

KHN's 'What the Health?'

Episode Title: Much Ado About (Vaccine) Mandates

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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](https://www.wfyi.org/podcast/sick) 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, Dec. 9, 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 Joanne Kenen of Politico and the Johns Hopkins School of Public Health.

Joanne Kenen: Hello, everybody.

Rovner: Sarah Karlin-Smith of the Pink Sheet.

Sarah Karlin-Smith: Hi, Julie.

Rovner: And Rachel Cohrs of Stat News.

Rachel Cohrs: Good morning.

Rovner: Well, no interview this week, but more than enough news to make up for it. So if it is December, which it is, there's likely a must-pass bill for Congress in order to avert Medicare cuts. These are known on the Hill as "Medicare extenders" — I'm using air quotes — because they are policies that have to be periodically extended or else they expire and cost providers money. That's something that does not go unnoticed by doctors, hospitals and other Medicare providers whose lobbyists frantically run around on Capitol Hill looking for a bill to attach these year-end policies to. Except this year, it looks like the Medicare extenders bill will serve as the engine and not the caboose. It's part of a compromise that will, if I understand it correctly, allow Republicans to vote for the Medicare provisions, which tend to be bipartisan, and make a temporary change to the Senate filibuster rules so the Democrats can raise the federal debt ceiling and avert a financial catastrophe without Republican votes or a Republican blockade of the debt ceiling bill. Am I describing this all right? Or can it all just kind of be chalked up to Congress doing its job, Rachel? You're following this, right?

Cohrs: Yes, I have been following this, and I think something that's interesting and important to point out is that this package of Medicare policies isn't our typical "Medicare

extenders” that we usually talk about. It’s a new breed of Medicare extenders because providers got a lot of relief during the covid-19 pandemic. So we’re looking at three main policies. There’s a 2% what we call “Medicare sequester” cut. That had gone into effect in 2013 and had stayed in effect until the CARES Act last year. So providers had gotten used to those cuts. But once they get relief, they don’t want to let go of it. So I think that was one aspect. Another one was a workaround for a Trump administration rule to make sure physicians are paid more because they were trying to pay primary care providers more. But then it’s a zero-sum thing. So when you give some money to one person, you’re taking it away from another specialty. And then there’s also, just because Democrats have been using this budget reconciliation process with only 50 votes to work on their legislation throughout the year, they triggered additional Medicare cuts of 4%. So, adding up, for some physicians, it’s almost like 10% cuts that they were facing. So Democrats and Republicans did reach an agreement on how to head off some of those cuts, at least into early next year. They didn’t completely make them go away, but it just allows the provider lobbyists to live another day and potentially head those off in February.

Rovner: It’s important to remember this all goes back to budget negotiations, big budget negotiations, that say if Congress spends too much on X, then they’re going to have to cut Y. I mean, these are all about going after Medicare because it’s the big piece in the budget. And I think it’s important to stress that most of these cuts — in fact, virtually all these cuts — don’t affect patients. They just affect provider payments.

Cohrs: But then the argument is that if we have less money, then we can offer less to patients. That’s the interplay there.

Rovner: This bill, we’re still sort of negotiating over the big social spending Build Back Better bill, but it looks like the wheels seem to be greased and it’s going to happen.

Cohrs: Yes, I think [Senate Minority Leader] Mitch McConnell said on Tuesday that he expects to have 10 Republican votes to pass this. It’s been very controversial because raising the debt ceiling is very controversial, and doing it on a bipartisan basis these days is very controversial. But he says he has the support. I think they’re expected to vote on it in the Senate today, and then the House will take it up at a later time. But I think the plan is to avert the debt ceiling on a bipartisan basis.

Rovner: And take care of Medicare.

Cohrs: Yes. Both.

Rovner: Which will knock two things off of our continuing agenda. Well, let us move to covid. What’s the latest on what we know about the omicron variant, Sarah? I’ve seen all kinds of stuff. It spreads twice as fast, but it doesn’t cause as severe disease. Is that kind of, sort of what we think now?

