

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

**Episode Title:** Abortion Politics Front and Center

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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, Oct. 7 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 by video conference by Sarah Karlin-Smith of the Pink Sheet.

**Sarah Karlin-Smith:** Morning, Julie.

**Rovner:** Yasmeen Abutaleb of The Washington Post.

**Yasmeen Abutaleb:** Morning.

**Rovner:** And Joanne Kenen, who has a new job as journalist-in-residence at the Johns Hopkins School of Public Health while remaining a contributing editor at Politico. Congratulations, Joanne.

**Joanne Kenen:** Thank you.

**Rovner:** Later in this episode we'll play my interview with KHN's Aneri Pattani, who reported and wrote the latest KHN-NPR "Bill of the Month." This month's bill is for a covid test that cost as much as a nice new car, really. But first, this week's news. I believe I get to start this week by saying I called it when I suggested last Thursday that what Congress is very best at is kicking the can down the road. So now it looks like everything will come to a head. Spending bills, the debt ceiling and likely the big social-spending and infrastructure bills in December, instead of now. So, will another six or seven weeks make it more or less likely that Congress is going to agree to something on health care?

**Kenen:** Eventually, they're going to have to do something. We don't know what they're going to do. The big debate right now is do they go for a little bit of everything and hope to build on it later? Or do they jettison some programs completely and go more fully into two or three things, whether it's Medicare dental benefits or ACA [Affordable Care Act] subsidies or long-term care or Medicaid expansion — those are sort of the top four. There are pros and cons for the Democrats to either of those approaches. And we don't know how it'll shake out.

**Rovner:** And, obviously, what they're able to spend depends partly on what Sens. Manchin and Sinema, who basically have their own vetoes, since there's only 50 votes in the Senate, you know, agree as a top line. But also it's kind of how much they can raise from prescription drug savings, right?

**Karlin-Smith:** Right. That's definitely expected to be a big saver for the Democrats, and the Senate is a place where there's lots of questions about how far many more moderates or senators that come from very pharma-heavy-connected states are going to be willing to go. And even in the House, we saw some resistance recently from some lawmakers to going as far on drug pricing as they had initially seemed like

they would do a year ago. So that's going to be a big problem if there's a significant rollback to what they're willing to do on drug pricing.

**Abutaleb:** I was just going to say it does seem like the more time goes on, the less likely it seems they'll have something ambitious on drug pricing, especially just because drug pricing is always hard to do and pretty much never gets done. And it does seem like with this negotiation specifically, the longer it's gone on, the more you've seen, especially some of these more centrist or moderate lawmakers come up with concerns. And then you've got the Pfizer CEO, you know, as Politico reported, making direct appeals to his employees to oppose the prescription drug price piece of the reconciliation bill. And Pfizer obviously has a lot of political capital right now. So I just have to say I'm skeptical that they're going to get the big savings from that prescription drug provision because it just seems like by the time everything is said and done, it's going to be massively watered-down.

**Rovner:** And every single day you turn on the TV or the radio and you get all of these ads. I mean, the drug industry is spending hundreds of millions of dollars lobbying against this to the public in addition to on Capitol Hill.

**Karlin-Smith:** And they're changing their messaging. I was noticing yesterday that messaging from people connected with industry was: Is this even going to save actual Americans money or is this just going to save taxpayers' money? And I thought that was pretty interesting. It's not an argument I've seen them bring up recently. I've also noticed a lot of advertisement against this idea that supposedly is floating around in the Senate to tie Medicare prices to the Veterans Affairs. Sort of. It's kind of like a federal supply schedule price, and we don't even actually really have confirmation from the Senate Finance Committee yet that that's really what they want to do. So, I mean, they're so ahead of the game. We don't even know what this one big part of the Congress really is aiming for here. And pharma's already kind of like advertising against it and making it harder for them to do it.

**Rovner:** So one of the ways they could sort of make this whole package cost less — Joanne, you were talking about, you know, whether they want to do a few things well or many things a little bit — they could do many things a little bit and have it expire. I mean, I've heard some theories that, you know, you can start some of these programs, get them up and going, so people see the benefits and then have them expire really quickly, which wouldn't cost money. And then even if the Republicans, you know, take over the Congress again after the midterms, they'd be left to either extend the programs or have their fingerprints on killing them. Is that, that strikes me as sort of a live possibility here.

**Kenen:** And as we've pointed out before, it's once you give people a benefit, it is hard to take it away, particularly if it's helping large numbers of people and the middle class and your own voters. I mean, they tried to repeal Obamacare for years, which was helping their own voters, but they failed. So the other thing to do is pass things, but not have them start right away. So you pass the bill now in 2021 and certain benefits don't kick in until 2050. Now I'm exaggerating, but a couple of years from now, I mean, they're talking about that with dental.

