

KHN's 'What the Health?'

Episode Title: Congress Shelves Covid Funding for Now

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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, March 10, 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 Rachel Cohrs of Stat News.

Rachel Cohrs: Good morning, Julie.

Rovner: Joanne Kenen of the Johns Hopkins University [Bloomberg] School of Public Health and Politico.

Joanne Kenen: Hi, everyone.

Rovner: And today we welcome our newest panelist, Jessie Hellmann of Modern Healthcare. Welcome, Jessie.

Jessie Hellmann: Hi! Thanks for having me.

Rovner: So let us get straight to the news because, as usual, there's a lot of it. Congress is back this week and trying really hard to finish up the spending bills for fiscal 2022, which they should have done by (checks notes) last Oct. 1. The latest temporary spending patch expires this Friday night. Will they get this big omnibus bill over the finish line or are we going to need yet another short-term fix to keep the lights on?

Cohrs: I think they did pass ...

Rovner: Yeah, the House passed it.

Cohrs: The House passed last night a short-term extension.

Rovner: Oh, the House passed a short-term, too ...

Cohrs: I think, yes, for a couple of days. That pushes it into early next week. It's not that long and nothing like we saw last time. But, I think, just to give the Senate some time to come back into session. So I think we likely won't see a government shutdown tomorrow, but everything's up in the air still right now.

Rovner: Indeed! Alice [Miranda Ollstein], who's not with us this week, had, I think, the [tweet of the week](#), which said, "The wheels of the bus are [falling] off." I guess it all blew up over the covid funding, yes? What the heck happened?

Cohrs: Yeah. So I think that there's been a conversation that there's been disagreements among Democrats and Republicans for several months at this point about whether the administration ...

Rovner: ... which is why it's March.

Cohrs: Right. Yes, exactly. So there's been a whole lot of disagreements. One of them is over supplemental covid funding. And, basically, the White House is saying we are out of money for the covid response. We don't have money to buy more treatments, more vaccines, more tests, like, we're plumb out of money. And the Republican position is that may be true, but we ... instead of appropriating new money, we should look to other pots of covid-19 relief money and pull some money from there to finance some of these asks that the White House has been making.

Rovner: Money that hasn't been spent yet.

Cohrs: Right. Yes, which is a very complicated process. And there are lots of confusing words to describe where money is at in the process. But, basically, leadership struck a deal. They thought they had an offset that their caucus, the Democratic caucus, could swallow, where they were taking "unspent money" from state and local aid. But rank-and-file Democrats were really mad because it didn't affect all states equally, and lawmakers have to represent their districts. And governors were making some noise, like, it was just untenable for them to use that money to pay for this covid relief spending. So I think that ...

Rovner: And they were only offsetting part of it, right? They weren't offsetting the whole ... it was, what, \$15 billion?

Cohrs: Half. Yeah. So they were proposing \$15 billion and ... about \$7 [billion] of that was offset, but that was too much. Apparently, that deal did not fly with the caucus. So the Democratic leadership in the House just pulled that covid relief funding out entirely, and it's kind of unclear what the path forward will be.

Rovner: Yeah, and that was my next question. So the big omnibus spending bill now goes to the Senate because the House did manage to pass it at, like, midnight last night, but without the covid funding. So ... is there something for the covid funding to then ... This is the last really must-pass, must-pass bill, right?

Cohrs: Yes, I think there's a question about whether more Ukraine funding could be needed in the next few weeks. They can always do an emergency supplemental on its own. Obviously, these disagreements, if they have more time to negotiate, to socialize in their caucus, I think there has been shock on the Hill over the past few hours about how this has all turned out. And I think maybe the White House will be a little bit more forthcoming and aggressive about explaining why they need this money and what they hope to spend it on. So, I think it doesn't mean that there's nobody ever, by any means ... it's still very fresh after this happened, but I don't think there's a solid plan right now as to how to move this forward.

