

## KHN's 'What the Health?'

**Episode Title:** *Roe v. Wade* on the Rocks

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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](http://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 on Thursday, Dec. 2, at 10 a.m. this week. 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 Alice Miranda Ollstein of Politico.

**Alice Miranda Ollstein:** Good morning.

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

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

**Rovner:** And Shefali Luthra of The 19<sup>th</sup>.

**Shefali Luthra:** Good morning.

**Rovner:** Later in this episode, we'll have an interview with Blake Farmer of Nashville Public Radio. Blake reported the latest KHN-NPR "Bill of the Month" about two trips to the emergency room, but only one with a really big bill. But first, this week's news. We will start with the Supreme Court this week. We are still waiting for a decision in that Texas case, where abortion after six weeks of pregnancy has basically been unavailable since Sept. 1. But, on Wednesday, the justices heard oral arguments in the case where they could and very well may, judging from what was said, overturn *Roe v. Wade*. Shefali, what's this case about?

**Luthra:** So, this case is — on its face, right? — about a 15-week ban to abortion in Mississippi. As we know, *Roe v. Wade* and *Planned Parenthood v. Casey* have pretty clearly cemented the right to an abortion up until fetal viability, which typically occurs [at a] 23- to 25-week window. So we often say 24 weeks. And Mississippi has used this case to argue that the *Roe v. Wade* and *Planned Parenthood v. Casey* precedents should be completely overturned and that, instead, states should have the right to essentially determine whether abortion remains protected or not. And as you mentioned, Julie, as I'm sure we'll get into, it seemed quite clear that there is a majority for, at the very least, upholding Mississippi's law, which would inherently weaken those protections and, quite possibly, and maybe even likely, overturning *Roe v. Wade* entirely.

**Rovner:** So when Mississippi originally asked the court to take this case, which was like a year ago, the court delayed and delayed and delayed its decision on whether or not to even hear it because this case had been struck down as being in violation of *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*. But now, Mississippi said, at first, we just want you to uphold our 15-week ban. Yesterday, the state's solicitor general said, the heck with that, and asked the court to overturn *Roe* entirely. Alice, I see you nodding. Why the change?

**Ollstein:** Well, if you want to look at the timing here, what has changed on the court since they first petitioned the court to hear the case and now, is Ruth Bader Ginsburg died and was replaced by Justice Amy Coney Barrett. So when Mississippi originally petitioned the court to hear the case, the court had a different makeup, and they made the argument that they thought would be most appealing to the justices at the time, which is that you can uphold this 15-week ban without overturning this long-standing precedent. And they then felt that they could sort of throw that out the window and push for full overturning of *Roe* and *Casey*, which they did yesterday. And it was interesting to me that Chief Justice [John] Roberts sort of tried to get them to go back to their original arguments and said, Well, what about just upholding the 15-week ban? And, you know, "15 weeks isn't that different from 24 weeks, of course." People who are dealing with an unwanted pregnancy might disagree with that. But he was, you know, trying to make that argument. And really no one on any side of the case was buying it. The lawyer for Mississippi said, Nah, you really have to go all the way and overturn *Roe*. The lawyer for the abortion clinic said, You know, look, if you uphold the 15-week ban, what's to stop states from pushing that earlier and earlier and earlier? There's no legal justification for a 15-week ban that couldn't also be made for a 10-week ban or even earlier.

**Rovner:** And Mississippi has passed its own six-week ban to go along with its 15-week ban, right?

**Ollstein:** Exactly. And that just proves the point. And so they were saying, you know, really, this would give states a green light to ban abortion at any stage of pregnancy.

**Rovner:** So, you know, there's been some suggestion that Chief Justice Roberts, who worries about the court's reputation, might try to broker some sort of compromise where they find a way to give states more latitude to restrict abortion without at least saying that they're overturning *Roe* and *Casey*. But that's going to be a really hard needle to thread, right?

**Luthra:** It just seems that the votes aren't really there. As Alice pointed out, and as Justice [Elena] Kagan pointed out, and lawyers on every side pointed out — right? — once you move the line, if you aren't immediately overturning *Roe v. Wade* in name, you're going to come back here in one year, maybe two, and do it all over again.