**Rovner:** Yeah, the Medicare drug benefit passed in 2003, and it didn't start until 2006.

**Kenen:** Which was partly a cost-saver and partly an implementation issue. And they eased it in with some assistance earlier to low-income people.

**Rovner:** Which they also did with the Affordable Care Act. And in both cases, that sort of early program was not a huge success and was a big sort of bureaucratic bungle. One would think that they've learned that trying to sort of have a main program that starts later and doing something in the interim — not as easy as it sounds.

**Karlin-Smith:** The other thing we didn't bring up is the idea of means-testing some of these programs to narrow the population of who would receive the benefits to people on the lower end of the income scale to again make it a little less costly for the government. Of course, that could have pros and cons and trade-offs, including that it's not always so easy if you just go for those narrow populations to help them get it, it can kind of create more bureaucracy and make it harder. And then there's also, again, questions about, sort of, the political buy-in of doing that and kind of the long-term sustainability of some of those programs if you go that route.

**Rovner:** Yes. Well, that's something that Sen. Manchin says he wants. And Sen. Manchin also apparently is going to introduce an abortion controversy to this bill, too, even though reconciliation bills don't generally lend themselves to abortion fights. But it seems that Sen. Manchin says he won't support a bill to extend Medicaid in the states that haven't expanded it unless it includes a "Hyde Amendment"-type restriction on that funding. Now, it took me a while to figure out what he was talking about because Medicaid funding is already restricted by the Hyde Amendment in the separate spending bills. And Democrats, many of them argue that the new Medicaid coverage would still be covered by that restriction, which there's a separate fight about whether that's going to stay. But one presumes that it will because it probably can't get through the Senate without it. I think the real question here is whether Manchin really won't vote for a bill unless it includes a permanent-law Hyde Amendment. Remember, the Hyde Amendment that goes in the spending bills has to be renewed every year, although it has been renewed every year since the 1970s. But if Manchin were to say that he wouldn't do it unless, you know, there was a permanent ban on federal funding for abortion, I would imagine that that would drive all the progressives away. You know, it seems like a small thing that could hang up this whole bill. But if you remember it, this small thing hung up the bill that was supposed to fix the ACA in, what was it, 2018?

**Kenen:** There's no such thing as a small abortion amendment or a small abortion fight. And, you know, the original ACA too got stuck in abortion politics at the last minute, and there had to be that, you know, [President Barack] Obama had to come in and massage that. We don't know what, Manchin's in a negotiating position. Does he really want to sink the entire Democratic agenda? Probably not. He's got a lot of cards on the table. We don't know which ones really matter to him at this point. One thing that's ... struck me as interesting with both Manchin and Sinema is, in all the haggling around the ACA in 2010 — I guess it was 2009, fall of 2009 — the centrist Democrats who had demands that were blocking that, in general ... there were some ideological across-the-board things, but there were a lot of deals-for-their-own-state things. The famous Nebraska "Cornhusker" deal with Ben Nelson and the Louisiana Purchase with Mary Landrieu. And it's sort of a sign, another sign of the nationalization of our politics that it's not local, that everything is national now because Sinema and Manchin are not looking for a deal for West Virginia Medicare or Medicaid or just some hospital or some whatever. It's not a local thing they're pushing for for their state. They are pushing for, you know, really rewriting the entire Democratic Party agenda at the moment.

**Rovner:** That's right. I mean, because for Manchin in particular, you know, his state would be disproportionately helped by most of these programs, even if they're not means-tested.

**Kenen:** Right. He comes from a poor state.

**Rovner:** This will clearly continue into the rest of the fall. So let us turn to covid. We have some breaking news. Just this morning, Pfizer is formally asking the FDA [Food and Drug Administration] for approval for its vaccine for kids aged 5 to 11. Sarah, all of my parent friends keep asking me, when could this happen?

**Karlin-Smith:** So it seems like FDA has set up a timeline that it could happen maybe right before Halloween. If you look at how they've done the past approval, so they had, even before Pfizer fully submitted their application, they had already scheduled an Oct. 26 advisory committee meeting to look at the product, which is really unusual that FDA would do that before they have the full application. So it gives you a sense of how fast they're trying to move here. So, in the past, what's happened is essentially the advisory committee has voted. If that's been positive, it moves on to the [Centers for Disease Control and Prevention's] CDC's Advisory Committee on Immunization Practices, usually within a day or two. And then at times it's only been hours till we get the clearance, so I mean, that assumes again, everything is pretty straightforward in terms of the data, and everyone agrees it's safe and effective and so forth for this population. But it does look like potentially late October, early November we could see a vaccine available for this younger-children population.

