KHN's 'What the Health?'

Episode Title: Oh, Oh, Omicron
Episode Number: 226
Published: December 16, 2021

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, Dec. 16, at 10:30 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 Margot Sanger-Katz of The New York Times.

Margot Sanger-Katz: Good morning.

Rovner: Alice [Miranda] Ollstein of Politico.

Alice Miranda Ollstein: Hello.

Rovner: And Mary Ellen McIntire of CQ Roll Call.

Mary Ellen McIntire: Hi, everyone.

Rovner: So there is — I know I say this every week — but this week there really is a ton of news. We will get right to it. We're going to start with covid this week. I called the segment in the rundown "Oh, Oh, Omicron." Please feel free to groan, 'cause Joanne's not here. But while the omicron variant is starting to grow rapidly, it's still delta that's doing the most damage. This week, we marked the almost incomprehensible milestone of 800,000 Americans dead of covid. More of those deaths actually took place this year, in 2021, than in 2020. Why do people keep acting like the pandemic is over when clearly it is not?

Ollstein: I think it's really doing a number on folks to wrap our brains around the fact that we're entering Year 3, and I think that the winter surge that's already underway with the new variants, it's just leading folks into a place of "Is this ever going to end? Is this just going to be our lives for the foreseeable future?" Hard lockdown policies and restrictions aren't sustainable forever, and they've sort of lost the "Oh, let's just pull together for the short term and we can beat it" mentality because we have not shown our ability to do that.

Rovner: I found that, you know, here where I live, just outside of Washington, D.C., they put the mask mandate … the mask mandate was off for, I don't know, about a month and a half and now it's back on. But most of the areas around us, there isn't one, and I find that people are, you know,

they're just tired of wearing masks. They're tired of being careful. And yet, at the same time, I'm seeing more and more people around me who are getting sick with covid.

McIntire: I think the numbers are kind of impossible to wrap your head around — like, 800,000 is so, so much more than the initial projections that we were talking about almost two years ago when this started and became the reality. And just the fact that we've been dealing with it, I think, also there's starting to be more of a sense of almost resignation to the fact that at some point people are going to get it. At least in my social circle, I feel like in the past few weeks that's something that people have really sort of been like, "Well, at some point everyone's going to get it, so I want to be safe if I'm going to travel to see family for the holidays or I have a big event this weekend, I'm going to be safe and take precautions ahead of time." But sort of the idea that "I'm going to stop living my life broad scale and stop going out to restaurants or going to the gym" or whatever is just not the mentality that people have anymore at this point.

Rovner: Or going to holiday parties! We're at this place where we're like, "OK, yeah, we know we should probably be hunkering down more because we know that omicron can probably evade even people who are double vaccinated and boosted. And yet I don't see a lot of behavior change. Speaking of people acting like the pandemic is over, The Atlantic this week published a piece that's getting a lot of pushback. It's called "Where I Live, No One Cares About COVID," and it makes the case that covid is really just something the media elites and people on the coasts are paying attention to. First of all, even though there's a lot in there that's really questionable — honestly, there's lots of evidence that pregnant people should not drink alcohol [but] the piece suggests that that's something that just overcautious doctors recommend. I think the broader point of the piece is spot-on: Most of America, for better or worse, has moved past the pandemic. Anybody here think The Atlantic shouldn't have actually published this piece? I saw a lot of reaction saying, "Why did they even do this?"

Sanger-Katz: I mean, I don't think that anyone should be prevented from publishing these articles, but I feel like the article at the headline level is, in fact, describing something that is true, which is that, for a long time, large swaths of this country have just not been taking a lot of precautions against covid and have been frustrated by the restrictions because of convenience reasons, because of culture war reasons, whatever. And I think it is valuable to have that perspective — for the Atlantic audience that does tend to be more of these coastal, highly educated people who are engaging in more protective behaviors. But that said, I think 1,300 people are still dying every day from covid, and we talked about 800,000, which is the total. And in some ways that number is so big, it's hard to think about. But 1,300 people every single day. And deaths are up, I think, like 40% over the last two weeks. So I think that the piece is wrong in the sense that covid is not still touching the lives of lots of Americans and lots of American communities. I think both things can be true. It can be true that people in your community are going about their lives as if the pandemic doesn't exist, and also that they know lots of people who are getting sick. They have relatives who have died. And it is a weird global reality. And I just think the tone of the piece felt wrong to me because I think it was describing something that was true but being kind of flippant about the consequences of it.