**Rovner:** But isn't that Roberts' point? I mean that, you know, Justice [Sonia] Sotomayor was pretty blunt, saying, you know, look, normally when you overturn a precedent of this age, I mean, *Roe* was — we're almost to the 50th anniversary of *Roe*, it was decided in 1973 — when you're overturning a precedent like this, something has to have changed, something other than the makeup of the people on the court. And she was pretty blunt about suggesting that this could, you

know — yes, the Supreme Court could get what pro-lifers have been working for gradually for 50 years, but it could also blow up the court's entire reputation.

**Ollstein:** Well, the question of what has and hasn't changed in the last 50 years was a key part of the arguments yesterday, and Mississippi in its written briefs, not as much in the arguments, tried to make the case that so much has changed in society, that abortion isn't necessary anymore, that people have more economic opportunities and more supports, and this and that and the other thing. I mean, I think this pandemic has sort of put that to lie a little bit — the state of working parents. But they did, in oral arguments, also try to argue that the availability of contraception also makes it not necessary for abortion to be protected. And then Justice Amy Coney Barrett jumped in and said, "Well, you know, you could always give babies up for adoption. So doesn't that solve the problem?" And again and again, the attorneys for Mississippi's only remaining abortion clinic and the Justice Department said "No, no, no. The core question of whether a person has the right to control their own body and decide whether or not to continue to be pregnant has not changed." A lot of things have changed since the '70s. That has not changed.

**Rovner:** And one of the big ironies is that, you know, it's always been more dangerous to give birth than to have an abortion. But now that we have an increasing maternal health crisis, it's much more dangerous for the woman to carry a pregnancy to term than it is to have an abortion, which I think did get raised by somebody at the arguments.

**Ollstein:** That didn't come up as much. But it was interesting to me that they did get in a little bit to why contraception isn't the be-all [and] end-all solution because a lot of people are uninsured and can't afford it. And, you know, even if you take it, there is a fail rate. And so there still will be the need for abortion, is the argument that they made.

**Luthra:** And I think the point about Mississippi, in particular, as the state we're talking about is worthwhile as well, given that Mississippi has one of the highest rates in the country of pregnancy-related deaths. We know it is also much worse for Black women — right? — who are traditionally lower income in Mississippi due to many historic reasons and are more likely to be uninsured and face all these barriers that Alice was talking about.

**Rovner:** So how does the Texas case factor into all of this? We're expecting that decision soon. The court rushed the oral arguments on it, but we're not expecting the Mississippi decision until the end of the term, most likely, which would be sometime next summer. Could the court allow abortion providers to sue over the Texas law and then overturn *Roe* before that lawsuit even gets to the Supreme Court?

**Ollstein:** So, yes, we could see that kind of mixed decision. But I think that would happen because the Texas case mostly focused on the weird enforcement mechanism of that particular state law, where private citizens are allowed to bring lawsuits to enforce the abortion ban instead of the state itself. And so the outcome in that case may more hinge on those technicalities than the core questions of abortion rights. And so you could see the court allow the Texas law to be challenged but uphold the Mississippi law and, you know, potentially chip away at or overturn *Roe v. Wade*. But I also think that we could see the Supreme Court just continue to sit on the Texas case, as

they've done for months already, despite rushing to set up the arguments, you know, faster than they've done in a really long time — many years. They have allowed the Texas law, which effectively bans most abortions in the state, to continue for about three months now. And so, I think, because we haven't seen a quick resolution, it could be a while to come.

**Rovner:** In fact, one would expect that it would be focused on that and not on the bigger abortion rights question.

**Luthra:** No, I think the policy of what's happening in Texas is instructive also, right? Because we do have this functional preview of life without *Roe v. Wade*. And what's actually really interesting to me, at least, is that what's happened in Texas has had a direct impact on Mississippi, right? The clinic, Jackson Women's Health Organization, has seen this really dramatic surge in patients coming. And that's because many are coming from Louisiana, right where Hurricane Ida decimated abortion clinics and also a lot from Texas, where people are waking up at 3 in the morning and driving six hours to get there and doing it all again two days later because of the waiting periods. And what it really speaks to is that in this future world we're talking about you're going to see people making these really expensive, arduous treks that will become a regional ... especially as more and more states have the ability to restrict, if not outlaw, abortion.

