KHN's 'What the Health?'

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Julie Rovner: Hello! And welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent for Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, Jan. 6, 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 Tami Luhby of CNN. Happy new year, Tami.

Tami Luhby: Happy new year.

Rovner: Alice Miranda Ollstein of Politico.

Alice Miranda Ollstein: Good morning.

Rovner: And Mary Ellen McIntire of CQ Roll Call.

Mary Ellen McIntire: Hi, everyone.

Rovner: Later in this episode, we'll have an interview with my KHN colleague Victoria Knight, who wrote the latest KHN-NPR Bill of the Month about a billing error in a half-million-dollar bill for neonatal intensive care. But first, the news. So when we last met, which was two weeks ago, omicron was spreading rapidly. But I think we really had no idea just how rapidly or how widely it would spread. This week, I think for the first time, we're seeing some of the societal breakdowns that come from so many people being sick at the same time, even if many of them are not very sick. But hospitals are once again closing to nonemergency services. There aren't enough people to drive snowplows or school buses, and some businesses are closing, not because they're being required to, but because they don't have enough workers to stay open. Is this what it looks like when society actually collapses during a pandemic? Is this the beginning of it?

McIntire: Maybe.

Luhby: Well, I think we are seeing definite ramifications, but I think, fortunately, at least if omicron follows the pattern that it did in South Africa, this will be temporary. I'm in New York, which was hit very badly, and I was watching in horror the numbers coming out of the states that were just skyrocketing each day. And they seem to have leveled off. They're not quite coming down yet from what I saw, but at least they're not shooting up anymore. It's a little hard. I live in the Bronx, and we're at, like, 27% positivity, I think, the last time I saw. So it's scary to go even higher, but it seems at least to be leveling off. So, yes, there are problems. Macy's downtown has been cutting back its hours in its flagship store because it doesn't have enough workers, but I think hopefully we'll stay at this level and hopefully improve soon.

Rovner: You see these science fiction movies about pandemics, and that's actually what happens is that everybody gets sick and society stops working. And I know that was part of what drove the [Centers for Disease Control and Prevention] to shorten its isolation requirements. I think that — combined with the fact that for many people, particularly for vaccinated people, even if you get covid, which you're now at this point apparently likely to do, you're not very sick — as long as you can find a way to not spread it — i.e., wear a really good mask — you probably can keep society going. This is back to the CDC's not-great ability to communicate that it wasn't making this decision so much for politics reasons as for actually keeping services going to people who need them, right?

McIntire: I think it's confusing and scary to people as well. I think people are sort of like, OK, for two years now, we've heard about a 10-day quarantine if you get sick. There might be good reasons to, and scientific reasons to, cut it to a five-day with this particular strain, with omicron. But I don't think people see really any proof to that. The CDC didn't really come out and explain this decision at a time that people were, you know — it was the holidays [and they were] not necessarily paying attention to the news. We're kind of stepped back and got this at a scary time. And I think that that's been really challenging for a lot of people as they're trying to figure out, OK, what is safe for me to do? How do I protect my family and myself while also continuing to go about my life? Because two years into this pandemic, people don't have the same capacity for shutting down, staying home, in the same way that they did two years ago in March 2020.

Ollstein: I think the perception has definitely been that economic and not public health concerns are driving a lot of this, and there's a lot of anger and frustration that I'm hearing. And also the confusion — a lot of the messaging around the severity versus transmissibility of the variant is really throwing people, and hearing that it may not be as severe is not really helpful when even this so-called milder form can still, as you said, bring society to a grinding halt just because of the sheer level of infections right now. And so the perception is that corporate America wants people back to work no matter what. And public health guidelines are being adapted to make that happen. Whether or not that is the case, that is the perception right now. And I think that is fueling a lot of frustration from people who have spent two years trying to avoid getting sick.