Karlin-Smith: It seems like the scientists are leaning in that direction. But, again, there’s still a ton of caveats, that we need to learn more and study this more deeply, because one thing that’s important to think about is every population that this is impacting in different parts of the world come to it with different levels of prior covid infections, different vaccine

status. So one thing I've seen is when looking at people in South Africa, a lot of people had prior infections. A lot of South Africans tend to be younger on the whole compared to the U.S. So you have to be very careful comparing this, and they're still learning. Right now, that does seem to be the general theme, though, is it's likely more infectious but potentially not as severe. But the issue, of course, is at the rate — they think it is more infectious. If that many more people get infected, it could still be just as big of a crisis for our health care systems and end up leading to just as much severe outcomes. And we're also starting to learn more this week about how well the current vaccines do against ... protecting against the variant. And, again, a lot of this data is very preliminary. It's looking at lab studies in small populations, and these lab studies are looking at one aspect of immunity or antibody response to the virus — not your much more complicated immune system. But there does seem to be some consensus building that the vaccines don't do as great a job neutralizing this version of the virus, then some of the prior strains we've been facing.

Rovner: And speaking of people who lack immunity, I saw an interesting press release from the FDA [Food and Drug Administration] this week. I didn't see a lot of coverage of this, but apparently they've approved, at least for emergency use, a new monoclonal antibody that will be used as a preventive, not necessarily as a treatment for people who are immune-suppressed and might not respond well to the vaccines. Is this potentially a game changer, at least for those people who have been frantic, even though they've been vaccinated? They don't really have much protection?

Karlin-Smith: Right. I mean, this seems like it'll be helpful for people that, either for whatever reason had some kind of allergic reaction or inability to get the vaccine or, again, have gotten the vaccine but because of an underlying disease or condition or the state of their immune system don't really respond well to it. So basically, you get like a prophylaxis two-course treatment of this AstraZeneca monoclonal antibody combination. And the hope is that this is also in combination with the vaccine, if you're able to get that booster protection. And of course, we know protecting the immunocompromised is also good for all of us because there's lots of speculation that when the virus does tend to mutate, it often mutates in people who have the most trouble fighting it off and have these prolonged infections because of that.

Rovner: So, basically, the immunosuppressed is where more variants can come from.

Karlin-Smith: Right. That's one theory. You know, what happened with this current variant. Though, again, there's multiple theories, no sort of proof and so forth, but it's always good to protect the most vulnerable among us. It adds benefits to all of us.

Rovner: So while it seems that there's more reason than ever to encourage people to get vaccinated, Republicans on Capitol Hill have launched a legislative attack on President [Joe] Biden's vaccine mandate for private employers, which, for what it's worth, isn't even really a vaccine mandate. It's a testing mandate that you can get out of by getting vaccinated. In any case, Republicans are using the Congressional Review Act, which allows fast-track votes with only a 50-vote majority needed to try to cancel the administration's rule, because mandates are not popular in general (see the Affordable

Care Act requirement for people to have health insurance). The Republicans managed to pass this with the votes of two Democrats: West Virginia's Joe Manchin and Montana's Jon Tester. And in the House, while the Democrats aren't going to bring this up, there is an effort by Republicans to get a majority of members to sign a discharge petition, which would bring it directly to the floor. Remember, they would need to turn only three Democrats to make that happen. Now, President Biden has said he would veto this if it got to him, and Congress would need its regular two-thirds to override. So it seemed unlikely that this will happen. But if it's not going to happen, why are Republicans doing this? Do they really think they're going to make hay with their voters?

Kenen: Yes, and that's why they're doing it. I mean, we've seen the politicization of vaccine get sharper and sharper and sharper and sharper, and we've talked many times about the politicization of the pandemic and how those of us who cover health care politics still didn't ever expect a mask to become a symbol of liberty as opposed to a way of keeping out germs. So there's anti-vaccine sentiments on left and right. It is not — one side doesn't own it, but one side has become larger and more impassioned and more political about it. So we've really seen this become, now, in Congress ... and there are probably two Democrats, possibly three — not all Democrats are entirely comfortable with the vaccine mandates as it becomes more political and they're from purple or redder states ...

Rovner: ... or even states with a libertarian bent.

Kenen: Right.

Rovner: I mean, I'm sure that's why Jon Tester ended up voting for this.

Kenen: Montana's ended up pretty reddish now.

Rovner: It is pretty reddish, but it's also *really* libertarian.

