

KHN's 'What the Health?'

Episode Title: Record ACA Enrollment Puts Pressure on Congress

Episode Number: 231

Published: January 27, 2022

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 are taping this week on Thursday, Jan. 27, at 10 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today, we are joined via video conference by Joanne Kenen of Politico and the Johns Hopkins [Bloomberg] School of Public Health.

Joanne Kenen: Hi, everybody.

Rovner: Sarah Karlin-Smith of the Pink Sheet.

Sarah Karlin-Smith: Hi, Julie.

Rovner: And Anna Edney of Bloomberg News.

Anna Edney: Good morning.

Rovner: Later in this episode, we'll have an interview with Diana Greene Foster of the Bixby Center for Global Reproductive Health at the University of California-San Francisco. She's also the lead researcher of the "Turnaway Study," a comprehensive look at the lives of women who sought abortions and did or in some cases didn't get them. The study is, shall we say, more relevant than ever, as the Supreme Court looks like it's about to roll back abortion rights. But first, this week's health news.

So I thought we wouldn't talk about the Supreme Court this week because this is the first Thursday that is not a decision day in the last several, and then Justice Stephen Breyer announced that he'd be stepping down. Breyer has been a reliable moderate to liberal. He wrote the majority opinion in *Whole Woman's Health v. Hellerstedt*. That was the 2016 Supreme Court case that upheld, perhaps for the last time, *Roe v. Wade*. Assuming Democrats in the Senate are successful in replacing him — which really is an if in the 50-50 Senate — it won't change the fact that conservatives will still have a six-vote supermajority on the Supreme Court. So why is his stepping down so important for right now?

Kenen: He's 83 years old.

Rovner: That's, that's an important reason.

Kenen: From our perspective, he seems to be in good health. But I think there's been pressure on him to retire. The court is 6-3. Were he to hang on and then have a health crisis ... When we get closer to the 2024 election or after the 2024 election, it would be much more of a battle than it is today. It will be a battle. But how much? We don't know. It is not a change in power. It's a centrist-

left-liberal justice who would presumably be replaced by another liberal justice, perhaps more liberal, but it wouldn't change the 6-3. [West Virginia Democratic Sen. Joe] Manchin has not been opposed to [President Joe] Biden court nominees so far, and there is the possibility of getting a couple of Republicans — not many, but it's not impossible to get to ... see a scenario. But it's also, it's a broken Congress and a broken country, and there'll be a fight. Is it [a] brief, symbolic fight, or is it a Congress being what Congress has become for months? It's too soon to know. It could be relatively brief.

Rovner: Biden has vowed that he's going to appoint a Black woman. There has never been a Black woman on the Supreme Court. Manchin — who, as you point out correctly, has not opposed Biden's judicial nominees up until now — is going to be obviously under intense pressure from anti-abortion advocates who would like to have a seventh vote [among] the nine Supreme Court justices. Although because this is not going to be a shift in power, maybe they won't. I guess it all remains to be seen. But one thing that it's clearly going to do is complicate an already crowded election year schedule on Capitol Hill, where the Senate Finance Committee chairman, Ron Wyden, looks to be starting over on the Build Back Better legislation by focusing it on health care and energy tax credits. We also have breaking news just from this morning. The administration's announced that 14.5 million people have signed up for coverage under the Affordable Care Act, on the marketplaces, with the enrollment still open in half a dozen states, including California. They obviously credit that in large part to the enormous subsidies that were created in last year's legislation, which means that the Democrats are going to be under enormous pressure to continue those subsidies so that many of those 14.5 million people won't discover right before the midterm elections that their subsidies are going away. So do we think that what Wyden is talking about is the beginning of what the final legislation, assuming they can get it, is going to look like?

Karlin-Smith: I actually just had an article published last night that was looking at the drug pricing health care aspect of Build Back Better and what happens to it. And pretty much everybody I talked to — and it ranges from people who ... on all sides of the debate believe that if Congress is able to get a smaller reconciliation package done this year, health care is likely going to be in it. And they talk about the drug pricing reform and the [Affordable Care Act] subsidies, and people probably remember the drug pricing negotiations and so forth. There's a big savings, so that can be used to help fund the other health care priorities. So there's obviously questions about — as we know, they couldn't get the bigger Build Back Better package done. And there's questions that come up as to — if you pull things out, what Democrat does that annoy, and how do you figure out all those things to get people who maybe were OK with something because something else was in there and now it's not. But most people seem pretty confident that health care goes if this kind of a smaller social spending bill goes.