Rovner: I completely agree with everything you just said, which is that the perception is that this is economic. But one of the things that [CDC Director] Rochelle Walensky, the CDC, keep saying and that I think is not taken enough into account is that there's science, meaning evidence of what we know about the variant, but there's also science and what we know about human behavior. And I think what the guidelines are attempting to do what people will do — I think they're at the point where if you get … if you test positive but you have no symptoms, you're just not going to stay home for 10 days. Better to get people to stay home for five days than for zero days. Or they're worried that people won't get tested because, "Oh my God, if I test positive, I'll have to stay home for 10 days, and that's going to be a huge mess." And now that people are testing positive without being very sick … which is not to say that some people aren't still getting very sick — they are. Where there's a huge problem with … when you get that many people, it's like the flu: Every year, we get tens of thousands of people who die from the flu, although we get hundreds of thousands of people, if not millions, who get the flu and just stay home sick for a week or two. I feel like

there's a behavioral science element to this that's going unnoted. And I've seen a few behavioral scientists on Twitter who are kind of bemoaning the fact that it would be better if we had more social scientists involved in creating these guidelines so that we don't get this feeling that everything has to be based on the epidemiology.

Ollstein: I think that's true, but I think you also get into a chicken-and-egg situation where, is it assumptions about behavior driving policy? Because policy also shapes behavior. You could have had the government say, and there were those who said, "People just won't be willing to wear masks, so we shouldn't recommend them." But, as we've seen, most people are willing to wear masks. Obviously, many are still not. But you get into a situation where you can change what people are willing to do if you provide enough supports. Maybe people are willing to stay home for 10 days if they get paid to stay home for 10 days, if they get food delivered to their homes. Other countries have found ways to support people in quarantine a lot more generously than the U.S. has.

Rovner: I think that's absolutely true. One of the biggest problems of late 2021 that has followed us into 2022 is a shortage of covid tests, both rapid and laboratory-based tests. Some are suggesting the tests be reserved for those with the most need, people with symptoms and schoolchildren. But then there are other people who are traveling and they're required to — or to even get into certain places if you've not been vaccinated. Is there any chance that we're actually going to have to start rationing tests?

Luhby: Well, I think to some extent we are because they're impossible to find, at least the at-home tests. And I know several people who've had symptoms over the past week or two and can't determine … They're just assuming they're positive, but they don't actually know because there's no way to test. I have a friend in Maryland who said that she started feeling sick on Sunday. She couldn't get a test until Thursday or Friday. She didn't figure it was worth it, and she couldn't find anything in any store. So she's just assuming she's positive. But she doesn't actually know.

Ollstein: I think also the testing shortage has exacerbated some of the same access disparities we've been seeing throughout the pandemic. I know in Washington, D.C., at least, the local libraries have this wonderful program where they give out free rapid tests, but often the lines are very, very long for them, and you have to get in them early in the day in order to secure one. So who has time to stand in line in the middle of a workday in order to get a test? It's the same, upper-middle-class, wealthier, whiter folks. And those are not necessarily the folks who are most at risk right now. And so, again, we're seeing these same disparities that we saw all the way back at the beginning of the pandemic.

Rovner: So starting next week, rapid at-home tests are supposed to become reimbursable by your insurance if you're insured. My KFF colleague Larry Levitt posed an interesting question on Twitter this week. Will there be limits on what can be charged, and if there are, who's going to be left holding the bill, the insurer or the patient? Are there going to … We have heard basically nothing about how this is going to work, and you can see that people either are going to go out and try to buy up as many tests as they can and get reimbursed for them, or insurers are going to say, "We'll

reimburse you for two a week," which is a problem if you have multiple kids. It strikes me that this is going to create as many problems as it's going to solve.

McIntire: I think it will be really interesting to see when the guidance for this policy comes out … how have insurance groups tried to influence that? There are a lot of groups that are like, "Yes, we're open to this, but we don't necessarily want to be reimbursing the person who's just buying 20 tests that they find at CVS and doing it." Is there a reason, is someone testing because they have symptoms? Is someone testing because they're traveling? So I think it'll be interesting to see how the administration goes about doing that. But this is also not the most consumer-friendly way of making sure that people can get their money back for this test. It's not the easiest thing for someone to remember to keep their receipts and their filings, and how this actually addresses the consumer will be really interesting to see as this comes out. And how much of it is something that people just sort of say, "Yeah, yeah, I'll do this next weekend or next month," and then move on.

Rovner: Eventually, I suspect the U.S. is going to have to do what many other countries have done, which is just make them free for everybody. And we'll hope that … then I can already see the black market — people are going to go and get in line and get as many as they can and then turn around and sell them because that's what happens in the United States. Meanwhile, tomorrow, Friday, the Supreme Court takes up a quartet of vaccine requirement cases, two each challenging the federal government's vaccine or test mandate for employers and two challenging the Centers for Medicare & Medicaid Services mandate for health workers. Now there is a long history of government using its power to protect the public health. But with this Supreme Court, who knows what can happen, right?