Kenen: Yes. So at every step of the way, on vaccination, [it] has become more political. And in Congress, particularly in the Senate and a lot of House Republicans, too, did promote vaccination. But now you even have some who are promoting vaccination but opposing mandates, you know, because there's still this scientifically ridiculous way of talking about vaccines. Is it something that's just about me? When you're talking about an infectious disease, it is about everybody. If it is something that only affects me, if I want to do a risky sport, I'm risking myself. But if I'm risking becoming infected with an infectious disease that I could give to others, such as the immune-compromised, whom we were just talking about, it is not just about me and my body, it is about my community, my society, my family, my friends, my co-workers, the people I go to church with, whatever. So that still doesn't get through. It has become this symbol of liberty, and it's getting more intense, not less intense.

Rovner: And oddly, I mean, one of the things that I keep seeing, you know, in my social media feeds are doctors in parts of the country, particularly now in the Northeast, that are getting really hard hit by delta. I mean, we're not even talking about omicron yet. We're having a delta surge in a big chunk of the country. Hospitals are overwhelmed. Patients

who want non-covid care are having trouble getting it. Hospitals are starting to stop, you know, elective surgeries again. And yet people are still, you know, so consumed with the “this is my individual right not to get vaccinated.” ... Well, if you get hit by a bus and you go to the hospital, you're going to have a problem because all the people who exercise their individual right not to get vaccinated are now crowding hospitals with covid.

Kenen: Well, we've been here before and we're going to be here again. This is just not over. I mean, it comes in waves. Sarah outlined some — I don't want to say hopeful, but relatively hopeful — signs that ... I mean, I think that we can be reasonably confident that omicron [AH-micron] or OH-micron — and the fact that we can't even agree on how to pronounce it, you know, how can we agree about anything else? Well, I think we can be reasonably confident — although none of us are ever confident about anything with this virus anymore — but I think we can be reasonably confident that it's not the worst-case scenario, right? When it first emerged over Thanksgiving weekend, everything awful was on the table. We do have some immune protection from the vaccines and prior infection — we don't know how much. We do have some vaccine efficacy — we don't know how much. There are some hints, as Sarah mentioned, that it might not cause a serious illness, although if it causes a lot of illness, it still means there are crowded hospitals. So we don't know a lot. But, you know, I don't think people are quite as panicked as they were the day after Thanksgiving. But it's a bad situation, you know, and we've talked a lot about poor countries not having enough vaccination, but they're also having plenty of vaccine-hesitancy issues of their own for a whole lot of reasons, some of which are similar to vaccine hesitancy in our country and some are unique to their own circumstances.

Rovner: Yeah, I mean, sometimes I'll throw up my hands and think, Ugh, we're just such children compared to the rest of the world, and then I'll look around and say, No, pretty much everybody around the world is tired of this and they want it to be done. And some people are just sort of declaring it done when it's not. And it is not unique to the United States.

Kenen: No. And nor is the politicization. You've seen demonstrations in much of European countries about vaccines, about shutdowns, about all sorts of stuff. It is tapping into other political trends and political insecurities.

Rovner: So in the meantime, one of the interesting things that happened this week is that, in New York City, Mayor [Bill] de Blasio ordered all private employers to require vaccines or testing for their workers — the first big city to do this. Are we going to end up where primarily blue areas, which are already more vaccinated than primarily red areas, are basically fully vaccinated and red areas are not? I mean, are we going to end up with this patchwork of some parts of the country are going to be a lot safer than other parts of the country? Or does the fact that everybody moves around a lot mean that everybody is going to be unsafe until everybody is safe?

Cohrs: Yeah, I think with that mandate and just all the other ones in the works, I think it'll be interesting to see how the courts turn out on this, whether this goes to the Supreme Court, how ... if they decide, how sensitive that decision is. But you know, certainly it is very different at the local level right now. And you see the governor of Michigan, you know,

saying some states have certain mandate policies [but] I don't want to do that right now. So I think, you know, we may see more uniformity depending on how this works through the courts, but until then, there definitely is a disparity.

Kenen: But we've seen that pre-vaccination. I mean, we've seen that in terms of when there were stay-at-home orders, you know, how strict were they, how long did they last? How were they lifted and where were they lifted? You know, we've seen that since 2020. We've seen that since March and April of 2020. Since the very beginning, some states have had mask mandates. Some states have not had mask mandates, some states restricted certain bars and, you know, tattoo parlors or whatever and other states did not. It has been an inconsistent response, largely, not 100%, but largely along red-blue political lines since the beginning. And it's one reason we're in the mess we're in.

