

## **KHN's 'What the Health?'**

**Episode Title:** Contemplating a Post-'Roe' World

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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, Feb. 24, 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 Alice Miranda Ollstein of Politico.

**Alice Miranda Ollstein:** Good morning.

**Rovner:** Shefali Luthra of The 19th.

**Shefali Luthra:** Hello.

**Rovner:** And my colleague Rachana Pradhan of KHN.

**Rachana Pradhan:** Hi, Julie.

**Rovner:** Later in this episode, we'll have our latest KHN-NPR "Bill of the Month" interview with my KHN colleague and cubicle mate Jay Hancock. This month, patients fell into a loophole in the new surprise bill law that you really need to know about. But first, this week's news. Let us start with abortion. The Senate is back next week from its Presidents Day recess. It's scheduled to vote on the Women's Health Protection Act, which passed the House very narrowly last year. This bill, which would basically write the protections of *Roe v. Wade* into federal law would need 60 votes to pass in the Senate, which it is *not* going to get. So why is Senate Majority Leader Chuck Schumer bringing it up for a vote anyway?

**Ollstein:** So, we know why they're bringing it up. I'm curious why they're bringing it up now. Schumer said right after the House passed it last fall that he would bring it up soon. I guess this is "soon" in Congressland, but it is several months later and they're doing it on a Monday night when everybody else is focused on the coming Supreme Court nominee and potential war in Russia. So, I mean ...

**Rovner:** And the State of the Union, which is Tuesday.

**Ollstein:** Exactly, exactly. And so, basically, even its biggest supporters admit that it's not going to have the votes to pass. They say the idea is to force all senators to go on the record about it, so voters know where everybody stands. But again, this is basically Democrats' only real strategy for defending abortion rights at the federal level right now, and it's essentially a messaging vote. And so a lot of abortion-rights groups and supporters are a bit frustrated that when the Biden administration is asked what it's doing, they basically say, "We encouraged Congress to pass the Women's Health Protection Act." It's like, well, that's not going to happen. So what else are you

doing? And they have this reproductive rights task force and such, they're intervening legally against Texas' abortion law, although that didn't go anywhere. And so it's really unclear, at least at the federal level, what can be done as the Supreme Court is preparing to, if not completely overturn *Roe v. Wade*, then significantly roll it back.

**Rovner:** Yes, and even though, I will say, today was a Supreme Court decision day, we did not get any indication ... including that this minor, quasi-abortion-related case out of Kentucky that we thought might happen. It did not yet, so we'll have to wait. So next week is also President [Joe] Biden's first State of the Union address, as I mentioned. Biden, who was pretty strongly anti-abortion in his early days in the Senate, has not actually uttered the word "abortion" yet as president, according to the website [didbidensayabortionyet.org](http://didbidensayabortionyet.org), which is a real thing. Any reason to think that might change in this speech?

**Luthra:** No. If you read any statement that the president or vice president has put out in the past year, they are very careful to say "*Roe v. Wade*" and "reproductive health" and "women's health" instead of "abortion." It's honestly very clunky to read sometimes, but it seems that there is just this real intense nervousness around using the word, for whatever reason. Whether it's personal or political, who is to say, right?

**Rovner:** It is divisive. Even within the Democratic Party.

**Luthra:** There is also the question as to whether the vote from the night before might spur Joe Biden to actually use the word "abortion." But we have a pretty clear track record so far of him being very careful to not, which is problematic for voters too, who don't always fully know what *Roe v. Wade* actually means, right? "Abortion" is much clearer language, but unless something dramatic shifts, it's just hard to imagine him changing tack now.

**Rovner:** I know. I'm always fascinated by all of these polls that say, you know, the public supports *Roe v. Wade*. It's like, does the public actually know what *Roe v. Wade* does? You know, when you actually dig down, I think the answer is: not really. I mean, they know sort of generically that, yes, *Roe v. Wade* means that women and doctors get to decide about abortion and not the government in very, very general terms. Because then when you start to ask about specific abortion restrictions, then you start to get much more support. And this is not something that's recent. This is something that's been true as long as I've been covering abortion, which goes back to the late 1980s. The American public has always been conflicted on this issue. I think the Biden administration is sort of a classic case of showing that conflict.