Ollstein: I just think it's a great example of, you know, it's easy to point fingers at other people's bubbles and blind spots, and it's harder to see your own. And people in the media and big high-income cities are in a bubble and are influenced by, you know, their communities and the things they hear. But also this person writing about his community, like Margot said, people in his community are dying of covid. Their loved ones absolutely are thinking about this and are touched by this. You know, people in his community are getting long covid and are struggling for months and unable to work. We know from the data that that has to be true. And yet he doesn't seem to acknowledge or have any interaction with any of those people. And so he is in his own bubble, as we all are. So I definitely agree that there was a lack of acknowledgment of that in there.

Rovner: Yeah, I should point out that the writer is from southwestern Michigan and Michigan is a state that is currently in the throes of a very large and severe wave that has the hospitals pretty much all over the state full. So meanwhile, if confusion is a problem, here is another case study. The Supreme Court this week upheld New York's vaccine mandate for health workers. Yet it seems that many hospitals are dropping their mandates because they can't hire enough workers, and they're worried even about losing the few who refused to be vaccinated. Is this a mandate thing, or is this just about how terrible it is to work in a hospital right now? These hospitals are so completely overrun with covid patients, and yet we have people outside behaving like it's all over.

McIntire: I think that maybe it's a little bit of both. The vaccine mandates, several different ones are pretty controversial. But, you know, we have talked a lot over the last couple of years about physician burnout and hospitals having a hard time hiring people and having enough staff to deal with, you know, not just covid, but all of the delayed health care that people have been needing and regular health care and procedures that patients need done. So it sort of seems like maybe a combination of the two of just, yes, this is a problem, but it's just an added problem on top of another issue. And hospitals might feel like, Hey, we want to have this mandate, but we need people to take care of our patients more.

Rovner: I think that seems to be where this seems to be going. All right. Well, speaking of the Supreme Court, the Supreme Court last week in a rare Friday decision signaled even more strongly that the conservative majority seems likely to overrule *Roe v. Wade* in 2022 and roll back abortion rights. The only question remaining is to what extent. In this case, involving a very creatively written Texas law, the court ruled that abortion providers in the state can sue some state officials, but not many. It also ruled that the U.S. Justice Department could *not* sue to stop the law, and, most important, it left the Texas law in place for now, meaning that abortion after six weeks of pregnancy is unavailable in the nation's second-largest state and has been since Sept. 1, even though technically the right to abortion remains on the books. Alice, this was painted by some as kind of a split decision, but it really wasn't, was it?

Ollstein: Yeah, this is an example of why it's best to read an opinion slowly and carefully before popping a take on Twitter. Because even the plaintiffs in this case, even Whole Woman's Health, the abortion clinic in Texas, at first described it as a narrow win and then as folks analyzed it more, and it really sunk in how bad this was for the abortion rights side, that really became clear. And like you said, you know, basically the most important point is they are leaving the law in place for now. And even [Chief Justice] John Roberts, who's no fan of abortion and no progressive,

described this as an endorsement of Texas' attempt to make an end run around constitutional precedent and shield its law from scrutiny by the courts. So the case is allowed to move forward in some form. The court sort of cut off what the clinics saw as their most effective means of getting this law blocked in the lower courts. But cases are continuing to play out in both federal and state court. And, of course, hanging over all of this is what the Supreme Court is going to do on the bigger question of abortion rights.

Rovner: But also, while this particular case was about abortion, it's pretty clear that what the law has done here is let a state deny its citizens a constitutional right by outsourcing enforcement to those who oppose that right. This could stretch way beyond abortion, right? We're already starting to see it in some other states with guns?

Ollstein: So California basically did what justices on the Supreme Court warns could happen, which is to apply this same enforcement scheme to other topics besides abortion, saying, "OK, well, if you're going to do this for abortion, we're going to empower regular citizens to sue one another over gun rights." I think that it is more to prove a point. I don't think this will end up actually functioning in practice. There is nothing preventing courts from being hypocritical and applying this standard to some and not others. But I think it's a way that California is attempting to shine a light on the possible implications of the Supreme Court's actions on abortion.

Rovner: And Margot, you had a wonderful piece last week, sort of a graphic about what would happen if the court actually does overrule *Roe*, which it certainly looks more and more likely that they will.

