KHN's 'What the Health?'

Episode Title: Vaccine Approval Moves the Needle on Covid

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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. 26, at 10 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 video conference by Tami Luhby of CNN.

Tami Luhby: Hello.

Rovner: Joanne Kenen of Politico.

Joanne Kenen: Hi, everybody.

Rovner: And Sarah Karlin-Smith of the Pink Sheet.

Sarah Karlin-Smith: Hi, Julie.

Rovner: Before we get to the news, a note about our schedule. We'll have no podcast next week. I will be on vacation, and I hope most of our listeners will be, too. We'll be back on Sept. 9 with a special on the future of public health. And we'll be back with our regular news on Sept. 16. OK, now this week's news.

We will start as usual, I guess, with happenings on Capitol Hill. The House as scheduled, if not predicted, passed the first preliminary steps on Tuesday aimed at completing both the Senate-passed infrastructure bill that moderate Democrats want and a budget resolution that will trigger a social-spending budget reconciliation bill that liberals want. This was not as easy as it seemed. House Speaker Nancy Pelosi is walking the narrowest of tightropes. She can only afford to lose three votes to get anything passed, assuming no Republican support. But, as usual, Pelosi managed to do what she said she would. What are the prospects going forward for the big social-spending bill? And did anything that happened this week make those prospects better or worse? There was a brief, I guess, rebellion by some of the moderates who want to vote on the, quote-unquote, "hard reconciliation bill" first and have made clear they do not support $3.5 trillion — that's the current price tag for the social-spending bill that will include all of the health provisions.

Kenen: Well, it didn't get derailed. I mean, it's still alive and moving forward. There is a lot of mysteries about what's next. They said they can't do $3.5 [trillion]. They didn't say what they *can* do. There was sort of a glaring at each other across the precipice, and they sort of managed to find a way across that through a procedural agreement about what happens when. So Pelosi did manage yet again to keep the Democrats more or less

together. We won't have a really clear sense of what's in and what's out until September. But, you know, there's a big difference between I can't do $3.5 trillion, but I can do $3.3 or whether I can only do $2 [trillion]. I mean, there's a huge — we don't know where they're going to end up, and we don't know how they end up, wherever they end up, what comes or goes. But the key thing right now is it's still on track. They came back early to deal with a crisis between the moderate rebellion, the so-called Mod Squad. And Pelosi got them across that barrier. More barriers to come. But it's a pretty good sign that she did work that out.

Rovner [laughing]: Or at least holding their fire. I feel like, you know, as tenuous as this all is, I think both the moderates and the liberals know they're likely to lose the House next year, anyway, just because of redistricting and how it's controlled in so many key states by Republicans. But if they're going to be able to keep Congress, they're going to have to get something here done. And that's, you know, it's the one thing that I think holds them all together: that they all need to get something done, even though they don't necessarily agree on what that something is. At some point that may all fall apart, but I imagine it won't fall apart until probably, oh, I don't know, October?

Luhby: They're going to have a very busy September. And they're going to have to make a lot of compromises, you know, I mean, they want to make the more generous subsidies for the Affordable Care Act permanent. They want to make the child tax credit enhancement permanent. But these things may not end up happening. They may end up being only several years, which means, of course, that they'll have to fight about it again at some point. But, you know, Politico already reported that it looks like lowering the Medicare age is out and it's going to remain at 65. But they will expand benefits or they hope to expand benefits to dental, vision and hearing. So it'll be a lot of horse trading coming up.

Rovner: We were surprised — I think we talked about this a couple of weeks ago — that lowering the Medicare age was even in there, because the health industry does not support lowering the Medicare age. But they do support adding benefits, that it made more political sense to add benefits like hearing and vision and dental care than it does to try to lower the eligibility age. And surprisingly, even Bernie Sanders has been for adding benefits, so that's — if they're going to do something to Medicare, I'm guessing that's it. But again, I think you're right, I think a lot of these things are going to be time-limited to keep the moderates from freaking out about the ultimate price tag. And then we're just going to be back doing this again. It's the “full employment for health reporter” bill.