**Rovner:** I know lots of people who are counting down the minutes to making this available for their younger kids. Do we know anything about the really little kids, the under 5-year-olds?

**Abutaleb:** I think that still seems unlikely before the end of the year or early next year. It's a tricky question because even with the 5-to-11 [age group], they've had to figure out the dosing. I think it's about a third of the dose that's given to adults. I've talked to some pediatricians who have said that there are some parents who will have to weigh the pros and cons of getting their kids vaccinated because the risk to younger kids is fairly low. Not to say it's negligible, because obviously we've seen some young kids get really sick and end up in the ICU, especially more recently with delta. But I think it seems to be a much trickier question with the really little kids. Obviously, you have a strong contingent of parents that are really eager for it just to, you know, eliminate one more big concern about the health of little kids anyway. But it does seem like it's not that simple of a question about what dose you give of the vaccine and whether everyone's going to decide that it's worth the trade-off, just given the risk to kids compared to adults.

**Rovner:** Yeah, that and I mean that's sort of for grown-ups. Yeah, I mean, the small risk of complications compared to the big risk of getting very sick from covid, but obviously kids [are] less likely to get very sick. And so that presumably same risk of complications would weigh slightly differently. Well, while we're talking about kids, adults are still in the battle over boosters. It appears that many outside experts think the Biden administration got out a little far over its skis in pushing boosters for so many people. Is there starting to be a booster backlash here?

**Karlin-Smith:** I think there's been a booster backlash to some degree all along. I mean, even from the initial announcement, which was in late August, that Biden was looking to clear boosters by Sept. 20. So I don't know that it's really changed much, but perhaps the dynamic would have shifted a bit if we got maybe better, more complete data once they actually got to clearing the boosters. There's still a lot of questions as to how well boosting really prevents, like the most severe outcomes from covid. We know it generally does seem to probably help prevent infection, but there's lots of debate as to whether that's really a goal we should have right now, and we don't have really a lot of long-term understanding of the safety or effectiveness of boosting. This wouldn't be such an intense debate if there wasn't this sort of

elephant in the room that most of the world doesn't have access to any covid vaccines. And there is this risk to the entire world, including the U.S. population, which is the longer you allow huge swaths of the world to remain unvaccinated, the more likely we might induce variants of this virus that may be more virulent and escape the vaccine. So I think that's where a lot of the trade-off or tension has come from, and both the CDC and FDA largely shrunk away from even really being willing to debate that publicly, which was a bit surprising to me, particularly on the CDC side.

**Rovner:** Yasmeen, you wrote a related story this week that kind of terrified me about what a terrible job the U.S. is doing with data, with all of this data. I mean, some of it is clearly a dearth of testing, but also we're not keeping very good track of breakthrough cases. I mean, we just, you know, because we don't have a national health system, we don't really have very good national health statistics, right?

**Abutaleb:** Yeah, I mean, we were, my colleague and I were trying to understand why the booster debate had been so reliant on foreign data, which seemed to also contribute to the controversy because part of the debate got tied up in the reliability of the Israeli data and the U.K. data and whether it applied to a population like the U.S., which is so different from Israel's, which is much more homogenous and much smaller than obviously the U.S. is. And we've known this the whole time. The U.S. has had a data problem from the very beginning of the pandemic. And it just really hasn't improved. And I think it was really exacerbated by the booster debate because you saw them having just so little U.S. data to go off of to decide whether or not this was a good idea. There were some CDC studies, but they weren't sort of these nationally representative holistic studies that you had out of the U.K. and Israel. And what we found is just, you know, the U.S. health system is highly decentralized, like we all know. You've got the local health departments reporting into the state health departments, which then are supposed to report into the CDC. But there's no standardization of what counts as a positive case, what counts even as a death, how they count infections. There's no real requirements on timeliness. Obviously, they urge it, but no one's required by law, so you've seen some states, especially as the pandemic has worn on, wait up to three weeks to sometimes submit their data. And it's not standardized, so it's almost like the numbers we do have are estimates, they're not really concrete numbers in the way that other countries might have. And on the booster debate, there were a couple of factors. There was the CDC decision in May to decide to only track the breakthrough infections that resulted in hospitalizations. There's some mixed commentary on that. There are people who say, including in the administration, who say that's where this all started because they stopped tracking it. Other people say it's unreasonable for the agency to have to track every breakthrough infection and these studies that they're doing are a better use of time. But then the problem with the CDC is it doesn't release its data in a very timely way. So it's just the U.S. is behind the eight ball every step of the pandemic. You know, in the beginning, it's like we were four weeks behind, and it just seems to be getting further and further behind the more we get into it. Now we're 20 months into this. So, I think maybe some aspects have gotten better. I think on the booster debate, the CDC did try to share some of its data a little bit quicker than it has in the past. But again, they're small studies, they're focused on specific populations. And even when you looked at the slides presented in the CDC advisory committee meeting, there were groups where they said, We don't know, we just have no data.