Ollstein: Yeah, it's really been mixed recently from court decisions on these vaccine mandates. They've mostly been about state-level ones so far. But now we're getting into what the federal government's powers are. And we've really seen the Supreme Court go in different directions when it comes to the government's power to control the pandemic. So I think it's really up in the air.

Rovner: Yeah, they seem to have been bowing more to religious … There were a couple of cases where states wanted to ban indoor religious services, and the Supreme Court said no. But I think on vaccine mandates, at least the bits that have gotten to the court, they've seemed to be pretty strongly saying, "Yes, the federal government has — and state governments have — pretty broad powers when it comes to ensuring public health."

Ollstein: And at the same time, you have Republicans in Congress attempting to use the Congressional Review Act to get rid of these very same mandates, and it already passed the Senate. The House is expected to attempt to get over 218 votes by pressuring swing-district Democrats. And so there's arguments about the vaccine or test mandate being burdensome for businesses. Obviously, having your workforce get covid is also very burdensome for businesses.

Rovner: As we're seeing!

Ollstein: I think even if the Supreme Court does uphold the Biden administration's right to impose these mandates, you could see ongoing challenges either on Capitol Hill or elsewhere.

Rovner: Yeah, I think this argument is definitely not over. So after covid, I think the issue we've talked about most often on this podcast is surprise medical bills. So I am pleased to be able to say that legislation to bar most surprise bills, including those sent by out-of-network providers who work at in-network facilities, took effect Jan. 1. But this isn't going to solve the problems of everyone with their outrageous bills, right? Tami, you've been writing about this.

Luhby: Yeah. So surprise billing has definitely been one of Americans' biggest headaches. It's always topping the list of fears that people have when it comes to health care. There are about 10 million surprise bills a year, according to estimates. One in 5 ER visits produced a surprise bill, 1 in 5 in-network hospitalizations, from the radiologists or the anesthesiologist or some doctor's assistant. And, according to a recent study by a Health and Human Services Department, the bills can be about $1,200 on average for anesthesiologists, $2,600 for surgical assistants and even $750 for childbirth-related care.

So the new law, which was passed — there was a lot of delays, a lot of starts and stops on this in Congress, but it was finally approved in late 2020. And, basically, it protects patients when they receive emergency care or scheduled treatment from doctors and hospitals that are not in their insurance networks that they did not choose. And when you're in an emergency situation, you're basically taken to the nearest emergency room, and no one is calling your insurer to see if it's in-network. And so in these cases, consumers would only be responsible for the in-network cost sharing in these situations — their deductibles, copays, coinsurance, etc. This does apply to air ambulances. However, an important thing that people should know is it does not apply to ground ambulances, which are also the source of many large bills.

But even with this new law, we're at the beginning of the year, everybody's deductibles have started again. And so what people define as a surprise bill is a little different. So people will still be getting bills of thousands of dollars, or hundreds of dollars at least, that they may not have been expecting, and that's because their deductibles kicked in again. And it's going to take a little while before their insurance starts to cover it. The one issue that's happening that's not on the consumer side, because consumers generally are protected, but on the back end, there's been a fight now, as always, between insurers and providers.

Rovner: Which is what delayed this passing in the first place.

Luhby: Yes. And it's been interesting to see the back and forth behind the scenes, but the American Hospital Association, the American Medical Association and some other providers have filed lawsuits that aren't challenging the consumer protections but are challenging how the remainder of the bill is paid on the back end. And so they, the providers, think that the thumb has been put on the scale toward the insurers by basically having arbitrators consider the median in-network rate as the standard. So we'll see what happens on that end, but as far as consumers go, the protections should be in effect.

Rovner: But as you point out, it's important, it being January, most people's deductibles have rolled over again, so it doesn't mean that you will only ever have to pay your in-network copay. But most of the egregious bills that we've been writing about for the last [four] years will stop

happening, although I have no doubt that we will have plenty of Bills of the Month to continue with, even with the surprise bills law in effect now. Meanwhile, Congress is back, sort of, and still talking about Build Back Better, the big social spending and climate change bill currently being blocked by Sen. Joe Manchin, although it may also be blocked by Sen. Kyrsten Sinema. We just haven't heard very much from her. What is the latest, my Hill folks? From what I read, they are either resuming negotiations or not resuming negotiations.