Rovner: It strikes me as literally the last thing Democrats would need would be to have this record enrollment in the Affordable Care Act and have those subsidies disappear on Nov. 1 of 2022, right as people are starting to sign up and right as they're going to the polls for the midterms. It's hard to imagine Democrats seeing that as anything but a disaster.

Karlin-Smith: Yeah, people talked to me and said that it really would be political malpractice for them not to pass some of this health care reform if they have a chance because they've been

campaigning on it for so many years. There's a good chance the House or Senate doesn't stay Democratic after the midterms, so if they really want to follow through, this may be their last chance for a while.

Rovner: Yes, and I think they know that. But this is the Senate that we're talking about, so they don't ever do anything until they have to. They're the ultimate college students: "I will study three hours before the test."

Kenen: And then ask for an extension.

Rovner: Yes, and then ask for an extension.

Over on the other health committee in the Senate, the Health, Education, Labor, and Pensions Committee, Chair Patty Murray and ranking Republican Richard Burr have put out a discussion draft of a bill that would reengineer the federal public health apparatus to better prepare it for the next pandemic, of which there clearly will be one. What are some of the big ideas here? And would they work? And what are the chances that this makes it across the finish line? Obviously, given that Burr is retiring, so it's his last chance to put his mark on public health. Anna, I see you nodding.

Edney: I think in terms of some of the bigger things that are in there, there's a lot of focus on the Centers for Disease Control and Prevention, probably kind of the splashiest piece being that the CDC director would be confirmed by the Senate, which has not been the case before. And then there's things about data collection, which clearly the U.S. has been very bad at throughout the pandemic.

Rovner: Very slow at.

Edney: Yeah, slow. And we're just not seen as a leader on that at all. And the states have taken up a lot of that. It's a patchwork, so some states don't do so well as others do. And there's a lot of trying to shore up the Strategic National Stockpile, which we've also seen has struggled throughout the pandemic. And I think there's some appeal, I would assume, to some Republicans who may otherwise be against any legislation getting through in some sense because it is making the CDC and the director particularly more accountable. And I think that that's something that everyone has wanted to push for, particularly given that it seems that Rochelle Walensky currently is making a lot of decisions on her own and then tells the White House, and then that's what happened. So I could see some appeal. Whether there's the ability to get that done before Burr is gone — especially given all the things you just talked about, Justice Breyer and other things that need to get passed — that's a big question, and I don't know if it can happen.

Rovner: I saw this and I smiled because I thought ... after 9/11 and the anthrax attacks, which were three weeks apart back in 2001, Congress actually buckled down and did a lot of work on public health and a lot of work on bioterrorism and a lot of work on pandemic planning. We knew even in 2001 that there was going to be a pandemic. And Burr was in the middle of all of that. He did a lot of that legislation. When he leaves, he will have left his mark on — I don't want to just say the public health service because that includes other agencies — but really the major public health

apparatus in this country. And I'm wondering if that might be a push to actually get something like this done. Maybe Congress can behave not like the college student waiting until the last minute.

Karlin-Smith: One thing I checked on when this proposal came out from Murray and Burr the other day was: When was the last time they reauthorized that pandemic legislation? You were mentioning the Pandemic All Hazards Preparedness Act, and for better or worse for Burr, that was in 2019, so it doesn't need to be reauthorized for a while. That would be an obvious vehicle to do it because they may need a bigger legislative vehicle. But obviously covid-19 perhaps is enough of an impetus, and this has been something that Burr has really pushed for a long time. And although on the flipside of it, one thing Republicans have not been great at every appropriation cycle is funding the CDC and increasing funding for the CDC. So I think that's going to be an interesting dynamic moving forward. Unlike agencies like [the National Institutes of Health] and other health agencies, which tend to be popular on both sides of the aisle, CDC has not been, and this is CDC-heavy legislation.

Rovner: And actually in the past, there's been at least some support for CDC on the Republican side because there's been at least one Republican senator from Georgia, which there isn't anymore. So I think that probably is going to go into this too, because obviously the vast majority of CDC staff is in Atlanta, unlike the rest of the [Department of Health and Human Services].