Kenen: It's not a surprise that [Bernie Sanders is] for adding benefits. It's that he's not insisting on lowering the age; I mean, he always has wanted those benefits. The other thing I have not heard, but it could pop up again, is a buy-in, a Medicare buy-in. I have not been hearing that — I mean, we've heard it on and off for 15 years now or maybe more. It has not been part of the conversation in this bill. It is a possibility that someone will throw that in the hopper, that you won't get free Medicare, but you would have the right to buy in at a certain age, you know, 62, 60 … whatever they decide. Again, I'm not saying it's likely, but would any of us be shocked to hear it at least floated again? No, that could be floated.

But since the ACA subsidies were enhanced, it may not be as needed or desirable as it could have been a few years ago.

Rovner: No, and there are at least a half a dozen bills to do that that are out there. So I think we'll see. We'll all be back in September and see what it is that they think they're going to be able to put in this package.

Let's turn to covid, because there's a lot of covid news this week. The biggest news, I guess, is the FDA's formal approval of the Pfizer-BioNTech vaccine, which henceforth will be called Comirnaty — I believe that's the pronunciation. Sarah, you cover the FDA more closely than the rest of us. What's with these impossible names?

Karlin-Smith: Well, it seems like, I mean, this name in particular, Pfizer was trying to get very creative and combine "community," "covid," "mRNA." The names actually go through a pretty formal approval process by FDA to kind of make sure it's not too similar to another drug name, there's not going to be confusion. Of course, a lot of people, I think, were talking about this week that Moderna has kind of an easier-to-remember-and-pronounce brand name, Spikevax. But, you know, I think if you think about it, the fact that we have the time to even, like, ponder, you know, the strength of the brand name, I don't think that's bad PR for the company. We're not arguing about whether this is a good vaccine. There's nothing controversial going on here. So, if all we have to talk about is whether they picked, you know, not the best brand name perhaps for people to pronounce, I think, you know, Pfizer's probably having a good week here.

Rovner: Yeah, Twitter was very excited about the name. Well, according to a poll from my colleagues at KFF, 31% of vaccine holdouts said they would be more likely to get the vaccine when it had full FDA approval. Now that it does, do we really expect these folks to get it or are they going to find some other excuse?

Karlin-Smith: I'm a little bit skeptical, particularly because that same polling also showed about 50% of the people didn't really understand whether the vaccine was fully approved or not at that time point. So it's hard to know. I think the bigger difference we'll see now is that companies, private businesses, employers are feeling more emboldened to either push up mandates for people to get vaccinated or institute them now that there is full FDA approval, even though the Justice Department and others had kind of said that wasn't necessary for these mandates. It's just led to a lot more momentum and comfort among companies to do that.

Rovner: Yeah, we've seen both public and private, I mean, you know, government workers and big companies now mandating vaccines.

Luhby: Right. And you have the military and New York City teachers. … It has momentum now.

Rovner: It does. But Delta Air Lines — poor Delta with the unfortunate name, joining Corona beer — has decided that rather than have a mandate, they're going to have sort of increasing hurdles for the unvaccinated, including frequent testing. And, at the very end, starting in November, if you're still unvaccinated, a $200-a-month surcharge to your health

insurance. Now, experts have pointed out that this is actually probably legal. It's not — an insurance company can't do this, but an employer under the guise of a wellness plan can do this. And there's been a lot of debate about whether or not this is a good idea, or whether it's a slippery slope to other things. Tami, you've been kind of looking at this. What are you finding?

Luhby: I have and I have to say I was pretty surprised by Delta's move because, you know, this was in the news earlier this month when Mercer came out with a study saying that a lot of employers are considering it. And there were, you know, a bunch of stories. But even Mercer said they only knew of one or two that were actually putting it — or a handful, I should say — that are actually putting it into effect. And Mercer pointed out that companies were probably going to wait until there was full authorizations. Then I spoke to several other experts who said, actually, not only did they not hear from many of their members that they were going to do this, but they also didn't think it was a good idea. They didn't think that the idea of, you know, the stick and the punishment was the best way and the most effective way to actually get more people vaccinated, which is the ultimate goal. And even Mercer said that they thought that the penalty would be $20 or up to $50. And here comes Delta with a $200 surcharge. So it'll be very interesting to see if other companies follow this.

Rovner: Are we seeing any results yet from these mandates? I guess most of them are pretty recent.

Kenen: We are seeing an increase of vaccination rates has gone up. I don't know that we can totally figure out at this point how much is because of the mandates and how much people just are scared by what they're seeing with delta. Younger people who thought they didn't need a vaccine may think they do now. I personally have not seen any study that breaks that apart in a reliable way. Presumably it’s both fear of delta plus mandates. School is starting, colleges are requiring it. You know, there are some deadlines for some mandates that are *now*. So my assumption would be it would be both.

