

KHN's 'What the Health?'

Episode Title: Boosting Confusion

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Julie Rovner: Hey, "What the Health?" listeners, this is Julie Rovner. If you like our show, then you should check out "Sick," a podcast from WFYI and PRX. This season, the team at "Sick" is investigating prisons. Incarcerated people are entitled to health care under the Constitution, but a lot can go wrong in a place that's supposed to keep people healthy yet designed to punish them. What happens inside a prison affects all of us. Visit sickpodcast.org and listen to "Sick" wherever you get your podcasts.

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, Nov. 18, at 10 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go.

Today, we are joined via video conference by Rachel Cohrs of Stat News.

Rachel Cohrs: Morning, Julie.

Rovner: Sarah Karlin-Smith of the Pink Sheet.

Sarah Karlin-Smith: Hi, Julie.

Rovner: And Tami Luhby of CNN.

Tami Luhby: Good morning.

Rovner: Later in this episode, we'll have an interview with Dan Weissmann, host of our other KHN podcast, "An Arm and a Leg." Dan has some cool stuff planned for this year's insurance open season (if there's anything about open season you can call cool). But first, this week's news.

So the House still hasn't voted on the huge social spending bill yet, but it still looks like they could by the time this week is over. Any suggestions that there's trouble? And have we heard yet from the estimators at CBO [the Congressional Budget Office] about what this thing might cost? Rachel, where are we?

Cohrs: Yeah, so I think things are looking pretty solid so far. But again, so this ... the CBO has been kind of putting out incremental estimates on different committees' work and, kind of, the big, most controversial ones are not quite done yet. They said it'll be done by Friday ...

Rovner: And those would be health care, right!?

Cohrs: Yes, all the health care stuff is in those. So we are still in wait-and-see mode. But I think, like, I just had a conversation with congressman Kurt Schrader [D-Ore.] yesterday, and he thought

they were going to be able to work out their differences this week. So it'll be an end-of-the-week rush, but what's new?

Rovner: And, of course, for those who don't remember, congressman Schrader was one of the moderate Democratic holdouts on the prescription drug price part of it, right?

Cohrs: Yes. And he also signed a statement with a couple of other moderates saying they wanted the CBO score before they were going to vote. So yes, I think they're staying on the same page there.

Rovner: So as an old person at the table, I can say I have spent many, many weekends before Thanksgiving on Capitol Hill covering Congress. There's something about that weekend before Thanksgiving that they're dying to get stuff finished so that they can go home that Saturday and Sunday before Thanksgiving. It's a very common time for Congress to be in and doing stuff, and it looks like it's possible that that's going to be the case this time. But we'll tell you next week.

As we have also been suggesting for some weeks now, [Dr.] Robert Califf has won the nod from President [Joe] Biden to head the Food and Drug Administration — or *re-head* the FDA. He was commissioner briefly at the end of the Obama administration. What do we know about what he might focus on? I know he's kind of a data nerd. And what are his chances of getting confirmed? Sarah, you're over there nodding.

Karlin-Smith: Yeah, I think his chances of getting confirmed are probably fairly good. I don't think the Biden administration would have nominated him if they hadn't done some decent vetting on that. The issue is probably going to be he may lose a few Democratic votes, particularly, perhaps, Sen. Joe Manchin, Sen. [Maggie] Hassan or Sen. [Ed] Markey, who raised concerns in the past about Califf and his connection to the opioid crisis. I'm also kind of interested to see, since Califf left the FDA, he's worked more directly with the drug industry, and that could be a problem for some Democrats. But I think, most likely, he'll get enough Republican support to put him over the finish line. In terms of priorities, you know, a lot of his priorities may look kind of similar to what he did or tried to do last time at the FDA because he was there for such a short time. So, like you mentioned, he is a big data nerd and really interested in kind of clinical trial reform and improving that system. And the downsides of the U.S. trial system have really been highlighted during covid. So I think there'll be a lot of momentum to fix that and other things he's focused on. Not super sexy, but really important is hiring at the FDA. The FDA has long struggled to recruit and retain enough staff at times, and even maybe at the moment, I don't have the exact numbers, but they often run with hundreds of vacancies in their drug center alone. So that's going to probably be another big priority. There's some tobacco stuff that should be high on his agenda as well. So those are some of the top issues.

Rovner: And, you know, Califf's nomination was formally sent to the Senate on Nov. 15, which was literally the last day before acting Commissioner Janet Woodcock would have had to step down had no nomination been sent under something called the Federal Vacancies [Reform] Act. So the administration did dodge that bullet. But there are several high-level Human Services appointments at HHS that are yet to be named, and things are not in great shape, and agencies at

places like the [Administration for Children and Families]. Do we have any idea what's taking the administration so long on these nominations? I know there's, you know, muttering about the Senate taking too long, but these are not *confirmations* we're talking about. These are actual naming of officials to head these, these agencies and sort of sub-agencies, and it's just not happening as fast as it's supposed to.