Ollstein: Really, we are nowhere different than we were before we left for the holiday break. The rank and file are just waiting for direction from leadership on where this is going. Leadership says they are continuing to negotiate between Manchin, Dem leadership, the White House. All the same players who were talking before are still somewhat talking, but there hasn't really been any meaningful progress. And I think the fact that we're just not hearing about it and the Senate is mainly focused on other topics — the voting rights bill, etc. — is not too bright a sign for the prospects of Build Back Better. That said, people on the Hill still insist that some version is going to pass at some point this year. When it is, and what it includes, is still very much up in the air. But there's hope on the health policy front that because Manchin has vocally supported drug price negotiation, he's for the Obamacare tax credits, he's for some of the stuff, that some of it will get through. It's not going to be everything that the House passed or that we've been talking about for many months.

Rovner: Although Democrats certainly do know that if they don't do anything, things like the Obamacare tax credits will expire. And right before the next election, people are going to discover that suddenly they have to pay much, much more for their health insurance, which I imagine Democrats don't want to have happen. So we will see how this works itself out. But, yeah, it's January — they have plenty of time to deal with this.

McIntire: I just think what one of the big questions on BBB right now is, "What is the next timeline?" Democrats have signaled that they're going to be focusing on voting rights in the next couple of weeks. And then government funding is up again in mid-February, I believe on the 18th. That could be a deadline, but obviously those are sort of different in that government funding would require, whatever they do, some Republican support. Democrats are approaching this bill without intending to get any Republican support. So I think that what is the next deadline for Democrats to try to reach an agreement on this is a big question for a lot of members because it's hard to make progress, of course, in Congress without saying, "OK, here's the date we need to do this by." So I think that's kind of the next indication of how seriously are they trying to take this at this point.

Rovner: Yes, Congress is the world's most important undergraduate facility. They don't do anything until it's finals time. So in news outside of Washington, a jury in San Jose, California, convicted Theranos founder Elizabeth Holmes of defrauding potential investors, although it acquitted her on charges of defrauding patients who were given flawed blood tests. And the jury failed to reach a verdict on three of the 11 charges. Even the few convictions, though, could expose her to a very long sentence in federal prison. This trial has been touted as a metaphor for Silicon Valley investing and its creed, "Fake it until you make it." Will this actually serve to make

investors more likely to do their due diligence? Or is this just kind of a blip on the radar of let's invent magic health things?

First of all, I would say I've been following this trial because I find this whole story fascinating. But I feel like it does say something about the health system and how we … I mean, it used to be that health advances tended to come from government-funded research. And that's obviously not been true the last 20 or 30 years. Now we're seeing health advances come from individual investors who start companies, and sometimes it pans out. And in this case, it not only didn't, but it endangered hundreds of thousands of patients. And I just wonder if there's going to be any chastening of the venture capitalists. I know there's a lot of venture capitalists in health care who are professional health care policy people and professional health care providers. A lot of them have M.D.s and Ph.D.s after their names. But I wonder if we're going to be maybe a little more careful in bringing things to market after this. Or is this just a really bizarre story about a really bizarre human being?

Ollstein: It seems like we haven't found a happy medium between making it possible to bring new innovations to market but also having the checks and balances and vetting required to make sure that the products actually work. We've seen some pretty sketchy covid tests get out there, and the FDA say, "Whoa, whoa, whoa, whoa, don't trust these." And so I don't think we have the system in place to make sure that it's possible and not too burdensome for innovations to become available to people but also enough gatekeeping to make sure that there aren't scams or fraudulent products out there.

Rovner: And if you go back and really follow the Theranos story, they really did — they defrauded the FDA and CMS also. This was not a case of regulators falling down on the job. This was a case of them being very clever in how they worked around the regulators. And I think in the end, it was the regulators who ended up blowing the whistle. So this was not a case of failed regulation, but it certainly was a case of something coming to market that shouldn't have.

So it's a new year. And while the health agenda looks a lot like it did in 2021, getting control of the pandemic and passing a big social spending bill, I imagine there will be some other big health policy stories, too. I can think of a few right off the top of my head. We will start with abortion. The Supreme Court is likely to scale back or overturn abortion rights. Alice, this could be a really big story for the coming year, right?