**Rovner:** Yeah. And before we leave this, we should point out that if *Roe* is overturned, there are 26 states that are ready in one way or another to make abortion illegal. They either have trigger laws; they've passed laws that said, if and when the Supreme Court overturns *Roe*, abortion will become illegal in this state; some of them have pre-*Roe* bans that are still on the books that aren't being enforced because of *Roe*. Some of them are simply ready to act. And if you look at the map, it's basically the South and sort of the middle of the country going all the way up to the Canadian border. There will be big, big swaths of the United States where women will be literally hundreds of miles from the nearest legal abortion clinic.

**Ollstein:** What I keep trying to emphasize in my reporting is that we already live in a country where your ability to get an abortion is dictated by where you live and, in many parts of the country, it's already out of reach for a lot of people, whether due to distance or cost or other factors. And so the idea that should *Roe* get overturned and the country would become a patchwork of access, it already is a patchwork of access. It would just drive the divide further apart. And you would have states like California and Illinois who are already adding staff, adding hours to their clinics in anticipation of a surge. You know, you would see people having to go to those places and, in a lot of places, it would just be completely out of reach.

**Rovner:** Well, the Supreme Court heard two other health-related cases this week that were overworked with this one. I promise we will get to [those] next week. I just wanted to let listeners know that we didn't ignore them, but we're going to do it. Meanwhile, we're going to move across the street to Congress, where lawmakers are looking down the barrel of a crazy, busy December with visions not of sugar plums, but of continuing resolutions, debt ceiling extensions and Build Back Better dancing in Democrats' heads. Let us start with the spending bills because they expire at midnight Friday. As of now, it looks like a handful of Republicans could shut down the government over the vaccine mandate. Somebody explain to us what this is about.

**Ollstein:** This is a gambit by a small handful of conservative lawmakers, and it is not supported by the leaders of the caucus. Mitch McConnell ...

**Rovner:** ... who would rather not shut down the government ...

**Ollstein:** Mitch McConnell said today that he thinks this is a bad idea, that he thinks that the vaccine mandates are already getting blocked by courts and they're going to have other opportunities in the future to weigh in on it. And this is not going to get them the result they want. There's no way Democrats would agree to this, and there's no way President [Joe] Biden would agree to this. It's sort of, you know, the 2013 Obamacare shutdown all over again. So we will see if it gets traction.

**Rovner:** Yes, for those who don't remember, in 2013, Ted Cruz basically single-handedly refused to let the continuing resolution pass as the new fiscal year began on Oct. 1, and we had a two-week shutdown just as we were trying to get healthcare.gov up and running, and it crashed and burned. And I really would not like to relive October 2013 again, if I can possibly help it. What's the status of the Build back better bill? So [it] passed the House just before Thanksgiving? It's now in the Senate. Senate Majority Leader Chuck Schumer says he wants to finish it before the end of the year. Possible?

**Ollstein:** Well, it's always possible. But considering how delayed they are with the spending bill and also the National Defense Authorization Act, which we're hoping to get out of the way by now but have not yet because of fights about other things, it really puts it more in question. So right now in the process, they are going through aspects of the bill with the parliamentarian to see if they can fly under the reconciliation rules. So Schumer said he wants the bill on the floor by Dec. 13. We'll see if that happens. It seems kind of ambitious, but we haven't really even seen the Senate's version of the bill, which was really striking.

**Rovner:** Well, my periodic reminder [is] that the Affordable Care Act passed the Senate on the morning of Christmas Eve. So there's something about the end of the year that sometimes actually pushes Congress to get stuff done. Meanwhile, because there's not nearly enough news, we have a new covid variant to talk about. Sarah, tell us about omicron — or “omnicron,” as President Biden has been calling it.

**Karlin-Smith:** Yeah, so this new variant was first detected in South Africa, although it's important people need to remember that that doesn't mean that's where it actually originated, and there's been a lot of confusion about that. I guess right around Thanksgiving in the U.S. people started hearing about it, and there's been a lot of panic because there are so many mutations in the spike protein of the virus. And that's kind of how we've been able to target it for vaccination and so forth. Right now, the WHO — the World Health Organization — has declared it a “variant of concern,” which suggests they are worried that other “variants of concern” in the past ... maybe it's more transmissible, perhaps. Could it cause more severe disease and things like that? The bottom line right now is that we actually don't know the answers to a lot of these things. So it may possibly be not something we have to particularly worry about. Viruses mutate a lot, and not all of the mutations are harmful to humans, and sometimes they actually mutate in ways that are

beneficial. So I think we need to wait a few weeks to really get a better sense of how much we need to be worried about this. Of course, they think right now, despite President Biden's comments early in the week, that we don't need to panic yet. It does sort of feel like people are already gearing up to be in panic mode over this.