**Pradhan:** I was just going to say, in general, now, though, we of course have a major foreign policy crisis on our hands with Russia invading Ukraine. How much they will even talk about this is, I think, very up for debate. I think if people are pretty heavily expecting that national security, Russia invading Ukraine, and the pandemic are going to be ... *were* going to be major focuses anyway.

**Rovner:** And now even more so.

**Pradhan:** Right. And so do you just flip to reproductive health in light of the vote and abortion issues? But the State of the Union, I think, historically, even almost right until the moment that it is given, is subject to changes depending on what happens in the world. And now, very much so, that's going to be the case.

**Rovner:** Adding another layer to this, March 1 is also the six-month anniversary of the Supreme Court allowing the Texas six-week ban to take effect, essentially stopping abortions in that state, even while *Roe* is technically still on the books. I know that abortion-rights groups are really frustrated that Texas is just sort of happening along and nobody's really paying attention.

**Luthra:** Yeah, I mean, we're still seeing what we saw when the law took effect in September. People can't access abortions. There was a really great story in The Washington Post last week examining how people are trying to come in even earlier if they can. And sometimes that doesn't work either. And what happens then is you have people going to every length possible. You have clinics in neighboring states just completely swarmed with patients from Texas. I spoke to a woman in Alabama this morning who says that they are seeing Texas-based patients in Alabama. Like, that's days and days away. And then you have ...

**Rovner:** And Kansas! Apparently Kansas and Colorado.

**Luthra:** Yes. And you have waiting periods, right? Which means a multiple days' lodging. And it's very clear that everything that people thought would happen when the law took effect is, in fact, happening. And as we get more data, it will become clear that this really has been, for people who need abortions, a reproductive health crisis of sorts. And a lot of us just aren't really thinking about it because what else is there to say?

**Rovner:** And because there's so much, as Rachana points out, there's so much else happening in the world. So, meanwhile, Republican-led states are also busy preparing for what could be a post-*Roe* world as early as this summer. But, contrary to some earlier predictions, it's not Texas that these states are copying. Florida, Arizona, and West Virginia are all close to passing bills that would ban abortion after 15 weeks of pregnancy, which, not coincidentally, is the limit in the Mississippi law, the one that's currently before the Supreme Court. Is that because they think the court won't go so far as to overrule *Roe* in its entirety? Or is it for political reasons in those states they think it's easier to pass a 15-week ban?

**Ollstein:** So I did a piece on this this week, and it's really interesting depending on who you ask, because, of course, for some on the right, they say, "Look, the Supreme Court has allowed the Texas model to go forward." They have not yet ruled on the Mississippi model, so why are all these states following the Mississippi model? And they're also flagging that if you set an abortion ban after 15 weeks of pregnancy, the vast majority of abortions in the U.S. happen before that point, anyways. And so, if their goal is preventing the most abortions possible, that doesn't accomplish it. Of course, many people get abortions after 15 weeks of pregnancy for all sorts of reasons, but it has a lot less impact than a six-week ban. But it's interesting. So a lot of people on the right also say, "Look, our goal of overturning *Roe v. Wade* is to give the decision back to the states, and states naturally will make different decisions on where they want to go on abortion.

Florida has a different political makeup and won't look exactly like Texas, and that's fine, and that's what we want. We want each state to decide for itself." But a lot of other conservatives are really frustrated and feel that 15 weeks doesn't go far enough. And even the proponents of these 15-week bans are promoting a mixed message. They're at the same time, saying, "Oh, this is a reasonable compromise, this is a moderate solution." But those same people are also saying, "We eventually want to ban all abortion, and this is just our first step." And so I documented that and those tensions in my piece this week.

**Pradhan:** And I think there has been a lot of disagreement in the anti-abortion movement, I think for many years now, as Julie, I'm sure, knows. Her historical, institutional knowledge is way beyond what I have. But I just remember, even from within the last decade, these ballot initiatives in some states to have "personhood" amendments, which basically would say that from the moment of conception, this person is a human life. And so abortion would be outlawed in totality, and that was not widely supported at all by some of the biggest anti-abortion forces.