Sanger-Katz: Yeah, I think that there is maybe not enough recognition of how major a change that would be in this country's culture and health care system and that there are at least 22 states, you know, different organizations have different counts of how many states they will predict. But I think it's safe to say there are at least 22 states that are poised to ban all abortions almost immediately once the Supreme Court makes that possible. And what that means is that women in those states will have substantially diminished access to abortion. They, of course, can travel to states that have abortion clinics. There's, you know, obviously nothing preventing them from traveling, except that traveling is time-consuming and costly. It involves having a car, having time off from work, having day care, and many of the states that they would go to that are the states that have abortion that are neighboring the states that would ban it, they often have waiting periods, so they would have to go to another state, have a visit with a clinician and then wait around for a couple of days before they could actually have an abortion. And there's quite a lot of research from previous clinic closures that shows that the longer the distance, the more women just can't get over the hurdle. We had a piece this week that we were just looking at the demographics of who gets abortions in America, and I really was just struck by how substantially this is a procedure that is being used by women in poverty. The most recent statistics show that basically half of women who have abortions are below the poverty line, so they're really quite poor. And then another 25% are between 100% and 200% of the federal poverty level. So these are women who are living with very low incomes, you know, potentially not with very stable jobs, typically have other children. And the fact that they may now have to travel hundreds of miles in order to obtain an abortion means that many of them just simply will not. And based on the Texas

history, looks like we're looking at a decline in the number of abortions in the country of around 14% just due to these state bans. And I think there are a lot of other factors that we don't really fully understand in terms of how the remaining clinics will be able to accommodate the patients who can travel.

Rovner: I was just going to say, one of the things that we've seen in Texas is that clinics in the neighboring states in New Mexico and Oklahoma and Louisiana are completely overwhelmed by trying to — you know, there's not that many clinics left in several of these states, and now they're being sort of flooded by patients from Texas. And, so, people in those states are having, you know … what was already limited access, they're impacted by what's going on in Texas. And obviously, if that were to expand to much of the South, which are the states that would likely ban abortion, it would get even harder. But meanwhile, one big difference in a world without *Roe v. Wade* in 2022 compared to 1973 is the existence of medication abortion via the abortion pill mifepristone. And Alice, we're expecting news from the FDA [Food and Drug Administration] on that today, yes? What are what are we expecting them to do?

Ollstein: Groups on both sides of this that have been pushing the FDA expect the FDA to loosen their restrictions around medication abortion. So they already loosened some restrictions on it just for the pandemic, the argument being, you know, any risks from mail delivery of the pills is outweighed by the risks of making people physically come into a clinic and potentially catch covid when picking it up. And so …

Rovner: But this is, I mean, remind people what some of the restrictions have been. It's not like you can just go to the pharmacy and, you know, your doctor can call in a prescription, you can go pick it up. That's not how this works.

Ollstein: Right. So for the last 20 years or so that the medication has been available, the FDA has said that patients have to physically be handed the pill by a medical provider, even though they can then go home and take it at home. But still, the physical distribution had to be in person just until this year, when it was relaxed a bit for the pandemic. And so now triggered by any ACLU lawsuit that has been simmering for years, they're reevaluating those rules permanently because over the last few years there have been studies in other countries, but also now that the rules have been suspended during the pandemic there's a lot of data showing that there's no real difference in safety — whether you pick it up from a pharmacy, get it delivered by mail or get physically handed it by a doctor. There's really no difference in safety. And so groups like ACOG, the American College of Obstetricians and Gynecologists, have been pushing the FDA to update the rules and allow for this mail delivery. Now, of course, states who have been anticipating the FDA making the federal rules looser have rushed to implement their own restrictions. And so now a lot of states do require the pills to be distributed in person by a doctor, no matter what the federal government ends up saying. And that's only expected to accelerate following the expected decision.

Rovner: So there will be an abortion pill. How available it will be will depend, like everything else, on the state that you live in.