Cohrs: Yes. Well, I think back when [HHS] Secretary [Xavier] Becerra was starting out, in conversations, I think, with former secretary Donna Shalala, she was really adamant about, you know, we have to get these positions filled right away, and it just hasn't happened. And I think the administration is fighting on a lot of fronts. But, I think, in a lot of these areas, we haven't really seen HHS publicly out front. So, I don't know if that's part of the strategy. Things take a long time. You know, these pandemic-era jobs, they may be difficult to fill. Like, we don't know, there's just a lot of calculus behind the scenes.

Karlin-Smith: Yeah, I think, with FDA, but also with some of these other agencies, like the Administration for Children and Families and the HHS agencies dealing with the border crisis and so forth, I mean, they're dealing with a lot of hot-button issues. And I think in the past these agencies have flown under the radar, but you don't always hear a lot of coverage of some of these child protective services agencies and so forth. And you know, there may be some reluctance. Certainly, I know with the FDA there was a reluctance for people to take the job now at such politically charged times and to walk into crises they didn't create and, you know, take a lot of the heat for trying to figure out how to deal with them and fix them.

Rovner: And certainly, I know in a lot of these science positions, and this goes back to what you were saying about hiring at the FDA, you know, you give up a lot to go to work for the government, often in terms of salary, sometimes in terms of benefits. We saw during the Trump administration there was an effort to uproot people and, you know, move whole agencies to other parts of the country. You know, it used to be you went to work for the government and you got paid a little less, but you had job security. That's not really true anymore, is it?

Karlin-Smith: Yeah, certainly. I mean, certainly not in some of these high-profile positions where obviously you're sort of at the whim of the president and of the political situation. And again, you kind of have to make this cost-benefit analysis or lifestyle analysis of, "Do you want to move to Washington?" "Do you want to move to Washington for the salary change, for the amount of time you think you'll be there?" A lot of people, I think, do just, you know, want to serve their country. There's oftentimes very lucrative opportunities for them after they hold those positions. But, I think, this is just a unique time where people may be, you know, a little more reluctant to uproot their lives to address some of these conflicts.

Rovner: Well, while they're still trying, 10 months in, to get things staffed up. Medicare officials announced next year's premiums, and there's going to be a big jump in the monthly premium for Part B — that's the optional part of the program that pays for doctor and outpatient care. Monthly premiums are going to go from just under \$150 to just over \$170, and literally half of that increase is thanks to just one drug that Medicare hasn't even said it will pay for yet. Tami, you wrote this story. Tell us about it.

Luhby: Yeah, so it's really interesting. I mean, when the FDA first approved this back in the spring, in June, several Medicare experts said that this is going to affect everyone on Medicare, not just Alzheimer's patients, and it's even unclear which Alzheimer's patients will benefit. And you know, I won't get into all the controversy surrounding the FDA approval, which is now under ...

Rovner: We'll let Sarah do that.

Luhby: Yeah! ... which is now under, you know, multiple investigations. But the impact on Medicare is that about \$10 of this \$21-and-change increase is due to Aduhelm because the trustees and the actuaries have to make sure that Medicare has enough money coming in to actually cover it, *if* they do decide to cover it. And, you know, the actuaries stressed, Medicare stressed that the fact that this rate increase is not any indication of whether Medicare will or will not, or how it will cover Aduhelm, but they just need to put this into reserve. And, you know, it's just a stark example of high drug prices and what the impact on Americans as a whole can be, or particularly on Medicare beneficiaries as a whole. And the administration is using this as an opportunity to once again call for drug price reforms, particularly negotiations.

Rovner: And Sarah, it's been a couple of months. Remind us of the controversy about Aduhelm.

Karlin-Smith: So Aduhelm was approved by the FDA, despite the overwhelming majority of the agency's sort of independent advisers rejecting it and saying it shouldn't be approved. The drug has been controversial because, while it seems to, you know, attack these plaques that Alzheimer's patients develop in their brain, the company has not been able to prove it actually improves the course of the disease. And there's some serious safety concerns and safety concerns that when they occur are quite expensive to deal with as well. Besides even the cost of the drug, for people that do end up needing it, there's a lot of MRI and other testing associated with it that are also going to balloon costs for Medicare. And added to that, there's some controversy over, I think, how closely the FDA and the company work together to get this approved. So, it's really been on all fronts, from the FDA scientific side to the high pricing and impact there — kind of a big controversy.

Rovner: What happens if Medicare decides *not* to cover it? Can they rebate the premium increase?

Luhby: That's really interesting, actually. Kaiser Family Foundation says that it would actually take an act of Congress to change the 2022 premiums, which, you know, Congress has made changes to Medicare premiums, but not retroactively. I mean, you know, even during the pandemic last year, they limited the amount of premium increase for 2021, which is a smaller factor as to why the premiums are increasing so much for 2020, too. But yes, it would actually take Congress to do that. But I guess it would come out potentially in the wash for 2023 if they decide either not to cover it or not to cover it fully — but it would be really interesting.