**Rovner:** I know it's, you know, public health officials are trying to walk this line between expressing concern, but not causing panic, by encouraging everyone to get vaccinated and encouraging those who are already vaccinated to get boosters. But as we already mentioned, there's a building backlash to vaccine mandates, hence the spending bill possibly getting held up. Might something about omicron change this? I mean, there does seem to be, since we've been talking about this, there does seem to be more people lining up to get the boosters, which is probably not a bad thing, even if it's not because of this.

**Karlin-Smith:** Right. In terms of people needing boosters, particularly, we know uptake among older Americans, where the case for boosters is really strongest, has been fairly low, including in nursing homes and places where people tend to be really at higher risk of the disease spreading. So, right, even if this variant doesn't turn out to be problematic, you're still dealing with delta and pretty big waves in a lot of parts of the country and winter coming. So it's a good idea. Again, one of the questions that we don't have an answer to that I didn't address before is: How will this variant impact the vaccine? So, does it interfere at all with the vaccine's ability to add protection? So there's a lot of questions there. And you know, I did find it a bit strange that CDC [Centers for Disease Control and Prevention], early this week, when they fully took off any restrictions on who qualified for a booster in the U.S. As long as you're over 18, they're now saying you should get one instead of, before, there were all these caveats that kind of basically anybody who was over 18 could get one now, but they were kind of like ... there were subtle language distinctions around, you know, whether you really should or whether, you know, you might want to consider it. And now they're just saying everyone should, and they're using this new variant as the justification. And that seems a little bit, again, unfair based on what we know about the variant so far.

**Rovner:** Which is not much!

**Karlin-Smith:** Right! It probably would be better to just make the case that we think you need a booster because of current situations, not because of unknowns about a variant, which, again, we don't know how problematic it's going to be, and we don't even know how good the vaccine will be at addressing this variant.

**Rovner:** So the Biden administration, which I imagine is less than thrilled about yet another possible covid surge, today is putting out what it's calling its winter covid plan. Most of it feels pretty familiar: masks, distancing, vaccines. But there's one kind of new twist with making testing more available. What's that about?

**Karlin-Smith:** Yes, they're going to require private insurance companies to reimburse people for over-the-counter tests. Right now if you go to a testing site and get tested, most insurance has to cover your costs, but if you go buy one of the over-the-counter take-home rapid tests at CVS, you don't [get it covered]. I think this is probably one of the most significant things in their plan. And

yet at the same time, there are a bunch of caveats, so it only applies to people with private insurance. It doesn't apply if you have Medicare or Medicaid. You do first have to pay fully — right? — out front and then get reimbursed, which [for] anybody who's dealt with that in the U.S. health system knows it can be a pain. It also doesn't deal with people who are uninsured at all. And the Biden administration is saying, you know, they're going to make a push to make more of these tests freely available at local public health sites and clinics. And that's good. But I think what I'm seeing is a lot of people are raising health equity issues, which is the people that most need access to these tests and most need help affording these tests might not have access. And then, of course, that doesn't even get into the issues we know the U.S. has been struggling with: actually having enough supply of these tests, regardless of the price or affordability.

**Rovner:** I was just going to say, and I've been beating this drum for weeks that, you know, people who come back from Europe say they're available for a dollar at the grocery store or they're available for free everywhere. A lot of people are coming back from Europe and bringing handfuls of them back. I mean, it's not that these tests are that expensive to make, but somehow I guess we decided in the summer when it looked like things were getting better that, you know, all the companies that were making these tests decided not to make enough, and then everybody went back to school and they wanted tests. And now, you know, if you can find them, I mean, if you have a couple of kids who are going to activities and you want to, you know, test them frequently, it turns into a lot of money pretty fast.