Sanger-Katz: There's also quite a — I wouldn't call it robust, but I would say emerging — black market for abortion pills. So I think an important thing to understand about these pills is that they are inexpensive to manufacture. They are relatively safe. They are not large in volume, they're easy to transport. And, you know, for many years, women have basically been Googling their way to Indian pharmacies that will mail you some pills from overseas. And there was a really interesting study done by a group called Gynuity a few years ago, where they basically ordered pills from up from, like, 10 places that they could find on the internet. And then they had a lab test them, and they were all the real thing. And there now are more organized groups — there's a group called Aid Access that's run by a doctor. It's based in Europe, where basically women can have a telemedicine appointment with a European doctor who will give them advice. And then they have pills mailed to them, again, from Asia, from India. But it's like, you know, somewhat more vetted than the random thing you find on the internet. And they've been basically distributing these pills to thousands of American women. And some of these pills can be obtained over the counter across the border in Mexico. I think that the FDA, of course, is trying to regulate these pills in a way that ensures that they are authentic, that they are safe and effective, that they are accompanied by appropriate medical advice. And all of that is, I think, important. But there's also the potential for women who don't have access to that system because of state restrictions, because of financial barriers, because of other reasons to obtain pills on the black market. And I think that that is potentially what the future of illegal abortion in America looks like. You know, people talk a lot about like back alleys and coat hangers, and I don't want to pretend that there aren't desperate women who will do desperate things if they're unable to end pregnancies that they don't want to carry. But I do think that this is a different time than before *Roe*. And I think the availability of this technology and the ease with which it can be obtained does change the picture. And I think we'll see more of these kind of … a colleague and I in a piece that we wrote a few years ago called them "invisible abortions." These abortions that are not being tracked by anyone, that are not occurring through the traditional medical system but are still happening.

Ollstein: So "self-managed abortions" is the … official term.

Sanger-Katz: That's the technical term but I think that a telemedicine abortion, where you get pills in the mail from a licit source is still self-managed. But I think, you know, the kind of black market self-managed abortion is its own thing.

Ollstein: Right. Although, you know, this won't be an option for everybody for a lot of reasons, but in particular because the pills are only supposed to be used up to 10 weeks of pregnancy. So by the time somebody realizes they're pregnant, figures out how to obtain them, it could be too late. And so, you know, in a post-*Roe* world, it will be an option for some people, but not for others.

Sanger-Katz: Of course. And you also have to have the savvy and the resources to figure out how to get them, to have the money or, you know, to pay for overseas things. I mean, there will remain barriers, but I do think that this is an option that exists that didn't exist before *Roe*. And I think, you know, it will be part of the landscape and already is, frankly.

Rovner: That's why I asked the question. All right. Well, speaking of the FDA, it took the Biden administration more than 10 months to nominate somebody to run the agency that regulates a

quarter of all products in the United States. It apparently took the Senate Health Committee only a single two-hour hearing to make it pretty clear that Dr. Rob Califf will become the next FDA commissioner, despite some fairly high-profile opposition, including Sen. Bernie Sanders. Califf, who ran the FDA for a year at the very end of the Obama administration, did take some heat at the hearing for his handling particularly of the opioid crisis, which the FDA was indeed in the middle of. He managed to skirt questions about the impending abortion rule changes, pointing out correctly that he is not part of the process that's there now. But will his confirmation really be as easy as his hearing seemed? And if so, why did it take so long?

McIntire: It sort of seems like he's on track. It seems that, despite some Democratic opposition from Sen. Sanders on the panel and then more broadly within the caucus, once it gets to the floor, it seems like he's going to have enough Republican support to 1) get out of committee and then also make it to the floor and be confirmed back to leading the FDA. I think there's going to be probably some more pressure on him than there was. I think he's also coming into a pretty different FDA, and I think that despite, particularly, Republican support for his nomination, this is something that lawmakers are going to continue to press him on in office. You know, the FDA has changed a lot in terms of trying to get pressure to get faster approvals for covid treatments and vaccinations, and I think this is something that …

Rovner: And tests!

McIntire: And testing, yeah, of course. I think this is something that a lot of people are going to want to see broadened beyond the pandemic to, sort of, how can we speed up and try to continue using this to modernize the FDA, which is obviously known to be a little bit slow on a lot of things, can really take its time with decision-making. So I think that will be something to continue to watch, assuming and when he gets confirmed.

Rovner: Anybody see any potential hidden land mines here? I was kind of taken, I watched the hearing, by, you know, really the most emotional questioning came from some of the senators from some of the states that are hard that were hardest hit by the opioid epidemic, particularly Sen. Maggie Hassan from New Hampshire. If you spent any time reading the books or watching the documentaries about the opioid crisis, you can see that the FDA really did fall down on its responsibility to make sure that these drugs were safe and hold at least some culpability for the opioid crisis. And it'll be interesting to see, you know, how closely Congress tries to ride herd over the FDA going forward.

Ollstein: Well, of course, this jumped out at me because it's what I've been focusing on. But even though he sort of waved away questions about the fate of the abortion pill regulation, it's notable that anti-abortion groups are calling for Congress to block his confirmation over his past support for enabling better access to the pills. So because Republican votes are needed to get him over the line because of opposition from some Democratic senators, the anti-abortion groups calling for them to block him could be meaningful. We'll see.