Karlin-Smith: Medicare is sort of trying to make a national, what they call, like, a national coverage decision here. If they somehow chose not to cover it there, there's still processes where sort of different regions of the country and the Medicare administrators there could cover it, so that might also impact premiums. Still, it's a very complicated.

Luhby: Right. And just to give one perspective, Kaiser [Family Foundation], in its report earlier this year, said that if just a million patients of the roughly 6 million, I guess, estimated Alzheimer's patients in the U.S. — if only a million of them receive the drug, spending on Aduhelm would exceed \$57 billion a year, which is far more than Medicare spends on all other Part B-covered drugs combined. So it's a lot of money.

Rovner: And yeah, so just a reminder that the Part B premium is set to cover a quarter of Part B costs. When Medicare was first passed, it was supposed to cover 50% of Part B costs. So that would have been, you know, I remember when they set it at 25% some years ago, the Part B premium was around \$50 a month. So it's already, you know, it's gotten to the point where people, particularly people on fixed incomes, which many people on Medicare are, are really feeling it. It's a lot of money and this is a really big increase. Rachel, do you think this whole controversy about Aduhelm could complicate Califf's nomination? I'm sure that there's going to be a lot of senators who are going to be anxious to complain about it, and that would be an obvious place to do it.

Cohrs: Yeah. I think he definitely may be asked about the Aduhelm approval process, and it's actually because this isn't the only drug. Like, I think, Eli Lilly has a drug that, you know, they might like to see under this kind of accelerated approval pathway. And I think there's definitely been some interest on the industry side. It's like, Oh, well, if this is the new standard, well, maybe our drug might meet it. So I think the future of that will be really pivotal for Califf, you know, if he is confirmed, to deal with and to, you know, set the path on that. So I certainly could see it coming up in the confirmation hearings.

Rovner: Yeah, I think it's safe to say that even after the pandemic is done, FDA is still going to be the locus of many hot-button issues as it always is. All right. Well, let us turn to covid. Cases are going back up after several months where it looked like the pandemic might be finally starting to wrap up. And just in time for holiday travel and get-togethers. Which brings us to the booster question for the week. Passing by the fact that many Americans haven't yet had a first shot, there seems to be a pretty strong push, particularly by governors of states with rising caseloads to boost the immunity of those who have stepped up, even against the official advice of federal health officials who said that boosters are medically indicated only for the elderly, those with health conditions or those likely to be exposed on the job. Now it seems that those federal health officials are following the crowd. Sarah, what's going on here? Are they just jumping on the moving train?

Karlin-Smith: You know, I don't think the federal government here is acting because the states are, sort of, getting out in front of them. In fact, the Biden administration, for people who follow this podcast regularly know, has long wanted all adults in the U.S. to be eligible for boosters. What's happened in the last few weeks is there's been more data to make a stronger case for younger people to get boosters, including Pfizer, which submitted a study on 10,000 patients in the U.S., kind of focusing on actual, like, covid outcomes from boosting, which we didn't have there. And now it looks like there's even potential for FDA to clear both Pfizer's booster for 18 and up and maybe even Moderna's for 18 and up, perhaps today, because there's the expectation it has to come because CDC is supposed to meet to give it the final clearance. But there's still some controversy lingering there over whether, you know, we really need to boost younger people and

what the long-term benefit of that's going to be and whether there are safety trade-offs. But I think at this point, a lot of people feel like we just need a much more simplified process because figuring out whether you qualify or not seems to not be going over well in the country.

Rovner: Yeah, I got my booster this week, and every time I tried to make an appointment, you know, they make you go through the whole screen. Are you eligible? It's like, Yes, just tell me if you have an appointment! So I imagine it would make that a little bit easier if just everybody who wanted a booster was eligible. And, frankly, it's not like they check. I mean, if you really want a booster now, you can certainly get one. They just make you say that you're eligible.

Karlin-Smith: Right. That's why I sort of find the state action a little bit interesting and funny because I'm not quite sure what they're doing is technically, you know, quite legal because really under an emergency use authorization, there's no, what is known as sort of, off-label use, which is kind of going like, you know, doing things kind of broader than the FDA, based on kind of doctor preference. Under the CDC's provider agreement, providers are also very tightly limited and, again, into who they can provide these vaccines for. But at the end of the day, even if these governors didn't act, really, any adult who checks off one of the reasons you could qualify for boosters is likely going to get it because there's just self-attestation, nobody's verifying, you know, whether you work at a job that puts you at high risk of covid or have a particular medical condition that makes you more vulnerable.

Rovner: Is there concern that some of the confusion over the boosters and who should get them, has sort of undermined confidence in the vaccines in general? I know, you know, there's some people say, Well, if we need boosters, do they really work? And others who say, does everybody need a booster? It has not helped the whole public information system here to have such mixed messaging on boosters.