**Rovner:** And in the meantime, I mean, one of the big issues is that there's not enough testing. I mean, all of these vaccine mandates tend to come with, OK, if you don't want to get the vaccine, you can be tested frequently. Well, you know, we know that Abbott stopped making a lot of these, you know, their antigen tests that are available at the drugstores over the summer before delta, because it looked like, you know, people weren't going to need them, there wasn't going to be much demand. Now there's an enormous demand for testing and not nearly enough tests, and the administration says that it's going to

get tests out, you know, more tests and they're going to be cheaper, but there's going to be a lag before that's all available, right?

**Abutaleb:** Yeah, they announced this \$1 billion purchase on Wednesday of a bunch of rapid tests that they say you're going to quadruple the number available per month by December. And obviously, that's a good thing. I think there's a question as to why it's being done now and not several months ago. The testing problem is nothing new in the U.S. You know, there was maybe this brief period in the late spring or early summer when cases were coming down where there wasn't a testing problem. But I think we can all agree, everyone, including the administration, was a bit overconfident in that period that things would continue on that trajectory. And like you said, there's going to be a lag. So it's not like this problem is going to be fixed today or tomorrow, just because they announced that on Wednesday. There have been so many reports — and I think we've probably all experienced it at various points in the last couple of weeks, I know I have at least two or three times — where you need to get tested and either the test you can find is a \$100 or \$200, or you can get a PCR test, but you have to sit and wait for 48 hours. And it's just, it's, I think it's kind of baffling that this problem is still as congested and as vexing as it was almost at the start of the pandemic.

**Rovner:** I actually went to something and I came home and I thought I really should get tested, and I really couldn't find a test. And by the time I figured out how I could find a test, it's like, well, it's been three weeks. Obviously, I didn't get anything. Which I think a lot of people are sort of experiencing. But as we get into sort of more of a travel season, there's going to be more people who, you know, want to get tested before they see family members and there's not a lot of tests out there to get. Well, let us move on because obviously we will come back to this. There is other health policy news this week. The Biden administration reversed one of the most contentious Trump administration health care policies, effectively reinstating Planned Parenthood's eligibility to participate in the Title X federal family planning program. Shameless plug here, we are tracking how long it takes the Biden administration to reverse these Trump policies on a page called “The Great Undoing” on the KHN website. I'm wondering if the timing of this change is because that's just when it got done — redoing formal regulations does take some months — or because abortion and reproductive health is suddenly at the very top of the news. Or maybe both.

**Kenen:** I was actually surprised that it took this long. I mean, I thought they would do something on Title X and abortion really fast. For reasons I don't entirely understand, the regulatory law is supposedly easier to undo the Trump health regulations than the way they really tied up in knots, and it's going to be harder to undo, the environmental regulations. But I thought this one, they would at least make clear they were going to do it or do some kind of interim something or other to get Planned Parenthood back in. But yeah, it is now. I mean, the big difference is, there's no federal funding for abortion and some states have limited ... use their own money, but basically that didn't change. What Trump changed is that these clinics couldn't even refer or talk about it. And that cut them off and cut Planned Parenthood and similar clinics off. ... Not every Planned Parenthood clinic does abortion, which is not widely understood.

**Rovner:** Only about half of them actually do abortions.

**Kenen:** And so you could walk into a Planned Parenthood or any abortion clinic. And any women's health clinic that didn't even do abortion and they were not allowed to tell you how or where to get one. And they were kicked out of the funding. Some states made it up. Many did not. It was a big blow. So that is now changing. And also what I'm not sure about is, because I haven't read, actually you might

know if you read further into these stories than I did. The Trump administration also opened the door to some faith-based clinics getting Medicaid funding. Some of them do provide some prenatal care or STD testing that would qualify them for Medicaid. Others do not do reproductive health but did have to partner to a certain extent. But they're certainly not where most women, I mean, they're opposed to not just abortion, but to contraception in some cases. I'm not sure if they reversed the status of that. I would guess they would, but I didn't have time to check.