Rovner: And it's worth pointing out that nominees get blocked all the time over issues that have nothing to do with their particular abilities or background. It's like if somebody wants to make a

point about the agency that the nominee is for, then you end up with some of these confirmation fights. So I guess we will see what happens with Dr. Califf going forward. So elsewhere on Capitol Hill, I guess we have to give Congress a little credit for not shutting down the government, at least until next year sometime, nor breaching the debt ceiling, at least until after the midterms, and for getting the annual defense bill done. Still, it is beginning to look a lot like *after* Christmas for the Build Back Better reconciliation bill. Apparently, the bill is not yet complete. Sen. Joe Manchin is not yet on board. The parliamentarian has not yet finished going through it. But the longer this drags on, the harder it's going to be to actually do it, right? I mean, do we think they can do it in January or, if they missed this December deadline, is it going to drag into the spring?

Ollstein: So Congress never does anything without a sword hanging over its head. So they might try in January. But some folks think that, because the short-term spending bill was punted … to February, that could prove the next, you know, tension point that actually forces some action on this. But again, it is that they just ran out of time before the end of the year, especially with the parliamentarian's process, which is ongoing. But, I think, more important than just running out of time is that they just haven't reached an agreement on some of the fundamentals. And if you need every single vote of all 50 Democratic senators, you can have all the time in the world and it still won't get done.

McIntire: It's hard. Yeah, it's really hard to see how they pick momentum back up. I feel like they've really lost any momentum that they had going into the month and, after the House passed the bill, there's nothing right now that seems to be there to push anyone to make a policy change, in terms of what they need to see to get the bill passed, i.e., specifically, Joe Manchin doesn't seem like he's in particularly any sort of a hurry to try to get to an agreement. So, you know, I think the February C.R. [continuing resolution] deadline is probably the next most meaningful deadline, and we'll see after the holiday break. I think, at this point, we're just waiting for a formal announcement of when that's going to start, if they can get a deal on a package of nominees and get out of there before next week, take a couple of weeks and be away from each other and then come back in January and see what happens. But a lot of the problem is that they're just out of time. There is no way that they can make all of these decisions, and I think in the last 48 hours you've really seen Democrats coming to terms with that.

Rovner: They did get an awful lot of stuff done in December, considering how much was on their list.

McIntire: It's Dec. 16 and all of the quote-unquote "must-pass things" are done, which I think is something that hasn't always happened in the last couple of Decembers. So, yeah!

Sanger-Katz: I think the fundamental problem is that they still don't agree. Of course, there are all of these procedural hurdles that they face. And I think, you know, every time we talk about the Senate, we get very focused on those. But I think at the end of the day, they just don't have the votes to pass the bill. And I think as soon as they can reach consensus about what they want to do on public policy, which again, I agree with everyone else, has mostly to do with mollifying Joe Manchin, who seems concerned about the fiscal impacts of the bill. I think they can get it done.

Momentum or lack of momentum, I think at this point, really just comes down to whether or not he and the White House and congressional leadership can cut a deal that they can all live with.

Rovner: Well, I want to talk about insulin for a minute because I feel like it's the perfect example of why this bill is so hard. The bill, at least as it passed the House, seeks to limit the amount people with insurance have to pay for insulin to no more than $35 a month, which is significantly less than many Americans pay now. But the provision wouldn't cover everyone. There are loopholes. It might not even make it through the process because it's not clear whether the parliamentarian will allow provisions that regulate private insurance and what's supposed to be a federal budget bill. Margot, this is your extra credit this week. Why don't you talk about it?

Sanger-Katz: Oh yeah. So, Jonathan Cohn at HuffPo had a really nice article on this called "Insulin Prices Could Be in for a Pretty Big Change if Democrats Get Their Way." And I think he just does a nice job of laying out what the impacts of this policy change would be. I mean, I do think insulin is a really great example of a medicine that has enormous health benefits, that does prevent people from having more serious complications from diabetes that are bad for their health and happiness, but also …

Rovner: It prevents them from dying!