Karlin-Smith: Right. It's really hard to go around saying, "These vaccines at two doses are really, really good and they're really good at, you know, especially, you know, preventing the worst outcomes like hospitalization and severe disease and death." And then also say, "But we kind of think you might want to get a little extra, you know, protection." And I think some of that, some people would argue, is just the nature of developing products really quickly in the pandemic. Some people feel like this always should have been a three-shot vaccine, but again kind of wanted to speed this process along in terms of the interval, it was dose set and everything else. You know, we did the best we can, and people need to sort of be a little bit more comfortable adapting to changing science. But I certainly don't think this has helped with people that have been overall resistant to vaccination. And for better or worse, unfortunately, as you know, the head of the CDC has said, we can't boost our way out of this pandemic. We really need to get the unvaccinated vaccinated. So boosters are kind of like a nice-to-have bonus and certainly good for people already vaccinated to get that little added protection. But the impact on those who are unvaccinated can be concerning because we really need those people vaccinated.

Rovner: Perfect segue into my next question, which is that it's not just the usual vaccine-hesitant population who remain unjabbed. My colleagues at KFF have been tracking this as time goes on, and more and more of the unvaccinated now identify as Republicans. Back in April, 4 in 10 of the

unvaccinated were Republicans or Republican-leaning, compared to one-third who were Democrats or Democrat-leaning. By October, 60% of the unvaccinated now say they're Republicans, compared to just 17% who say they're Democrats. Interestingly, gaps by income, geography and race and ethnic groups, sort of the traditional vaccine gaps, those have narrowed, leaving partisanship what KFF calls, quote, "the strongest single predictor of vaccine uptake." There are some serious implications for this, right?

Luhby: It's interesting. Just we can see in New York, where New York City is pretty blue and Upstate New York is pretty red. I mean, that's talking still about party rather than geography. And there's a huge schism in the state now where the governor this week said that she's very concerned about rising rates Upstate because of the lower vaccine uptake up there, as opposed to New York City, which is somewhat higher uptake but much lower numbers.

Rovner: And I've seen concern that this, sort of, the anti-covid vaccine [attitude] is spreading to kind of the anti-everything vaccine — that you're starting to see people, you know, Republicans, in particular, are talking about, you know, well, why do we even have these requirements for childhood vaccines? And why isn't it all about people with individual right or responsibility to protect themselves? And they seem to have sort of lost this whole idea about community protection.

Luhby: Well, when I was driving, we went not even very far upstate, maybe 45 minutes outside of New York, and there was a big sign on someone's lawn that said, "Don't comply." And that's kind of, like, one of the new mantras. But it's like, OK, so right now, it's maybe "don't comply with a mask mandate" or "don't comply with the vaccine mandate." But what is it going to be "don't comply with," you know, next week or next month or next year?

Rovner: Well, meanwhile, on the vaccine mandate front, the federal employer mandate is on hold, while the raft of court cases challenging it get consolidated in the Republican-appointed-dominated 6th Circuit in Ohio. That doesn't necessarily bode well for the future of this mandate, or does it not matter since it's likely to end up at the Supreme Court no matter what?

Cohrs: I mean, obviously it's a really big legal issue that I think the Supreme Court has somewhat danced around the edges of. But I think this OSHA [Occupational Safety and Health Administration] mandate, I think it would make sense for it to end up there. So, you know, this consolidation, you know, certainly seems like it's one step in that direction.

Rovner: I saw a story this morning that said that, you know, in the end, this could be the Supreme Court's chance to actually scale back how much power the federal government even has over worker protections. You know, maybe in the end, the backlash of this will be worse than having tried to do it. If you recall, you know, President Biden said early on that he didn't want to do a mandate. And I'm wondering if this may have been why, because if you spin this out to its likely ending with a very conservative Supreme Court, even if they uphold this mandate that, you know, well, there are limits of what the federal government can do to protect workers.

Karlin-Smith: And that's sort of how this case has been framed so far by those challenging it, which is, right, kind of them saying, like, OSHA, you know, can protect people against asbestos and

certain other hazards in the workplace. But these vaccinations are sort of outside of the realm of what to protect people from. Which is interesting because it, kind of like you mentioned, I think there's a good chance the Supreme Court might uphold this mandate to some degree, because there has been, even on the conservative side, this general recognition that there's been a long precedent of certain types of vaccine mandates in this country dating back to, you know, people always talk about George Washington and smallpox. But, right, there could be these other ramifications and certainly the time of dealing with these court battles will also impact, you know, the vaccination campaign in the U.S. unless we get some kind of lifting of this stay while they're hearing it.

Luhby: One thing also just harkening back to the booster discussion is what is fully vaccinated and what is fully vaccinated going to be in a couple of months? Is it going to be the two shots or is it going to be the booster? So that's something to consider because I know several people who've, I wouldn't say, rushed to get their first two shots, but didn't have an issue getting their first two shots, but are hesitant on getting the boost, though. We'll see.