Luhby: Yeah. In New York City — I don't have the numbers in front of me, but — they are requiring a vaccine or testing and they'd really hope that this would push a lot of city workers to get vaccinated. And it did increase the number, but not as much as they had hoped. And New York isn't, I mean, obviously our numbers are up, but it's nowhere near what we're seeing in the South. So, the fear here is less. So, presumably, the mandate or the requirement of weekly testing is what's pushing people. So, yes, more people are getting vaccinated, but not at the numbers that they were hoping.

Kenen: But it is a pretty significant spike, no pun intended. You know, there is a surge in … it's not up to the levels of March and April, but I believe it's up to sort of where we were in June that it has significantly bumped up.

Luhby: Yes.

Rovner: Yeah. I think it's like a million a week.

Luhby: Yeah.

Rovner: If you look at the little graph, it's definitely going up.

Luhby: And you see that in the Southern states, where there is a lot of fear.

Rovner: Yes. Because there are hospitals that are completely overwhelmed.

Luhby: Yes.

Rovner: Florida has what somebody just said, you know, two or three days of oxygen left.

Luhby: Oh, they've asked Orlando to limit their use of water so they can save oxygen. It's crazy. And, you know, I have a friend who lives in Florida and she's been vaccinated. She was actually part of one of the trials. And when we were talking all of last year, you know, she was talking about it and it didn't seem that immediate to her. And I spoke to her, like, a week or two ago. And she said she knows of five people who died in the past week.

Rovner: Speaking of Florida, the governor of Florida, who is against mask mandates and against vaccine mandates, has decided to go all in on monoclonal antibody treatment, making it widely available, they're opening clinics and apparently training emergency medical technicians to deliver monoclonal antibody treatment to people with covid, which can indeed lessen the severity of the virus. But I'm puzzled by the politics of going all in on treatment and all *not* in on prevention.

Luhby: It's the American way, unfortunately.

Kenen: Well, it's both [Govs. Ron] DeSantis and [Greg] Abbott. It's Texas and Florida. The antibodies do help. I mean, this is a good treatment, but it is expensive for the taxpayer, which is footing the bill at the moment. And it is also … you have to time it right. So, you have to have testing available and widespread, so if you have a really mild case, you have a window. Sarah might know — it's like a few days, right? You have to do it soon after infection or it won't work as well and won't prevent that escalation to severe disease. If you're asymptomatic, there really has to be surveillance, you know, if you know you're exposed and you get tested. But I mean, it's so widespread, not everyone's going to know when they're exposed. Even if you do wear a mask, you know, we all know people who have had breakthroughs, even though they are vaccinated and wear masks. So it's not that those are not helpful. They are. There's far less covid among the vaccinated masked population and far less severe covid. I mean, we don't want to let that sort of myth, "Oh, the vaccine doesn't work anyway" to spread. The vaccine does prevent severe illness. But this antibody, which is an infusion, it's not a pill, it has to be done fast.

Karlin-Smith: In some ways it's good that DeSantis and other governors are, you know, pointing out that these tools are available because they have been underutilized throughout the pandemic. And partially because of the barriers Joanne mentioned, you really have to act fast once you initially get covid, and know you're at high risk for severe progression, and then go find a facility that can administer it, which isn't always easy. But I think there is, like, this interesting dynamic. Kaiser Health News had a good story yesterday about it and someone was quoted as saying it's hard to understand the mindset behind people who would very easily embrace these antibodies, which are also granted emergency use authorizations. They're not fully approved by the FDA and, actually, are

sort of much newer scientifically development-wise than the mRNA vaccines, which, yes, people think of them as being really new, but the science behind them has been in the works for, you know, a decade and so forth. So there's an intellectual kind of confusion around why you'd feel comfortable doing one and not the other. Perhaps it's, just the nature of it is, once you actually get sick, you're a bit more motivated to act than before. But we'd all definitely be better off if people took the preventative step first.

Rovner: Among the biggest group of unvaccinated are kids under 12 because they're not eligible to be vaccinated yet. Now that the vaccine is officially licensed, doctors can legally use it off-label, in theory giving it to kids. Both the American Academy of Pediatrics and acting FDA Commissioner Janet Woodcock are warning against this. Do we expect to see it happening anyway, like we saw with a lot of people sort of surreptitiously getting third shots? And why shouldn't kids get it now?