Ollstein: Absolutely. And it is already. You have state legislatures coming back into session this week, and states are rushing to pass restrictions on abortions. Some are going all the way toward passing a Texas-style bill that allows individuals to sue one another over abortions early in pregnancy. You also have states looking to put ballot initiatives before voters later this year that would put abortion restrictions in state constitutions. You have states moving in the other direction, trying to shore up abortion rights protections ahead of a potential Supreme Court decision. And so you really have a lot of activity, and I think it's one of the top things to track this year.

Rovner: Yeah. Another big story is going to be the state of the nation's health care system. The stress is already showing as health workers quit or get sick. Is there a possibility that our health system just kind of stops functioning, grinds to a halt? Or am I being overdramatic here?

Luhby: I think if we made it through 2020, we're probably going to make it through 2022. So, again, the nation, New York early on, Southern states later — we've been through this several times, and so I think we'll make it through this one. But I don't think, and there've been stories that have come out, that we're going to necessarily be as prepared as we should be or taking all of the right lessons from the last two years into the future. We've seen stories about states restricting public health officials' authority and their work. So the pandemic has shown that we're … the country is not necessarily ready and willing to do what it needs in terms of public health to protect us for the future.

Rovner: I just really worry about burnout. I feel like in 2020 there was just a lot of adrenaline and plus, particularly, the hot spots moved from place to place and a lot of workers moved with them. Remember, there were all those stories about people getting on planes and going to New York to help with the big outbreak. Well, now everybody is kind of inundated. And so you can't really move people around because you need people everywhere. And we're starting to bring in National Guard to help with basic things. I worry that we're going to scar our health provider workforce for a generation, if not more.

Luhby: I think that's true. I have a cousin who went into nursing, graduated, as a second career. And she's in her 40s, and she graduated right before the pandemic. So she had a very rough entry into it. And she in December left her job at the hospital because she just couldn't take it anymore. And she's still doing some per diem work, but she went back basically to her old career.

McIntire: Yeah, I'm in my late 20s, and I log onto social media and I see friends from high school, college acquaintances, who work in the health care field, and they're just posting on Instagram, on Facebook, begging people, trying to just show how burnt out and how just down to the wire wherever, the hospital or the doctor's office, or wherever it is that they work. So I do think that addressing that is going to be a big issue because that's just not sustainable, particularly if it's people who are early in their nursing career, as a second career or are the younger people working in a hospital who are already feeling this. That's potentially a generation of doctors who might say — doctors, nurses, other professionals who might say — "OK, I did the hardest thing I could do in this, I'm going to go find something else."

Rovner: Yeah, I'm at the age where I have friends who are starting to retire, and one of the people that I train my dogs with is a cardiac intensive care unit nurse, has been for years, and she's old enough to retire. But I think that a lot of people who might have hung on for another couple of years are just saying, "I don't need this anymore" and hanging it up. And I know that there's large numbers of people who now want to go into medicine, which is a great thing, but there's a long lag time in what it takes to train people. And I feel like more people are leaving than are coming on at the moment. Also another story I think that will be a big story of 2022.

Luhby: And immigration will be part of that story as well.

Rovner: That's right, because we get so many of our nurses from other countries and doctors too.

Luhby: And nursing home staff.

Rovner: That's right. So, yeah, health professionals at every level. While also still on the agenda from last year, drug prices in general and Aduhelm, the controversial Alzheimer's drug, in particular. Just the mere possibility that Medicare could approve the drug has already caused a $10-per-month increase by itself in this year's Medicare premiums. Tami, you've also been following this one. We are far from finishing arguing about this, right?

Luhby: Yes, and we still don't know whether to what extent Medicare is going to approve Aduhelm. But, yeah, it's definitely been a concern. And it's something that a lot of lawmakers and others have pointed to as the need for a drug price reform as part of the Build Back Better bill. But as we know, that's on hold right now, so we don't know where this is going. And, at this point, Medicare premiums are probably not going to be brought down this year, no matter what Medicare does. They'll maybe be able to adjust in the future, but seniors and the disabled are going to be dealing with those higher premiums for 2022.

Rovner: Yeah. And I suspect … I think this big Medicare Part B premium increase has kind of flown under the radar. And I think as soon as people start seeing it, they're going to start complaining. And I bet by February, we're going to be hearing more about it from members of Congress. Well, I want to go around the table here and see what each of you think will be the most important story that you will cover this year, at least knowing what you know now in the first week of January. There are obviously no points off for being wrong here. Obviously, big things can come up, but starting now, Mel, what's the story that you think you're going to be spending the most time on this year?

