

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

**Episode Title:** Booster Time

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**Julie Rovner:** Hello and welcome back to KHN's "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. 19, 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.

**Rovner:** Today we are joined via videoconference by Margot Sanger-Katz of The New York Times.

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

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

**Alice Miranda Ollstein:** Hi, Julie.

**Rovner:** And Kimberly Leonard of Insider.

**Kimberly Leonard:** Hi.

**Rovner:** So, I want to start with the latest on Congress' effort to do something about prescription drug prices and Medicare and the Affordable Care Act. Alice, the house is actually coming back early from its August break. What do we expect them to do?

**Ollstein:** So, we have sort of a showdown happening right now between moderates and progressives in the House. A small group of moderates are insisting that the House first vote on the bipartisan infrastructure package that the Senate passed. They say we should just get that signed into law as quickly as possible, get the infrastructure projects underway, that will help us have something to show voters so we can actually keep control of the House in the midterms, which is something they're worried about. But progressives and a lot of Democrats fear that if that happens, then they won't have the votes or they won't have the time or the momentum to ...

**Rovner:** Or the pressure.

**Ollstein:** Yes. Or the pressure, or the leverage, to pass the budget reconciliation that starts the process of this massive vehicle for all of Democrats' other priorities, including all of the health care pieces that we've been tracking, the Medicare, the Medicaid stuff, the drug pricing stuff. What's going to happen next week — maybe; we'll see — what

Speaker [Nancy] Pelosi is pushing is they're going to vote on a rule to set up votes on both bills to pass the budget resolution.

**Rovner:** Which starts the reconciliation process.

**Ollstein:** Right.

**Rovner:** So, the idea is they will pass the resolution next week or they will set up a rule to pass the resolution when they get back?

**Ollstein:** Both.

**Rovner:** OK, so the rule will be to pass the bipartisan infrastructure bill and then they're going to do the budget resolution.

**Ollstein:** Right. And also included in the rule, maybe, is something on voting rights.

**Rovner:** Oh, God.

**Ollstein:** So, it's a mess. But the idea is they need to get everyone behind the budget resolution in order to move that forward.

**Rovner:** To start ... because the reconciliation process takes many weeks.

**Ollstein:** Right, exactly. Exactly. And then they'll be putting together, the committees will be putting together, the actual policy over the coming weeks.

**Rovner:** So, they come back, they do these votes and then they leave again. Right?

**Ollstein:** Right. Right.

**Rovner:** But they could ... but it launches the work that the committees need to do with this — we talked about this last week — this fairly unrealistic date of Sept. 15. I don't think anybody expects them to make. I've seen, I mean every time I sort of look around, I see more people, more House members complaining and, you know, sort of the moderates and the progressives who are sort of still going at it. Do we expect them to resolve some of this by next week, or are they basically going to come together long enough to do this and then go back to fighting?

**Leonard:** I mean, it's kind of this big showdown. We'll see what happens. Speaker Pelosi seems very confident that she'll get her caucus in line. She usually does. She's very good at this. You know, she might be able to make some promises. For example, she might be able to say, well, OK, we'll pass the bipartisan infrastructure bill by a certain date. But again, that does sort of reduce the leverage that a lot of the party has on the \$3.5 trillion reconciliation bill. And you already have people over in the Senate — Sen. [Kyrsten] Sinema and Sen. [Joe] Manchin, both very conservative Democrats — who are saying that they don't even believe that 3.5 trillion is the right number. You have

a lot of opposition to increasing taxes. If they do have anything in there on prescription drug prices, that'll be really hard. The pharmaceutical industry is very powerful. They often get what they want. And so, yeah, we'll see what happens there. But it will be a lot of negotiating going on, and they're supposed to get it all done by next Tuesday.

**Rovner:** I'm already seeing lots and lots of ads on cable TV about drug price regulation, and pretty much the same line that the drug industry has been pushing since I started covering this in the 1980s, which is if you don't let us charge as much as we can, we're not going to have enough money to invent new drugs. It is a refrain that continues because, I guess, so far it has worked.