Rovner: I confess I went to go look up, like, how long before my booster takes effect? They don't actually tell you. It's a week, by the way, or a week to 14 days. Sort of like you're, quote-unquote, "fully vaccinated" 14 days now after your third shot. But, you know, we have these, sort of, dueling mandate-no mandate fights in some states, which are catching, particularly, health employers in the middle. In Florida, the governor has called a special session to try to get the Republican legislature to ban employee vaccine mandates. But Centers for Medicare & Medicaid Services is requiring health workers to be vaccinated in order for their employers to get Medicare and Medicaid reimbursement, which is obviously something that most health facilities need in order to continue to survive financially. Florida is also considering a bill to create its own occupational safety and health administration and pull out of federal oversight. But that would take years and would have to be approved by the federal government. I mean, is this all covid theater or are real people about to get hurt in all of this?

Cohrs: Quite a bit of it is theater. I think these hospitals are in a really tough position, and I think, at least for the short term, I think they are going to go where the money is, which is Medicare, you know. And I think it's important just to remember that, you know, Gov. Ron DeSantis is very clearly considering a presidential run — clearly sees this as a winning issue for him. But, yes, I mean, these health care providers are absolutely caught in the middle, and it's just going to be a very difficult kind of path ahead for them. So I guess we'll see how the special session goes and what the expectations are for these employers as they try to navigate these two, like, dueling expectations for them.

Rovner: I am glad I'm not a health care employer in one of these states right now. All right. Well, finally, on the covid front, both Merck and Pfizer seem to be eager to license manufacturing for their respective anti-covid pills that are now, I think, both before the FDA awaiting approval. But drug companies seem less thrilled to license their vaccines to manufacturers in other countries. Is there a reason why they're more anxious to let others make the pills than make the vaccines? Is it a manufacturing thing or is it a financial thing?

Karlin-Smith: I think it's a little bit of both. Although Pfizer's CEO talking on Stat Summit would certainly like you to think it is largely a manufacturing issue. And they've argued companies, businesses, governments and other parts of the world just don't have the capabilities to really get the vaccine manufacturing up quite as fast. Whereas, it is true, both the Pfizer and Merck antivirals are these small-molecule pills, and there's lots of experience across the globe of companies manufacturing, you know, generic versions of small molecules. And it will certainly be easier, no one's doubting that, but there has been a lot of good reporting. The New York Times had a nice piece a number of weeks ago kind of showing that there is more capability and knowledge of how to produce mRNA vaccines that has been being developed in other parts of the world. And if they just got a little bit of assistance from some of these companies and patent rights and so forth, it could probably be done. So, it's not quite as, you know, a clear-cut story as the drug industry would like you to believe.

Rovner: Yeah, I was just, I was curious to see that these companies seem to be so forthcoming about how, well, let's get this treatment out to everybody. It's like, why aren't you as eager to get the prevention out to everybody as you are to get the treatment out to everybody?

Cohrs: And just the vaccines, you know, have different storage requirements, too, as compared to a pill. There's obviously ways to build capacity in that respect. But I think that's just important to remember, too, that there are a lot of other requirements that make distribution of this easier, too.

Rovner: But obviously this pill, I mean, assuming that these pills are approved and that they work as advertised. I mean, they could change things in a way that the current treatments we have don't. As someone said, it could actually turn covid-19 into a bad cold or a mild flu if they really work well, right?

Karlin-Smith: Right. Because unfortunately, right now we do have some treatments that can help kind of reduce the severity of the disease. But you have to get infused in a medical setting over a course of a number of days, and there just hasn't been a lot of uptake of them. Anything you can just, kind of, get dispensed by your doctor and take it home is going to probably be much more impactful and they're cheaper as well.

Rovner: We will see how this goes. All right. That is the news for this week. Now we will play my interview with Dan Weissmann, host of the "An Arm and a Leg" podcast. Then we will come back with our extra credits.

We are pleased to welcome back to the podcast Dan Weissmann, host of the "An Arm and a Leg" podcast. Dan is branching out for the coming season, and he's here to tell us about it. Hey, Dan.

Dan Weissmann: Hi, Julie. Thanks so much for having me.

Rovner: So you're starting something called the "first-aid kit." Tell us about that.

Weissmann: We talk on "An Arm and a Leg" about why health care costs so freaking much and what we can maybe do about it. And we've been focusing a lot in the last couple of years on practical self-defense, like, what can we actually do about this now for ourselves? And I've learned

a bunch of things. And listeners have been asking, “Hey, can you write all that stuff down? So I don't have to just, like, listen to podcast episodes and try to take notes really fast?” And I've been like, “That's a totally good idea. We should totally do that. How and when will I make time?” And now we're doing it. So, we're doing it in the form of a newsletter called “First Aid Kit.” And you can subscribe to it. You can go to armandalegshow.com/newsletter, and it's available on [Substack](#). We tweet about it all the time. And it also publishes directly to its own website. So, if you go to armandalegshow.com/newsletter, you can read all of it there. And we launched last week, and the first order of business is “We're in hell. Who wants some burn cream?”