McIntire: So I was sort of thinking about this question and thinking about, OK, BBB here is the obvious answer of, especially in the first couple of months of the year, where I'm seeing where I'll be spending my time. And then after that, assuming Democrats pass something that gets signed into law, how are they campaigning on that? But one specific thing that I'm really interested to see how members address, particularly as we're looking at what health provisions might get into a bill and what might be cut, is how they address public health funding. This is such an important issue, particularly now in a pandemic. But as other areas of public health haven't maybe gotten as much attention as they needed to have had or should have had throughout the last couple of years, how do Democrats and Republicans address funding public health? And this is something that I think Republicans have really been focusing on in the last couple of weeks, saying: "A little under a year ago, Democrats passed a huge spending bill, and they argue that this was a covid response bill, but only so much of it actually went to the covid response and public health issues." So I think that's something that I'm really interested to see how both parties talk about and also any potential legislation that may or may not come together.

Rovner: Tami?

Luhby: Well, for me, I'm actually going to be watching what happens to Medicaid enrollment once the public health emergency ends, which could be this year or maybe not.

Rovner: Maybe not.

Luhby: Maybe not. During the pandemic, enrollment — and I just looked up the numbers — Medicaid and [the Children's Health Insurance Program] has skyrocketed to 83.2 million as of June. That's up nearly 18% since February of 2020. And that means there's an additional 12.5 million people who are receiving Medicaid benefits. And CMS generally thinks that a lot of this is driven by the continuous enrollment requirement that was part of one of the early coronavirus relief measures from March of 2020. So, basically, states are getting a higher federal match to their Medicaid money, but that also means they can't kick anybody off. So once the public health emergency ends or if Congress decides to amend the legislation, Medicaid recipients will have to complete renewals in order to determine whether they're still eligible, and millions of people are probably going to lose their coverage. So the Biden administration already sees this coming and has taken steps to try to minimize the disruption, saying that states can have 12 months instead of six months to complete eligibility verifications and renewals. But I think it's definitely going to be a very important issue since we're talking about the health care of millions of people. And at this point, the Build Back Better provision to expand Medicaid in non-expansion states has stalled. So we're really going to watch, or I'm going to really be watching, to see how the federal government and state governments handle this and how enrollees are affected.

Rovner: I'm so glad you mentioned that because I had that on my rundown like four weeks in a row, and we never really got to it.

Luhby: Well, there's not that much new at this point happening with it, but at some point — potentially this year, potentially next year, who knows — this will become an issue.

Rovner: But when it happens, it will be a big story.

Luhby: Right, when the public health emergency actually ends.

Rovner: Yes. Alice?

Ollstein: So we already touched on this a bit, but I think this year is really going to be a lot about abortion and what happens both at the legislative level, at the judicial level and really what activist groups on both sides are up to. We just recently had the federal government loosen restrictions on abortion pills, allowing them to be distributed via telemedicine and by mail. You see a bunch of states moving to ban that very distribution. And I think we're going to see some legal clashes over that. Can states restrict a medication that the FDA says is safe and effective? This is sort of uncharted territory, a lot of it. And I think that you will see a lot of networks outside the law, which we, of course, saw before *Roe v. Wade*. I think if *Roe v. Wade* is overturned or meaningfully changed, eroded, gutted — however you want to say it — I think we're going to see a lot of that again and we already are. So I think that coming on top of a pandemic where people might not be as able to travel out of state as they were before, [it] is really going to be a major theme.

Rovner: Yeah, I think that for me, it's that combined with the health care workforce story, which we already talked about at some length. All right, well, that is the news for this week and our

predictions for 2022. Now it is time for my interview with Victoria Knight about the latest KHN-NPR Bill of the Month. Then we will come back and do our extra credits.

We are pleased to welcome to the podcast my KHN colleague Victoria Knight, who reported and wrote the latest KHN-NPR Bill of the Month. Victoria, thanks for joining us.

Victoria Knight: Thanks so much for having me, Julie.

Rovner: So, this is the second Bill of the Month for neonatal intensive care in just a couple of months. Tell us about this baby and the parents and exactly what happened here.