Kenen: Julie just mentioned the bioterror preparedness bill that went through after 9/11 and anthrax. It was a dual-use bill. In other words, it was easier to get it through Congress calling it a bioterror defense bill. It was Sen. [Bill] Frist and Sen. Edward Kennedy, but it was designed in a way to be dual-use, so that if you give the states money for biopreparedness, they did it in a way that also was ... Julie and I remember Sen. Frist was very concerned about hantavirus at that point; that seemed to be on his mind. So what you do for bioterror and preparedness in the states overlaps with what you need to do with any natural biohazard in the state of pandemic or some other kind of outbreak. But then in the Great Recession, they roll back again, so they didn't finish what they set out to do in the early 2000s and then they cut back. So, yes, the CDC has never been the darling of Congress, and NIH gets a lot more love. And even it has its ups and downs in funding, but it recently has had another surge of funding. And even if this gets through, do they stick with it? Do they put the money in year after year because public health has to be year after year. You don't fund it for this year and say, "OK, we did it." It's ongoing by definition; surveillance and preparation is ongoing.

Rovner: It was 20 years ago that they last did a big push on public health, and you can't wait two decades between these. All right. Well, let us turn to covid. Last week, we talked about what the Biden administration has managed to accomplish or not in its first year, and I specifically left covid out of that discussion because I thought it deserved its own discussion. Handily enough, we got several big thinkpieces about just this subject over the weekend from The New York Times and Politico and the Financial Times, to name a few. The basic thrust of those pieces is that putting scientists back in charge was not enough, that our public health agencies, specifically the CDC, FDA, and NIH may need a major rethink at least in terms of how to handle a pandemic. So I want to go around the table. I want each of you to say what you think the biggest covid achievement has been for this administration and what its biggest miss has been. Joanne, why don't you start?

Kenen: Well, clearly they put vaccination on a really strong footing at the beginning of the administration. The first six months or so were quite good. They got a lot of people vaccinated fast and exceeded a lot of their own goals. So the first six months were on track, and we all felt more optimistic by June or July. But they made a really fatal mistake and then they made it again, which is they didn't expect covid to totally go away, but they thought it was bonfires, not forest fires. So there would be outbreaks and you could rush in and stamp them out and not let it get out of control. And they knew that there might be variants, but they really underestimated the variant threat. They didn't ... They were talking about, "Well, there could be variants," but they weren't planning for there could be variants. And delta came and hit way worse than they anticipated, than a lot of private-sector side or other outside-the-White-House scientists as well. And then again after not being prepared for delta, then they weren't prepared for omicron. They weren't prepared. By then, they knew that they weren't going to get everybody vaccinated. They should have done better on a therapeutic or medicine and testing, and they didn't. And now we're going into what is hopefully a lull, maybe a really long lull, but they damn well better understand that this virus is capable of sending one curveball after another. If we buy a lot of tests and we end up throwing them out, great, but we can't assume that when we get out of this, that it's suddenly time to dance.

Rovner: Yeah. Anna?

Edney: You know, I think what they've done right side is — you feel the seriousness of the virus. It's no longer a joke in the White House, and people are wearing their masks and things like that. And I think that sends a message and is supportive throughout the country. I agree completely, though, with what Joanne said, that they missed on a lot of it. And so that seriousness hasn't exactly translated into certainly getting it under control in any way. And you mentioned putting the scientists back in charge hasn't exactly worked. I'm not sure I believe the scientists are in charge. I think that that's been really the hard part, and watching all of this is — it's not as overt as [former President Donald] Trump was, but there are a lot of times where you wonder, like, OK, the White House is making an announcement before the scientists have even made their decision on anything. Or it's a small group of people and not the career scientists. A lot of people know that we haven't heard from CDC that often. Finally did, I think it was a few weeks ago. They had a press conference, but it's just been the director and the others on the coronavirus task force. So agreeing with everything Joanne said, plus the fact that I don't really think the scientists are in charge yet.

Rovner: Sarah?