Sanger-Katz: Yes, but it also causes all kinds of expensive hospitalizations and other things. And yet, to me, it is kind of the stunning example of all of these weird incentives and complications in our health care system that essentially, like, we know that this is medicine that people need to stay healthy and to prevent them from having expensive other problems. And yet we create all these financial barriers for people to take it. And so, this policy is, of course, an effort to address that to say, we're going to ask people to pay for their insulin, but only so much that it can't be infinite. And then just under the hood, there's all kinds of weird stuff. You know, every weird thing about our drug pricing system is evident in the case of insulin. You know, the drug companies have increased their prices enormously over time for medicines that are not particularly innovative. And there is also this very complicated and weird system of rebates and negotiations with pharmacy benefit managers — perhaps more on insulin than in almost any other class of drugs. That leads there to be incentives for the prices to be higher or leads insurance companies to cover more expensive insulins and not less expensive insulins. So, in some ways, this is kind of a blunt way of addressing it. But just saying, we're going to put a limit on how much we can ask people to pay for this and a way of not resolving the underlying weirdness, which I think is quite hard and involves lots of changes that would be unpleasant for various important health care lobbies. One thing just about this fight before the parliamentarian that I think is interesting is that, you know, the pharmaceutical industry in general is opposed to lots of parts of the drug regulation in this Build Back Better [legislation]. But they're fine with this — this actually doesn't hurt them. They think it's good for consumers. It protects consumers from the high cost of drugs and makes them less angry at the pharmaceutical industries, and the cost will mostly be borne by insurance companies and pharmacy benefit managers. So, while I think there is a strong legal argument potentially to be made that this does not follow the "Byrd rule," I also think there's a little bit less interest-group momentum behind challenging it, and so curious to see how vigorously it will be argued by Republicans.

Rovner: Well, speaking of drug prices, as if to give the Senate yet another push, Democrats on the House Oversight Committee have issued a report based on a three-year investigation that finds — wait for it — drug prices are too high and that many drug price increases are unjustified. In response, Republicans on the committee issued their own report, suggesting the drug industry middlemen, those so-called pharmacy benefit managers, aren't doing much to promote competition and are themselves driving up prices. Of course, it is perfectly possible that both sides are right here, right? I mean, that's basically what you were just saying, Margot.

Sanger-Katz: Yeah, it's just a very weird, messed-up, convoluted system that we have. And there are lots of places where the weird incentives are leading to higher prices. I don't think it has to be either-or. It could be both. But I think each of these industries, of course, has a very strong incentive to point the finger at the other one.

Rovner: And so far it's been neither rather than both.

Sanger-Katz: Right. I do think that the report from the Oversight Committee, which is the culmination of a couple of years of investigations, is not the first report that they've put out. They've had numerous hearings. They've had some other reports along the way. I think there's not blockbuster findings in this investigation, but I think that they really do go through and demonstrate lots of things that the pharmaceutical industry does that make drugs more expensive, that seem to be somewhat manipulative or unjustified ways that they use the patent system, ways that they increase prices in order to hit various bonus targets for their executives. There's just a lot of good details in this report that help illustrate some of the shenanigans in this industry that we have been aware of at a high level.

Rovner: I have files dating back 20 years on all of these shenanigans. And Democrats and Republicans promising to do something about it and not having done it yet. Well, to move to some other special interests on Capitol Hill, I think we talked about the pushback to the Biden administration's surprise billing regulations the last time you were on, Margot. But now we have a lawsuit: The American Medical Association, the American Hospital Association are suing to block just the piece of the rules that affects how much they're paid when a bill is in dispute. It's this so-called arbitration system. I think the question that consumers want to know is, could this lawsuit delay the start of the protections that are supposed to begin Jan 1?

Sanger-Katz: I do not think so based on my read of the lawsuit and also my conversations with the litigants. Their goal is not to prevent the law from going into effect, it's just to delete some of the instructions that would be given to the arbitrator who helps. So, you know, when there's a dispute about how much an out-of-network provider should be paid, the way the law works is that there's some interim payment that is made that tides things over. And then the two parties go to an arbitrator, who is going to decide ultimately how they're going to settle. And the fight is about what instructions should be given to the arbitrator. And so what this lawsuit is asking is for a court to say, delete this section of the instructions for the arbitrator and let the arbitrator make a decision based on whatever other information and/or their own gut instinct. But I think they are not looking to eliminate the consumer protections. They're not looking to eliminate this process itself. So it is a little bit of a narrow request that they are making, because they feel that the

regulation is giving the arbitrator too-specific instructions about which factors to consider in reaching a price — particularly, that there is a typical price, a median in-network price, that in the legislation is one of the considerations that the arbitrator is supposed to consider and the provider scale the regulation tells them to consider it more heavily than other considerations, in a way that may bias them in this direction. So that's what the fight is about. It is about this relatively narrow thing. I think the stakes are high in terms of the fiscal impact of this legislation and its effect on insurance premiums. Because if we have a system that rewards out-of-network providers with very high payments relative to what in-network doctors get, it creates incentives for them to stay out of network and to use this process more often. If we have a system that pays them very low amounts relative to what in-network doctors are getting, then it creates an incentive for insurers to drop doctors from their networks, to use the system for that purpose. And so, I think finding this balance is important. The more doctors get paid for this kind of care, the higher insurance premiums are going to be. The less they get paid, the more it will be reduced. But also, the less these doctors are going to get paid. And you know, some of them are looking at pay cuts that are concerning to them. So this fight is very much about how much do insurers get, how much do doctors get, to some degree — not about the core consumer protections that the law provides.