Kenen: And we should point out it's the first time they're doing what they need to do, which is plan for the next variant. And maybe the next variant won't come. Maybe it'll be really mild. Or maybe it won't come for a year. Or maybe it'll be this little nothing thing. But that's been the flaw. It's like we keep saying, Hurrah!! It's over! And we don't ... we've been caught flat-footed. This time they're planning. You can disagree with elements of the plan. People that are public health

experts ... nobody loves all of it. But there is a plan. There is a plan that involves vaccination, surveillance, medication, treatment, testing. Forget what you think about how each component is going to play out. There is a plan, but you need money to pay for the plan and we are just setting ourselves up for being caught flat-footed without drugs, tests, etc. in addition to the ongoing global issues. But yeah, it's — I think I probably said this at some point in the four years we've been podcasting — my mistake, after all my years in Washington is, every once in a while, I still think they're going to do what makes sense. But I don't know what they're going to do.

Rovner: Yeah. I think they don't know what they're going to do. But before we just talk about the covid money, there's a lot of *other* things in this bill. It is a combination of the annual appropriations bills for various departments ...

Kenen: Doesn't have the Hyde Amendment?! I mean, it does have the Hyde Amendment.

Rovner: Well, yes, I was going to get to that. It includes things like funding for NIH [the National Institutes of Health] and CDC [the Centers for Disease Control and Prevention], but because it's a big must-pass bill, it also serves as a vehicle for sometimes lower-profile bills. One proposal that apparently *has* made it in would close a loophole that banned FDA from regulating "synthetic" nicotine, which means some makers of vape products targeted at teens who were able to continue selling their wares because they were using this synthetic nicotine now won't be able to. This is a not insignificant thing, right?

Cohrs: Yeah, I think my colleague Nick Florko is definitely the expert here, but he definitely thought that this was a significant development. I think Puff Bar was the main company that he had pointed to as still selling these flavored vape products.

Rovner: ... which sounds like candy. I kept looking at that ... truly, a vape company called Puff Bar?!

Cohrs: Right. It is, and I think the statistics are that it is pretty popular among young people who are using these vaping products. So I think it's definitely ... you know, we have a new FDA commissioner. [It would] definitely be a boon to his regulatory efforts if he has some new authority from Congress to move that ball forward.

Rovner: Meanwhile, Rachel, you're following what might happen to payment for telehealth visits. Currently, Medicare's paying for those under the public health emergency, but that's supposed to stop when the emergency ends, but they're going to phase it out. Is that the idea?

Cohrs: I think they've just punted the issue a little further past the end of the public health emergency, and HHS [the Department of Health and Human Services] has not said definitively when they're planning to end the public health emergency. There's been some speculation that it might be July, depending on ... they're ramping up planning on the Medicaid front. So, who knows? But at this point, Congress has decided that they're going to extend the statutory telehealth flexibilities another five months after whenever the end of the public health emergency is, which, if it were in July, would conveniently put that in December —about when they might be talking about this again. So who knows what's gonna happen?

Rovner: *After* the elections.

Cohrs: After the elections. Exactly. So I think ...

Rovner: Because telehealth is popular among seniors, right?

Cohrs: It is popular.

Kenen: Not just seniors. I mean, it's popular.

Cohrs: Yeah, right. I think this policy specifically applies to seniors, but it's certainly a larger conversation. And nobody wants to see ...

Kenen: Well, also the disabled. I mean, Medicare covers a lot of disabled people, and think about how hard it is for some of them to ... Yes, you have to go physically into your doctor or health care provider for certain things. But some of these intermediate check-ins and milder things, if you have limited mobility, and/or you can't drive yourself, and/or public transportation is really difficult for you, and/or you need to, you know, get your daughter-in-law to come get you. Yeah, I mean, telemedicine, you would think it would be an incredible efficiency and there'd be a lot less — for physicians, on the physician side, too — fewer appointments canceled, missed, people very late, no-shows, all that. You would think that for a certain, this big chunk of the Medicaid-Medicare population, including the “duals,” it would be a big deal. I don't hear people talking about those mobility issues so much.