Rovner: So meanwhile, we are still, after almost two years, unable to figure out how to get people tested in short order, either prophylactically or for those with symptoms. We talked a little bit last week about how the Biden administration's quote-unquote "winter covid strategy" includes requiring insurance companies to reimburse covered people who buy at-home tests. But that doesn't even start until mid-January, and it's not retroactive. Why is this so hard? This seems to be one of the things that other countries are managing to do that we are not.

Karlin-Smith: One problem the U.S. has faced here is we have less of these tests approved, so there's less competition, so the companies making them are charging more. Even the tests that are approved in the U.S. are often available much cheaper overseas.

Rovner: Or free! I mean, apparently they're being handed out!

Karlin-Smith: Right. And I think what public health experts say about these tests is that's really the best way to actually get them to be used and used frequently enough to make a difference. And the U.S. is so far really resisting that call. There is a[n], I think, infamous now snide remark, and maybe that's not the best way to put it, from President Biden's press secretary at a White House press briefing this week, where she was pushed about why the White House isn't doing more to make these tests more available, more affordable. And she said, Well, what do you want us to do? Mail one to everybody? And actually what most people are saying is, yes, not only mail one to everybody, mail lots to everybody and don't charge. Because we just know that the lower the barriers to access and the more we give these to people, the more they're likely to use them. But right now, the policy the Biden administration is going to put in place in mid-January only applies to people with private insurance who are going to have to dole out your money first and then try to deal with getting reimbursed. It's not clear what they will actually reimburse you for. So are you going to have to prove you had some sort of medical symptoms that made you want to get a test versus deciding, OK, I have a family wedding to go to, but I want to be safe and make sure I'm not infectious first. They might say, Well, that doesn't count. And so basically, it's been a big struggle in the U.S. to really implement these broad, sweeping public health measures in the way that other countries are just more used to tackling public health.

Kenen: They have to be both affordable and easy to get to. To say, well, those of you who are privately insured can submit a claim, you know the way Sarah just outlined versus, you know, they're going to be at community health clinics, they're going to be at places like that. You can go get one if you need it. They just have to be accessible. They have to be someplace you don't have to skip work [for], you don't have to hire a babysitter, you don't have to get on three busses to get to the clinic. They've just got to be in your home or really visible. There are some places we've seen some pop-up centers for testing, you know, a tent. So if you're going to have them in some combination of mailing them to people. I think one of the arguments about mailing them is "some people won't use them and it'll just cost money and they won't use them." So maybe come up with some hybrid that you mail some, but you also have them visible, free, cheap, you know, in the pop-up tent ...

Rovner: Or, I think, in Europe they're at the grocery store and at the convenience store.

Kenen: Just make them where you can get them, make them where you can get them, and where it's easy to get them and where it's not 9-to-5, and where there's no barriers and there's no language [barriers]. And, you know, the word public-health people use, and we've used it at times, is "layers." There's not one solution to fighting a pandemic that's this deeply entrenched. You need to do lots of things. Lots of protective layers, lots of surveillance layers, lots of tools. So, testing, yeah, if you were to go to a wedding or you're going to have people over for Thanksgiving or whatever, whatever, whatever, you know, make sure you're not infected. And also these new drugs, particularly the new Pfizer drug and the others in the pipeline, they seem to be really, really, really effective and really important in saving lives. But you've got three days to take them, and sometimes your symptoms can be really, really mild or, as they start out, really mild. So to have the incentive, do I have a sniffle today or ... is this the beginning of covid? Because I've got three days to find out and get that medicine! Particularly for high-risk unvaccinated people, you need testing available, and those home tests you would want to confirm it if you think you're sick. You'd follow it up with a PCR [test]. But as one layer, you got to have testing. Aaron Carroll last night and The [New York] Times had a really good explanation of how these work and how we have to think about them.

Karlin-Smith: Particularly now that we know, again, that yes, the vaccines are really good and generally very protective. They're not foolproof, and we have a society that has been resistant to, you know, most restrictions — our activities and behavior. ... Public-health people call these harm-reduction approaches. And we're used to thinking about this, I think, in some other sectors of public health — like condoms for safe sex, PrEP maybe for HIV — but we sort of have to get that ingrained in our society, like, sure, OK, fine. You guys can all go to this concert and take that risk because it becomes much safer if everybody has this cheap, rapid test beforehand. And without that, we're just, again, we're kind of allowing this pandemic to keep simmering and burning.