**Ollstein:** I think one of the reasons that Democratic leadership in the House is pretty confident this whole thing will go through is that the same folks who, the same moderates who are protesting here also are very invested in pieces of the bigger reconciliation package — some of the SALT tax stuff, for instance, but also some of the health pieces. Some of them are the main co-sponsors of some of those pieces. And so the idea that they would, you know, jeopardize all of that is not really realistic. Plus, when you have nine moderates writing this letter to Pelosi, you know, threatening to blow it up — and, yes, nine is enough to block if they all voted together, but progressives are threatening to do the opposite to block the bipartisan bill and they have just many, many, many more on their side to do that. They just have the numbers.

**Rovner:** I don't doubt that there are two bills that all the Democrats can vote for. What I am dubious of is whether they can find it. So we will let them continue and we will turn to covid because we are clearly not lacking for news on the covid front.

**Sanger-Katz:** I think part of the reason why it's so hard to answer your question about whether or not they're all going to come together on this bill is that we're so much at the beginning of this legislative process. So a lot of what we're talking about is sort of procedural in what order there is. The bipartisan bill is basically cooked. It's ready to be voted on. There's an expectation that it will pass the House. And so this gamesmanship is about this other bill. And the other bill, as you say, you know, there has to be a rule. There has to be a vote on the budget resolution. But then the actual kind of meat of the bill, like what is in that apparently \$3.5 trillion package. We basically just have bullet points on a lot of important aspects of this bill. And I'm most familiar with the health care aspects of the bill, obviously, because that's what we all care about the most. But even something simple like prescription drug prices, we know that is going to be some aspect of the package. No one working on it has decided what the policy will be, what the legislative language will be. All of that still has to be negotiated, conceptualized, written and scored. And a lot of other pieces of the health care package actually sort of depend on that piece, because that's going to be a big revenue raiser that will sort of determine to some degree the budget for some of the other things that members of Congress want to do in the Democratic caucus. There seems to be some consensus, for example, about trying to come up with a solution for the population in the Medicaid gap in the states that have not expanded Medicaid. And that's another area where there is no legislative language. There is a couple of different approaches that are under negotiation and lawmakers are talking about, and I think there is a good-faith effort on

all of these issues to legislate. But the fact that there is a budget resolution does not mean that we actually really have a piece of legislation that can be passed any time soon or that even individual lawmakers can decide how they feel about. So there's, I think we have to get a lot closer to actually having a bill. And then once we have a bill, then there's going to be additional horse trading and negotiation, and people may have various sticking points or deal breakers or demands, but it's just so much of it right now is so nebulous and theoretical that I think understanding how any individual lawmaker is going to vote on it is just very difficult.

**Rovner:** This reminds me a lot of where we were with the Affordable Care Act in the summer of 2009, except that we didn't have Afghanistan blowing up at the time. But yeah.

**Sanger-Katz:** I think that a more recent example is the Republican effort to repeal and replace the Affordable Care Act, which, of course, was not successful. They were ultimately able to vote on a budget resolution, but then they didn't have the policy and there was negotiation. There were multiple bills, there was horse trading, there was ... you know, and they did get close. They were, you know, quite close, obviously, to passing the final skinny repeal proposal. But, you know, the devil is really in the details. And if you're going to do anything approaching \$3.5 trillion worth of public policy, there is a lot of details that need to be sorted out. And we're just not there yet.

**Rovner:** Yeah, I expect we're going to spend the entire autumn on this. All right. Well, now let's talk about covid. We've had a lot of news in the past few days, but I want to start with the big picture. After last week's announcement that a third dose of vaccine would be authorized for people with compromised immune systems, the Biden administration announced on Wednesday that everyone should expect to get a booster dose starting eight months after their last dose of vaccine and pending FDA and CDC approval starting in mid-September. Now, this change in policy is apparently based on data from other countries, including Israel, showing that vaccine efficacy starts to wane after about six months. And even people who are fully vaccinated can end up seriously ill, although it is still rare. But the idea that even healthy, fit young people will be eligible for a booster while at-risk health workers in underdeveloped countries can't even get their first dose is not sitting well with most global health experts, who point out that the rampant spread of new variants in other countries is more dangerous than the increased possibility of mild illness here. My former KHN colleague Emily Kopp tweeted this after yesterday's briefing: "Trump administration, America first. Biden administration: It's SO important to acknowledge the importance of health equity and the urgency of being an arsenal of vaccines for the globe. But America first." Does she have a point?