**Rovner:** Yes, it failed in Mississippi!

**Pradhan:** It failed, and some of these groups that are very, very active at the state and federal levels in trying to limit abortion never got behind that approach. At that time, 20-week bans were the most-pushed strategy among certain groups, so this has never been something that they've been unified on, how exactly they should go about it.

**Rovner:** Yeah. Both sides have disagreements about how best to proceed.

**Luthra:** I do think it's worth noting that West Virginia and Arizona, two of the three states that are pushing these 15-week bans, have pre-*Roe v. Wade* abortion bans still on the books, also. West Virginia's goes back to, like, 1848, but what it says then is that when we think about impact, depending on how the court rules, we could see abortions banned at 15 weeks. We could see it much earlier in these two states, but not in Florida, because they have this constitutional protection and they don't have a pre-*Roe* ban.

**Ollstein:** And a lot of states want to take a wait-and-see strategy. Like Shefali said, some states say, "OK, let's pass all different kinds of things. And so we have our bases covered so that no matter what the Supreme Court does, we'll be able to ban as many abortions as possible, no matter what the legal landscape is after the ruling." But some say it's more prudent. We'll avoid a lot of expensive court battles if we just wait and see what the Supreme Court does and then respond accordingly.

**Rovner:** So one last note, on the international front, as the U.S. is reeling abortion rights back in, Latin American countries are busy making abortion more widely available. Colombia this week became the latest majority Catholic South American country to have its court decriminalize abortion. It follows action in Argentina in 2020 and Mexico last year. (I know Mexico is not in South America.) Across the pond, France is also extending the period during which women can seek abortions, although its laws are still more restrictive than those of many of its European neighbors. It seems like most other countries are expanding abortion rights while the U.S. is contracting them. Is that just because of where we are in the political cycle in the U.S.?

**Ollstein:** I think it's interesting that this comes as conservatives are making arguments in court that the U.S. is an outlier, but they mean it in the other way. They are arguing that the U.S. is an outlier in that our abortion rules are more expansive or flexible than most countries', and they feel that we should be more aligned with the restrictive policies in other places. But, as you point out, right now, we are an outlier in our trajectory in that, in the U.S. because of the makeup of federal courts, we are moving towards a more restrictive, less access abortion future, where other countries, including much more religious countries that are far more Catholic, in Latin America in particular, are moving towards loosening abortion restrictions. And I think that's really interesting. I think it has to do a lot with the social movements in those countries that have been mounting these really strong protests. I'll also point to Ireland as another very religious country that has recently liberalized its abortion laws. So I think we are becoming an outlier and not the way that people on the right are claiming.

**Pradhan:** I think one thing to keep in mind also on all of this is, piggybacking on what Alice said, when courts are perceived as getting ahead of public opinion, very monumental decisions like this get perceived and responded to in a very different way. And so if we think about when *Roe v. Wade* was decided in the '70s, I think American public opinion was in a different place, potentially, at that time versus now, when these things are happening in some of these very religious countries. Still, if they're seeing or ... responding to what is commonly accepted among people already, then the backlash is not going to be as swift. But in the U.S., that did not happen before.

**Rovner:** Yeah, we're definitely in uncharted waters here. Well, Rachana. and I am really glad that you were here this week because I want to talk about [your story on what happens to Medicaid](#) when the public health emergency ends. It looks like the Biden administration will keep the public health emergency declaration active at least until July. Or at least they'd said that they would give states 60 days' notice, which they have not done yet. But still, at some point, the public health emergency *will* end. What happens to Medicaid at that point?