Rovner: Although what you do hear is people saying, well, if telehealth is so much easier, we're going to use that much more of it. And it's going to cost that much more. It's always the trade-off. Things that are more convenient and more efficient sometimes end up costing more.

Kenen: But you can figure it out. And it doesn't matter. They find other ways of gaming the system. There's nothing in our system that you can't game. So, yes, people are not necessarily intentionally gaming it, but it's not the cost saver we thought it would be in all contexts. But there are probably ways you could come up with coverage rules that you could do X a year.

Rovner: And, Jessie, also tagging along on this legislation is an amendment to the 340B drug discount program that we have talked about way too many times on this podcast. Is this the last time? Or is this just another plug-in for what they're trying to do? Speaking of things that both save money and cost money.

Hellmann: I don't think this is the last time Congress is going to deal with the 340B issue, but this is definitely something provider groups have been pushing Congress to deal with for the past year or so. They say that there are dozens of providers that had to leave the program because their patient mix changed during the pandemic. And so they're no longer eligible for these discounts. They're saying this is costing some safety net providers a lot of money. So this fix would basically from the date that the bill is signed into law allow them back into the program for the rest of the year. I've been talking to some people, though, and there is some disappointment that it's not retroactive, so they're not going to get back that money for the past several months that they've not been in the program. But they are happy to see that it was at least fixed in some capacity.

Rovner: Yes. And like everything else in this omnibus bill, we're just sort of plugging the hole so we can deal with the bigger issue later. Before we leave the omnibus — yes, as Joanne pointed out, for all of the talk about Democrats on Capitol Hill and wanting to do something about abortion — and we'll come back to abortion a little bit later — the Hyde Amendment, which there was an effort to get rid of, which bans most federal funding for abortion, is in fact in this bill. And family planning providers are unhappy that they did not get any kind of increase in funds even though the Biden administration has eliminated the very restrictive regulations that the Trump administration had imposed. Is this just a recognition that Congress may be marginally pro-abortion rights, but something like this that needs 60 votes in the Senate, they're just not there yet?

Kenen: I've never thought they could get rid of the Hyde Amendment. They never thought for years ... I mean, it's been around since, what, '75? '76? Julie will know the exact year. They've been talking about the last couple of years stripping the Hyde Amendment. I never thought they could get it through the Senate, even if it was a Democratic Senate. It just was a really heavy lift politically.

Rovner: Yeah. There have been members of Congress who are now very pro-abortion rights, including the president of the United States, who vote for a lot of these expansions of abortion rights but draw the line at public funding and federal funding for actual abortions. And getting rid of Hyde, I think, will probably be the last thing that happens in Congress.

Kenen: States can use their own money. Most don't.

Rovner: Several do.

Kenen: Yeah. That is an option. It's not a widely exercised option. But since they didn't get it through after talking about it, you might see some state change. I don't expect to see a lot of state change in that direction.

Rovner: All right. Well, before we come back to abortion, let's go back to covid for a minute. It's not just the funding for covid that's uncertain right now. There seems to be a backlash building to the loosening of restrictions from the left even while the right, including congressional Republicans, are still protesting things like vaccine mandates that are going away as fast as people are complaining about them. Is everybody just cranky right now?

Kenen: We've been burned by two variants, right? We thought it was safe to go back into the water or, in this case, the air. And it wasn't. So I think people are really cautious. ... Many Americans either have risk factors or live with people or visit and love people with risk factors. I think it's going to take people a little while to understand that we're not in the same world we were even a couple of months ago. First of all, if you're not vaccinated and you worry about it, get vaccinated and boosted. The booster rate is really low. Still, the vaccination rate is much higher than booster, right? Secondly, there's increased evidence that if you are at risk or you're a family member of someone at risk, that even you wearing a good mask — not like a year-old schmatta, but a KF94/KN95, the good masks. And you can get them now and there are places you can even get them for free now. That is quite protective. If you want to go into a grocery store — I'm not

talking about spending 12 hours 3 inches away from someone actively infected, but do you have a reasonable amount of ... a high-quality mask, one-way masking — there's increasing evidence that it is protective. And there's not as much disease around. There's a lot less virus around. There's fewer people who can give it to you. And there's also a drug now — the distribution is still messed up. I'm not sure how to pronounce it. Evusheld? People will have to look it up because I might be butchering the name.