Rovner: Which is, in one line, everything you need to know about the health care system.

Weissmann: Unfortunately, yeah, because we cannot win them all. This is really the worst of all possible worlds, because who the heck knows what could be actually worse than this? But it's pretty bad. It's pretty bad. Everybody says, like, if you were designing a health care system that were to do the worst job of serving people and [causing] misery ... the most, you'd have a hard time coming up with something that was more effective than what we've got. And so it's important to say that upfront, because this really is a first-aid kit. It's not like a visit to a functioning trauma center, which is kind of what we all need. We need expert help with everything anybody can throw at it, and we don't have that. That's not available. We can't actually win them all. But as I've been finding out, we don't have to lose them all either. There are a lot of tricks, and nothing works all the time, but things are worth trying. I find it cheering to know we're not necessarily entirely helpless all the time, and we're not alone. So that's the idea.

Rovner: How optimistic. So it's November. Lots of people are in open season right now, and choosing health insurance is something everyone doesn't love, including me. Is there some secret to success here now? This is your sort of first topic that you're hitting on with your first-aid kit.

Weissmann: Right. We think we're coming out in November. We should address this right away. It's a big opportunity. And the answer is no, not exactly. In fact, one of the first stories I ever did was talking to a really famous economist who had done a study about choosing health insurance, a series of studies about them and what he concluded was: Most of us are terrible at it. But even people who are good at it, even people who are smart about it, find, like him, are intimidated by it. He was gearing up to help his just-turned 26-year-old son pick health insurance for the first time. He was like, I'm sure I'm going to screw this up. It's impossible, I would say, given his testimony to pick the best health insurance for yourself. The good news is it's not necessarily impossible to weed out the worst ones. It's a lot more trouble than it should be, but it's not impossible to do that.

Rovner: So it's about setting expectations.

Weissmann: That is my entire shtick here. Like, OK, we can't solve all the problems. This is just a first-aid kit and like, OK, no, you can't pick the best health insurance. But if you're willing to, like, sweat a lot and curse a lot and rely on the beverage of your choice to get you through this, you can probably avoid getting as screwed as you could get. I'm just like Mr. Sunshine.

Rovner: You are.

Weissmann: But that's what I'm offering. I'm offering a quarter-full cup.

Rovner: But seriously, I mean, I have I have subscribed to your newsletter, and I'm impressed that there are some, you know, short takes. You don't have to read 400 pages to say you're not going to be able to figure out how to get the right one.

Weissmann: Yeah.

Rovner: There's some obvious mistakes that you can avoid.

Weissmann: Yes! It takes much more work to avoid them than it should, but you can. The economist that I interviewed found through a series of studies that most of us are starting at a disadvantage because we don't understand the basic terms. And probably those listening to this podcast do — the basic terms like deductible, coinsurance, copay, out-of-pocket maximum and how they interact, like being able to then do the math. That's actually kind of complicated, so it's not that surprising that most of us are not great at it right out of the box. Those are the building blocks is kind of knowing what the heck this even means because it's written by people who write insurance policies for a living, not by, not for human beings.

Rovner: Cook for Thanksgiving. Figure out health insurance. Which would you prefer to do?

Weissmann: Right! Yes.

Rovner: What else is going into the first-aid kit here?

Weissmann: You've read the first of what's going to be three episodes of "First Aid Kit" that deal with picking health insurance — there's learning what scenarios to run. And it occurred to us as we started putting out this segment like, Oh wait! Not everybody knows the things that I now take for granted because I've been covering this for a few years. Things like, Oh, wait, remind me, what's a PPO? What's an HMO? What's the EPO? I had, there were new ones on me, so we had to get all those things defined. And then the next thing is, if you're looking for health insurance and, one, there's a lot of bad stuff out there. There's a lot of things, essentially, the bottom line is, if you're buying your own health insurance and not getting it from work, you really want to be looking on the Obamacare exchanges, which is not an opinion about: Was the ACA a good idea? Could it be improved? It's not an opinion or any of those things. It's just that, like, if you want to buy health insurance and what you're looking to do is protect yourself from financial ruin, that's your best option. Because everything else out there is really leaving you open to a lot of bad stuff. And the most interesting thing that was kind of news to me, actually, in doing this reporting was, it's not enough just to want to get Obamacare. You have to actually type into the address bar of your browser. A limited number of websites, the most important of which is healthcare.gov. There are other sites like this one called HealthSherpa ... where you're just going to find Obamacare-compliant plans. These are plans that cover preexisting conditions, that cover the full list of 10 essential benefits like, you know, mental health, maternity care, preventive care, like, all kinds of things, like cancer, like the kinds of things you want health insurance for. If you want that, you can't trust Google to take you there. Georgetown University researcher Dania Palanker, who I talked to last week, found out — and she's not the first, she's just the most recent to do these