**Ollstein:** Another issue with the new plan is that it doesn't start until mid-January and it's not retroactive. You can't get reimbursed for tests that you took before then. And so anyone who was hoping that this could go into effect so they could test before holiday gatherings is out of luck.

**Rovner:** Yeah, they have to buy them themselves.

**Ollstein:** Right. They have to pay out-of-pocket.

**Rovner:** The new covid pill, which is moving forward from the FDA [Food and Drug Administration] advisory committee, may be not as big a breakthrough as we thought a couple of weeks ago, from Merck's press release?

**Karlin-Smith:** Right. I think a few weeks ago, people were really excited, saying, "This is a game changer in our management of covid to have a simple-ish pill you could take at home to help prevent people from getting really sick and hospitalized." Unfortunately, as we got more data on this particular antiviral, it turns out that the final data from the study shows it's still a significant reduction in risk of hospitalization and death from the pill, but it's not quite as strong as the interim data is. So people are a little less enthusiastic and partially because there's some safety concerns as well with this pill. Right now, it doesn't look like it's really going to be recommended much at all for pregnant women due to concerns about risks to the developing fetus. There's also what some people say really is just theoretical, and we don't have to panic about it. But because of the way this drug works, people worry it could encourage the virus to mutate in ways that could be harmful. I think that it got a kind of a positive but not overwhelming endorsement from an FDA advisory committee. It probably will have uses for some people, particularly those, again, most

likely to suffer severe outcomes from covid. But we don't know a lot about, say, what the impact would be if you're fully vaccinated and get covid. Do you really need a pill like this? And would it be helpful? It seems like this is going to kind of be something that might hold us over until ... or maybe we'll get it cleared around the same time as Pfizer's antiviral.

**Rovner:** I was just going to say there's ... that's another pill in the pipeline.

**Karlin-Smith:** Right. That seems to both not only have better data so far. Of course, again, we could always be surprised because we've been getting a lot of press release data and then they'll fill it in later. But it also doesn't come with the same safety concerns. So I think that that's probably going to be the pill that gets people excited once it's cleared, more than this Merck pill. But, you know, it's a positive incremental step.

**Rovner:** Well, because, of course, this is all so clear. I spotted a story out of Maine about a doctor actually having his license suspended for spreading covid misinformation. According to the story, Dr. Paul Gosselin has been suspended for 30 days by the Maine Board of Osteopathic Licensure, although the specific allegations are not yet public. I've seen lots of states open investigations into doctors spreading misinformation, but this is the first actual action I've seen by a licensing board. Has anybody else seen doctors actually getting punished? I think in this case the doctor was writing people excuse letters to not be vaccinated that were possibly ... that they ... for which they did not have legitimate medical reasons not to be vaccinated.

**Karlin-Smith:** I mean, we've seen a lot of, oddly enough, permission for doctors to do things that are not medically recommended. We've seen courts, you know, uphold the physicians' rights and patients' rights to kind of get drugs we know are likely not going to have any scientific evidence of curing covid. So this seems kind of significant that someone's getting punished to a degree for giving out poor medical information in this country.

**Rovner:** Well, speaking of covid misinformation, we have a new partisan divide, which is over natural immunity, with Republicans claiming that people who've recovered from covid should be considered vaccinated because they have natural immunity. But that's not really how this works, right?

**Karlin-Smith:** Right. It's really complicated because nobody denies that you don't get any kind of future benefit from having been infected with covid. The question really becomes: When were you infected? How bad was your infection and what your body's response? And it's a lot harder for scientists to know how much protection any one person received from having the virus. And, say you had the virus very early on in the pandemic, you might not be best positioned to respond to the delta variant. So it's much more predictable the protection you'll get from a vaccine and it's more of a gamble to hope that your previous exposure will protect you. And, you know, as we've seen with the vaccine, most people need at least two shots to be well protected. And that's because there's this idea of you sort of prime your immune system and then you give it another boost. And I'm talking more about the second shot than this third booster — you know, later. And that kind of helps your body really be fully prepared. So some countries have been willing to say, if you had a prior infection, you can only get one shot of a covid vaccine and consider that, for now,



fully vaccinated. But I think everybody widely recommends you at least get some form of vaccine ... that one infection is not enough to protect you long term.