Rovner: That's how I've been pronouncing it.

Kenen: But that is also available. I actually know a few people who've taken it who are at risk for whatever medical reason or who are in that small group that couldn't take a shot or a second shot, which is a very small group. But there are some people who can't. It's rare, but there are some people who can't. And transplant patients who are seriously immunocompromised.

Rovner: Who are purposely immunocompromised, basically.

Kenen: Less virus circulating. More tools to fight it. Greater knowledge about how you can protect yourself [using] masks. And I think people are going to get a little bit more comfortable as they get used to, as they see. Even deaths are beginning to fall. They're still really high, still around 1,400, but that's better than 2,000, and it's moving in the right direction. So I think you'll see some of this, just a change in people's comfort level. And we all have the option of wearing masks whenever we feel we need a mask.

Rovner: I feel like people are confused at this point, and we seem to even be seeing a splintering of opinion among public health professionals about where to go from here. Even though, as you mentioned, Joanne, the Biden administration put out a pretty lengthy document about preparing for future variants and the next pandemic of something that's not called the coronavirus, there are a group of about 30 experts, including some of Biden's own former covid advisers, who say that plan doesn't go far enough [and] we need more attention to things like good ventilation, among other things. But if there's no consensus even among public health officials [about] what to do, how ever is anybody ever going to figure out what they should do to keep themselves and their families safe? I feel like we're in this sort of limbo zone right now where nobody's quite sure what to do or whose advice to take.

Kenen: Well, one of the things they've done wrong is — we've talked about it — there's a light switch, you know, “masks on, masks off.” And then people feel whiplash, and they feel confused. And we're not talking about it. This is becoming my own personal cliché. I've probably said it on here before, but it's a good image. We're not talking about it as a dial. You can dial down, and you can dial up. Right now, it's safe to dial down, while understanding that there are people who are at risk and we need to do things that are protective of them, including young children who still aren't vaccinated. Again, when the virus is in a lull, you're less likely to get it if fewer people around you, have it. We're in a relatively good spot this minute. We might not be in two weeks. Cases are rising in a couple of European countries; it's bad in Asia. Today we're in the better place.

Rovner: New Zealand is having a spike.

Kenen: Right. It's not over, but if we're going to be learning to live with it, when there are times that it's safer, then people within their own personal comfort spaces can have a little bit more normalcy while still a clearer message from the government on how to protect yourself and your loved ones if you are the at-risk population. But we're not at the same risk we were in January, just because now if you go into the supermarket, fewer people around you who cough are going to be coughing omicron. There are fewer cases.

Rovner: Well, another thing that seems not controversial but turns out to be controversial is the Biden administration's "test to treat" proposal, which we talked about briefly last week. The idea is that you could go to a community health center or a MinuteClinic, get tested, and if you test positive get prescribed one of the anti-covid oral medications right on the spot. But the American Medical Association has come out strongly against the plan, arguing that there are lots of contraindications to potential drug interactions involved with these covid pills and that should be handled by a physician. Pharmacists and advanced practice nurses, who are mostly the people who staff these clinics, argue back that they are more than capable of managing this task. Is this just another venue for the same old fight between doctors and people who want to do parts of those doctors' jobs?

Cohrs: Yeah, I think this is classic and I think has created quite a bit of frustration about the AMA's position that the purpose of the organization is for them to represent the interests of their members, specifically their financial interests. But I think when you're practically looking at these antiviral pills, you have to start them really early. And for someone to get a test, even if they have an at-home test and then schedule a doctor's appointment, it's really hard sometimes to get a doctor's appointment and just impractical. So I think this is an effort by the Biden administration to streamline that process. But I think they have waded into these licensure issues that are as old as time. And I think it reflects that larger question of cost versus efficiency versus expertise. And certainly there are times, I think, when we see management of practices hiring less-qualified people to save money when maybe they shouldn't be doing that. So I think there's a wide spectrum here, but this certainly was not a great look publicly for the AMA to be just territorial in this situation over prescribing of these drugs specifically.