Karlin-Smith: Kind of echoing a little bit of what Anna and Joanne said, I think they've definitely made improvements from the Trump administration on aligning the political leadership and the White House, the scientists. And they seem much more like they're on the same team. They're sending the same messages. You don't have Anthony Fauci standing behind one of our political leaders at a press conference trying not to roll his eyes or grimace. They've certainly had a different stance and made progress in that way. I definitely agree with Joanne that a huge failure in the U.S. has been not planning for some of what we knew could be very bad future steps in the virus and in this pandemic. And that's a theme that we alluded to before, which is the U.S. doesn't

fund public health very much when we're not in a fire situation. And we don't think about it much when we're not in a fire situation. But I think the other thing to emphasize, too, is we just really haven't paid enough attention to the global need to respond to covid. And that no matter how vaccinated the U.S. is, these huge swaths of the world that are unvaccinated or don't have the resources to tackle covid are going to be a threat to us for a long time. We've seen a little bit of shift recently in the administration thinking more about that, but they did the booster rollout. That was very controversial because the question is what is more beneficial to the U.S. Is it more people around the world having more first shots? Or people in the U.S. having second or third shots? And the White House has always said, "Well, we can do both," but it's not clear that's actually happening in reality.

Rovner: All right. Well, I get to go last. And I think the one thing the administration has done pretty well is actually get things and money out the door, which is not an easy thing, which I don't think they get very much credit for. And I know there's lots of fights about money. And it's not always in the right place, and it's not always gotten where it's supposed to go. But compared to the Trump administration, I think they've done a way better job, obviously, at getting, you know, PPE [personal protective equipment] to two health care workers and getting vaccines and getting the National Guard to help, you know, even direct traffic and now help in hospitals. I think, and this will come as no surprise to anybody, I think the biggest failure has been on communication — that there has just not ever been a single message. And, obviously, it's hard to have a single message here, but you can at least say that, hey, the virus keeps changing; we're going to have to change with it. And instead, you get all these, you know, what look like flip-flops. "Oh, well, so-and-so said this last month." He was talking about something completely different! So I feel like the communication is still lacking, and that's such a basic piece of public health. I'm still surprised that two years in, we still do not have this handled. And speaking of "failure to communicate," it seems that people for whom the CDC has recommended a fourth vaccine dose, those with compromised immune systems, have been turned away at many pharmacy counters by workers who obviously haven't read the guidelines. This is obviously upsetting to those who risk themselves by going to a public place and standing in line, only to be told no. Apparently, according to my colleague and colleague Lis Szabo, who broke the original story, the CDC had a conference call with pharmacies yesterday to reiterate that these people *are* eligible for a fourth dose. But again, even though I know things are changing fast, why can't we communicate this stuff?

Edney: Liz talked about it a little bit in her story that the pharmacists were asking for a clear "just give us, like, a sheet that tells us exactly who should be getting what." And it is kind of amazing that that isn't out there, why we can't do it. I guess I don't know the answer to that.

Rovner: That was kind of a rhetorical question.

Karlin-Smith: So and just to be clear, actually, when Liz first raised this issue on Twitter, where she was hoping that as the U.S. thought about whether we did or didn't need fourth booster shots that they would focus on immunocompromised people first. And I was, like, I had this little flicker in my brain. I'm like, Wait, I think they've actually already done that. But you know, there's so much going on. And I checked, and they actually did this in October. You had to be six months out

from your last shot to get it. So at that point, very few people, if anybody, was eligible and so people really have just started becoming eligible. I think a lot of the confusion stems from immunocompromised people are actually the first people where the CDC and FDA cleared additional shots. But at that point, it was really tied into the booster debate. I actually wrote a headline like “Don't call it a booster” because, for them, what they said was you need three shots of the mRNA vaccines to have your initial series — that immunocompromised people needed three shots. And then, technically, the fourth is the booster versus for non-immunocompromised people, you get two shots and the third shot is a booster. And I don't think that's been communicated very well.

Rovner: No, it has not.

Karlin-Smith: And that's also led to confusion because you want to make sure — in [some] cases the booster shot is not the same dose as the original shot. And you want to make sure the immunocompromised population is getting three full doses before you might get that smaller booster shot. But yeah, it just seems like something the CDC never really advertised since that initial decision, and that's come back to haunt them now that people are actually eligible.

Rovner: Yet another example of “failure to communicate.” Anna?

