we could see, we could see an appeal filed in the next 24. I mean, by the time we're finished with this podcast some state legislator could have appealed it or some other, someone with standing could have appealed it. So who knows? But it looks like it's going to go through.

Rovner: And to circle back from our discussion at the top, helping the people in these — I guess now we're down to 12 — states that have not expanded Medicaid, helping those people get coverage is something that Congress wants to do in this reconciliation bill. Right? I think that was one of the things that you forgot.

McIntire: Yeah, I realized that afterwards. Yeah. I mean, again, this is one of those things that there are a lot of different proposals going around the Hill. It's not clear how exactly, but it does seem like a priority. You know, in the earlier reconciliation bill, Democrats tried to give Republican states that haven’t expanded sort of even more incentive to do so, and none of them took them up on it. So I think now they're trying to say, OK, if we're going to incentivize you and you're not going to do it, we're going to take steps to sort of just go around you and not give you the option here. So it'll be interesting to see how that affects Missouri as it goes forward and any of these other states sort of, if they end up doing something on this front.

Rovner: Yeah, I mean, it's tricky because if you want to pick up, I mean, there's a couple of million people in states like Florida and Texas and Georgia who don't have any access to coverage because the, you know, when Congress passed the ACA, the

Medicaid expansion was supposed to be mandatory. So there wasn't going to be anybody left out. But then the Supreme Court made it voluntary. A bunch of states didn't expand. And these people don't have access, basically, to any federal help for health insurance. And, you know, there's been a lot of talk about actually extending federal help to them, making them eligible, you know, for the ACA coverage. But the concern is that if they do that, then some of these other red states that actually expanded will want to cancel their expansion. I mean, sort of, do you want to reward the states that were holding out or do you want to continue to hurt these millions of people who are working poor and don't have any access to health insurance? And this is going to be a tricky part of this whole package, I imagine.

McIntire: Yeah, I think your point on you don't want the Republican states who have expanded to cancel it, I think that's going to be, you know, a needle that they try to thread, of how to avoid that so you're not, you know, putting more cost on the federal government and raising the price tag of having something like this. But how you thread that needle seems really tricky.

Rovner: This is not happening by Sept. 15. And also on the subject of Medicaid, the National Association of Medicaid Directors this week wrote to the Centers for Medicare & Medicaid Services to urge that Medicare cover the new expensive and unproven Alzheimer's drug Aduhelm, that one that was controversially approved by the FDA a few months ago. Why are they asking this? Because they say if Medicare doesn't, then Medicaid will have to, and that it could bankrupt state Medicaid programs. Alternatively, it seems the drug could also be put on a special list of drugs that Medicaid doesn't have to cover. But this is turning into quite a budget deal, isn't it?

Kenen: Well, that would be for the duals?

Rovner: Yes, for the duals. That's exactly who it would be for. It would be for people who are Medicare eligible, but also low income. So they get both Medicare and Medicaid.

Kenen: So, this is already a small percentage of the population with extremely big drug, big medical bills. It's not just …

Rovner: Right. That's right. These people are among the most expensive, but there are some pretty eye-popping estimates from the Medicaid directors. I mean, you know,

when you sort of think about how this plan, how this drug plays out in the real world, you know, it's not just Medicare and it's not just private insurance. Now we have Medicaid as part of this. I remember when the big hepatitis C drugs came out with their $80,000 price tags that there was a lot of concern. And there was, I mean, it did, it seriously raised costs for state Medicaid programs. This drug is more expensive. And unlike the hepatitis drugs, it needs to be taken indefinitely, whereas the hepatitis drugs were, what, like a three-month course? And it was a cure.

Kenen: And it was a cure. It was done. I mean, the hepatitis drug is very expensive, but there was never any question about its efficacy. It's a really amazing drug. There are a few of them now, but those were breakthrough drugs. Those cured a virus in eight to 12 weeks and that, they cost a lot of money. There were also some savings associated with that over the long term. In retrospect, at the time, which was — what? I think it was 2014 — it was a huge amount of money for Medicaid and insurers, but mostly Medicaid. And it was hugely controversial. But both the number of people affected by this, the amount of money and the duration of time, this is a whole new planet — forget "ballgame."

Rovner: If they're good, they're going to do something about drug prices. They're going to have to figure out what to do with this particular drug. All right. Well, that is the news for this week.