Kenen: Yes. And many, many Americans don't have a personal physician, don't have a family doctor, don't have a primary care doctor for economic and other reasons. And also, most doctors are not very available nights and weekends, and there is this three- to five-day window. You know, you get diagnosed with covid at 5 o'clock on Friday, and you can't see your doctor until Tuesday or Wednesday — you've lost your window. I mean, I think each state has their own rules about who can prescribe what. But yes, there are contraindications that if you have certain conditions, you can't take these drugs. Or you might not be able to take these drugs, not be able to handle them. I mean, this can be worked out. You may be a situation where somebody does have a couple of complicated things. I'm going to put them on the iPad right now, [have] the pharmacist consult with the physician about this patient right now — you can do things like that. You can designate someone that you send the question marks to, and most people don't have contraindications. They have covid? Give them the medicine.

Rovner: So, yeah, this is sort of a fight that probably didn't need to happen but was completely predictable.

Kenen: Totally predictable.

Rovner: Meanwhile, it's not just funding where Republicans are trying to differentiate themselves when it comes to covid. In Florida, where the governor last week yelled at a bunch of high school students who dared to wear masks in his photo op, the surgeon general this week — this is the Florida surgeon general — defied both the CDC and the American Academy of Pediatrics [and] recommended that healthy children not get vaccinated against covid. Are they courting the pro-covid vote? Is there a pro-covid vote? I'm looking at blank faces. What is happening in Florida? I mean, seriously, the governor and his surgeon general are basically doing everything they can to say covid is over, let's move on.

Kenen: They're sort of saying covid never really happened. I mean, they're not going quite that far, but they're saying covid was never really — I mean, I read what the surgeon general in the state said. And basically, he's not accepting the breadth and depth of this crisis, retroactively looking, you know. I just wonder what — he says healthy kids don't need a shot? Well, if you want to keep them healthy, that's sort of the point of shots. I don't know his views. I have not seen — what are his views on other childhood vaccines? Is he anti-measles and mumps and tetanus? I don't know. And he may not be, but the logic of “healthy kids don't need the shot.” We give healthy kids lots of shots because we want to have healthy kids be healthy kids.

Rovner: Continue to be healthy kids.

Kenen: Yes, yes. And I don't think there's an anti-covid vote per se, but there's an anti-covid medication. anti-covid crisis, anti-covid still being here, anti-covid of the future, anti-covid ... you know I could ... I'll stop. But you know. Denial is not necessarily denial, totally, but minimizing. Denial of the ongoing threat and minimizing the past damage. And that is a political constituency.

Rovner: And it will continue. All right. Well, surprise bills are back. Still. When we last talked about this back in January — I actually went and looked it up — we mentioned that the ban on most surprise bills had taken effect, but that provider groups were suing to block the fallback mechanism to agree to a price for out-of-network care, so this would not be pushed onto the patient. Well, they've gotten a federal judge in Texas, of course, where all federal health regulations go to get challenged, to agree with them that the Biden administration's rules went beyond what the bill passed by Congress intended. Jessie, you've been following this whole surprise-bill mess. What happens now with this lawsuit and with the arbitration process?

Hellmann: The Biden administration hasn't indicated yet if they're going to appeal, though, I would expect them to. They already withdrew a part of the guidance that specifically dealt with the parts of the rule that were thrown out by the judge, but they're expected to issue updated guidance in the coming days. The dispute-resolution process is going to go forward from here. They're just — the arbiter is going to be instructed to consider a bunch of different factors equally. Instead of putting a bigger weight on the median contracted rate, which the arbiters — initially in the rule [were] supposed to pick the offer that was closest to that rate, which was seen by the

Biden administration as a guardrail for keeping health care costs down. But then the Texas Medical Association sued. They argued that that unfairly favored insurance companies. So we'll see where it goes ...