**Pradhan:** Well, this is a doozy of a process that states and the federal government are going to have to undertake. So, just as a refresher for people, Medicaid right now has historically high enrollment levels. It's over 70 million people just in that program alone. The program provides health coverage to everyone from people with disabilities, to the elderly, to children, to parents, and to adults without children, and pregnant women, we can't forget them. The interesting thing is, of course, so while the pandemic has been going on, [the] normal, typical routine verifications to check whether someone is still eligible, who would've been suspended if you're not eligible anymore, you can't be removed right now. Whenever it is that this public health emergency ends, those routine procedures will start again, and they will have to occur for everyone, basically, who is on Medicaid right now. And so the concern is now, of course, of the people who are on the program now, they have other insurance options. So it's not as if millions of people all of a sudden are going to be dropped off because they're ineligible and you have nowhere else to get health insurance. The problem is getting them there and finding those people. We have seen, of course, tremendous economic upheaval over the last two years for a lot of people who have experienced job and housing income disruption because of the pandemic. And so locating them and telling them, notifying them that, "Hey, you may not be eligible for Medicaid, but you can get coverage

elsewhere,” is a really, really monumental task for every single state in the country. So it's really fascinating because, of course, Medicaid covers a lot of people, but there are certain populations that are more likely to, even on a monthly basis, experience disruptions and whether they would qualify or not. The elderly in nursing homes? Not so much, right? I think they're pretty stable as far as enrollment goes, historically. But people like pregnant women, of course, whose pregnancy status will change, or young parents of young children or children in general who grow past the age 18 — and do they qualify or not? Those populations have historically experienced what we call churn throughout Medicaid, and they're the ones that, I think, people are most worried about will potentially fall off and no one will find them and they will go uninsured as a result.

**Rovner:** One of the other big worries — and Alice, that's why I'm glad *you're* here — is that people in this redetermination process often people get redetermined incorrectly. That was what we saw in Arkansas, when they had the work requirements, and it wasn't so much that people weren't working; it's that people couldn't *prove* that they were working. I mean, that's going to be a big concern here, that people who actually might still be eligible might have difficulty proving it just because there's going to be such an enormous number of people who are going to have to go back through this process.

**Ollstein:** Absolutely. And you're going to see a lot of variation between states that are going to be doing all they can to reach those people and help them find other forms of insurance. And states that are going to try to move as fast as possible to dump people off their rolls so they can save money as a state, based on the state's political ideology or the particular officials in power, or their financial situation. You could see huge disparities in terms of the rate of uninsured going way up in some places more than others.

**Pradhan:** I think one other thing to note, too, is how good their IT capabilities are, right? In the story that I wrote with a few of our colleagues at KHN who are in other states and who talked to their Medicaid officials or their state health departments about what they were trying to do, I think there is a fairly broad recognition actually among the states that they do not want people who are still eligible to fall off. They don't want to lose people because of administrative burdens. But a lot of the ways that they try to notify people are through letters in the mail. Well, if you've moved, I mean, poor people move around a lot. So they don't have stable housing, a lot of them. So there are situations where you don't get a letter in the mail and you have no idea. And the way you find out eventually, perhaps, that you don't have health insurance is when you eventually go to the doctor or you end up in the hospital. And all of a sudden someone is telling you, you don't have this coverage that you thought you had. And of course, that has very large health and financial consequences for these vulnerable people.

**Rovner:** So while we are on the subject of Medicaid, Republican-led states that haven't yet expanded the program under the Affordable Care Act, and at least one that has, are still fighting the expansion. In South Dakota, the Senate turned back the latest expansion effort, although there are now efforts to get the question on the ballot this November. But in Missouri, where voters have already approved expansion via a ballot measure, the Republican legislature is working to defund it and thereby nullify what voters did. I'm wondering if, in the end, when the public health emergency is over, are the states that didn't expand going to be happier than the states that did?

**Pradhan:** That's an interesting question. Someone asked me about this the other day and I said, You know, I don't know that "happier" is the way ... they probably might be a little more secure in their decisions. But I certainly think there is no incentive to expand once the public health emergency ends because of this. But it is true that they will have fewer people to have to do this for. And, because of what I said earlier, certain populations on Medicaid are fairly stable throughout the year. But adults without children are not that ... and so if you have expanded ...

**Rovner:** And that's, of course, the expansion population.

**Luthra:** Right, and that is the expansion population. So I do think states that have expanded may have a little bit of a tougher time finding these individuals who have been on the program as compared to people who have restricted their eligibility to not cover those individuals.