Kenen: It's the difference between taking a test and keeping your fingers crossed.

Rovner: Exactly. All right. Well, we spent a whole lot of time last week talking about the Supreme Court and abortion. So much time, in fact, that we didn't even mention that the

high court also heard two other health cases, significantly less high-profile, but still important. One of those cases has to do with the 340B program. That's a federal drug discount program for facilities that serve low-income populations. We have talked about it before. Specifically, hospitals are seeking to reverse a cut to the program made by the Trump administration and allowed to continue by the Biden administration. But one way or the other, this case is going to create winners and losers in the hospital community, right, Rachel? This is sort of like what you were talking about before. If one hospital, the cuts that they made went to other hospitals, and if the cuts get reversed, those other hospitals are going to lose them?

Cohrs: Mm-hmm. That's right. And I think that came up during the arguments, too, that there are hospital groups, associations that are on different sides of this case. And this ... specifically, there are some metrics that a hospital has to meet to be eligible for these 340B drugs, related to, I think, like Medicaid inpatient hospital days. So I think some hospitals really benefit. But the for-profit hospitals aren't eligible for these benefits at all. So they think it's kind of unfair that they don't get them. And some studies say that they provide similar levels of uncompensated care to nonprofit hospitals. And again, not all not-for-profit hospitals qualify for these, either, and it's both of these cases. I think it was interesting to listen during oral arguments that the justices are a little frustrated sometimes, and were just like: "These formulas are so complicated. How are we supposed to understand it?" Most of the commenters didn't understand it on these rules. I think they, you know, are doing their best to wrap their arms around it. But especially with this 340B case, the liberal justices were more focused on the formulas, focused on how the government sets these pay rates. Whereas the more conservative justices were focused on these larger issues of how much authority does the judiciary have to check rules made by the executive branch. So it's kind of unclear exactly how far they're going to veer in either direction right now. This could either be a really narrow ruling or something really broad. So I think it wasn't really clear which direction they were going. So we're just going to have to wait and see.

Karlin-Smith: This issue of how broad they go with this ruling ... there were some conservative justices that my colleague who covered this case pointed out that seemed to want to use this case to potentially take a big swing at the "Chevron deference" or the "Chevron doctrine," which basically says that if Congress has written laws that are not super clear or a little ambiguous, the agencies in charge with writing the rules and carrying out the administration of those laws get this deference to figure out how to make those work or what Congress intended. And there were a few justices that seemed like they might take this 340B ruling and go beyond whether CMS [the Centers for Medicare & Medicaid Services] had the authority to issue this rule here and payment cuts for drugs ... and just more broadly attack the concept of Chevron deference, which would be hugely consequential for pretty much every federal agency writing rules. So again, I'm not sure they have enough justices to do that, but there was one line where I think it was the chief justice asked AHA [the American Hospital Association], "You know, if we have to deal with Chevron deference and really overhaul it for you to get a win here, what's your reaction?" They were like, "Well, we want to win." That could be interesting to follow going forward.

Rovner: It's the classic "Be careful what you wish for."

Karlin-Smith: Right.

Rovner: Yeah, I mean, because it would affect not just every federal agency, but it would affect Congress, too, because it's about the agencies interpreting what Congress does. And that's ... actually, we should get to the other case, which is in some ways similar. It involves hospitals that serve a quote-unquote “disproportionate share of low-income patients.” And if you think the 340B case is complicated, this one apparently turns on the definition of the words “entitled to” in the Medicare statute. But again, lots of money potentially at stake and Chevron deference, whether entitled to ... I think this one has to do with whether people are actually entitled to Medicare or whether they're both entitled to Medicare and getting it.

Kenen: It has to do with entitled versus eligible. And I think there was an issue about the over-65 population versus the disabled population, which became eligible years after the original over-65 population. I did not listen to it, but I read accounts of it, and it was just like [the] closest the Supreme Court can say to “WTF?”

Rovner: Also, it makes you wonder why they took the case.