**Ollstein:** I mean, this is generating a lot of criticism, including from U.S. epidemiologists who are saying, I saw the comparison that this is like giving people an extra life jacket when they already have one. Meanwhile, a bunch of other people are drowning — and those people who are drowning could pull you down, too, which is the idea that if we use the supply of vaccines to give people a third shot, instead of using them to give a bunch of people around the world a first shot, then that allows variants to develop in other countries. And those variants could make their way back to the U.S.

**Rovner:** As we saw with delta, which started in India.

**Ollstein:** The idea that even worse variants could emerge. So, I mean, the Biden administration counters that we're doing both. We're sending vaccines abroad and getting people boosters here at home. But I've also seen people disagree on the strength of the data that it could help that much here.

**Sanger-Katz:** But the domestic politics, I think, are kind of obvious. I think there are these global health equity issues and there are all of the people that you would expect to be concerned about this are making these arguments. But I think for the Biden administration officials, if they really feel that the vaccines that people have received are not adequate to continue to protect the American public against the most serious consequences of covid in this new delta phase, I think it's pretty obvious why they think it's important to take care of people domestically. I think it's important for the country to seem like it's on the right track. I think it's important for our economy, for people to be able to work and engage in commerce and all these other things. So, we're seeing this with Afghanistan as well. I think that it is very hard in the face of an urgent domestic need to overweight the kind of global consideration. I think it takes a rare politician who can really say, I'm going to put Americans on hold because I'm concerned about this global issue. Biden, I think, fits into that mold of someone who is primarily concerned with American interests. While at the same time, I do think that the Biden administration has taken actions to try to improve the global vaccine supply to the degree that it can.

**Rovner:** One of the concerns about recommending a booster is that it could increase doubt among people who haven't gotten the shot yet. It could increase hesitancy, because there's a perception that the vaccines don't work. In fact, the fact that you need a booster is kind of evidence the vaccines do work. That's been sort of one of the holdups about recommending boosters in general. Right?

**Sanger-Katz:** I think that has certainly been a consideration that a lot of public health officials have worried about, is doing things that might increase vaccine hesitancy. At the same time, I think, in the face of increasing evidence that the current regime of vaccinations are not adequate to protect people against the serious consequences of this new variant, I think you have to weigh those things against one another. And what they decided is that it's more important to keep people who want to be vaccinated safe and healthy than it is to withhold that vaccine and encourage the people who have remained holdouts to get over the finish line. I understand that that is a difficult balance, but I do understand, I also understand why they made the choice that they made. I did some reporting a few weeks ago, kind of looking at who still is not vaccinated. And most of the work that I did was really looking at adults who are not vaccinated. Obviously, children are another huge group, and they have different challenges because they do not have an approved vaccine yet. But when it comes to adults, the majority of adults who are not vaccinated at this point are people who are very strongly against vaccination. There are people who remain who are open to it and who could be persuaded. And I think those are the kinds of people where these arguments about, well, will it be one and done or am I just going to have to get a vaccine all the time?

Those kinds of arguments may sway, but I think the people who are still not vaccinated are increasingly people who have pretty strong ideological objections to getting vaccinated. And it's not clear how easy it will be to get those people to yes.

**Rovner:** Although we have seen that, I mean, since delta started to kind of march through the country, the vaccines are going up. I mean, they're still not obviously what they were in the late winter and early spring, when people were clamoring for them. But we are seeing more people getting vaccinated every week now than we did a month or two ago, which probably is a good sign. I know one of the big difficulties in whether or not to recommend boosters is a lack of data. The CDC isn't even collecting data on positive cases among vaccinated people unless they end up in the hospital, so we don't really have any good information on how common these breakthrough cases are. Is there any way to start to gather this data now, or has our vaccination effort been too diffuse? And unlike other countries that were using their data, we don't have a national health care system.

**Leonard:** Collecting data throughout this pandemic has been a major problem, whether it's infections, whether it's hospitalizations, what percentage of people have covid symptoms for months after infection? We still don't have good data on that. And so it would probably require a really long time to actually set this up and be able to tell, you know, how many people are getting infected. And another thing is that a lot of people who are vaccinated and get covid have such mild symptoms that they might just decide to isolate instead of get tested or they might not even realize they have covid. They might just think that, you know, OK, I have a cold because, again, their symptoms are so mild they might not even think to go in and see a health care professional. So the data, even if they were to collect it, they have to set up the infrastructure and it would be hard to get people in in the first place to be able to track all of that.