Knight: Yeah, so Bisi Bennett wrote in to us. She and her family live in Orlando, Florida. What happened was [in November 2020], she gave birth early to her son, Dorian, in her car on the way to the hospital, and Dorian had to spend two months in the NICU. And he had to get a lot of care while he was there. But Bisi had insurance the whole time. Still, she ended up with a $550,000 bill, and that was really due to an administrative error on the part of the hospital.

Rovner: Now, mom works in insurance, right? Mom knew to tell the hospital that her insurance was changing over at the end of the year.

Knight: Yeah, absolutely. She told them a couple of days into the new year. She was, like, hey, this health insurance is changing. And there is a little bit of a grace period. And she definitely did it within the grace period. So, she was on top of it.

Rovner: And yet she got this bill for half a million dollars. But the hospital kindly offered to let them pay in installments, right?

Knight: Yes, instead of actually billing correctly. They offered Bisi a payment plan of $45,000 per month for 12 months.

Rovner: Because everybody just has $45,000 extra hanging around …

Knight: Yes!

Rovner: … that they can put toward their insured child's medical care. If she had insurance, why did her insurance companies not pay the bill or at least pay their share of the bill?

Knight: Basically, it stemmed from an administrative error on the hospital's end. Because her son's stay was from November 2020 through January 2021, the hospital was bundling all of the dates together and billing both insurances for all the sets of dates. So the 2020 insurance was, like, “You’re billing for dates in 2021, when we didn't cover her,” and the 2021 insurance was saying the same thing about the 2020 dates.

Rovner: Just the opposite, right?

Knight: Yeah, exactly just the opposite.

Rovner: So instead of the insurance company saying, “We'll pay you for our share,” they're saying: “You're billing us for stuff we weren't gonna cover, so we're not going to pay you any of it.”

I mean, presumably the insurance companies could have done this correctly, even though they were billed wrong, right?

Knight: Yes, the insurance companies told us that they told the hospital to fix this error, separate out the 2020 dates and separate the 2021 dates, and then they would pay it. Allegedly — that's what the insurance companies told us — they told the hospital that in spring of 2021 and the hospital never fixed it, and so the insurance didn't pay and then Bisi got stuck with the bill.

Rovner: And how long did it take to work all of this out? I mean, this was clearly just an administrative error.

Knight: Baby Dorian got out of the NICU last January — so, about a year ago — and Bisi got the half-a-million-dollar bill first in March of 2021. And then she was dealing with trying to get the bill resolved literally through most of 2021, and it wasn't until she wrote in to us and I called the hospital about the bill in October of 2021 that it finally got resolved in November. So it was almost a year long. Baby Dorian was born in November of 2020, so it was basically a year-long ordeal.

Rovner: So the baby's basically going to be walking by the time they get this bill resolved. How much did they ultimately have to pay of this half-a-million-dollar bill?

Knight: Once the hospital fixed the error and the insurance processed it, she was left with $300 [to pay]. So, thankfully, yeah, the half a million was reduced to $300.

Rovner: That's a lot better than $45,000 a month.

Knight: Yes, exactly.

Rovner: So what's the takeaway here? You obviously can't control whether your baby comes early and whether it comes like as years are going to switch or whether your employer is going to change insurance. I mean, what *can* you do in these cases?

Knight: Yeah, this was a really frustrating situation, and obviously it only got resolved when she wrote in to us. There are other avenues that you can pursue. It's important to always call all the entities involved — you know, the hospital, the insurance company and also your company's HR department can offer and help, since insurance can be through them. And then if that's not working, then try to go to your state's department of consumer services. It looks different in every state. You know, it might be the attorney general's office or there might be a separate department for consumers. But reach out to them and tell them, "Hey, I'm getting this crazy bill, and the hospital won't work with me on it," and they will often reach out to them. So, you know, if you're contacting these entities and they're not doing anything, then you sometimes have to go to outside help. This time it was us, but there are other options as well.

Rovner: Terrific. Victoria Knight, thank you very much.

Knight: Thanks for having me, Julie.

Rovner: OK, we're back. It's time for our extra-credit segment where we each recommend a story we read this week we think you should read, too. Don't worry if you miss it. We will post the links

on the podcast page at khn.org and in our show notes on your phone or other mobile device. Tami, why don't you go first this week?