Kenen: Like they didn't really understand it. It's really mushy law. You know, whoever wrote it needed to go back to a law-school-writing refresher course. It was really murky. And because of these larger issues about who gets to interpret and who gets to decide, it has implications beyond. They'll probably try to do this one narrowly because it's so bizarre. I don't know that they're going to use this to hang large philosophical statements about the role of the administrative state.

Rovner: Yes, I'm trying to remember the last time the Supreme Court had a bunch of convoluted, complicated, sort-this-out Medicare cases. But just a reminder it is often several months after the court hears a case that we get a decision. Although these aren't the kind of blockbuster cases the court typically holds onto for its last days of the session — we're likely to see the abortion decisions at the very end — but we could see these cases, assuming they figure out what they want to do, around February or March. So I want to check in on the trial of Elizabeth Holmes in California. She's the Stanford dropout who founded Theranos, a Silicon Valley startup that promised to be able to run thousands of blood tests with just a few drops of blood from a finger. A promise the company proved unable to keep. Holmes is on trial for fraud, specifically for lying to investors about things like contracts with the military, which didn't exist, and endorsements of the Theranos technology by pharmaceutical companies, which also didn't exist. I confess I am obsessed with this story ever since the company's fake-it-till-you-make-it cover was blown by The Wall Street Journal's John Carreyrou in 2015. Most of the coverage of the trial has centered on whether it might help clean up some of Silicon Valley's excesses. To wit, that sort of fake-it-until you-make-it — how long can you fake it and how legally can you fake it? But I wonder whether it might also help people think twice about promises not kept about health technology, too. There are so many health startups. You know, we hear all these big promises. And you know, on the one hand, science does amazing things. Look, we now have treatments and vaccines for this disease that didn't exist two years ago. But we also have Theranos out there. I mean, what are people going to take away from this?

Kenen: There's a lot of things in health tech ... a lot of easy money. There's a lot of money, and a lot of it ends up not working or does less than ... it works, but it doesn't really have a health-improving significant impact. But this was blood tests. This wasn't like how many steps did you take or some smoothing record-keeping or something. This was alleged lies about blood tests, and people depend on blood tests to find out if they have diseases or whether their treatments are working. And it sort of catapulted into a whole different class, plus her story and how she sold herself. And she was, you know, an image genius and a publicity genius and getting rich, powerful people to invest in her genius. And it was nothing. I mean, they didn't work and the machines didn't work, they were taking them to regular labs to do ... everything that is alleged to be true was pretty shocking. It's beyond the rest of health IT in the sense of, you know, the chutzpah level and what was on the line. I mean, the line was diagnosis. That was what was on the line.

Cohrs: I think you mentioned The Wall Street Journal reporting and just some of the testimony this week. I mean, she acknowledged that "the way we handled The Wall Street Journal was a disaster for us. And, you know, we made a big mistake." So I think that's also there's a takeaway of like what accountability is out there now. Like, has anything changed? Is it up to reporters to really figure this out? I know there has been some talk about some quality measures at CMS, but that, you know, it's just really complicated. And there's just so much going on here that, yeah, I think that's an open question for sure.

Rovner: Yeah, you know, the federal regulatory part of this didn't work very well as it should have. I mean, they were in Walgreens all over the Southwest, actually taking blood from people and doing tests. And, you know, as Joanne said, mostly on third-party machines that they had bought because their technology wasn't working. But there were a lot of people who got a lot of inaccurate tests of a process that should have been regulated by both the FDA and the Centers for Medicare & Medicaid Services who regulate commercial laboratories. So it's, you know, this has been a cautionary tale for more than just Silicon Valley, I guess, is my point. Is this going to change anybody's behavior or are we all just sort of watching and gaping because this has been quite the fascinating story?

Karlin-Smith: There has been this long-running debate or sort of tension between CMS and FDA over who regulates certain types of diagnostic tests. It's one of those lingering issues that hasn't gotten resolved, but kind of pops up in and out of Congress, in and out, depending on which political party is in charge at the various agencies and so forth. I haven't necessarily heard a lot of that topic being discussed in light of this case, but it is sort of an interesting, high-profile example to think about whether, you know, if FDA had more authority here versus CMS, could this have been prevented in any way and protected patients differently? So that's one thing to think about.