Edney: I was just in that vein going to say, it seems like we need a whole rework of what we're calling vaccines and vaccinated. Like, we're still saying “fully vaccinated” when that can mean so many different things. So I think that's another communication challenge that could be addressed if they sat down and worked it out.

Rovner: Yes. And, you know, I realize it is hard to rebuild a plane while you're flying it. I get that. But there's a point that if pieces are falling off, you're going to have to do something. Well, one place the administration apparently is making some belated progress is on rapid testing, albeit as the omicron wave starts to recede in many of the most hard-hit areas of the country. Meanwhile, we got an actual answer to why Medicare, whose patients are among those most vulnerable to covid, isn't included in the free government test program. It turns out that Medicare doesn't cover most over-the-counter medications, of which this is considered one. And Medicare is set up to pay providers, so it's hard for them to reimburse patients. Now there's a push to figure out how to include Medicare in the free test program. Is there any chance it's going to happen? Maybe as part of legislation to lower the Part B premium in light of the non-coverage and cut in price of Aduhelm, which sort of artificially boosted the Part B premium? Could we see that folded into something?

Karlin-Smith: I'm not really sure if Congress has gotten anywhere near thinking about dealing with the Part B stuff for Aduhelm and legislation. But the other thing I'm not clear on, too, is right now it seems like a lot of members of Congress are pressuring the administration to do something about the testing issue and Medicare. And that's a question I still have in terms of: Can/does Medicare have any leverage, and under certain pandemic authorities, to just adjust the rules on their own? Or does Congress need to step in? And I haven't seen any clarity from lawmakers that they think it's on their plate. They seem to be right now hoping that the administration does it.

Rovner: That the administration will do it?

Karlin-Smith: Right.

Kenen: First of all, theoretically, Congress could pass a really narrow law, bipartisan, on this. But when does anything Congress do stay simple? I mean, theoretically, they could. They could just have a bipartisan agreement to write something that's four paragraphs long and voice-vote it, right? Do it. But the other thing is Medicare — apparently, they can't change the law on their own. We don't think there's executive power to just get around it. But they are making their tests available in community health centers and some other places. They could make more of a concerted effort. But again, this has to do with communication, you know, to make them available for anyone 65 and over much more easily — in doctor's offices and pharmacies. They're doing some things

Rovner: They could send them to senior centers.

Kenen: They could. I'm not sure how much seniors are going out to senior centers.

Rovner: That's true. Good point.

Kenen: I mean, you're not going there. So a lot of them are closed. But they could find a way of making them more widely available or having pharmacies always reserve some of the ones they have for giveaway to 65 and over. I mean, it wouldn't be perfect, but you could have Meals on Wheels, distribute them. That wouldn't get everybody either, but that would help with the homebound. There are ways that you could distribute them more widely, but, of course, since we don't have a lot, you don't want to distribute them in places where they're going to sit around. But they haven't thought about this enough. They could do more.

Rovner: Clearly. The plane is flying. Well. So, after last Friday's March for Life anti-abortion demonstration here in Washington, on Sunday anti-vaxxers held their own, albeit considerably smaller, demonstration, which featured, among other things, Robert F. Kennedy Jr., noted anti-vaccine activist, saying things are worse today for Americans than they were for Anne Frank — a comment for which he was later forced to apologize. But more seriously, anti-vaxxers have for decades come from both the left and the right fringe of politics. Yet now I feel like they're becoming part of the Republican coalition. Anna, I guess this is where I call on you for you to talk about your extra credit, right?

Edney: Well, yeah, I think it's sort of being tied up with individual freedom, clearly, and that does tend to come more from the right and the left in that sense. And so the extra credit, it's an Associated Press story by Michelle Smith, and the title is "[How a Kennedy Built an Anti-Vaccine Juggernaut amid COVID-19.](#)" So, talking about Robert Kennedy's son, Robert Kennedy Jr., he has this charity called the Children's Health Defense Fund, which I didn't even realize it was his. I get lots of emails from them throughout the day that I try not to open so I don't raise my blood pressure. But he also wrote a book, and so he's going everywhere trying to talk about this book, saying, "If 300 of you" — it was a meeting that they were having — "If 300 of you buy this now, I could be at the top of the bestseller list, we'll really stick it to Jeff Bezos and Amazon." So there's just there's a lot of anger that he's able to tap into at the left, and it's just tied up in so much. And I

feel like Sarah, in a way, is going to talk about this with her extra credit, pointing it towards a person. And so, it's just a really interesting look at how this is all funded, the tactics he's using and this misinformation campaign. And they really took a deep dive. And I think that that's something important to do because without them having to say it, you just connect the dots to the fact that he's making a lot of money off of these people who believe him.