secret-shopper surveys. You go to Google and you type in, like, “ACA enroll” or “Obamacare plan,” and the first bunch of results that fill your screen, when you look at them closely and squint, they have the word “Ad” next to them. They look like very legitimate results that say “Get Obamacare,” but if you go to any of those sites, like, the actual healthcare.gov shows up halfway down the screen, or you have to scroll to it if you're not on a very big screen. If you go to any of those sites, they will prompt you to, like, you know, give us your phone number. We'll call you to set something up, and then you will get hammered with calls from people looking to sell you mostly junk insurance, mostly stuff that is not ACA-compliant. And this researcher made two avatars, one relatively young and healthy, the other, like, 48 years old, high cholesterol, heart condition. And both of them, but, most importantly, that second person kept getting pushed like, “Oh no, you don't want Obamacare. Those are too expensive. That's not going to work for you. I've got something better for you — cheaper, gonna work for you.” And in the role of this person, the researcher would ask, like, “Will that cover me if I have a heart attack?” “Oh, absolutely!” “What about my cholesterol meds?” “Totally covered!” Like, totally not true. Totally not true.

Rovner: So it's not saying that it's just confusing. There are people who would like to get in your pocket, who will sell you a bill of goods, basically.

Weissmann: Yeah. Even if you're, like, taking my first piece of advice, which is, like, you should really look at Obamacare, that's where you're going to get a deal. That's where you're gonna get coverage that you need. The other thing is that Obamacare is actually right now a super, super, super good deal. This is where you should be looking. The American Rescue Plan, the big stimulus bill that passed, I mean, Julie, you know all of this.

Rovner: The things that we talk about every week on our podcast.

Weissmann: Yeah. As listeners to your show well know, you know, the American Rescue Plan included these big pumped-up subsidies to make Obamacare plans much cheaper for really most people. Almost. I mean, almost everybody qualifies for some subsidy, and many people qualify for incredible subsidies, like, basically free health insurance or even better, super cheap with all of the stuff that usually makes your life miserable, the copays, the deductibles, all that, shrunk down like Ant-Man. I feel like one of the things about this project is that I didn't quite expect, but shouldn't be a surprise to me, is how much there is for me to learn. I've been doing this for three years and like, “I know a lot, I could tell people stuff! I could write a newsletter” and as I go into it, I'm like, “Whoa, holy moly. There's traps within traps.”

Rovner: There are. Well, Dan Weissmann, I'm glad you're there to help explain them, and we will see you around the podcast app.

Weissmann: Yes, <https://armandalegshow.com/> is our website and “An Arm and a Leg” is our podcast and “First Aid Kit” is now our newsletter.

Rovner: Great. Thank you, Dan.

Weissmann: Thanks, Julie.

Rovner: OK, 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 and in our show notes on your phone or other mobile device. Tami, why don't you go first this week?

Luhby: Well, my selection was by our “What the Health?” veteran podcaster Joanne Kenen, who until recently was at Politico. And she's now a contributing editor there and also the Commonwealth Fund's journalist in residence at Johns Hopkins. So her piece is an opinion piece that ran in Politico called “[‘We Don’t Fix This Because We Just Don’t Care About Old People.’](#)” which is a quote that's in her story. We actually, even on this podcast, we talk a lot about different things about health. But one of the things a lot of Americans don't talk about that much is long-term care and the health care of people when they get older in terms of not necessarily the medical care, but the other types of care that they need. And so she kind of goes over what initially this year looked like. It might be a very large federal infusion for long-term care for the first time. President Biden had wanted to put in \$400 billion initially into this, and it's now been whittled down to \$150 billion, which would still be a huge amount if it goes through. It would help, there are 800,000 people right now on the Medicaid waiting list for home and community-based care. So that would help with that. But it basically just shows it's a story that kind of goes over how Americans have treated long-term care and how politicians have — which has not been a high priority. And so the last quote, which is the headline of this story, is from the woman who runs the National Association of Health Care Assistants. They represent the long-term care workforce, and it basically says, “We don’t fix this because we just don’t care about old people. Old people don't matter in this country. And they never have” — which is sad and which isn't really true because obviously the Social Security and Medicare forces are very strong, but long-term care isn't.

Rovner: I like to remind people that I wrote one of my first really big stories as a health reporter about long-term care in 1987 and thought, “Oh, well, you know, by the time the baby boomers start to retire, we'll have taken care of this.” She said to her 25-year-old self. It is still out there and it's still a big issue. Sarah.