Rovner: Well, we'll see how this case ends up working its way out. Finally, this week, we remember former Sen. Bob Dole of Kansas. Dole is remembered mostly as a World War II hero, the Republican leader of the Senate in the 1990s, when Joanne and I were baby reporters on the Hill. And as the failed Republican presidential candidate in 1996. But he was really important to a lot of big health policy achievements. Joanne, you covered him pretty closely. What stands out to you?

Kenen: Yeah, I covered him on the Hill and I was on his campaign [for] parts of 1996. And he was a conservative. There's no question he was a conservative and earlier in his career, he was really seen as sort of a hatchet man. Although by the time Julie and I started covering him, he was somewhat softened and quite funny.

Rovner: I think he was always quite funny.

Kenen: Yeah, but he would have these sort of snarly one-liners, followed by a smile, and I'm not sure the smile ever carried on TV. I think that, you know, he sort of seems snarlier on camera than he did in person. There was sort of a wink in person. But I think the things he was actually proud of were very bipartisan and very "meeting American people's needs." He had a huge influence in expanding access to food stamps, what we now call SNAP [the Supplemental Nutrition Assistance Program], and we would not have the Americans with Disabilities Act without Bob Dole. And I think that if you asked him, that might have been what he was proudest of. He came back year after year after year on the Hill to celebrate its anniversary. He did it with [former Sen.] Tom Harkin, who was a very liberal Democrat, and ... has it solved all access issues and all equity issues for people with disabilities? No. Has it made an enormous change in their ability to go where they need to go and do what they want to do? Yes, it's a huge, huge piece of legislation.

Rovner: One of the things I was struck by in a lot of the retrospectives on Dole was him saying, you know, over and over again, that compromise is not a dirty word. And you know, when I was covering health policy in Congress in the '80s and '90s, I mean, everything was about negotiation, and most of the things were bipartisan. There was always a partisan fight at the very big level of, you know, do we ... should everybody have access to health insurance or not? But in terms of making the trains run, making Medicare and Medicaid run, I was there when they passed the CLIA, the Clinical Laboratory Improvement Amendments, which gave the federal government more authority to regulate what clinical labs actually do. Those were all hugely negotiated between Republicans and Democrats, and it took weeks and months. But they usually ended up in a place where these things would pass overwhelmingly, that most members of both parties would vote for them. And that was due in no small part to people like Bob Dole and his staff and the staffs at the time at the Ways and Means [Committee] and Finance and Energy and Commerce committees that knew how to work together and knew where the landmines were to avoid and actually got things done. I mean, they came to Congress to legislate, and I feel like that is sort of not the case anymore. Now they come to Congress to make points, but not necessarily make laws.

Kenen: Well, that was one of the things Dole wrote [in] an op-ed before his own death. He wrote it, I believe, last January for publication in *The Washington Post* *after* his death. And his final message was really about: What did he want to leave us with? It was a message about bipartisanship and cooperation and respect. And also, you know, the *Post* a day or two later ran an op-ed from Tom Daschle, who was the Democratic leader for part of the time that Dole was the Republican leader in the Senate. And, again, it wasn't about their battles. It was about decency. Daschle's younger and healthier, 20 years younger and healthier. But had it been the other way around generationally, I think Dole would have

written the same thing about Daschle. And that era is no longer, that's not where we're living right now. There was nothing about their battles, it was all about Dole's service.

Rovner: Yes, and it was not personal. It was about policy. The personal shots were rare. They fought about policy. I won't say that there weren't a lot of partisan disputes, but at the end they would say, OK, well, you're not going to agree with that. So we're not going to do that. What *can* we do? As opposed to now, which seems to be an awful lot of talking about what *can't* we do?

Kenen: Yeah, it was the honor in half a loaf, and now it's like Russia, we're the crumbs. You know, that was like, I can't get everything I want, but I'm going fight as hard as I can to get as much of what I want ideologically, what my party wants. But at some point, I understand I need to cut a deal, and we find a point where we can both live with it, and that's what we rarely see now.

Rovner: All right. Well, that is the news for this week. Now it is 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. Rachel, why don't you go first this week?