Karlin-Smith: So, the big barrier here may be that all of the vaccine right now is being distributed by the federal government and providers have to sign agreements with CDC in terms of how they will administer it. And those agreements seem to essentially bar off-label use. And CDC, actually, the day the vaccine was approved and they were getting lots of questions about it, updated their website to very specifically call out that off-label use under their agreement is not permitted for young children, it's not permitted for booster shots. People I've seen say that some big health systems and so forth are basically reminding doctors of these requirements. The question is, will CDC actually enforce this? Right now we know more than a million people have gotten an unauthorized booster. I haven't seen CDC do anything to go after bad actors there. In particular, you can think about San Francisco General Hospital very publicly announced they were doing this, and we didn't see any action. So perhaps it's just sort of a veiled threat. And talking to bioethicists …

Rovner: That was for immunocompromised people, right?

Karlin-Smith: No. So, San Francisco General was offering people who got the J&J vaccine an mRNA booster.

Rovner: Oh, that’s right.

Karlin-Smith: Yeah, an uncleared use. And the big reason FDA and the AAP [American Academy of Pediatrics] are cautioning about this is the doses being tested in children under 12 are smaller. And one of the reasons is because they're trying to, I think, find the best benefit-risk balance because we have seen higher incidence of myocarditis, this heart inflammation, in younger people, particularly younger males. So, ideally, it would be good if we can find a dose that prevents them from getting covid or prevents severe covid, and that also has less side effects. So I think that's one of the big reasons there's caution right now. They want to get more data before proceeding with vaccinating young people. Even in Pfizer's approval, they were actually asked to try studying lower doses and even older people who the vaccine's already approved for. But, you know, in talking to bioethicists, some people do say it is a little bit arbitrary, right? If you have an 11½-year-old who is, you know, bigger than most 12-year-olds and, you know, they're going to school, you know, in Mississippi and there's no mask mandates, what's the benefit-risk trade-off for them? You

probably shouldn't be giving it to a 3-year-old right now. But, you know, it does put, I think, parents and doctors in difficult situations because there are a lot of people quite worried about their children's risk of the virus now.

Rovner: Yes, indeed. All right. Well, and, from what I'm calling the "Department of Facepalm," calls to poison centers, particularly in the South, are rising because people are taking Ivermectin, an anti-worming medication for livestock and dogs, because they read on the internet that it can prevent or treat covid. Seriously, how are people not trusting a vaccine that's now fully approved by the FDA, but they're trusting a tube of paste wormer from the local feedstore?

Luhby: Yep. I didn't even understand that tweet when it came out with the FDA initially, where it says you are not a horse, you are not a cow. I was like, what?!

Rovner: Yes, I know. I think it's notable that the FDA itself tweeted that really people should not do this. I'm kind of mystified by this. And, apparently, it's spreading. I mean, you know, we all joked about bleach when [President Donald] Trump mentioned it, but people actually did. I mean, there were a lot of calls to poison centers. And now, apparently, there's this myth floating around social media that Ivermectin, which *is* approved for human use in certain situations, but certainly not in the formulations that we give it to our horses and cows and dogs. We don't get heartworm or the kinds of worms that livestock get. And it really is dangerous to take. And yet, you know, people are willing to do this when they're not willing to get a vaccine. And I'm still having trouble rolling this around in my head.

Karlin-Smith: Yeah, it just points to all the bad information that's out there and people's, perhaps, inability to discern between quality information and good sources of data and bad sources of information. And it seems like the people that are getting thrust with a lot of the anti-vaccine inaccuracies are the same people that get targeted with these messages around these supposed miraculous cures for covid that are not. Figuring out how to break down those misinformation campaigns has been quite difficult throughout this entire pandemic.

Rovner: Yes. And I guess we should recognize that there's been so much misinformation around the pandemic. But, before the pandemic, there was lots of misinformation around lots of other things that people just don't understand how to discern what is reliable information and what is not reliable information. And, in addition to everything else, there are bad actors who are purposely spreading wrong information. And, you know, it's hard out there. Well, before we leave the FDA for the week, according to The Wall Street Journal, Janet Woodcock is definitely out of the running to keep the FDA chief job permanently. But she has to leave as "acting" at some point. Right, Sarah?