Rovner: And I just, you know, I feel like the anti-vax movement, the *strengthened* anti-vax movement, is going to outlive the pandemic, which worries me greatly.

Edney: Yeah, that's absolutely true.

Kenen: There's always been an anti-vax movement in this country and there've been some people on the left and some people on the right for different reasons. But, particularly on the right, they're not exclusively. It has merged or blended with this red-hot anger. I don't want to say that the anti-vaxxers and the Jan. 6 people are the same. They are not. But there's an overlap and there's an energy that overlaps and a fury that overlaps. And there's a difference between anti-vax and vaccine hesitancy, people who are afraid as opposed to people who are militantly opposed. It's more complicated than we're going to get into right here. But there is this strain that is becoming mixed in with other forms of political disaffection and anger and "fury" was the word. I mean, it's dangerous going forward for public health and for other things.

Karlin-Smith: I was going to say we've already seen some attempts by states and more local politicians to try and use this to implement other laws and bills and so forth that would make it harder for school districts and other places to mandate vaccines for a whole range of illnesses that we've long required and basically eliminated in this country because of these vaccine requirements. So it's pretty scary to think about what could happen if this becomes something where we start allowing lots of children and so forth to not be vaccinated against other preventable diseases.

Rovner: I mean, we've seen what's happened in a lot, in some of these anti-vax pockets of the U.S. where, you know, suddenly we're having measles outbreaks. This obviously predated the pandemic. There's a reason that these childhood vaccines are mandated in most places, because if you don't have them, these diseases come back and people forget how terrible a lot of these diseases actually are. You know, they think of them as being not a big deal. But, like covid, some percentage of people, particularly kids who get them, are going to have severe aftereffects and in some cases are going to die from them. I feel like the pandemic is pushing back. Public health is not only going to come out, not stronger, it's going to come out weaker from this pandemic, which is, I think, a concern that public health, again, is not thinking about because they're too busy fighting the fire that's in front of them.

Kenen: All around them.

Rovner: Yes. And around them. Well, I have one workforce issue that I want to bring up. I was going to have a longer discussion about workforce, but we're running out of time. A hat tip to my KHN colleague Jordan Rau for picking up on this. In Wisconsin, one hospital sued another when, basically, most of its radiologists decamped from one to the other. The details aren't entirely clear,

but it seems that one doctor got a good offer, told his colleagues, they got similar offers, and the original hospital declined to match the offers, but then tried to block the doctors from going to their new jobs, saying it would jeopardize the original hospital's ability to serve trauma patients. Apparently, the judge in the case is not buying this, but I wonder if we're going to start seeing more things like this. There are already a lot of non-compete clauses in doctors' contracts to prevent exactly this sort of thing. But these doctors were not under contract. They were at-will employees and therefore free to leave. I mean, is it ...? We're hearing so much about the shortage of health workers. Are places going to start just sort of grabbing, in total, workers from other hospitals and then leaving those other hospitals high and dry?

Edney: I think that's definitely a possibility. And, you know, their other option is the traveling nurse, which is, you know ... I'm sort of surprised they didn't give a competitive offer because if you're looking to fill places, you're paying 300% more. The pay for traveling nurses is a lot more, so ...

Rovner: ... and traveling doctors.

Edney: ... and doctors, yeah.

Rovner: Right. And this is part of the frustration of the workforce, is that they're working side by side with people who are getting paid multiples of what they're getting paid, and they're basically suckers for being loyal to their facilities.

Edney: Yeah. And ... but I do wonder, you know, should we reach the end of this pandemic, how this all plays out. Because right now "traveling" I don't feel like means you're having to go very far. You can go down the street to the next hospital, or something like that, that needs workers. That's going to change at some point. Possibly if more people come into the workforce, that "traveling" means going farther and that may be less appealing to people down the road.