**Rovner:** So even in the absence of good data, there's a bunch of other breaking covid news from the Biden administration. First, it is planning to require not just federal workers to be vaccinated, but nursing home workers to be vaccinated if the nursing home wants to continue to receive federal funds, which is most nursing homes. The long-term care industry is not particularly happy about this. But we have seen that a lot of workers in nursing homes have declined to be vaccinated. Is the moment approaching where we are moving from the carrot to the stick? I'm seeing sort of more and more vaccine mandates.

**Ollstein:** I think so. And the Biden administration has made it really clear that is their preference, that individual employers be the ones to implement the mandates, not the government, but they've been waiting and waiting and cajoling and pressuring. And that hasn't really worked. And so now they're bringing in the hammer, so to speak, and using the threat of, you know, using the power of the purse to compel this. And I think that, you know, this is an area where they have a lot of the leverage because of the federal health dollars. They have that control more than in other parts of the economy. But I also think that because, you know, nursing home deaths were just such a huge and devastating piece of this pandemic, this is maybe also an area where there will be less of a public backlash. I know you noted that within the industry there is already

somewhat of a backlash, but I mean, a public outcry that they definitely want to avoid and I think has been scaring them away from getting tougher in other areas.

**Rovner:** Yeah, I mean, I know, you know, more and more private organizations are starting to require vaccines with, you know, limited exceptions for religious and medical reasons. We had the first surge of people who were really anxious to get vaccinated, and then we had a bunch of people who were like, OK, I should probably do this. Or they saw somebody get sick and they did it. And now we're trying to sort of pull people in and, you know, with the ... not quite to the level of France where, you know, you basically can't enter a public place unless you can prove that you were vaccinated. But we seem to be at sort of that next level of, you know, you really should do this and it's going to be hard for you if you don't.

**Sanger-Katz:** And we're also seeing the industries that are really leading with vaccine mandates are the ones where there is the most risk both to workers or to other people. So hospitals, it's not universal among hospitals, but we are increasingly seeing not just the federal VA hospitals, but also a lot of private and nonprofit hospitals are requiring their workers to be vaccinated. And that makes sense, because those are people, first of all, who are interacting with a lot of patients who may be vulnerable. They're interacting with a lot of patients who may have covid. And that's the reason that they're in the hospital. And also there, as we are experiencing this new wave of covid infections, these are people who are [a] really vital workforce to keep the public safe. And I think there's concerns about them getting sick and being absent as well as spreading the virus. You know, now we've seen this new pressure on nursing homes. Nursing home residents are incredibly vulnerable. Nursing home workers were a major vector for this virus early on in the pandemic. And another place, I think, where we're starting to see a lot of these mandates is in meatpacking, which is another place where we just saw, you know, rampant transmission early in the pandemic, because these are people who are working very long shifts, very physically close to one another and not particularly well-ventilated spaces. So a lot of employers may feel that their workers can take their own precautions if they don't want to be vaccinated. But I think in the kind of workplaces where there's a lot of risk to others of transmission, the employers feel that they have a responsibility to their workforce and to their patients or customers to make sure that their employees are not vectors.

**Rovner:** So also on Wednesday, the president escalated the masking debate. Announced he will take federal action if necessary to protect school officials in states that are banning mask mandates, including most notably Florida and Texas, but also Arizona, Iowa, Oklahoma, South Carolina, Tennessee and Utah. This has become super politicized, but in states without these mandates, there are literally tens of thousands of kids already in quarantine because they've been exposed to classmates who have tested positive — and school's only been open a couple of weeks. Are we going to end up with remote school again in some of these states?

**Ollstein:** We already are in some of these states. Many districts have been forced to go remote already. In some places that has led them to reconsider the mask mandate bans or narrow the opt-out ability. You know, in some they said parents can opt their kids out

of wearing a mask just for any reason. And now they're sort of tightening that. So it needs to be for a specific disability or something. I think that schools are really the tipping point. If parents can't send their kids to school, they can't go to work themselves. We saw that last year. And so I think this is going to be a real tipping point as schools start to open around the country, as we've already seen.