Karlin-Smith: Yes, she can stay until about mid-November, I think, is the general deadline. So, the White House still has a bit of a time to figure out who is going to fill her role. And seems like they have some short list, but nobody that they've clearly settled on yet, and, you know, some of the names on the short list still raise my eyebrows because I'm not quite sure if Janet Woodcock isn't politically palatable why some of the other names that have been floating around for a while would be, particularly like Michelle McMurry-Heath, who is the head of the BIO [Biotechnology Innovation Organization],

which is not quite as big and well-known as the pharma lobby, called PhRMA. But it's the second-biggest pharma-biotech lobby, and not only do they represent drug companies, they represent kind of ag [agricultural] companies and other things that get regulated by FDA. So it's … I have a hard time seeing how Democrats who would oppose Woodcock for her seemingly being too close to industry over the years would find the head of a major industry lobby that FDA regulates palatable.

Rovner: Yeah, and remember, you know, we have this 50-50 Senate. And even if they can find some Republicans, which they have occasionally done … it just seems so glaring, though, that we're almost to the fall. We're in the middle of a huge, you know, pandemic surge and there's still no nominee to head the FDA. So, I know, we talk about this every week.

Kenen: You know, like, in February it was one thing. We're going into September, it's another. And we're not going into — we're smack in the middle — of delta. You know, there are a lot of questions about therapeutics and vaccine booster dosages and, you know, future vaccines and getting therapeutics out. There's a big difference of taking two months, which is pretty standard — you know, when people were screaming in February, there's no FDA commissioner, that's pretty standard, actually. But September?

Rovner: Yeah, this is late.

Kenen: There are rumors that a bunch of people turned it down, I don't know who those people are. Sarah, might. You know, that some people don't even want to deal with this job because it's been so politicized and it's a tough job.

Rovner: And then there were strange rumors like Zeke Emanuel, who's very talented in many things, but not really the things that FDA does. So he shot that down pretty quickly.

All right. Well, there is some non-covid news. There are more troubles in price transparency land. The Biden administration last week delayed for six months the implementation of the Trump administration's transparency rule for health insurers. And over at The New York Times, our podcast colleague Margot Sanger-Katz did a pretty impressive graphic showing what a continuingly bad job hospitals are doing, complying with *their* version of that price transparency rule, which has technically been in effect since the beginning of the year. Most hospitals simply haven't complied. But of those that have, it turns out they are charging dramatically different prices for the exact same service based on who's paying for it. For example, at Erlanger Health System in Tennessee, a flu shot may cost $54 if you have a Cigna plan, $104 if you have Blue Cross and $201 if you have UnitedHealthcare. So key question here. Will more transparency of this sort actually narrow some of these differences or might it drive prices up if they see, you know, oh, wow, they're only paying this much, maybe we should charge them more?

Luhby: Well, this has been the debate among … yeah, this has been the ongoing debate. And, you know, when a lot of us were asking Seema Verma, who was the former administrator for CMS, and this is the question. So, a lot of studies have shown that people are not going to necessarily shop around. But the interesting thing, and this is, of course, what some of the industry were arguing is that the insurers are going to shop around. And

if I'm with United, why am I paying $201 for a flu shot when Cigna's only paying $54? So that in that way could lower the price because United is saying, "I'm not going to pay that much." But, on the other hand, if another hospital in that area, you know, if you get the data on the hospital and they find that another hospital is able to get Cigna to pay $200, they're going to say to Cigna, "Well, we've been giving you a break at $54, but the hospital down the block is, you know, you're paying $201, so therefore you now have to pay us $201." So, it could go a lot of different ways. It'll be very interesting to see what happens.

Rovner: Yeah, I'm fascinated by this whole transparency thing and obviously it's still in court — I think the insurance part. The hospitals went to court and lost, but I think the insurers are still suing. So, this will be another "watch that space."

