KHN's 'What the Health?'

Episode Title: The ACA Turns 12
Episode Number: 239
Published: March 24, 2022

Kitty Eisele: Did you ever think you'd become a parent to your parents? It happened to me a lot earlier than I expected. And I kept a diary.

Eisele (from her audio diary): *OK, Ernest Hemingway, here's your mug that says "Ernest Hemingway" on it.*

Eisele's father: *OK, good.*

Eisele: *Be sure to drink your Ensure, and I'll make you a milkshake later.*

Eisele's father: OK.

Eisele: I'm Kitty Eisele. I host "Twenty-Four Seven: A Podcast About Caregiving." It came from my experience moving back home to take care of my dad as he aged and trying to find advice about how to do it. I called friends and experts and complete strangers to ask about everything from how to give my dad a shave to how to talk about dying. And sometimes hearing about other people's crazy experiences made me laugh and feel a lot less alone. "Yeah, I put sanitizer on my mother's hand and then she ate it." I want to make it easier for us to take care of the people we love when they can't care for themselves. I hope you'll give it a listen. You can find "Twenty-Four Seven: A Podcast About Caregiving" at tpr.org/247 and wherever you get your podcasts.

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 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 Anna Edney of Bloomberg News.

Anna Edney: Hi, everybody.

Rovner: Rachel Cohrs of Stat News.

Rachel Cohrs: Morning, Julie.

Rovner: And today, my colleague Mary Agnes Carey of KHN, who has graciously agreed to host for me next week while I take a few days off.

Mary Agnes Carey: It's great to be here.

Rovner: Let us get straight to the news because there's more than enough of it. Wednesday marked the 12th birthday of the Affordable Care Act, which is most definitely a "tween." Let us go around the table. I want each of you to name what you think is the ACA's most important legacy

12 years in — and you can't say that it's still alive, even though that may be its most important legacy. MAC [Mary Agnes Carey], what's the most important thing that the ACA has brought us?

Carey: Just the millions of people that have been able to access and keep coverage, right? To take away that fear of you want to start your own business or you can't afford health insurance or you don't want to change a job because you are afraid of not having your health insurance. I just think to have millions of people insured — and it's just become part of the conversation. It's not the outlier, you know, that it was for years and years and under this threat of repeal-and-replace and this legal threat of the Supreme Court. I'm not saying that's over. I mean … definitely Republicans still dislike it. And if they take control of Congress and the White House, they might try to repeal it again. They still don't have a unified replacement. But I just think that it has had staying power, and that has been an incredible legacy.

Rovner: I did notice this month that one — I guess it was Sen. Rick Scott, wasn't it? — who muttered about repealing it. He had to walk it back the very next day, which is unusual for Republicans. Rachel, what's the most long-lasting legacy of this 12-year-old law?

Cohrs: So I think mine's related, but I think just as someone in my mid-20s who grew up with the Affordable Care Act in place, I think just the expectation for people with preexisting conditions or that young adults can stay on their parents' health care plan until 26. Becoming a health care reporter, learning so much more about it, I was kind of surprised to learn [what] used to be accepted practices before the ACA. So I think just taking a step forward in ensuring access — not just with cost, but also legally — to ensure more continuous coverage, especially for people who need it most.

Rovner: Anna.

Edney: I think it's really difficult to choose one, and those were two really good ones. The first thing that came to mind for me is what I'll just … I'll say. And that's Medicaid expansion and reaching so many low-income people who were in this weird zone before where … health coverage was just unaffordable. But they didn't quite fit into Medicaid, either. And so I'm going to go with that one.

Rovner: Which is what I was going to go with. But since you did, I'm going to go with all the stuff that people don't know is actually in the bill — starting with the minimum loss ratios, the fact that people … insurers can no longer make an unlimited amount of profit off of each premium dollar. And the no-cost coverage of preventive care and things that, as Rachel was saying, we all take for granted unless you're old enough to remember when it wasn't there. Like many laws, there's a lot of things that this law brought to us that people have no idea. One of the continuing paradoxes of the ACA, though, which boosted insurance coverage dramatically yet left millions of Americans still uninsured — or insured but unable to afford care — is that this time next year, things might, well, look either much better or much worse. As my friend Jonathan Cohn, who sat with me in the House press gallery 12 years ago when Congress took the final ACA votes, wrote this week, quote: "Officials in Washington and state capitals face a series of key decisions about the future of Obamacare, and, depending on what they decide, literally millions of people could gain or lose

health insurance, although not too many people outside of political and policy circles seem to have noticed." What are some of those decisions and why is it so low-key, that one would think that this would be as big a deal as some of these big repeal fights?