Karlin-Smith: So I looked at a piece by Sarah Jane Tribble of Kaiser Health News and Emily Featherston of InvestigateTV called “[As Big Pharma and Hospitals Battle Over Drug Discounts, Patients Miss Out on Millions in Benefits.](#)” And it's a story about sort of a little-known program called 340B, which requires drug companies to provide rather huge discounts on medicines to certain hospitals and outpatient clinics that serve a disproportionate share of people that are low-income, either don't have insurance or have insurance that really is not adequate and so forth. And the idea is that they buy the drugs for this really heavily discounted price but get reimbursed by Medicare and other parties at the standard rate. So they have these excess funds to spend on, again, charity care, helping serve these patients that maybe don't have the income to fully get their health care served otherwise. But what's happened since Obamacare was passed is that there's been this huge explosion in the amount of health facilities that qualify and how they can partner with contract pharmacies to dispense the medicines. And the drug industry feels like the program has kind of gotten out of control, and hospitals and pharmacies are making money off of it and not doing the proper amount of, again, kind of charity care and so forth with those savings.

It's come to a head recently because some drug companies have basically just decided we're not going to honor some of these agreements in terms of providing discounts to contract pharmacies. And there's a number of cases in court, and it seems like I feel like every week it's ping-ponging back and forth as to whether the drug companies are winning or the hospitals are winning. This is likely going to be probably, I think, eventually somehow settled by the Supreme Court and/or require congressional intervention. One of the problems with 340B is that a lot of it's, like, the way it's run is done by guidance, not regulation, which doesn't carry the force of law. And so that's, I think, helped the pharmaceutical companies in their protests here. But you know, as the headline sort of says, and as the story tells these two, you know, huge behemoths in our country, fight this out, there are patients that were getting benefits from this program that are no longer seeing that support because of the drug companies' decisions, you know, to sort of try and circumvent the program. It mentioned the patient that was taking half-doses of insulin and so forth, which can be really dangerous.

Rovner: Yes, it's like the surprise-bill fight, sort of, the big guys fight, and the patients get caught in the middle. Rachel.

Cohrs: So my extra credit this week is headlined "[Why the Justice Department Is Targeting Private Equity](#)," by Tara Bannow in Modern Healthcare, and I think this is part of a private-equity package that she worked on that released this week. And I just felt, like, this was just really interesting in a trend that I hadn't really been aware of. Private equity is really difficult to report on. And I think there's just this really interesting opportunity here for maybe some accountability for these private-equity companies that are kind of looking for a return on investment to think about why health care is a different beast than a lot of other industries, just because you're caring for *people*. And there's a lot of legal liability that, you know, health care providers deal with on a regular basis. But if private-equity owners are really starting to be, kind of, named in these lawsuits, I think that is a really interesting opportunity for us as reporters to kind of learn more about how they work, what they know, when they know it. And just for these investors to take a step back and really think about being a little more hands-on and running a tight ship when they do make these acquisitions.

Rovner: So my extra credit this week was going to be Rachel's private-equity story, but I figured it would be easier to just ask Rachel to tell us about it because you wrote a related story this week.

Cohrs: Yes, very similar kind of topic here. And thanks for giving me the opportunity to talk about it a little bit. So, I got a tip about six months ago that Ascension, the country's largest Catholic hospital system, has 142 hospitals — very big operation — has been over the past five or six years, building out their own private-equity fund in partnership with a very big global private-equity firm where they're investing in health care companies. And I think it was just such a counter to this narrative where private-equity companies are buying safety-net hospitals and closing them. All very sad. But, like, this tax-exempt, wealthy, religious institution is investing, and they're saying that they're doing it to, you know, help expand their charity that they can provide, as you know, a nonprofit system. This story was just an examination of "What are they doing?" It's a pretty unique setup, but some other kind of systems have dabbled in it, too. Who are they investing in and what reflections that actually show in the charity care that they're providing? So, yeah, it took

a while to put together. There's still a lot more out there, but it's just a deep dive into kind of Ascension and how they're operating in the financial space.

Rovner: Yeah, lots of money and lots of big power in health care this week. Well, my actual extra credit is from The Atlantic by the Pulitzer Prize-winning science writer Ed Yong, and it's called "[Why Health-Care Workers Are Quitting in Droves?](#)" And yes, this is similar to my extra credit from last week and my interview with nurse educator Rebecca Love. If you didn't hear that episode, it would be right behind this in your feed. But Ed is so much a better writer than I am that I just have to read one paragraph from this story that you really should read all of. Quote "Health care workers aren't quitting because they can't handle their jobs. They're quitting because they can't handle being unable to do their jobs. Even before covid-19, many of them struggled to bridge the gap between the noble ideals of their profession and the realities of its business. The pandemic simply pushed them past the limits of that compromise." It's a really, really powerful story with some amazing stories from some really, really tired health workers that you really should read.

On that somber note, 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'll do another Q&A soon. We are at whatthehealth — all one word — @kff.org. Or you can tweet me. I'm @jrovner. Tami?

Luhby: @Luhby — L-U-H-B-Y.

Rovner: Sarah?

Karlin-Smith: I'm @SarahKarlin

Rovner: Rachel.

Cohrs: @rachelcohrs

Rovner: We will be back in your feed next week. We'll be there early, so you can listen while you're cooking or traveling for the holiday. In the meantime, be healthy.