Rovner: And patients! But they didn't say that part ...

Hellmann: Yeah, exactly. The point that supporters of this part of the regulation would note is if you take away this guardrail, that could lead to an increase in health care premiums. So it's all going to come back down to patients eventually.

Rovner: Yeah, exactly. It's one enormous circle. Well, meanwhile, we already knew that ground ambulance care was not covered by the surprise bill protections. But now it turns out there's *another* loophole in this bill for some lab work. Rachel, your colleague Bob Herman wrote about this. Now what do patients need to look out for?

Cohrs: Yes, he did write about this. It was just really [great on-the-ground reporting](#). We've had a lot of conversations about when you're having surgery or something like that that you might see a provider that isn't in your network and you might not know about it. And there are some cases that I think Bob came across where you're in the same building as where the test might have been ordered, but the lab isn't owned by the same company, or is it a network? So you might still be getting surprise bills for that.

Rovner: And it's the lab that your doctor sent you to.

Cohrs: Right.

Rovner: You basically go to the doctor, the doctor orders lab work and says, "Here, take this to the lab," and you go to the lab and then you get a surprise bill.

Cohrs: Down the hall. Yeah, yeah. And I think it just shows that lawmakers really did think about these really egregious examples. You know, air ambulance billing, these emergency situations, or where you can't control what provider you're seeing. But I think this is definitely a glaring example of something that wasn't covered. So I think we'll see going forward, as people start to get more bills, those cycles are still playing out, whether that's something that regulators or lawmakers might be interested in exploring, as just another facet of this issue.

Kenen: This, in theory, I mean, it is not the same exact situation because blood tests are not emergencies. And, I mean, in some of the cases, Bob wrote about, the doctor said, "Yeah, it's in your health plan" and the doctor doesn't know what's in my health plan. Half the time I don't know what's in my health plan. So there could be some kind of consumer protection. If you're unconscious or in an emergency room or in surgery and somebody comes in ... or a pathology that you have no control over is different. Here if you walk into a lab, you know, before they stick that vial into your arm, you should — they should ask for your insurance card and say, "Yes, we take you," or "No, we don't." And then you have the option of saying, "How much will it cost if I just stay here?" or going someplace else. Because it may be a convenience issue, but it's not the same blind, no way of knowing — you can know, but you have to have an ethical system ...

Rovner: When you're being airlifted from a car accident. Yeah.

Kenen: Right. I mean, so there could be, whether it's, you know, added into this legislation or some kind of consumer guidance, CMS [the Centers for Medicare & Medicaid Services] could play some role with this. States probably can, too.

Rovner: I'm sure other loopholes are going to pop up ... because people find ways to charge money.

Kenen: Loopholes R Us! American health care!

Rovner: Well, on a related subject, the Consumer Financial Protection Bureau, that controversial federal agency that was created during the financial meltdown after 2008 — the CFPB reports that 1 in 5 U.S. households owe medical debt and that medical debt accounts for 58% of all third-party debt collections. Now, the CFPB is going to look at whether medical debt should even be included in consumer credit reports. Since, as we've just been discussing, in most cases, patients don't even agree to a price in advance. So it's not like they've agreed to pay this and then they don't. It's not like your credit card bill. So I mean, this could really be a game changer if medical debt was taken out of credit reports, right?

Cohrs: I think I've listened to some of the materials with this announcement, and I think part of the argument that they're making is that, like you said, it's not something that you're consciously taking on a lot of the time, and it's less predictive of whether you're likely to pay future debt.

Rovner: Like your mortgage or your car payment.

Cohrs: Right. And there's a question of whether the charges are correct at all, which I think is another aspect that they were talking about, just that credit scores and collections [have] become this bargaining chip in these fights between insurers and providers, and patients are caught in the middle of a lot of times. So many of us have had experiences where we're mediating between an insurer and a provider. And I think that their argument is that a lot of this debt shouldn't be on people's credit reports anyway. Even if it is, it's not something they asked for had much control over. So I think ... it's going to be a really interesting conversation going forward.