**Rovner:** Yeah, I feel like schools are sort of the, as you say, the tipping point and sort of the place where all of this is coming to a head. Obviously, kids under 12 can't be vaccinated yet. And we're still waiting for the FDA on that. Is this where, you know, where most of this is going to play out?

**Sanger-Katz:** I think schools are a really difficult challenge for this year because of the increased transmissibility of this new delta variant. So last year, a lot of schools were closed, even though there was quite strong evidence that schools could be open safely. That if children were wearing masks and educators were wearing masks, and if certain other basic precautions were taken in the school setting, there was a lot of evidence from other countries and from the parts of the United States that had schools that were open that transmission was very minimal to nonexistent in the school setting. And we had a lot of large urban districts, particularly on the West Coast and to some degree on the East Coast, where schools remained fully remote, despite very strong evidence that school could be conducted safely. I think that we are really entering an era of somewhat uncharted territory in this school year. This year, in contrast, I think the vast majority of schools are planning to be in-person or already open in person full time. But we now have a different virus. The delta variant of covid is much more easily spread. It seems to be making children sick more often. It seems to be making some children more sick. It's hard to untangle those things. They sound like they're separate, but they're all kind of related, because, I think, the more the virus is spreading, the more you're going to see an unusual outcome. There is also a concern because this virus replicates so much more on your body — so people who have this virus are shedding a lot more of it — there is a concern that the kind of masks that are made and used by children, which are primarily cloth masks, are just not very good at preventing the spread. I think everyone thinks that a mask is better than no mask. But in general, the advice that's being given to adults who have access to better masks that have better filtration is: Use a better mask if you want to protect yourself against the delta variant. So I think we're really going to have to see. The political fights about schools are largely about mask mandates. But I think it is possible — hopefully it will not be the case — but I think it is possible that even schools that have mask mandates, that have good mask compliance, may still have problems with the outbreak of this virus. And we just have to wait and see. We don't have good evidence about what works to prevent transmission of delta in schools. And we know that these kids are going to be unvaccinated for much of the school year.

**Rovner:** Yes, you actually anticipated one of my other questions, which is, should we all be wearing better masks? I mean, delta is a really different animal.

**Leonard:** I think about this all the time. I've been thinking about it for months, because a lot of what I see people put on their faces, I think that can't work very well. You know,



there's all kinds of holes. It's hanging down their face. You have parts of the face that are exposed. It's not tightly around your jaw. You know, these masks have to be several layers. They have to be strong. They have to be well fitted. And, you know, the way that we sort of started a conversation about masks in this country was that it's better to wear something rather than nothing. Just use a bandana. Now, I think people are starting to say, well, OK, maybe not. Let's make sure that the masks that we have are actually effective. But, yeah, I've been thinking this for a while. I mean, I spend a lot of time on Capitol Hill, where, you know, you have a lot of members proudly wearing masks. But looking at them, you think, well, that's not going to be very effective in preventing the spread of the coronavirus. So I think that they definitely should become more vocal on this, especially with the school problem that we're facing.

**Rovner:** Although interestingly, I went to the doctor last week and I asked him, should I be wearing a better mask? And he was thinking, you know, the best mask is the one that you'll wear, that, you know, you're not going to want to walk around in a medically fitted N95. But you should wear something with multi layers, at least, you know, sort of wear the best mask that you can wear for hours if you're going to be inside with other people.

**Sanger-Katz:** But can I just say, like, a quick PSA, which is ...?

**Rovner:** Yes, please.

**Sanger-Katz:** Early in the pandemic or even midway through the pandemic, you know, a lot of us were wearing cloth masks because that's really what was available. The really good masks were in shortage and they were being reserved for health care workers or there was a lot of concern if you bought them you might buy something that was fraudulent that wasn't actually what it said it was. The global supply of high-quality masks has improved tremendously. These masks are not expensive and there are plenty of places where you can buy them, where their authenticity is verified. So you don't necessarily need to wear, like, a medically fitted N95 mask, which I wore one of those recently. And it actually is, it made me have a lot of respect for medical professionals who wear them for very long shifts. They are, it is a very extreme experience wearing one of those masks, but there are these KN95 and KN94 masks, which are sort of similar. They're made of high-quality filtration material. They tend to have your elastics instead of the around-the-head elastics and they're just much better than cloth masks. And you can get them for, like, less than a dollar each. So if you are the kind of person who wants a good mask, ethically and logistically, you can now easily get them in a way that really wasn't the case earlier in the pandemic.