Cohrs: My extra credit is a Stat piece by my co-workers Adam Feuerstein and Damian Garde and the headline is "Biogen's Reckoning: How the Aduhelm Debacle Pushed a Troubled Company and Its Fractured Leadership to the Brink." I heard this was in the works, and I had very high expectations sitting down to read it, and it absolutely exceeded them. It's just a look into the Aduhelm rollout, Biogen's Alzheimer's drug. It was a huge part of their portfolio, and it's just a look into the corporate maneuverings into ... OK, so this drug failed. One of its top scientists is out now. You know, its CEO is looking pretty precarious. And to me, from a health policy context, I think these business stories are really important because in America we entrust drug development and the choices about what drugs advance and what the landscape looks like to these investors, to these corporate boards, these VC [venture capital] firms. And I think this was really eye-opening to the messy background machinations that really shape what decisions get made in this arena. So, yeah, it was a great investigation, a ton of great detail. And hats off to them.

Rovner: Sarah.

Karlin-Smith: I took a look at the Axios story by Bob Herman that looks into these coalitions that pharmacy benefit managers, which administer the pharmacy side of health insurance benefits for big companies, encourage companies to be a part of. So essentially, this piece focuses on Aon, which basically it encourages companies to join together in these coalitions with the idea that, you know, the more people you have when you're negotiating with insurance companies or PBMs, the better deal you can get. The interesting thing about this story is the contracts and the things these companies are signing to be a part of these coalitions are basically preventing companies from really knowing what the PBMs in these coalitions are doing in terms of: Are they actually getting you the best deals and the best pricing? PBMs have been pharma's scapegoat, or maybe in the drug-pricing crisis they often point to them as keeping prices high and not the drug

industry. And that's probably one part of the crisis. Not all of it. But it doesn't bode well when you see things where the people that are supposed to be charged with helping organizations get people the lowest prices on drugs don't want you to see the fine print of how they're getting there.

Rovner: Or whether they're getting there.

Karlin-Smith: Right. And at a time when, like I said, the industry, the pharma industry is really trying to push PBMs as the evil part of the supply chain to get them a little bit of relief since the drug industry is getting hit pretty hard right now by the Hill, this is not a positive story for that industry, even though, again, like I said ... I mean, there's nobody can say that the drug pricing crisis is all on the PBMs or even that a majority of it is. But that certainly doesn't help their case.

Rovner: It does not. Joanne.

Kenen: Dahlia Lithwick in Slate has a piece called "We're Not Going Back to 'Before Roe.'" And her argument is that if the Supreme Court abolishes *Roe* [v. *Wade*] or doesn't go quite that far but upholds Mississippi with a 15-week ban, that it's not the end of the story. It's just the end of this 50-year fight and another fight is already underway, which would be to limit abortion further, including in the states that allow it. Before *Roe* is the anticipation it goes back to the 1970s map: Some states allow abortions, some don't. She says the fights in the "allow abortion" [places] — basically what we now call blue states — that there would be fights to limit it stringently or get rid of it there, too. And then there's another movement called "personhood," which is to give an embryo from the moment of conception the same legal rights as a full human post-birth. And that has tremendous implications for criminalizing women who maybe use drugs during pregnancy, who have a miscarriage under, you know ... could be blamed for it. There have been cases, still rare, but they have happened. You know it's just one battleground to another, and we don't know how far it goes or which issues get traction.

Rovner: If and when *Roe* gets overturned, that is not only not the end of the story, it's barely the end of the beginning of this story. My story is from NPR by my former colleague Geoff Brumfiel, and it's called "Inside the Growing Alliance Between Anti-Vaccine Activists and Pro-Trump Republicans." And it tracks not just how the anti-vax movement, which started out fringy but very bipartisan, sort of far left and far right people, has been embraced by Trump Republicans, in particular, and many Republicans in general. And as a result, the gap between vaccinated Democrats and vaccinated Republicans has grown. A point in the story, citing statistics from our KFI vaccine survey, "94 percent of Republicans think one or more false statements about COVID-19 and vaccine safety might be true." That includes things like believing that the vaccine changes your DNA or is actually killing people or makes it more likely to get covid — none of which is true. But this is kind of a worrisome trend that we're seeing. 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

questions or comments. Get those questions in for our “Ask Us Anything” episode. We're at whatthehealth — all one word — @kff.org. Or you can tweet me, I'm @jrovner. Sarah?

Karlin-Smith: I'm @SarahKarlin.

Rovner: Rachel?

Cohrs: @rachelcohrs

Rovner: Joanne.

Kenen: @JoanneKenen

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