**Rovner:** I think that's a separate issue about the faith-based family planning clinics and getting money through Title X. I've covered this long enough that I've seen it change from Republican administrations to Democratic administrations, then change back and then change back again. But it really is disruptive, particularly to women who are — and men! I mean, these are federally funded family planning clinics also serve men. They do a lot of STD testing and treatment. You know, it's not just about pregnancy and it has been the changes in funding up and down have been really disruptive, and one presumes that this will, you know, change back for a while. But we will see. So meanwhile, the bigger abortion issue continues to be red-hot, as the Supreme Court began its term this week. That includes a case out of Mississippi that could mark the end of *Roe v. Wade*. But what might get there first is that Texas law, a federal district court judge, last night temporarily halted the law in a case that was brought by the Biden Justice Department. But it's not clear whether that means that abortions after six weeks will resume right away, partly because if the temporary stay is lifted, doctors worry they could still be liable under the law for abortions that they do while the stay is in place, and also partly because by the time you hear this, the state could be overturned by the very conservative 5th Circuit Court of Appeals. One way or another, abortion is just going to be a gigantic issue going forward this year, right? I mean, it's hard to see how it doesn't color everything.

**Kenen:** This year and next. The Supreme Court is unlikely to rule this year and next year's also congressional races and Senate and House ...

**Rovner:** Yeah, when I say year, I don't mean the rest of 2021, I mean the Supreme Court term that stretches until next June or July.

**Kenen:** We would probably not see this decision until June. As to what you just said, I think we'll see things about Texas ping-ponging back and forth in all sorts of courts with — and copycat states with — getting upheld, getting overthrown, getting put on hold. I don't think we'll see clarity for some time.

**Abutaleb:** Well, and I think as long as there is not that clarity or the Texas law is still a possibility, you're going to see a bunch of states, like we saw right after the Supreme Court declined to rule on it a few weeks ago, a bunch of states try to pass their own laws. I mean, I think there was some commentary after the Supreme Court decision, or non-decision, a couple of months ago that the Mississippi law actually didn't look all that crazy anymore compared to what Texas had done.

**Rovner:** Yes, just a reminder the Mississippi law that the Supreme Court had agreed to hear back in the spring banned abortions after 15 weeks. The Texas law banned abortions when you can detect cardiac activity, which is about six weeks.

**Abutaleb:** Right, which is before most women know they're pregnant. And the Texas law is so weird and having private citizens enforce it, as you know, the legal workarounds they use to try to evade some of the legal scrutiny that they're, of course, facing anyway. It just seems like as long as that's an unresolved issue, as long as it's possible that that law remains, or stayed or unstayed, it's hard to see any ... I mean,

abortion is never resolved. But I mean, especially now that you have so many live trip wires that it's hard to see that going away anytime soon.

**Rovner:** One of the things that I found interesting this week was there are several polls that suggest that what appears the Supreme Court is most likely to do, which is uphold one of these stricter laws, is not what the public supports. Now, I have long been skeptical of polls on abortion because the results depend so very much on how the question is asked. But while generally the public doesn't like abortion but thinks the ultimate decision is up to the pregnant person, it does seem like the court could be setting itself up for a major backlash if it strikes down or otherwise upends *Roe*. Sometimes it feels like the Supreme Court does things not just because that's what it thinks the law is, but ... I know that particularly Chief Justice Roberts is very worried about the public trust in the court, and I wonder how much that's going to color what it is they're going to do here. I mean, abortion is so hard because you've got people at sort of the far ends of this who feel extraordinarily strongly. And then you have most of what I call the muddled middle who are somewhere in between.

**Abutaleb:** Well, I think Chief Justice Roberts' prevailing concern is always that the court doesn't look political, and I think it's hard to imagine that the court doesn't look political if they ...

**Rovner:** I'd say that that ship has sailed.

**Abutaleb:** Right. If they do something as ... well, especially if they do something as radical as overturn *Roe v. Wade*, I mean, the Supreme Court justices were all asked about this in their nominations, and they also say that they respect legal precedent. But this would obviously turn all of that on its head. So, I mean, sounds trite, but there's a lot at stake.

**Rovner:** Everybody's going to keep watching it. Well, meanwhile, on the personnel front, President Biden is soon going to have another vacancy to fill at the helm of a key federal agency. Francis Collins, the longest-serving director in the history of the NIH [National Institutes of Health], says he will step down from the post he's held since 2009 by the end of this year. Last week, we talked about how the administration has still not nominated anyone to head the FDA. Now they're going to have to find a new head for the NIH. Why is filling these top health positions so difficult for this administration?