**Rovner:** And you can get, there are apparently high-quality masks that you can get for your kids, too, that are better than what they've been wearing, but not full N95. I've seen, sort of, people urging that schools actually go ahead and buy them for the kids rather than rely on the parents. And, you know, here's a mask that we know is good. Well, I don't want to leave this without talking a little bit about politics. Texas Gov. Greg Abbott, who was reportedly thrice vaccinated, tested positive for covid and immediately went on monoclonal antibody treatment. But at the same time, Texas is bringing in

refrigerated trucks to store the bodies of those who are dying from covid. Florida Gov. Ron DeSantis is setting up state clinics to give sick people monoclonal antibodies, but he won't do anything to help prevent the virus from spreading in the first place. I'm not sure I understand the politics of this for these governors. It's their base who are ending up in the ICUs. Are we seeing sort of a growing case of "Do what I say and not what I do"?

**Ollstein:** My co-worker had an interesting piece on the GOP governors' hyping of these, for many people, quite expensive and onerous treatments for covid rather than the very cheap and preventative measures like masks that could be employed. And I, you know, it makes me think back to when Donald Trump was hospitalized with covid and emerged not saying, hey, you should really take this seriously, but sort of emerged saying, look, I beat it; it's not so bad — when he had access to these top-of-the-line treatments that more people have access to now than then. But still not everyone, and not many of the people who are going to get sick.

**Leonard:** I think part of what's happening, too, is that, you know, places like Texas and Florida emerged from last year's pandemic not really doing that much more poorly than some of the states that were incredibly locked down. I'm not saying they couldn't have done better than they did, but if you look at how many deaths, how many hospitalizations and everything that was going on and when different surges were experienced and all that, it wasn't as clearly defined like, oh, it's because they locked down or, oh, it's because they masked more. This is a different virus now, though, that we're facing. And so I think there's a lot more pressure, not just because it's how it's affecting kids, but because of how quickly it's spreading, because of the surge that we're having now. I think there probably is some more pressure to say, hang on, this isn't last year. We need to do things differently this year. But, I don't know, they seem to kind of be digging in their heels on this issue.

**Rovner:** I will be curious to see how this ends up playing out, but I guess there's more of it to come. Well, I wanted to talk a little bit about health care and capitalism, because two different stories related to this subject caught my eye this week. One is a story about how UnitedHealthcare is getting into basically the health app business, offering cut-rate telehealth and prescription drugs online for people paying with cash, sort of competing with some of these health care startups, basically going after the millennials and Gen Z'ers who live on their phones and laptops. The other story is actually a report from my colleagues at KFF which found that growth in spending for enrollees in private Medicare plans is not only higher, but growing faster than spending for those in the traditional Medicare program — which, of course, is hastening the insolvency of the Medicare trust fund and costing taxpayers more, although it seems to be providing a steady source of income for Joe Namath. But seriously, is competition and innovation the answer to our health cost problem, or is it the problem itself?

**Sanger-Katz:** It's such a hard question to answer, because it's such a broad question.

**Rovner:** But we see examples of where competition can clearly bring prices down. An example, we're sort of getting the private sector and it's clearly driving prices up.

**Sanger-Katz:** Yeah, I think the Medicare Advantage market is interesting and complicated, and I think that it is in many ways a mischaracterization of what it is to describe it as really competition. I think it is a very good business opportunity for insurers, and I think it does provide Medicare beneficiaries with options — in many cases, options that are more appealing for their particular circumstances than the traditional Medicare program. But it is not designed in a way where there is a lot of downside risk for insurers who understand how to operate in that program. And they don't really compete with one another on price in the way that, say, Affordable Care Act plans do. The real question about Medicare Advantage in some ways is about whether there is a benefit, aside from a cost benefit, to having these private players offering alternatives to traditional Medicare. Is it providing better care? Is it a place where you can have a laboratory to experiment with different ways of delivering Medicare? Is it giving seniors better customer service, better care coordination, additional benefits that they like? You do see Medicare beneficiaries are voting with their feet. I think Medicare Advantage either is just at about the threshold of half of the program or is about to cross that threshold. And that is driven by increased enrollment among new Medicare beneficiaries, of people who are coming into Medicare. A lot of them are choosing a private plan. So that tells you something.