**Rovner:** Definitely something that will bear watching in the next couple of months. Let's talk about covid. There's a little bit of good news — that the omicron wave continues to recede in most of the country, although there is another potential variant on the horizon, which we will not talk about today. Meanwhile, politicians of all stripes are rushing to play hot potato with unpopular mitigation methods, mostly masks and vaccine mandates, by leaving those decisions now up to local politicians or individual business owners. Meanwhile, people with compromised immune systems and kids under 5, who still can't be vaccinated, say they're being left behind/forgotten/sacrificed — pick your verb. What stage of the pandemic are we in right now, beyond the fatigue stage?

**Luthra:** We're in a weird mess. Some states and municipalities have a lot of decision-making. We are in some ways hitting a bit of a ceiling with populations we can reach for vaccines. And that, I think, includes, in some ways, children. Because we see parents of kids under 12, of kids under 5, the majority of them are still really skeptical about the vaccine. And what all this says is that we're still in this. There are likely more variants to come, more future waves. But a large portion of the public doesn't seem willing to continue making these sort of collective mask agreements. And we don't know how to reach the other unvaccinated folks. And it's just all around a bit of a mess, isn't it?

**Rovner:** I feel like we've gotten to the stage where people are just trying to pretend that it's not here anymore, or that it's somebody else's responsibility to figure out what to do about it.

**Ollstein:** I do think that there's some interesting polling showing that even as officials in power claim that the public won't tolerate the restrictions anymore — I'm thinking of Washington, D.C., for example, which just moved to get rid of their mask and vaccine mandates even before some of them were fully implemented. And there was some polling in The Washington Post showing that most people supported those mandates. And so I think a lot of this is driven by the business community and their needs and their influence on elected officials and not necessarily by the voting public. Of course, Washington, D.C., is a lot more progressive than most parts of the country, so it's not necessarily representative. But I think often you're seeing a split between who elected officials are truly responding to, and it's not always their constituents.

**Rovner:** Yeah, well, sometimes it's also the, you know, the loudest people. We're seeing the truck convoys from Canada moving into the United States, although they haven't managed to disrupt anything yet. But often politicians respond to the loudest voices, whether or not they are the majority. Just go to any school board meeting right now.

**Pradhan:** I do think that there is a good story in The [Washington] Post that I read this morning about individual actions, too, and sometimes when I think about these things by way of comparison. ... So the district, of course, had a mask mandate. I'm over the river in Virginia and we have had no such thing as indoor mask mandates for a long time now. And when I go to the grocery store, 95% of the people are still masked just because of a function of where I live. And so I think there will be a lot more variability in the consequences of what happens now based on just individual localities, politics, and risk aversion, as I should say.

**Ollstein:** I also think we're going back to forgetting how some of these basic mitigation strategies work. I hear a lot of people saying, Oh, if you're immunocompromised or you're the parent of a child under 5, then you can wear a mask and you can do this and that, and everyone else doesn't have to. But the purpose of masks is to protect other people more than yourself. And so, one-way masking for the vulnerable is not as protective as universal or near-universal masking. I mean, we just know this from being in Year 3 of a pandemic.

**Pradhan:** And I should highlight, there's been a great spate of stories actually recently, including from our own KHN's Victoria Knight, on how the immunocompromised are handling this moment — which is that they feel extremely left behind by our government and just society writ large. And so [it's] required reading, I think, for anyone who is trying to think about these issues right now and how it may affect people who ... you know, it's not like immunocompromised people have a sticker on their forehead saying, "I have something that might make me more at risk health-wise." Even parents [of kids] under 5, of which I am one. But it's a little more obvious when you have a child who is ineligible for vaccines.