**Karlin-Smith:** I would think that the NIH position might be a little bit easier to fill than FDA. FDA has been hard. It seems like the attention and scrutiny on FDA during the pandemic has been really high. So it's, I think, anybody accepting the job is walking into a very different situation, leading the FDA now than they would have, you know, two or three years ago. I mean, imagine if Stephen Hahn knew when he accepted the job what he was getting into, his entire tenure was colored by covid. And I mean, he would have had no way really to know that. So I think that's a big issue right now, is: Who really wants to deal with that kind of pressure and scrutiny? And I think they are having trouble finding a candidate that kind of can check all the right boxes for the Senate in terms of finding somebody who's willing, who also doesn't have any of the red flags that are going to steer members of the Democratic Party away because it seems like Biden really wants to get somebody who will be cleared by Democrats. Because if he was OK with Republicans having to help confirm his FDA commissioner, he probably would have nominated Janet Woodcock by now.

**Rovner:** Well, I'm old enough. And, Joanne, you are too, to remember when all the hot-button scientists ... were at the NIH, not the FDA.



**Kenen:** Stem cells! Stem cells!

**Rovner:** Yeah, stem cells, fetal tissue, cloning. I mean, it was, you know, I actually have a column out this week about how Francis Collins has, you know, kind of made the NIH boring again because it never was for most of my career covering health policy. And you have to wonder whether we're going to, you know, was it just Francis Collins or was it sort of ... was the timing good that there weren't a whole lot of super, you know, controversial science issues at the NIH? And will that get dragged back into politics with the next director?

**Kenen:** It will get dragged back into politics just because of the age we live in and the environment Washington operates in. Whether it'll be as, you know, knock-down, drag-out dysfunctional, I sort of think not. Maybe we will look at this differently in a few weeks. But I really can see a pathway to a bipartisan confirmation of the NIH director during a pandemic. They could also take somebody who is running one of the institutes already at NIH who's a known quantity.

**Rovner:** Which is what Collins was.

**Kenen:** Right. There's certainly scientists with administrative experience at many big medical centers and research institutes. I don't think it's impossible. I mean, but again, I mean, if you tell me it does get completely politicized and, you know, fetal cells and everything else getting thrown in and do we have another imbroglio when a key vacancy persists, I wouldn't be shocked at it. But at this point, if you had to ask me to bet, can we get somebody through fairly quickly or is it going to be a complete meltdown? I would guess with getting through, but I wouldn't be stunned if I'm wrong, you know, like we all know that everything can get politicized. Look at masks, right? But I do think that I can, you know, visualize a number of Republicans, I think we all can without naming them. We don't know exactly who they are, but can I think of, you know, some Republicans who are willing to believe that Biden should get somebody in the NIH pretty quickly and that there are establishment scientists who could run the place? Yes.

**Rovner:** Yeah. But we shall see. All right. One more this week in Cleveland, there's another opioid trial starting, this one charging four pharmacy chains with failing to adequately monitor prescriptions for abusable medications, thereby contributing to the opioid epidemic. It's the first of more than 3,000 similar cases brought around the country and could open up the big pharmacy chains, including Walmart, CVS and Walgreens, to billions of dollars in fines. I don't remember retailers being implicated in things like the tobacco fights. Why are retailers such a big part of the opioid problem?

**Karlin-Smith:** I think there's a question of essentially, like, were they doing their due diligence to make sure the prescriptions they were getting were legitimate or that were they properly flagging things that looked suspicious or doctors who were essentially operating as "pill mills" requesting too large of quantities. I think the pharmacies' argument is like, you know, we were just filling legitimate prescriptions. But there's also this question of did they turn a blind eye, essentially because they were making money off of this, too? You know, if you look at some of the numbers of some of these pharmacies, what they were doling out, I mean, it was like 20 opioids for every person who lived in that region or county. So that's kind of the crux of it is, and there's been basically legal challenges filed against, like, every part of this drug supply chain in the opioid debate, from the drug companies to the wholesalers, to the pharmacies, to people at more of the provider level who have certainly gotten in trouble as well.

**Rovner:** Let's sneak ahead. We'll talk more about the opioid crisis next week. That is the news, at least for now. Now we will play my "Bill of the Month" interview with Aneri Pattani. Then we will come back and do our extra credits. We are pleased to welcome to the podcast my KHN colleague Aneri Pattani, who wrote and reported the latest KHN-NPR "Bill of the Month." Thank you for joining us.

**Aneri Pattani:** Thanks for having me.

**Rovner:** So, we know that everything is bigger in Texas, but a covid test that costs as much as a car? What is up with that? First, tell us about the patient, who he is and why he went in search of a covid test in the first place.