Rovner: As in public health, this is a piece of an existing workforce problem that the pandemic is making worse. And I wonder if when the pandemic recedes, we're still going to have this. You know, the health care workforce is in, what I like to say, not a good place right now. We will talk about this more unless somebody wants to talk about it right now before we move on.

Kenen: Come back to it.

Rovner: OK, we will come back to it. All right. Well, that is the news for this week. Now we will play my interview with Diana Greene Foster and then we will come back with our extra credits.

We are pleased to welcome to the podcast Diana Greene Foster, who's a professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences at the University of California-San Francisco and director of research at the study group Advancing New Standards in Reproductive Health. Welcome to "What the Health?"

Foster: Thank you so much for having me, Julie.

Rovner: So you were the lead researcher of the Turnaway Study, a longitudinal analysis of what happens to women who seek abortions and either get them or are unable to get them. This could not be more relevant than ever if the court overturns *Roe [v. Wade]* later this year, right?

Foster: Yes, I had no knowledge that that was coming, and it's extremely unfortunate how relevant we are.

Rovner: So tell us why you decided to do the study and exactly what you studied.

Foster: So the study was started in around 2007, when we were interested in answering the question: Does abortion hurt women? And it seemed very important if that's a concern, which it was for a lot of people. To look at: Well, what are the only other options available to a pregnant person who doesn't want to be pregnant is to give birth. And so we needed to look at the harms of both. And we did this by following women who were recruited from 30 abortion facilities across the country, those who were a little bit too late to get their abortion and were turned away and those who are just barely in time and got their procedure. And because these 30 facilities had different gestational limits, we got people who were denied abortions and who received them at exactly the same gestation, but they had gone to different clinics with different limits.

Rovner: What were the principal findings?

Foster: We followed them for five years and to look at their mental health, to look at their economic well-being, to look at the trajectory of their lives. And what we find is no evidence of mental health harm from abortion. And, in fact, the ways in which the two groups differed showed that people who are denied abortions actually had worse mental health initially, in terms of higher anxiety, lower self-esteem. But the biggest differences were really in economic well-being. And that's consistent with what people tell us about their reasons for abortion is often that they feel they can't afford to have a child or another child. And we see large and very immediate differences in economic well-being, where women who are denied abortions are more likely to be poor, less likely to be employed, more likely to say that they don't have enough money for just basic living needs. When I published those data on women's self-report, an economist at the University of Michigan named Sarah Miller reached out to me and said, "I had a really great idea. Why don't you link them to credit reports," which is this, whenever you apply for a credit card, you find out your credit score. This is generated by a credit agency and they have all public records of your evictions, your bankruptcies, how much debt you have. And what Sarah Miller was able to show was that the two groups of people, those who were denied abortions [and] those who received were the same economically for the three years before they got pregnant and the five years after there were big differences in the chance of having a bankruptcy or eviction. And in the amount of debt people were carrying.

Rovner: This data has been used for a number of peer-reviewed studies, right? I mean dozens.

Foster: Yes. I think we're at 51 peer-reviewed papers because there were a lot of aspects that are super interesting that the study was able to address, like: What is it like to view your ultrasound and what's the effect of abortion protesters? What's the effect of receiving or being denied an

abortion on your education, on your life aspirations, on your relationships, on domestic violence? So there were a lot of outcomes that we were interested in. It kept us busy for quite a few years.

Rovner: So why hasn't all of this sunk in? Why do we continue to hear that abortion harms women economically and their mental health and sometimes their physical health?

Foster: We were just waiting to do this podcast. I'm hoping you're going to get the word out. I'm doing my best. It's very hard. It's so interesting that this idea that abortion hurts women has gone so far with no data. And the idea that being denied a wanted abortion hurts women has not yet carried in the same way. But I don't know, you know, maybe it takes a little while for ideas to percolate. And I think also we're so used to talking about abortion as this abstract political debate that we forget that there are people involved who are making this decision and they must have reasons for making this decision. And so then it shouldn't surprise us that when we try and make this decision for them that their outcomes are worse and we just haven't shifted to having it be a person-centered debate of the person who's pregnant and what their circumstances are and their motivations. We don't think about that. They're just a pawn in some political fight. And that's, I think, why we haven't thought about this right.