**Rovner:** Yeah, when you've got the toddler with you.

**Pradhan:** Yeah.

**Rovner:** Well, from the "Misery Loves Company" files, nobody else seems to be able to do this right, either. I would note that this week's prize for the place that was doing well but is now getting swamped is Hong Kong. My former Michigan Daily classmate Keith Richburg [writes for The Washington Post](#) that one of the problems that was caused by Hong Kong's great success with keeping covid out initially is that too many people decided that they didn't need to get vaccinated because there wasn't any covid there. And then, of course, the inevitable happened. Meanwhile, from the "Who Could Have Seen This Coming?" file, the global vaccine effort COVAX now has more vaccine doses than it can distribute. It seemed underdeveloped countries can't use what they have due to storage and distribution issues and to some extent vaccine hesitancy even in underdeveloped countries. What's the chance that the world actually learns valuable lessons from all of this? It's not just us. We're not the only ones who are stumbling. Everybody's stumbling right now.



**Luthra:** I think with the question of global vaccination, we all knew that supply chains would be an issue. We knew that storage and transportation would be challenges. We've had two years to figure it out. And given the U.S. status as a global superpower, we didn't, and that does to some extent fall on us. The vaccine hesitancy stuff, I think, is interesting. Because we had the experience in the United States of vaccine hesitancy. And what happens is you invest in outreach, and you do public health work, and you do move some people. And I think there's a real open question there of, "Are we and other wealthy nations that were privileged enough to buy vaccines first willing to put in that kind of work and help support similar outreach in other countries?" And so far, we don't talk about that, and we don't appear to have really shown an understanding of why that should be a priority.

**Rovner:** I know. I think the after-action review is going to be as much international, I think, as it's going to be national within all of these countries. All right. Well, one more topic. Since this is sometimes a nerd podcast, I have a really nerd topic we need to discuss: Medicare direct contracting. That's one of those test programs under the auspices of the Center for Medicare & Medicaid Innovation, whose job is, you know, to test programs. I've been watching this blow up the last couple of weeks, and I suspect it's all a giant misunderstanding. But it has touched off a battle between liberal Democrats who say it's an attempt to privatize traditional fee-for-service Medicare and other liberal Democrats who want to transform Medicare fee-for-service into a more value-based program. Now, if the administration put the kibosh on this, it will be far from the first time that a Medicare demonstration has bitten the dust after complaints from Capitol Hill. But I wonder if this could actually set back efforts to modernize Medicare in ways that most Democrats and most Medicare patients actually want. This was one of the things from the Affordable Care Act was to try to reshape the incentives in fee-for-service Medicare so that people would get better value care. That's exactly what this is supposed to do, right?

**Pradhan:** Yeah, one of the things I feel like ... There's so little that we have bipartisan agreement on these days, but demonstration projects under the CMS Innovation Center are definitely things that draw the ire of both Republicans and Democrats on Capitol Hill fairly widely in a way that we don't always see. But anything that that center does is going to get pushback from various corners because either you'll make it mandatory, which they have tried to do in the past, and the industry, the health sector throws a panic attack and says, "You can't force us to do this." And, you know, change is hard. I think that's one of the things that ... They're trying to really thread the needle between all sorts of competing interests. And it just goes to show that changing our very entrenched health care system is very difficult to do.

**Rovner:** Yes. Anytime a stakeholder gets poked, they're going to yell. All right. Well, that is this week's news. Now we will play my interview with KHN's Jay Hancock 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, and when we're in the office my cubicle mate, Jay Hancock, who reported and wrote the latest KHN-NPR Bill of the Month. Jay, thanks for joining us.

**Jay Hancock:** Hi, Julie. Really a pleasure to be here.

**Rovner:** So this month's family had a planned health expense that still went awry. Tell us who the family is, what happened, and what kind of care they got.

**Hancock:** So we profiled a couple named Greg Bull and Sugar Bull. They live in California, and they decided to start a family. And because of health reasons, they decided to work with a surrogate who is in Utah, which made it a little awkward, two states away. So this was right around when the pandemic was starting, and the surrogate was carrying not one, but two babies — one boy, one girl. And everything was going OK until she started to have some preeclampsia issues. This was early in 2020. Her OB didn't like that, sent her right to the hospital. It was an emergency situation. The twins were delivered, and they were OK. But they needed to spend some time in the neonatal intensive care unit — almost two weeks for one of them, about a week for the other one. And they racked up a lot of bills. They were fine. They went home.