**Pattani:** The patient is Travis Warner. He's a 36-year-old business owner living in Dallas. His company basically installs internet, audio, video and other systems in people's homes and offices. So towards the beginning of the pandemic, they got really busy. Everyone was looking for home office setups, and so he and his employees were constantly going in and out of people's homes, and they took precautions like masking and physically distancing. But in June 2020, he got a call from one of his employees that they had tested positive for covid. So, in turn, that meant Travis and his wife now had to find a test. And, again, early days of the pandemic here. Tests are in short supply, so they ended up driving about 30 minutes from home to a free-standing ER in Lewisville, Texas. And there they both got antigen tests, which are the rapid ones, and PCR tests, which are the long swab up your nose.

**Rovner:** And they were both negative, right?

**Pattani:** Yes, that's correct. So they got the good news. Both tests are negative.

**Rovner:** OK. And the bad news, of course, was when the bill came, which was for how much?

**Pattani:** For Travis alone, the total bill was around \$56,000. And part of that was the one covid test. The PCR one was charged at \$54,000. So, to be clear, that charge wasn't directly to Travis, it's what the free-standing ER wanted his insurance company to pay. But yeah, we're talking \$54K for a test.

**Rovner:** Which is just insane. And his wife wasn't charged nearly that much, right? 'Cause she had different insurance?

**Pattani:** Yep. So his wife actually got her bill first, and it came in around \$2,000, and her insurance company paid a little under a thousand. And Travis and his wife remembered thinking, Wow, that's so high for a covid test! And then, of course, his bill comes along, and they're blown out of the water.

**Rovner:** So, Congress made it clear near the beginning of the pandemic that insurers would have to make testing free for patients to prevent people who might have been exposed [to covid] from avoiding getting tested, because I don't know, they might get a bill for \$54,000! And Travis Warner, I mean, to be clear, was not told he was responsible for any portion of this bill. But how much did his insurance company end up paying?

**Pattani:** So, for that one covid test, the single PCR one, the insurance company paid a total of \$16,200. They also paid several hundred more for the second test and what's called a facility fee. So essentially, his insurance company paid nearly \$17,000 for Travis to get two covid tests.

**Rovner:** Which is a lot. I mean, before we get too far away, I want to point out that, you know, we're focused on the \$50,000 that they charge for the PCR test. But also, as you point out, there were hundreds of dollars charged for the antigen test, which are the same tests you can now buy at the drugstore, two for \$20, if you can find them. How do providers get away with charging these insane prices?

**Pattani:** They really are insane, and, I mean, the short answer is there's nothing stopping providers from charging that. I mean, health policy analysts that I spoke with said even when what is, you know, a clearly absurd and egregious charge like \$54,000 for a covid test, it's still perfectly legal, right? There are no caps on what providers can charge, so someone might say I'm going to charge \$100 for a covid test. Another person's going to say \$1,000, and both are fine. There's actually one report I came across in my research that found there are different prices charged for covid tests, even within the same hospital system. And the thing is, that's also not a covid anomaly, right? The same thing happens in our system for blood tests, for C-sections, MRIs and all other medical services. There's just no cap and there's no real standardization. Every provider can charge what they want to some extent.

**Rovner:** So what eventually happened with this bill?

**Pattani:** So, Travis didn't owe anything, right? So initially, his thought was, maybe I just ignore it. You know, there's a bill for my insurer, it has all these numbers on it, but I'm not responsible. But at the end of the day, the absurdity of that number just got to him. And he was like, I have to call my insurer and see what's up. So his call then prompted the insurance company to review the charge. And when I reached out to them, they said it was the provider's billing error. So basically, the insurance company went back to the ER and said, you know, this is not right and got back the money that they had paid. So, at the end of the day, things basically worked out. But I mean, in talking to Travis, he was just like, how often does this happen and it doesn't get caught?

**Rovner:** Yeah. And I was just, I mean, patients are tempted to say, Well, this is not my problem because I'm not being asked to pay any of this bill. But it really is patients' problems, right?

**Pattani:** Absolutely. So even if a patient like Travis doesn't have to pay out-of-pocket for that particular bill, when his insurance company pays, they then translate those costs into insurance premiums. So it actually ends up becoming more expensive for Travis and everyone else who pays for insurance.

**Rovner:** And runs up premiums for the health system. So what's the takeaway here? What should patients do or be on the lookout for?