Rovner: Yeah, I'm really interested to follow this. We've talked about medical debt, obviously so much. We have our Bill of the Month every month with people who get charged for things that they had no idea. And plus, you see in a lot of these stories, people say, "Well, I got this bill and I know it wasn't fair and I tried to fight it. But then I paid it because I didn't want my credit report to get dinged because I'd like to buy a house someday." So it would be, I think, really important if this goes forward. It will be an interesting discussion. So, like covid, we will have a week one of these days when we don't have to talk about abortion. But this is not that week. As of last week, the Texas law that bans abortions after cardiac activity can be detected, to be enforced by third-party civil suits, has been in effect for exactly six months. And while the first report showed that abortions dropped dramatically in Texas, a new study suggests that the abortion rate actually rebounded to a considerable extent as women either went to other states to get abortions or were able to order abortion pills online. Both of which explains why anti-abortion state legislators

are working to crack down on the availability of medical abortion, which we also discussed last week. This week, though, we're seeing efforts taking aim at that *other* way Texas women have been getting abortions — by leaving the state. Lawmakers in Missouri are pushing legislation that would allow individuals to sue people who help women obtain abortions in other states. And in Idaho, in another copy of a different law from Texas, legislation is under consideration that would enable the prosecution of parents who move out of states to protect their transgender children. I know these conservatives are counting on a conservative Supreme Court to uphold these kinds of restrictions, but it's hard to imagine allowing a state law to reach people who leave the state, right? I mean, these are more extreme things than I have seen before. Joanne, you've also ... you've been around for a while. Have you seen things that have gone quite this far?

Kenen: No. But we've seen a lot of things that we didn't think could happen have happened in the last couple of years. So, do I think ... are these more message bills than things [that] are actually going to happen? But, you know, we would have said that about the Texas law and it's now been in effect for six months. So I'm not making predictions. Do I think it's likely that these will end up the laws in these states that are enforceable? If I moved out of Maryland, I don't totally see how they do it, but I didn't see how they could do the Texas law either. And they've done it. So, so unlikely, but not impossible.

Rovner: I know, I'm sort of fascinated. We knew that states were going to pass these laws this year in anticipation of the Supreme Court rolling back or overturning *Roe v. Wade* later this summer, you know, probably the end of June. But I think what people were not expecting was some of these outside-the-box kinds of restrictions. I mean, what we're mostly seeing is states saying, "Well, we're going to do a 15-week ban in case they uphold that. And if they decide that they can go further, we're also going to do an eight-week ban and maybe a six-week ban." That seems pretty common and that was generally expected. But some of these other laws seem like, let's just sort of throw anything at the wall and see what sticks. Is that kind of where we are? Or are they anticipating that this is going to be good for them in the midterms? Is that why they're doing this?

Kenen: I think it does remind us that a 15-week ban is not what the anti-abortion movement wants. They want more than that. And that whether these specific bills become law, getting rid of *Roe* as it has existed for 50 years is just step one. How far it goes, whether we go to the "personhood" stage, what happens next? I don't know. But if what the court does is uphold a 15-week cutoff, which is going far compared to current law, it isn't far enough for much of the anti-abortion movement. And these are just things in the next wave of anti-abortion activity. I think you will see big efforts to prevent mailing of the pills. I mean, I think that if we have a 15-week ban, I think you can see efforts to prevent access to online medication as well. But that's not the same thing as these bills that you just mentioned, Julie.

Rovner: And we should point out that you can only take the pills up to 10 weeks. So they would not theoretically be affected by a 15-week ban. Right. All right. Well, that is this week's news. 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 links on the podcast page at khn.org and in our show notes on your phone or other mobile device. Rachel, why don't you go first this week?