And I don't want to step away from the news for three weeks without mentioning Texas and abortion. The abortion law that we've talked about here a couple of times, the one that would ban all abortions at around six weeks of gestation, is scheduled to take effect Sept. 1. This is the law that would be enforced not by the state but by individual citizens who could bring individual lawsuits against abortion clinics or doctors or even people who help women pay for the procedure or drive her to or from the clinic. There's a federal court hearing on a lawsuit to block it on Monday. But I'm told that if it takes effect as scheduled, nearly all abortions in Texas will stop as of next week. Meanwhile, last week, a federal appeals court ruled that Texas could go ahead with a ban on D&E [dilation and evacuation] — which is the most common procedure used after the first trimester of pregnancy. The ban was struck down by an appeals court panel, but then it went before the entire conservative 5th Circuit, which upheld it. Now, lots of states have passed these bans, but this is the very first time one has been upheld by a federal court. So, my question here isn't what's going to happen. We obviously don't know. But these are by far the most serious threats to abortion rights in a generation, particularly with the Supreme Court that's poised to scale back or eliminate abortion rights in a Mississippi case that it's going to hear next term. My question for you guys is, why is this getting so little attention? Is it just that there's too much else going on?

Kenen: Probably. And none of us know what's going to happen. But there's a fairly good chance the six-week ban will be blocked, at least temporarily, by a court between now and next week. Obviously, we don't know that. We're speaking on Thursday and next week is next week. That is likely to be at least put on hold pending further litigation. You never know with the 5th Circuit in Texas … they're very, very, very conservative. So it is more of an uncertainty in the 5th Circuit than it is anywhere else.

Rovner: And this particular law, this is unlike all the other six-week bans we've seen. This particular law is not going to be enforced … it's written to not be enforced by the state. So there's a question about who you can sue, even.

Kenen: Because of the nature of this particular six-week ban and the nature of the 5th Circuit, which is probably the most conservative circuit in the country, there is some question about whether it could go through or whether, you know, there's some kind of pause by the Supreme Court pending their taking something like this up. You know, Texas is a wild card, because of the 5th Circuit. I mean, I think it's, actually, some of my

colleagues at Politico reported, abortion is becoming an issue in the California recall race because people take it for granted and it is not 1973 anymore. So, I mean, I think that it has never become as much of a political issue as the advocates on the abortion-rights side want, because people have assumed it was in law and would stay in law. And that's no longer a certainty. And *Roe [v. Wade]* continues to exist as we have known it for the last [nearly] 50 years. So I think it'll become an issue, increasingly, but perhaps too late to stop what may be about to happen. We just don't know what the Supreme Court is going to do. You know, even if they uphold Mississippi, they could uphold it in numerous ways. And, you know, how much leeway do states have versus stopping something nationwide? I mean, they can do whatever they decide to do.

Rovner: I also wonder if, you know, both sides in the abortion debate have raised a lot of money off saying, you know, something is about to happen that wasn't going to happen. But now something might really be about to happen. And I'm just sort of surprised at how little, you know, particularly this Texas law, how little it's getting sort of, I mean, I'm hearing a few more stories … also, it's August. And, you know, people are distracted by other stuff. But still, this is a really big story. And I predict that if the law does not get blocked, suddenly people will realize that this is a very big story.

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? You have a great story, by you!

Kenen: This is my own story, which I don't usually tout. But this is an investigation and accountability story that I worked with, with two colleagues, Darius Tahir and Allan J. Vestal. We worked for months on this. There's something called state veteran homes, which are special nursing homes for veterans and sometimes their family, their spouses. And in all the years I've been covering health care, I didn't even know they existed until the pandemic. And they did not do well in the pandemic. So our story is called "Sadness and Death: Inside the VA's State Nursing-Home Disaster." And it was a disaster. And what we found out is that it's built to be a disaster. The VA finances these homes and the VA does one annual inspection, which until recently had a lot of holes in it, that now they're tightening it up. It was sort of a "please fix this" as opposed to "you must fix this." It was like "it would be nice if you fix this." It was not a strict-enough inspection. The VA pays for them, but it doesn't actually run them. The states run them, but they don't pay for them. So there's this huge structural regulatory gap. Plus, some of these buildings are, like, some of them are 100 years old. They were built for Civil War vets. So Congress is beginning to put some money into repairing them or updating them or renovating them or replacing them. But this regulatory — you know, "it's not my problem, it's your problem" — that remains a huge gap. And the death rates were really high, and we don't even know how high because some of the data hasn't even been released in some of the really hard-hit states. So it's probably even higher than we were able to tally. We did have three current or former VA secretaries talk to us on the record, which sometimes means they like the attention and hope this helps save lives.

Rovner: It's a really excellent, although depressing, piece. Tami.