Luhby: Well, my story is also about the health care staffing problems. My extra credit is a Washington Post story headlined "Nursing Home Staff Shortages Are Worsening Problems at Overwhelmed Hospitals." It's by Lenny Bernstein and Andrew Van Dam. Now we've known that nursing homes have had a tough time during the pandemic and their problems have continued during the recovery. But this story is really interesting because it not only lays out the staffing shortages that the nursing homes are facing, but it actually goes beyond that and explains how these problems are impacting the rest of the health care sector and, particularly, hospitals. So there are some scary statistics and anecdotes in the story. Four hundred and twenty-five thousand employees have left the nursing home and long-care facilities over the past two years. And what I didn't know is about 58% of the nation's 14,000 nursing homes are limiting admissions. They're closing beds because they don't have enough staff, and that is a problem in and of itself, but it's actually also impacting hospitals. So the story explains, for instance, they have this great — well, this great anecdote, great from a journalism perspective — that explains how some fully recovered patients at Erie County Medical Center have to stay in their hospital rooms because they're waiting for a bed at the nursing home next door. And it means that ER patients can't be admitted to the hospital because they don't have any beds, because the people in the beds are waiting for the nursing homes to open up. And so that is actually prompting 10% to 20% of people arriving at this medical center's ER to leave without being seen after waiting an average of six to eight hours. So this is all happening at a time when, of course, hospitalizations are rising again because of omicron. So, we tend to think of things a little bit siloed sometimes. But when nursing homes have problems, it actually filters out throughout the entire system.

Rovner: Yes, and we like to say we don't have a system, but the system that we do have is really interconnected. Alice.

Ollstein: So I chose a piece in The 19th by Orion Rummler that is focused on an issue that's kind of gone under the radar, so I wanted to flag it — which is that the Biden administration is restoring protections in the Affordable Care Act for sexual orientation and gender identity. And not only are they restoring some of those protections that the Trump administration tried to get rid of, but they are enhancing them, especially around care for transgender people. And I think that this is really something to watch this year as well, because there already is, and I think will be more, a lot of clashes between the federal government and states around this question of medical care for trans people, especially youth, children, minors. And I think that there's going to be a lot of legal battles over this, as well as tons of state legislation targeting trans individuals in the year to come. So something, again, something to watch, something to track.

Rovner: Yet another story for 2022 that's kind of a holdover from 2021. Mel.

McIntire: So my story this week is sort of tangential, I think, to the fairness discussion we were having earlier. It's Sarah Kliff's latest in The [New York] Times looking at prenatal tests that pregnant women can take to help identify the potential for some of the most rare genetic diseases and disorders that might … a baby may have. And I thought what was really interesting about it —

and I sort of was, like, “Oh gosh,” at first, “Is this just another example of Theranos?” And what's interesting is that the technology is actually … it's working, particularly for diseases like Down syndrome, where it's more of … when you get into these really rare tests … this is sort of a precursor of, OK, go get more tests. But women who are going through these and may be getting these answers of “your baby might have this” don't necessarily realize the amount of false positives that are associated with it and then the amount of additional tests, which can be expensive and questionable of how much insurance might cover them. But it's important as these women are preparing to give birth and having to make decisions, sometimes in very short timelines about whether to continue on with their pregnancy or not, depending on what they might know about their baby's future. So I just thought it was a really interesting article, particularly coming this week, in the wake of the Theranos news.

Rovner: Yeah. No, I did, too. It was a really good piece. My story is also about reproductive health. It's from The Washington Post and it's called “Men Across America Are Getting Vasectomies ‘as an Act of Love,’” by Emily Wax-Thibodeaux. The story’s about men who are seeking to protect women whose abortion rights are being threatened. But it includes a discussion of a parody bill introduced in the Pennsylvania state legislature that, quote, “would require men to get vasectomies after the birth of their third child or when they turn 40, whichever comes first.” It would be enforced by allowing Pennsylvanians to report men who fail to comply for a $10,000 reward. Obviously, that is a play on the Texas law that we've been talking about, barring most abortions that is currently in effect. But I would love to see what the Supreme Court would have to say about a law like that. So, obviously, another story that will continue throughout the year.

OK, that is our show for this first week of the new year. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review — that helps other people find us, too. Special thanks, as always, to our ace producer, Francis Ying. Also, as always, you can email us your comments or questions. We’re at whatthehealth — all one word — @kff.org. Or you can tweet me. I’m @jrovner. Mel?

McIntire: @MelMacIntire

Rovner: Alice.

Ollstein: @AliceOllstein

Rovner: Tami.

Luhby: @Luhby (L-U-H-B-Y)

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