Cohrs: My extra credit this week is headlined "[Maternity Wards Are Shuttering Across the US During the Pandemic.](#)" It's in Vox by Dylan Scott. And I just thought this story was so excellent and just something that I have been noodling around with my coverage of hospitals and maternal mortality because I think there's been so much conversation about racial bias training and interactions between one provider and one mother. But I think there's been less conversation about the financial drivers. And the U.S. is such an outlier in this category. And I think it's also an outlier in how we run our health care system. And maternity wards without neonatal intensive care units aren't very profitable, and a lot of times they're the first thing to go when a larger health system is trying to cut costs at an underperforming facility. And where are the underperforming facilities? They're in places where their payer makes their patients ... where more of them are on Medicare or Medicaid. And so many babies are born on Medicaid in the United States that it's just created this financial disincentive. And I think we see it playing out even in Washington, D.C., where there's so few maternity wards on the east side of the city. And even if you can, when you're actually giving birth, you can drive across the city, maybe to one of these other hospitals that's a little farther away, it affects the care leading up to delivery and afterward, which is where we see so many of these potential risk factors, and as side effects come up after delivery actually happens. So I just thought it was a really great encapsulation of some of these financial determinants of health that could be contributing to this crisis.

Rovner: Indeed. Joanne.

Kenen: Mine is a piece in Politico by my colleague Helena Bottemiller Evich. It's titled "[‘I Almost Lost My Baby’: Parents Demand Answers From FDA.](#)" It's about contaminated infant formula, and it's about both the five-month gap between the first reports and when the FDA pulled them. And although the FDA [has] acknowledged five hospitalizations and two deaths, Helena's reporting has shown there's many, many, many more suspected cases — some of the babies who were severely permanently injured. And why did it take so long and why aren't there answers and more forthcoming? These are some of the main brands of infant formula that many, many, many babies drink, eat, whatever the word is — subsist on.

Rovner: I have a friend with a baby who is affected by this formula, so ... or not being able to get it.

Kenen: Yes, and there's some really sad, some very horrifying stories and obviously vulnerable people.

Rovner: Yes. I think another one of those stories [that] it would be a much bigger story if there weren't much bigger stories dominating the news right now. Jessie.

Hellmann: So my extra credit this week, the title, it's from NPR. "[Delaware Is Shrinking Racial Gaps in Cancer Death. Its Secret? Patient Navigators](#)" [by Yuki Noguchi]. And I think this is especially interesting as President [Joe] Biden is talking about cancer and moonshot and ARPA-H are two of his legacy programs to really find new breakthroughs in cancer treatments and get treatments to more people. And so, and here I looked at this program that Delaware has been doing for about two decades now — it basically connects these patient navigators with patients that may face barriers to care, either because they don't have a car, they don't speak English, or they are low

income and it helps them get cancer screenings. And then, if they're positive, it connects them to two free years of care. And so NPR found that this has led to a sharp decrease in cancer deaths, particularly among Black men. So it's kind of showing how having people that can help you connect and understand the health care system can really lead to better health outcomes.

Rovner: You know, people keep talking about this. It's nice to see something that's actually demonstrating it. Well, my story is the latest from Ed Yong at The Atlantic. We haven't had one of its stories in a while. It's called "[How Did This Many Deaths Become Normal?](#)" As the U.S. nears the loss of a million people to covid — a number so numbing it's almost impossible to wrap your head around — Ed reminds us in his so eloquent way how 3% of the population have now lost someone close to them, and that, quote, "thinking about it is like staring into the sun, and after two years, it is no wonder people are looking away. As tragedy becomes routine, excess deaths feel less excessive." It's a very somber look and something more of us should be thinking and talking about if we want to minimize our next pandemic. Instead, it feels like too many of us are too busy planning our next vacation.

So that is our show for this week. As always, if you enjoy the podcasts, 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 — at kff.org. I'm @jrovner. Joanne?

Kenen: @JoanneKenen

Rovner: Rachel.

Cohrs: @rachelcohrs

Rovner: Jessie.

Hellmann: @jessiehellmann

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

[Correction: This transcript was updated on March 17, 2022, to correct the name of the state that is considering a bill similar to a Texas law that enables the prosecution of parents who move out of a state to protect their transgender children. That state is Idaho.]