Rovner: Right. Although that's been the fight all along. Alice and Mel, is there a chance that Congress is going to step back into this? I know there have been some angry letters, but I can't, you know, this was so hard for Congress to resolve to get to this point. I'm wondering if they *want* to step back into this.

Ollstein: I mean, they can barely get done the things that they've been attempting to get done all year. I don't see, you know, tackling another thorny subject that they already spent years working on only to get the solution that's now under attack. So I would say “outlook not great” for a revisitation from Congress, but you never know because this is an issue with a lot of major players that spend a lot on lobbying and pressuring Congress. So I think that the fight played out on the Hill for a while and it'll now play out in court.

McIntire: I would also just add there are some. There are some important chairmen and chairwomen on Capitol Hill who were involved in the crafting of this bill, who really like the rule. So I don't think that they are going to be that inclined to try to bring it up, even if there is some interest from other members.

Rovner: Finally, this week, and it's the thing that, I guess, ties everything together that we've been talking about. We got federal health spending numbers for 2020, and the numbers are complicated. The top line is that health spending was way up, as in 9.7% up, accounting for nearly 20% of the nation's GDP. But most of what we actually think of as health spending went up only slightly or even went down. Margot, what explains these numbers? They're very weird.

Sanger-Katz: Yeah, I think this is a report that is interesting, but we shouldn't think about the top lines in the way that we normally do. I think we often look to this national health expenditure report to tell us, like, is health care getting more expensive or getting less expensive? And I don't think this report really tells us that. So the reason why it has gone up so much is because there was a lot of emergency pandemic spending that was meant to stabilize our economies, to stabilize

employment, to stabilize state and local governments. So a couple of examples of this, as you may remember, there were these Paycheck Protection Program loans that allowed employers to pay their workers even if their workers couldn't work. A lot of those went to doctors, dentists and other kinds of health care providers. There was a similar program that provided forgivable loans to hospitals and nursing homes, other kinds of health care entities to help them stay afloat. And, you know, the reason why they were getting all of this money, of course, is because people were not going to the doctor because they were staying home and trying to avoid getting covid. So we actually had reductions in 2020 in the dollars being spent on health care by both insurers and individuals out of pocket. There was a relatively flat health insurance status despite the pandemic, but there was all of these special flows of money that were going out the door. There was also obviously a lot of direct spending on public health, and there was a lot of direct spending on Project Warp Speed, on this vaccine development program that helped us get these wonderful vaccines in such a short period of time. So all that money counts as health care spending, as far as the actuaries are concerned. But it doesn't tell us very much about the trajectory of health spending once the pandemic is no longer with us. A lot of this money is expiring. But some of it might stick around. I mean, I think this is a very small example, but I know you guys talked about last week that Congress decided to reverse some scheduled cuts in the Medicare program for Medicare providers. And, you know, those cuts had been in place for almost a decade, and they were reversed temporarily as part of this public health emergency. And instead of letting them expire, Congress has just pushed the ball down the road and said, No, we're going to continue this increased funding for Medicare providers because they're in a tough place. You know, you do that long enough and they come to rely on those additional payments. So, I'm very curious what the actuaries are going to say in their forward-looking forecast. They always do two reports every year — one looking back, here's what we spent on health care. And one looking forward, here is what we think the next decade is going to look like. That one, I think, is a couple of months away. But I'm curious how they think about the post-pandemic health care landscape and how much it's changed and how expensive it's going to be for all of us.