**Rovner:** Then the bills started to come, right?

**Hancock:** Then the bills started to come.

**Rovner:** How much was the bill?

**Hancock:** The bills initially were about \$117,000. The parents, Sugar and Greg, knew that they would be high, but they assumed that their insurance would cover them. This was an out-of-network hospital for their plan, and they knew that was going to happen. But we also knew that this was an emergency, and they knew that emergency care is usually covered in out-of-network scenarios. And so they really didn't think this was going to be a problem. It did end up to be a problem.

**Rovner:** And why did the insurance company say that they wouldn't pay the bill?

**Hancock:** We never know exactly the way — some insurance companies are very mysterious. One factor was that they didn't code it as an emergency. The surrogate was admitted not through the emergency room. She went straight to the OB ward, and there didn't seem to be any emergency codes in the file. And so the company just refused to pay. They started sending these benefit explanations to the family. Some things got paid. Most of it didn't. The family didn't understand why, and this went on for more than a year.

**Rovner:** During the middle of the pandemic.

**Hancock:** During the middle of the pandemic. As an aside, when they came to visit their babies, they had to quarantine before they were allowed to go in the hospital and see them. It was unclear when they were going to be able to bring them home. But, finally, that all worked out. They got them home. The twins are doing great, but they had these ridiculous bills to deal with.

**Rovner:** So this all happened before the new surprise bill law took effect, which was just the beginning of this year, 2022. But even if it had happened this year, they might still have gotten caught in this same sort of provider-insurer war, right?

**Hancock:** Exactly. The surprise bill law requires insurance companies to cover out-of-network emergency care at more or less the network rate, and had the law been in effect two years ago when the twins arrived, it would have been in effect. But what happened to the Bulls points up a loophole, which is that what if the insurance company denies that it's really an emergency. That could happen now, even under the law. You could have an emergency. You go to an out-of-network. You rack up all this care. And for whatever reasons, it's not marked down as an emergency by the insurance company, or the hospital won't supply the documents. And boom — you're back to the same situation that the Bulls faced even though you have this law that's supposed to protect against that.

**Rovner:** So what eventually happened with this bill?

**Hancock:** So this is another lesson in health care billing and health care finance. The family ended up hiring a patient advocate. There are these companies springing up now to wade through the billing morass and help families with surprise bills get them resolved. They hired a company called Resolve Medical Bills, which went in and basically knocked heads together, got the insurance company together, got the hospital together, made them talk to each other, and finally got these bills paid off more than a year later. The balance at that time was down to \$80,000, and to get that done, the Bull family had to pay them 10% of the savings, which was \$8,000, which they were very pleased about. Eight thousand is better than 80,000. But how many families can really afford to do that? It was still a ridiculous situation.

**Rovner:** Yeah. I just went through one of these myself on a smaller level, but the same thing for a dental bill. And the provider and the insurer refused to talk to each other, and it went on for eight months. And I don't want to think about how many hours I spent on the phone to get my \$2,000 bill paid, which eventually I did.

**Hancock:** And you're an expert at this, you know?

**Rovner:** Yeah, I'm an expert at this. It's still incredibly tedious. So what's the takeaway here? Just prepare for a fight no matter what?

**Hancock:** I hope not. The takeaway is to pay attention and also to pay attention to the appeal mechanisms that are built into the new No Surprises Act law. Those appeal mechanisms have two levels. One is you can formally appeal to the insurance company if a surprise bill that you think should be covered is not. And there's a process they have to follow to do that. And if that turns out in a negative way for the patient, there's an appeal process where you can go to an outside independent reviewer. If you start to see trouble in the beginning and don't wait too long ... I mean, just think about this. Be in touch with the payers. Be in touch with the hospital if they're not getting paid. If you're getting benefit explanations that you don't like, look at your alternatives. Be in touch with people. And hopefully it won't be a fight. But given the surprise bills that we've done here at KHN and NPR, don't be surprised either.