**Rovner:** Well, they have extra benefits. I mean, it's interesting to sort of remember the trajectory of this. In 1997, Congress, in the Balanced Budget Act, Congress cut a lot of things in Medicare. One of the things they cut was reimbursement for Medicare Advantage. And a whole bunch of plans dropped out of the program because it was no longer profitable for them. And in 2003, when the Republican Congress put the, did the prescription drug bill, they also, a big piece of that was to add a lot more money to make it a lot more attractive for these private plans to join Medicare. And they did. And they were getting paid enough that they were offering all these extra benefits. And hence you're seeing what you're seeing now. And, you know, the Democratic Congress cut that back a little bit. But obviously, it's still — as you mentioned, Margot — a pretty profitable place for a lot of insurers. And the insurers are happy, the patients are happy, and the taxpayers are getting the bill.

**Leonard:** Well, also, Democrats are planning to add more benefits to traditional Medicare. So that might shift whether people choose to go to Medicare Advantage or to traditional Medicare. It would also make traditional Medicare more expensive. But there would kind of be this shift that happens. But it would make traditional Medicare more competitive with Medicare Advantage, because right now, if you have traditional Medicare, you have to get all the other stuff with it. You know, the dental, the hearing, the vision. And, you know, there's a lot of cards, a lot of different accounts. And you got to do it every year. So it would, you know, simplify and also boost the traditional program.

**Rovner:** I guess the big question here that we're obviously not going to answer is, is regulation or competition going to eventually bring health prices down? And so far, the answer seems to be neither.

**Sanger-Katz:** Yeah, I think it's real tough. I think to the degree that you think a robust market in which insurers are competing against one another has the potential to lower health care expenditure, I would look to the Affordable Care Act marketplace before I would look to the Medicare Advantage marketplace, because these are insurers that are competing head to head on price and they are competing in a market where, at least until recently, people who are buying the plans were extremely price sensitive. We saw a lot more switching of plans in the Affordable Care Act marketplaces than we see in practically any other health insurance marketplace. And we saw huge, huge, huge popularity among the lowest-cost and second-lowest-cost silver plans and the lowest-cost bronze plans in almost every marketplace. So that really tells you that the people shopping in that market have historically cared a lot about price. And so they're sending a strong signal to the insurers, like, you need to get us a cheap plan if you want to get a lot of market share. So if that is a mechanism that will lower health care prices, that's where we're going to see it. I don't think we see particularly strong evidence for it so far, but it's not as mature a market. And so I think there's more to be seen. I think that question will become harder to answer because of the expanded subsidies under the American Rescue Plan that the Democrats hope to extend indefinitely. A lot of people now can get, like, free or for very close to free plans. And so I don't know if that will reduce some of the intense competition that the insurers were engaged in before.

**Rovner:** Well, the ever-changing marketplace — I'm sure we will continue to talk about that. 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. Alice, why don't you go first this week?

**Ollstein:** Sure. I picked a piece by Natalie Shure in The New Republic that is arguing against the idea that has been floated recently of requiring people who declined to get vaccinated for covid to either pay higher medical premiums or not receive coverage for the cost of them getting covid and needing treatment, and basically she walks through both sort of from an ideological standpoint, but also just from if your goal is to get people vaccinated she argues that this just won't work. And she points to in the Affordable Care Act, there was, you know, a carve-out for insurers could charge people more if they were smokers. And the evidence is that did not help people quit smoking. Instead, it just drove people out of being covered at all. And when they're not covered, they are not interacting with the medical providers who could help them quit. Similarly, she argues, if people are unvaccinated and are barred financially or otherwise from seeing a doctor, that prevents the person they might listen to the most from convincing them to get vaccinated. But also it sort of creates a slippery slope. And aside from this piece I've just heard recently, you know, it may be satisfying to say, hey, these people who won't get vaccinated, we shouldn't pay for their treatment. But, you know, where does that logic end? Do you also say if someone is speeding and gets into a car accident we shouldn't give them emergency care? Would you say, you know, someone who eats a lot of junk food doesn't deserve medical care? This whole idea of the deserving and undeserving can take us to a dangerous place.