Rovner: I feel like 2020 is always going to have an asterisk by it. When we look at historic spending, it's just like, I looked, it's like: "It did what?!" And then I read into it and I'm like, "Oh!" It was basically all of the money, you're right, all of the federal money that went out the door to stabilize the economy and the health care system. There were hospitals that had to lay off big chunks of their staffs because nobody … if they were not having a covid surge, then they didn't have any patients because they had stopped doing elective procedures. And, as you pointed out, a lot of people were hunkering down and staying home. So 2020 is …

Sanger-Katz: And also the really eye-popping number to me is that, you know, we approached 20% of GDP spending on the health care system. That's a whole lot of our economy, you know, people are always watching that. But, of course, in addition to the fact that the federal government pumped all of this money directly into the health care industry on purpose, the GDP also contracted because there was a huge recession related to the covid emergency. And so, you know, a big share of a smaller number is going to look even bigger. That does not seem to be permanent. The economy has really rebounded in the last year and the GDP is looking more normal again.

Rovner: Yeah. So we will see how that pans out. All right. That is as much news as we could get to 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. Margot, you've already done yours. Mel, why don't you go next?

McIntire: Sure. So my story this week, I wanted to highlight a story about burnout among pharmacists, as everyone is turning to pharmacies to get their booster shots as we head into this winter season and this latest covid surge, by two of my colleagues, Emily [Kopp] and Ariel [Cohen]. I thought this story was really interesting, kind of looking at boosters. Everyone is rushing to pharmacies, trying to walk in, trying to get their booster shots, and pharmacists are really burnt out and they don't necessarily have the same support right now as they're dealing with the surge, as they did earlier in the year when the National Guard and volunteers helped facilitate these. I think a lot of people went to mass sites to get their first vaccinations, and now they're, like, OK, why can't I get an appointment for three weeks at my local pharmacy? I'm being told to get one immediately. I'm just going to go and show up. And it's also a real struggle, particularly for older people for whom, you know, getting a booster shot is most important if they haven't already gotten one and they're trying to go get it. They spoke to one person whose mother did a dry run, got all of her groceries in the house and then she got there and there was a problem with her registration and they told her, try again and come back. And a lot of pharmacists are also deciding to maybe take a break from their job, quit their job, because it's just too much, really long shifts, not enough staff to work with. And the burnout is real. So, I know we've talked about this a lot with different workers in the health care field over the last couple of years, and this is sort of the latest group to really get this spotlight put on them.

Rovner: I feel like we're driving so many people to pharmacies for things other than picking up prescriptions without the pharmacies really having the workforce available to … and so, you know, every time I go to the pharmacy, I see frustrated pharmacists and frustrated patients. At some point this is going to come to a head. Alice.

Ollstein: So I have a very depressing story from the AP. It's called "How a Kennedy Built an Anti-Vaccine Juggernaut Amid COVID-19," and it's about Robert F. Kennedy Jr. and his anti-vax advocacy and just how much his involvement has completely allowed this anti-vaccine misinformation to skyrocket. He has been so successful at fundraising and using his family's name to boost this very dangerous work. Also, the websites he was involved in promoting got very little traffic before the pandemic, but they've just absolutely gone through the roof, and they're very effective at buying targeted ads on Facebook and other platforms, specifically targeting parents and drumming up fear of vaccines. Also targeting people of color. And it's so bad, and the pro-vaccine side, the science-based side, is not as good at getting this information out. It's not doing this kind of targeted work in as effective a way. And the platforms — YouTube, Facebook, etc. — that this is spreading on are not doing a good enough job at stopping it. And it's definitely something to pay attention to here.

Rovner: And lest people forget that the anti-vax movement has long been bipartisan. There have been people at the left end and at the right end who meet basically in the middle on this issue and

have going back some 20-30 years. So, it continues. Well, my story is from my KHN colleague Phil Galewitz, and it's called “West Virginia Sen. Manchin Takes the Teeth Out of Democrats’ Plan for Seniors’ Dental Care.” And it's a prime example of how all politics is not always local. It seems that West Virginia leads the country in the percentage of adults over age 65 who have lost all their teeth and has the third-highest share of people age 65 and older of any state. Yet their senator, Joe Manchin, who we've talked about a lot today, is almost single-handedly keeping a new dental benefit for Medicare out of the Build Back Better bill. Manchin says it will cost too much and will threaten Medicare's dwindling trust fund. Except the dental benefit wouldn't have any impact at all on the trust fund — that's for hospital and nursing home care. The dental benefit would be part of Part B, which is funded by general revenues and patient premiums. Welcome to how Washington works — or in this case, doesn't.

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 — which will now be in early 2022. We are at whatthehealth — all one word — @kff.org. Or you can tweet me: I’m @jrovner. Alice?

Ollstein: @AliceOllstein

Rovner: Mel.

McIntire: @MelMcIntre

Rovner: Margot.

Sanger-Katz: @sangerkatz

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