Now it is time for our extra-credit segment, where we recommend a story we read this week we think you should read, too. Don't worry if you miss it; we will post the list on the podcast page at KHN.org. Joanne, why don't you go first this week?

Kenen: This is a really good piece in Stat by Helen Branswell on something I have been thinking about, which was, Could we get a nasal version of the coronavirus vaccine? And it's called "A Snort or a Jab? Scientists Debate Potential Benefits of Intranasal Covid-19 Vaccines." Basically, you know, we do know that the vaccines that we currently have are really, really effective at preventing serious disease and death. They, we are learning, are not as good at preventing some infection. And a subset of that infection is what we're all worried about, which is the long covid, and including in young people. If you put it in the nose, which is where the virus still lives, despite your being immunized, you still, if you get exposed, [it] can live in your nasal passages, and that's how you spread it. You know, could you neutralize it there with some kind, it's like FluMist; it's like a … ? Plus, you know, there's some people who don't want to get vaccinated because they're afraid of needles, etc. It's a very good article on the pros and cons, both scientifically and policywise. Is this a good idea? Probably. Is it easy?

No. Is it going to happen? Maybe. But it's really a thorough, good, easy-to-understand discussion — as usual, with Helen's work.

Rovner: Yeah, it was. It was very thought-provoking. Mel.

McIntire: My extra credit this week is from JAMA. It's an article looking at the research that is being done in gun violence after lawmakers a couple of years ago made a policy change to allow research into gun violence through the CDC and the NIH and sort of looking at how researchers are trying to cast a really wide net. And, you know, what they're looking at making up for, you know, a couple of decades of not, not looking into this and also kind of trying to balance, OK, we want to continue to do this. So trying to make sure that they're not being political in this so that they don't have any reason to make this an issue again, and maybe to get even more funding than they already have, like the Biden administration has proposed. But I thought it was sort of an interesting look back at, this was a pretty major policy change a couple of years ago. A lot's happened. And what's, what's happening with it a few years on.

Rovner: Yeah, I was really glad that she did that story. Yasmeen.

Abutaleb: My extra credit is this kind of funny but also, I think, spot-on Atlantic article about why the vaccine cards are the wrong size. And it's something I thought about when I got my vaccine card, because I didn't know where to put it. So I just put it in a pocket in my purse and hoped I would remember I put it there. The author touches on all of these things. It's like too small to put in a drawer and you probably need it too frequently to stick it away with your birth certificate and your passport. It doesn't fit in your wallet, but you don't know where to put it — like, you don't want to lose it. And we also, because of how fragmented the U.S. health care system is, there's no app or anywhere we can sort of conveniently store it. It was funny — who at the CDC thought this was the right size? But they probably were under so much pressure that they just picked a card and didn't think a whole lot about it. You know, I sort of forgot about it. I just put a picture of the vaccine card on my phone in case I ever lose it. But it's totally right. Like, what are we supposed to do with them? And they're not laminated and you're not supposed to laminate them. Is there going to be a better way for us to keep it or to, like, be able to prove that we're vaccinated? Or why can't they update it? I don't know. There were so many sort of amusing questions in there, but also valid, like, I don't want to lose that card. What happens if we do start having to prove it more often?

Rovner: I went to the doctor yesterday and I forgot to take my card and he asked me when I'd been vaccinated. And I also forgot that I have a picture of it in my phone. I could have told him the exact date. So … but I was thinking about that story when I did it. All right. Well, my story is by William Wan at The Washington Post. It's called “Covid Killed Her Husband. Now It's Taking the Only Home Her Kids Have Ever Known.” And so, so much of what we read and watch and talk about when it comes to covid is numbers and statistics. This is a really microscopically close look at covid’s impact on one family in Missouri and how medical bills and loss of income can devastate the entire family. It is painfully sad and beautifully written, and I really highly recommend it.

So, that is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review; that helps other people find us, too. Special thanks as always to our ace producer, Francis Ying, who still manages to make us all sound good. Also, as always, you can email us your comments or questions. We’re at whatthehealth, all one word, @KFF.org, or you can tweet me. I'm @jrovner.

Kenen: I'm @JoanneKenan.

McIntire: @MelMcIntire.

Abutaleb: @yabutaleb7 — probably have to struggle to find that one.

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