**Rovner:** You can always write to us. Jay Hancock, thank you so much.

**Hancock:** Thank you, Julie.

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

**Ollstein:** Sure. So I have a piece from The New York Times by Claire Cain Miller that is looking at ... It's called "[A Key to Returning to Normal Is Paid Sick Leave, Democrats Say.](#)" So it's looking at just how many people in the workforce were out sick recently during the omicron wave, and it was so high, more people than at any other point during the pandemic. Even though we have readily available vaccines and all kinds of other new therapeutics and things to try to keep people healthy and safe, we have this. And yet we do not have legal protections for the millions of workers who have no paid sick leave at all and can't afford to miss work. And, of course, if they go to work sick, they spread, etc. And so this is looking at basically how our country is again an outlier compared to other wealthy nations on this front. Most others provide at least a minimum of paid sick leave to allow people to stay home from work. And we had very temporary programs in 2020, but they never reached all workers. And then we let them expire, and we haven't revived them since.

**Rovner:** One of those things that's in the languishing Build Back Better bill, right?

**Ollstein:** Exactly, exactly. And so now Democrats are looking at how else they could potentially pass some minimum form of paid sick leave. But it is, of course, an uphill battle generally.

**Rovner:** Shefali?

**Luthra:** This is from KHN's Markian Hawryluk. It is published on NPR, "[The First Public-Option Health Plan in the U.S. Struggles to Gain Traction.](#)" And I picked this in part, as you know, a shoutout to the real heads who remember the 2020 primary with deep nostalgia because this is about how a public option, that favored health reform expansion proposal by more moderate Democrats. We actually have one in Washington state, and shocker of all shockers, it is really hard to pull off and get hospitals to participate because they don't like to have their pay cut and public options pay less than private insurance. Instead, the story does a really great job of going through what the challenges have been in Washington state, how they try and get hospitals to actually take part in the public option, and what the implications are for other states that want to try a similar approach.

**Rovner:** And we should point out that the pay in the Washington state public option is a lot higher than [what] a lot of people are anticipating if there were a federal public option. Hospitals still don't want to do it. It's problematic. Rachana?

**Pradhan:** My extra credit this week is one of KHN's own, called "['Injections, Injections, Injections': Troubling Questions Follow Closure of Sprawling Pain Clinic Chain.](#)" It was written by two of my colleagues in California, Anna Maria Barry-Jester and Jenny Gold. It is really an incredible investigation into what happened after a sprawling chain of privately owned pain clinics closed and the consequences for patients. And they have found just some troubling, or alarming at the very least, developments and [looked] into the way that this pain clinic had been treating their patients. They got billing data from Medicare and Medi-Cal, California's Medicaid program. And I

really encourage you all to read it. I know that it took them months and months and months of diligent reporting. I have an inside track into how much effort they put into this. And so really, really just incredible work, and I encourage everyone to read it.

**Rovner:** Yeah, it's quite a story. Well, my story is from The Scientist. It's called "[Robert Malone Targets Physician Who Alerted Medical Board to Misinformation](#)." It's about a Maryland physician who traveled to Hawaii to speak at rallies opposing vaccine mandates. A Hawaii physician, concerned that his patients were becoming vaccine-hesitant, filed a complaint with the Maryland state medical board about the Maryland physician. But Malone, the Maryland physician, then publicized the name of the Hawaii doctor who filed the complaint, tweeted it to his hundreds of thousands of followers, and named him on the Joe Rogan podcast, which resulted in surprise threats and intimidation. Malone also filed what appeared to be a retaliatory complaint against the Hawaii physician. In the end, neither the Hawaii medical board nor the Maryland medical board acted on the complaint. But the episode raises concerns that doctors who are already hesitant to report their colleagues' bad behavior to authorities will be even more hesitant if they feel that they will be punished, too, in retaliation. Obviously, we as a society are still struggling to figure out what to do about scientific misinformation, but this seems a particularly ominous trend.

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

**Luthra:** I'm @shefalil.

**Rovner:** Alice?

**Ollstein:** @AliceOllstein.

**Rovner:** Rachana?

**Pradhan:** @rachanadixit.

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