Luhby: Well, I have also an excellent and depressing piece written by one of my colleagues, Ben Tinker, who has somehow managed to be the health editor at CNN for the entire pandemic and become a new father. And he wrote a story saying that "My Son Was Lucky to Get a Pediatric ICU Bed When He Needed One. He Shouldn't Have Needed Luck." And it's, you know, a very scary story about how his 16-month-old son got RSV, a respiratory virus. So he did not have covid, but he was very, very sick, needed to be admitted. He was in the hospital and, you know, at ICU for five days. And, you know, we've all been reading about how this surge, the pediatric hospitals are really suffering. And there are places, you know, for instance, in Texas that are turning away patients and children. And they have said to parents, "A child needs to die for you to be able to get a bed for your child." And so, we talk about the personal choice of the unvaccinated. But this is an instance where someone who is not even affected with covid could have been hurt. And I'm sure there are many children and other people who have been hurt and may have lost their lives because the hospitals are full. So Ben chronicles the very scary experience he had with his son and talks about, you know, he cites some statistics saying, I think, that Georgia's ICUs are at 94% full and that's the third-worst in the country. And, you know, he kind of ends it with this plea that says, you know, "We've made the same mistakes too many times throughout this pandemic, but tomorrow can be different. Tomorrow needs to be different — not only for ourselves, but for our kids. Thankfully, we know ways out of this nightmare: Wear a mask and get vaccinated.

Rovner: Yeah. And we're seeing pleas around the country from doctors, you know, it's not just getting covid. If you have a stroke or a car accident or, you know, fall off a ladder …

Luhby: Or cancer …

Rovner: Yeah, or cancer. I mean, there was a doctor who had to turn away a cancer patient from surgery because the hospital is full of covid patients. So it's not, I mean, there's a reason they're pushing everybody to get vaccinated. Sarah.

Karlin-Smith: So I looked at a piece by Atul Gawande in The New Yorker called "Costa Ricans Live Longer Than Us. What's the Secret?" And he chronicles Costa Rica's 50-plus-year journey, at this point, essentially to improve life expectancy in the country by focusing on public health and integrating that into individual health care in a way that the U.S. does not. And, also, really establishing a universal primary care system. And it chronicles the benefits that you can have by focusing not on, kind of, the newest technologies or the newest medicines, but kind of by going back to the basics, making sure people have clean water, sanitation. Some of the things that public health folks would tell you are really the biggest things in the U.S. that have contributed to our life expectancy improvements over the past few decades. And then also when you incorporate that with universal primary care, including going to people's homes, being able to kind of look at the system in a way that there's one anecdote in the story where, you know, a woman needed more adult diapers, she couldn't afford them. That could lead to bad health outcomes, if you're sitting in dirty diapers. And he was able to look at this system, find a family that had lost a loved one, re-route things. And it's just kind of shows how you can be kind of creative, even in a country that has far less resources than the U.S. to take care of people in a different way. If you mesh that population health mindset in with the kind of individual treatment mindset,

because in the U.S. we know we have these big disparities of care. If you're wealthy and can get access to all the fancy services and treatments, you often do really well. But we kind of neglect to take care of people without those resources.

Rovner: Yes, I think the big idea is having a system.

Kenen: They abolished their army in 1948 and that's a Central American country. Everyone else in Central America … I lived there right after college, so I know Costa Rica. I mean, it's a very war-torn peninsula and they put their money into social services instead of the military.

Rovner: It's a very cool story. All right. My story is from The Washington Post. It's by Christopher Rowland. And it's called "Long-Term-Care Facilities Are Using the Pandemic as a Shield." It's about how nursing homes who were given broad immunity last year to prevent families from suing over covid-related deaths or injuries are using that immunity to avoid responsibility for non-covid-related negligence. It is a classic case of no good deed going unpunished and a very sad story, and I 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 e-mail us your comments or questions. We're at whatthehealth, all one word, @kff.org. Or you can tweet me. I'm @jrovner. Sarah?

Karlin-Smith: I'm @SarahKarlin

Rovner: Joanne?

Kenen: @JoanneKenen

Rovner: Tami?

Luhby: @Luhby, L-U-H-B-Y

Rovner: As I mentioned at the top, we won't have a podcast next week. We'll be back on Sept. 9 with a special episode all about public health. In the meantime, be healthy.