Rovner: We actually, I mean, we obviously have a natural experiment going on, for better or worse, in Texas, where abortion is effectively unavailable at the moment. And if the Supreme Court does what we assume they may and undermines or overturns *Roe v. Wade*, we're going to see a lot more women unable to get abortions. Are you going to do more or do you think that the word will get out more? I mean, I guess there'll be plenty to study.

Foster: Yeah, I'm gearing up to try and look at what happens when I believe, as you do, it sounds like you do, that they'll say that *Roe* is over. And at that point, many states will be able to ban abortion. And I think the interesting question ... the Turnaway Study is very good for saying what are the consequences if women carry the pregnancy to term versus get an abortion? But it doesn't answer the question of: Who is it, who's able to transcend their state laws and by either traveling or getting pills? And who is it, who's not able to do that? And so it's not necessarily the outcomes, it's who does this affect, who is unable to work their way around the laws?

Rovner: So that will be the next chapter.

Foster: I'm working on it.

Rovner: OK. Diana Greene Foster Thank you so much for joining us.

Foster: Thank you so much for having me.

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. We've heard from Anna already. Sarah, why don't you go next?

Karlin-Smith: So I looked at a piece by Adam Johnson, who has a column on Substack called The Column. It's called "[Covid Isn't a Human Being, It Doesn't Care What You Think About It.](#)" And it's a really interesting piece about how politicians and others have used language to create a certain

anger mindset around the virus. And they basically somehow convince people that it's not covid that's making your lives more miserable right now. It's basically people who are trying to implement public health measures and other things to control the virus. He basically talks about this idea of anthropomorphizing or making human a virus that is just not that. And Republicans have made comments like "We can't live in fear of a virus." And I thought he made an interesting comparison, like, would anybody say that if you're in the middle of a hurricane, that, you know, we can't live in fear and we should just do what we want and think nothing's going to happen to us? And he also, I think, pushes back this popular sentiment right now, which is people want to believe that we're in an endemic state or closer to an endemic state, and that's just not the case right now. We have overwhelmed hospitals and record numbers of deaths and so forth. As much as you would like to, you can't whittle away a virus and pretend maybe your individual risk has gone down a lot, but the societal risk is still very high.

Rovner: It's a really good piece. Thank you. Thank you for pointing it out, Joanne.

Kenen: Jonathan Cohn and HuffPost [have] a story called "[The Right's War on Government Is Working and It Could Cost Lives.](#)" And he's talking, basically, he's jumping off the Supreme Court decision on vaccine mandates for workers that they struck. One of the arguments that he says Justice [Samuel] Alito was talking about is, you know, OSHA [the Occupational Health and Safety Administration] is not just into the mandate, it wasn't just affecting the workforce, the workplace, because you weren't just vaccinated at work, you were also vaccinated when you left work. And what Jonathan is talking about is a larger philosophical view from the right on the powers of regulation. What can the executive branch do? What can Cabinet members do? Cabinets departments do? And with a lot of implications, not just for health care but also for the environment.

Rovner: And many other things. I mean, this is basically the administrative apparatus of the federal government and the Supreme Court's desire to rein it in. And sort of we're back to the New Deal, if you go back in and read your history. My extra credit is a KHN story by Bryce Covert called "[After Miscarriages, Workers Have Few Guarantees for Time Off or Job-Based Help,](#)" and it starts out with an anecdote from a woman who had a miscarriage, took sick leave, worked from home as many of her colleagues were doing at the same time, and ended up getting fired when she told her boss she stayed home because of her miscarriage. He told her, quote "When my wife had a miscarriage in the beginning of our marriage, she only took a half a day off work." And it turns out that unless you live in states with specific leave laws, you're pretty much not guaranteed time off to recover from a miscarriage, even though it's supposed to be covered under the federal Pregnancy Discrimination Act. Considering that miscarriage occurs in 1 of 4 pregnancies, that feels like a pretty big oversight, and apparently it won't be fixed by the paid-leave parts of the big Build Back Better bill because those are the parts that apparently are not going to make it.

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

Karlin-Smith: I'm @SarahKarlin

Rovner: Anna.

Edney: @annaedney

Rovner: Joanne.

Kenen: @JoanneKenen

Rovner: We will be back in your feed next week. Until then, be healthy.