**Rovner:** I find the irony here, that every public health expert I've seen has said, that the most protected people are the people who had covid and *then* got vaccinated — that if you had it and you get the vaccine, you're even in better shape than people who've gotten two vaccines and a booster. And yet still, these are, among the people who don't want to get vaccinated, are the people who already had covid. So it is ... people's reactions to public health continue to leave me puzzled. All right. Well, that is the news for this week. Now we will play my “Bill of the Month” interview with Blake Farmer, and then we will come back with our extra credits.

We are pleased to welcome to the podcast Blake Farmer of Nashville Public Radio. Blake reported the latest KHN-NPR “Bill of the Month.” Thanks for joining us, Blake. I'm a big fan of your work.

**Blake Farmer:** What?! Likewise. Thanks, Julie.

**Rovner:** So we have a twofer this month, a husband and wife who ended up in two different emergency rooms and got two very different bills. Who are our patients?

**Farmer:** Well, yes, they are patients together. They are a couple in their late 40s, Jason and DeeAnn Dean, they live here in Tennessee, where I'm based, just moved back to where DeeAnn actually grew up in a small farming community called Dellrose. It's just a little north of the border with Alabama. They're sort of young, empty nesters, kind of starting new careers all around ... kind of fell when the pandemic did. They've got big ideas for a health and wellness business paired with organic farming ... anyway. They're on their own for buying insurance, is what that means. So they do have a high-deductible plan, which they were very aware that this was kind of a risk that they were taking. And then, of course, they actually needed to use that.

**Rovner:** So let's start with Jason. He cut his leg at work. It bled a lot. So he went to the ER for stitches, which seemed not an unreasonable decision. Then what happened?

**Farmer:** Well, yeah. And looking back, he does wish he'd tried an urgent care, perhaps. But there aren't all that many options in their small town. So, let me say, he was not covered by an employer's workers' comp insurance because he was working as an independent contractor, kind of doing this in-between construction work. So Jason knows that he does have this high-deductible plan, but goes to the ER thinking maybe he'll end up paying, you know, \$800 or \$1,000. They tell him his insurance will cover it, and he's not quite sure whether that even matters since he'll kind of be on the hook for all the costs with his high-deductible plan. But he goes along, and of course, no one ever tells him a real price. And even though he was bracing for a pretty hefty bill, he was really left speechless when it arrived.

**Rovner:** Because it said ...

**Farmer:** He got two bills, actually, and one of them was from the hospital, asking him to pay about \$3,400. And then another one from a physician asking him to pay about \$900. So a total \$4,300 for six stitches in his knee. That was 30 minutes in and out of the emergency department. They were just like, “You know, this can't be right.” You know, these bills. So they start the process of

questioning those bills, which you know, many of us have been through. And it's quite a maze of the phone tree. And this was right around August. And then, of course, his wife gets sick.

**Rovner:** So now DeeAnn doesn't feel well and — surprise! She resisted going to the ER at first, right?

**Farmer:** Yes, she did resist. And you know, that's understandable. But she is told by her doctor to go to the emergency room, she's got these symptoms. She's thinking it's covid. She hadn't been vaccinated, which she was kicking herself at the time for doing. She's since been vaccinated. But she tested negative for covid. So she was still having all these symptoms, getting really ill — I mean, sicker of than she'd ever felt, she says. But she refused to go back to this hometown ER that they were kind of fighting these bills with. So she tries going down into Alabama. But the ER there is flooded with covid patients, she wouldn't be seen all day. Eventually, she goes north to this public hospital just outside Nashville, in the city of Columbia. She gets in, has this battery of tests. They rule out everything and decides she has Rocky Mountain spotted fever, likely from a tick bite. She did not develop the telltale rash that goes along with it until going home from the hospital. So they didn't think of that initially, but they put her on some antibiotics. She starts recovering pretty quickly. It's a pretty simple solution, but Rocky Mountain spotted fever can be deadly or lead to organ damage if it was left untreated.

**Rovner:** Yeah, I mean, this really was an emergency, and it required some sophisticated diagnostic gear. So how much was her bill?

**Farmer:** You know what? She ended up being asked to pay about \$600, which she was equally shocked, given the treatment that she received was with the same high-deductible health plan.