**Pattani:** So first thing I want to reiterate is that covid testing should be free to consumers throughout the public health emergency. So, if someone goes and gets a test and then they get a bill, don't pay it. Talk to the provider, talk to your insurance company. But even beyond covid, I think the lesson here is to read those really long and dense bills and explanations of benefits that come from your insurer, that come from providers, even if you don't personally owe money. It's obviously not your job. Insurers are the ones who are supposed to be flagging these errors and not paying them. But if you, like Travis, catch that \$54,000 charge or some other egregious overpayment, it ultimately ends up saving you money and other normal people because then you all don't have to pay those higher and higher insurance premiums.

**Rovner:** Excellent. Aneri Pattani, thank you so much.

**Pattani:** Thanks for having me.

**Rovner:** We are back and it's time for our extra credit segment where we each recommend a story we read this week we think you should read, too. Don't worry if you miss it, we will post the list on the podcast page at KHN.org. Sarah, why don't you go first this week?

**Karlin-Smith:** Sure. I took a look at a piece “70 Years Ago, Henrietta Lacks’s Cells Were Taken Without Her Consent. Now, Her Family Wants Justice,” by Emily Davies in The Washington Post. A lot of people in the science health policy world are kind of familiar with this story, particularly with the book and the movie “The Immortal Life of Henrietta Lacks,” about a black woman who had cervical cancer in the 1950s, whose cells were taken without her consent. And, essentially, these cells have been critical to research. I mean, some of the most breakthrough important research of our time in terms of biotechnology ... are still continued to be used to this day. Her family has never really been compensated in any way, and all of these companies and parts of our science system have made a lot of money off of the products they were able to develop. And so they filed one lawsuit against Thermo Fisher Scientific about this. But there's indications in this story as well that they would like to get compensated from a variety of companies and institutions here. I think the big question it's going to be things around statute of limitations and so forth. Although, while this case is rather old in some ways, for many years, the institutions involved really kind of covered up whose cells were being used and how they were obtained and so forth. So it's a really fascinating story if you haven't actually read the book “The Immortal Life of Henrietta Lacks.” It's a pretty easy read for, you know, something in this kind of scientific policy space.

**Rovner:** And the movie was good, too.

**Rovner:** Yasmeen?

**Abutaleb:** Yes, I read a story in The Wall Street Journal about why so few therapists take insurance, which is obviously an even bigger problem now. A) because the pandemic has caused so many people to lose their jobs or lose massive sources of income. And B) because more people need therapists than ever, just given the terrible two years we've all been through. And the story sort of laid out some possibilities for making the costs a little bit less intense. If you're trying to find a therapist, and obviously the rise of tele-therapy has made it a little bit easier because people can access therapists and a sort of wider geographical range, and there are some who take payment on a sliding scale. But what I found interesting was that so many therapists don't take insurance because they feel the insurers don't reimburse them properly. And there was a statement from one of the insurers, I think it was Anthem, in the story saying, “Oh, we'll reward good outcomes” or something to that effect, which, you know, my mom's a therapist, so I know therapy is not that cut-and-dried. And it's not like going to your pediatrician's office and getting preventative bloodwork and identifying high cholesterol or something. So, I mean, it's just an insane problem, and it seems like something that's been persistent for several years. Some of the surveys cited in the story were from 2016. So obviously it's been an overlooked problem, but it does seem like a particularly egregious one right now. I mean, the need for mental health services is not going to go away, even when things start improving a bit more with the pandemic.

**Rovner:** Yeah, one would hope that shining a spotlight on some of these long-standing problems might help get things solved. Joanne.

**Kenen:** I was looking around for a story that would explain the global impact of the new Merck drug for covid, and I actually didn't find one that answered all of my questions. But the one — so maybe I'll just have to write it myself — but the one that I thought did the best job of explaining why this is really important for countries, particularly in Africa. Basically, Merck did license it to five generics, and even though they're going to make a lot of money from rich countries, it does look like they're going to make it reasonably accessible to poorer countries. So the best one I did find was in Vox by Umair Irfan. It was called “Why Merck's Covid-19 Pill [Molnupiravir] Could Be So Important.” It'll at least answer some of those questions or partially answer some of those questions.

**Rovner:** Well, I also looked at an international story this week. A story that you might have missed but shouldn't have, the endorsement by the World Health Organization of a malaria vaccine. Before we had covid, malaria was one of the diseases that public health doctors were most anxious to address. To quote from the story in The New York Times by Apoorva Mandavilli, quote, “It kills about half a million people each year, most of them in sub-Saharan Africa. Among them, 260,000 children under age 5.” This is not only the first vaccine to prevent malaria, it's the first vaccine ever to protect against a parasitic disease, which is a lot more difficult to create than vaccines against viruses and other kinds of ailments. It's apparently not the most effective vaccine, but it could still have a major impact in a fight against a gigantic public health scourge.

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. 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. Joanne?

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