**Rovner:** Yes, we had this debate during the Affordable Care Act.

**Ollstein:** We will always have this debate.

**Rovner:** So we're going to have it again. Kim.

**Leonard:** Yeah, I picked a story of mine at Insider. It's called "Amazon, Investment Banks, and even Big Tobacco Are Spending Millions of Dollars to Try to Get Favorable Marijuana Laws." I wrote the story through using lobbying disclosures that recently came in during the first half of this year. I was really interested to know whether lobbying had gone up as Senate Majority Leader Chuck Schumer, along with Sens. [Ron] Wyden and [Cory] Booker, were working on a discussion draft to legalize cannabis in this country. And yes, there was an increase. And so I learned from my reporting that a record 167 special interest groups lobbied on cannabis during the second quarter of 2021. And one of the big ones was Amazon. And Amazon recently came out in favor publicly of national legalization, and it was their very first time lobbying on the issue. And so the story also just lays out some of the big players from the medical field, the consumer, the financial services sectors. You know, everyone's competing for a slice of this market and how it's going to be regulated.

**Rovner:** It's quite a story. Margot.

**Sanger-Katz:** I wanted to recommend a pair of stories about the delta variant of covid. One in New York magazine called "Don't Panic, but Breakthrough Cases May Be a Bigger Problem Than You've Been Told" from David Wallace-Wells and another from the Atlantic called "How the Pandemic Now Ends" from Ed Yong, who's been a kind of wonderful digester of the main themes of this pandemic and a great read all along.

**Rovner:** And now a Pulitzer Prize winner.

**Sanger-Katz:** And a Pulitzer Prize winner, yeah. And you may have sensed in my comments today a growing concern that delta is very different than what we have experienced so far. Reading these pieces is part of what caused me to believe that, because I think what both of them do really well is they kind of pull together all of the little disparate threads that are out there and give us a sense that a virus that is as transmissible as the delta variant of covid is really is not a great match for the kinds of approaches that we've had to even regular covid. The idea that herd immunity, for example, is a viable exit strategy, I think, is basically thrown out the window by the basic math of this virus. It is so contagious that we would need to vaccinate something like 95% of all Americans, including children, to just have the vaccine alone prevent the virus from circulating. And what the New York magazine piece, I think, did really well was show how data that has been used by the Kaiser Family Foundation and also by the CDC to demonstrate the rarity of breakthrough infections of delta has some really flawed assumptions and is perhaps substantially underestimating the risk of such breakthrough infections. And this, of course, comes back to our discussion earlier about how we just don't have very good data on surveillance. But I think that reading these pieces, again, just sort of brought home for me that we are dealing with a very different virus now that creates some different challenges. And all of the things that we've

learned so far are important. But I think it is also important to realize that we are entering a new era.

**Rovner:** I also have a covid story. It's from my KHN colleague and fellow corgi owner Arthur Allen. It's called "Federal Vaccine Program Hasn't Helped Those Whose Lives Were Altered by Covid Shot." And it's about how the covid vaccines, which can cause some fairly serious side effects, aren't covered under the main federal no-fault compensation program that dates back to the late 1980s and was more aimed at childhood vaccines. There's actually a separate program for vaccines and treatments delivered under health emergencies like covid, but apparently no one has made it through the bureaucratic maze to get compensated, because that program requires much more in the way of proof that the vaccine was responsible for the injuries. If we really want to address covid vaccine hesitancy, this is something that we actually need to address.

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. And also, as always, you can email us your comments or questions. We're at [whatthehealth](http://whatthehealth.org), all one word, [@kff.org](http://kff.org), or you can tweet me. I'm [@jrovner](https://twitter.com/jrovner). Alice.

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**Rovner:** Margot.

**Sanger-Katz:** [@sangerkatz](https://twitter.com/sangerkatz).

**Rovner:** Kim.

**Lenoard:** [@leonardkl](https://twitter.com/leonardkl).

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