**Rovner:** And why were the amounts so different? I mean, the hospitals were what, an hour from each other?

**Farmer:** Yeah. You know, honestly, it's hard to tell from what was billed to her insurance, and she's really not asking too many questions, given she expected to pay so much more. Her insurance bill was for a Level 4 emergency room visit. As listeners probably know by hearing stories like this, there are five levels when you go to an emergency room. The fifth being, like, you know, you came in having a heart attack. Level 4 is pretty serious. Now, Jason, who was in this smaller emergency room with his stitches, he also was billed for a Level 4 visit, which is what they're arguing is way too high for this sort of simple cut that he had repaired. Even still, his level for ER charge was, you know, more than five times as much. Pretty hard to explain why.

**Rovner:** What eventually happened with Jason's bill? Are they still fighting it?

**Farmer:** Well, they are waiting to see how the hospital responds. They are moving beyond the letter-writing stage, where they've offered to pay about a thousand dollars, which they've kind of done their research, figured out this was fair and customary, is the language they use, for six stitches like this. You know, it is worth noting, I will say, Julie, that the hospitals, as you point out, they are different kinds of hospitals. The hospital Jason went to is owned by a hospital chain called LifePoint [Health], which was taken over in recent years by private equity investors. The physicians

who staffed the ER in that hospital are also private equity backed. They're from TeamHealth, which is one of the largest operators of emergency rooms in the country and is, frankly, fighting off lawsuits from insurers that are accusing it of systematically overcharging for these fairly routine procedures. Now, the hospital DeeAnn wound up at, Maury Regional, is publicly owned by the county government. Of course, that does not mean that you won't get a big bill, especially when you're talking about an emergency room visit. They are often run by these same contract management groups like TeamHealth. In fact, it seems TeamHealth runs this ER, but for whatever reason, she escaped a big bill. You know, call it luck of the draw.

**Rovner:** So what's the takeaway here? I mean, neither of these ER trips seemed optional. He was bleeding. She obviously had what could have been a life-threatening disease. Do you just have to kind of flip a coin and hope for the best?

**Farmer:** You know, the Deans are definitely rethinking their high-deductible plan, as you can imagine. You know, they just figured they were in good health, no chronic conditions. But like you say, Julie, what sent them to the ER — the both of them — were unexpected, so the risk they were taking suddenly became reality and not so much worth it when you're kind of at the mercy of whatever ER is going to charge you for your health plan. You know, even if you could do your homework ahead of time about who owns it, you don't know what you're going to walk out of there with. Urgent care probably would have been a better option for Jason had he thought of it at the late hour after work. He just didn't think it was an option in their small town. It's not like they're on every corner. DeeAnn knew that she needed to go to the hospital, as you say, and she's glad she made that extra effort and had the means to travel an hour to an emergency room. In fact, her parents ended up taking her. They certainly do have this bad taste in their mouth from their hometown hospital, and their real concern is more for their community, which frankly is lucky to still have a hospital at all. But as DeeAnn told me, you know, it still doesn't give them a right to charge everybody with private insurance so much.

**Rovner:** We will keep at it. Blake Farmer, thank you so much.

**Farmer:** You're welcome.

**Rovner:** OK, we're back. 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](http://khn.org) and in our show notes on your phone or other mobile device. Alice, why don't you go first this week?

**Ollstein:** Sure. So I chose a piece in The Washington Post by Rebecca Tan that is about abortion funds. These are these mostly volunteer-run groups around the country who are raising money to assist people who want an abortion but can't afford it, can't afford to travel for it. And, so, this is an interesting piece looking at efforts to coordinate around the D.C. area — between D.C., Maryland and Virginia — so that there's just one number people anywhere can call to get the help they need. And they are also, you know, staffing up because they're expecting the call volume and the number of people asking for help to just increase exponentially if there's a decision from the

Supreme Court next year that further restricts abortion rights. And so I think this is sort of an overlooked piece of it and something that is happening now in anticipation of such a ruling.

**Rovner:** Yeah. And I should point out, I mean, these abortion funds were mostly started in states where abortion was legal and available, but not paid for, particularly by Medicaid. So it was difficult for low-income women to, even if they could get them, they couldn't afford them. And so these abortion funds were started to help people to actually help women fund them. Sarah.

**Karlin-Smith:** So I looked at a story from Bob Herman in Axios called "[The Push to Revive an Industry-Backed Medical Device Rule](#)." During the Trump administration, CMS tried to implement a rule that would have basically required Medicare for at least a set number of years to automatically cover any device cleared by FDA that had gotten breakthrough status. The Biden administration has moved to revoke that rule. But there's a few efforts in Congress, particularly by some bipartisan lawmakers who get a lot of funding, as Bob notes, from the medical device industry to get this bill enacted. The issue has always been, with this idea, that FDA grants breakthrough designations very early in a product's development. So even if the product gets cleared, sometimes they don't end up being ... as the data has come out for the device, they don't end up being quite "breakthroughs" in a way that some people might think of. And the other thing is, there's always been this difference between FDA approval and their safety and efficacy and determinations. And then what Medicare has authority to do, which is, is it deemed reasonable and necessary for their population? And I did a whole panel on this last year. But, you know, people argue there's a lot of reasons that Medicare needs to have its independent authority to not just be a rubber stamp and cover everything FDA cleared. In particular for this medical device rule, one of the things Medicare and the Biden administration has raised is just because FDA cleared it doesn't mean it was studied in the Medicare population and people over 65. So it's an interesting thing. It's not something that's going to die. And, in general, even beyond breakthrough medical devices, there's a lot of push-and-pull over the years as to whether Medicare needs to just automatically cover everything that's FDA-approved.

**Rovner:** Yeah, it raises a whole lot of side issues in this story. Shefali.

**Luthra:** So this is a story by my favorite colleague, Chabeli Carrazana. She wrote it for The 19th, and the headline is, "[‘Am I Even Fit to Be a Mom?’ Diaper Need Is an Invisible Part of Poverty in America](#)." And it's this beautiful piece where she traveled to Missouri to visit a diaper bank, and she writes about diaper poverty, which is this really troubling issue for many new moms in particular, right? Diapers are unaffordable if you live in relative poverty; it's not covered by most welfare programs. And so these diaper bags, like the one in Missouri, have emerged to try and fill the need. There's efforts in Congress to try and get some sort of legislation passed that would help alleviate diaper poverty, but nothing has really taken off. And there's this anecdote in the story, and I recommend reading the whole thing because it's just so human and moving. But she talks about one woman who sold all of her silver jewelry for \$20 to buy one pack of diapers for her child. And what it speaks to, right, is when moms can't buy diapers, they question whether they can be good mothers. And what we find is that diaper need is one of the biggest drivers of postpartum depression, right? More than food insecurity, more than housing instability. And it is pretty much always moms who are the ones skipping their meals and giving up their other needs

to pay for diapers. This is such an important policy issue, such an important health issue, and I think it really merits more discussion, and I'm glad she spent some time with it.

**Rovner:** I would point out for those regular listeners, this is our second diaper story in a month. Sarah, I think you did the earlier one, but it is a really important and really sort of undercovered issue. And I feel, as we talk about reproductive rights so much, this is something that we get so excited about. You know, women having babies and then we kind of abandon them afterwards. So it's really important. And as Shefali points out, it's not just a story about poverty, it's a story about health. Well, my story is from my KHN colleague Sarah Varney, and it's a TV segment that appeared on the PBS NewsHour called "How Unresolved Grief Could Haunt Children Who Lost a Parent or Caregiver to Covid." It's about how at least 140,000 children around the United States have lost a parent or caregiver during the pandemic. And not only are there no programs to help them specifically, but, say experts, the trauma could affect them and those around them for generations to come. There's a line that really stuck with me of one mom who's now struggling to support her two daughters after her husband, who was a truck repairman, died of covid after being declared essential and required to go to work. She pointed out that if he'd been in the military, there would be a safety net for her family. Except there isn't because he wasn't, which feels like a pretty big oversight.

OK. 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. Get those questions in for our "Ask Us Anything" episode coming up in a few weeks. We're at whatthehealth — all one word — @kff.org. Or you can tweet me, I'm @jrovner. Shefali?

**Luthra:** I'm @shefalil

**Rovner:** Sarah.

**Karlin-Smith:** I'm @SarahKarlin

**Rovner:** Alice.

**Ollstein:** @AliceOllstein

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