Edney: I was going to say that … the same thing MAC was talking about is there's just so much going on right now. For some people, covid still being at the forefront of their minds, the war in Ukraine. And so, some of this stuff has just dropped off — and you just talked about we kind of take it for granted. I think we're at a point where the ACA has survived so much and it's just not something people think about as — not that it's threatened even now in the same way, but just that, you know, maybe the other things aren't at the top of mind. I really appreciated Jonathan's article because it did remind me even of these things, and one being that there was a lot of subsidy help in the covid relief package and that helped people be able to afford insurance, and that's going to go away. It needs to be renewed.

Carey: I was just going to say some of it just might be the framing of it too, right? In the sense of if you get people coverage, people get in earlier to the doctor, might stop something from becoming a chronic, life-threatening illness, right? Helps out with uncompensated care, which hospitals are covering. But if you get insurance coverage for folks, that helps even that out. I mean, some of this has been viewed in a different framework, but I think if there's a more holistic, if you will, view of what coverage means for the system, for state budgets, for federal budgets as well as people's own budgets, that it's a different framing that might make this more acceptable than the idea of the federal government's overpaying for subsidies or shouldn't pay states, or states are reluctant to expand their Medicaid rolls. I mean, there's a much bigger, broader, lasting impact here that doesn't really get a lot of attention.

Rovner: Although if Congress doesn't figure out a way to extend these subsidies, people are going to see really high premiums right before the midterm election.

Carey: Exactly. Not good.

Rovner: I'm surprised — I think that's the part that surprises me that's not getting more attention.

Carey: No, I think you're spot-on, and they don't want that to happen. That would not help the Democrats at all. But Republicans also know that would not help the Democrats.

Rovner: And plus, I think the unspooling of the Medicaid requirements, that during the pandemic states have been required to keep everybody who qualified for Medicaid on the rolls and, obviously, when the public health emergency ends, those people won't all still be qualified and how states unravel that is also going to be huge. I mean, we … know that there are states that still have not technically expanded Medicaid under the Affordable Care Act, but there could be an enormous amount of disruption. I think that's what's Jonathan was leaning towards. And I think people aren't really appreciating how much disruption there could actually be.

Cohrs: Certainly. And the Biden administration is facing pressure from states, which are in a tough position themselves because they're having to pay for people who might not qualify for the program, and during the public health emergency that was a trade-off. And obviously, they got

more money from the federal government to help with that. But, for some states, the trade-off is not worth it at this point. So I think it's very much something that CMS [Centers for Medicare & Medicaid Services] officials are talking about and are very concerned about ensuring states are on the same page. But they only have so much control over that.

Rovner: Yeah. Well, speaking of unfinished business of the Affordable Care Act, the Commonwealth Fund is out with a report on short-term health plans, those things that the Obama administration tried to rein in and the Trump administration went around and unrestricted. Well, it turns out the concerns expressed by health analysts were real. When you make it easy to get cheaper plans that cover fewer services, healthy people are more likely to migrate to those plans. Yet, this is one of the Trump health policies that the Biden administration hasn't touched yet, probably because these short-term plans are, well for healthy people, kind of popular. So is this just going to limp on, or is this going to [make] the Biden administration feel like it's going to have to do something about these plans again, now that we're showing that it is siphoning off healthy people and leaving sicker people in the Affordable Care Act risk pools?

Carey: I mean, maybe it's a question of political capital and timing. I mean, if you think about all the things we've just talked about, right, and all the other things in the ACA — whether it's the "family glitch" or the coverage gap, or you want to get the subsidies continued so more people can buy coverage — you've got all that on your plate. How much time do you want to spend pursuing something that would be perceived as taking something away from people who like these plans? I mean, a lot of people like them because, like you say, they're inexpensive. Now, they don't know …

Rovner: And if you're pretty healthy and you don't use health insurance, it feels like a great deal.

Carey: When you're running the table and you're looking at all the priorities, that may not be top of the list. Others might disagree, but that was kind of my thought when you asked your question.

Rovner: Yeah. And I've been wondering … Obviously, we're keeping track of these Trump policies as Biden reverses them. And this is one that's been sticking out as remaining untouched because they've actually gotten to a fair number of them in 14 or 15 months.

So a couple of weeks ago, we talked about a report from the Consumer Financial Protection Bureau about medical debt and suggesting that the agency might encourage the big three credit bureaus to stop including it in credit reports. Because as often as not, it's not even really debt but expenses that consumers never agreed to. Well, lo and behold, last week, those three credit bureaus — Equifax, Experian, and TransUnion — jointly announced that they would eliminate up to 70% of medical debts, including ones that were paid after they went to collection and everything under $500 from people's credit reports. Credit reporting agencies will also give consumers more time, a full year, after going to collection, rather than the current six months, to sort out those medical spending disputes between their providers and their insurers. It's not clear if this was to head off even more stringent action by the CFPB or whether that might still come later. But, in the meantime, this is a pretty big deal, right? Rachel, you were covering this.

Cohrs: Yes, I've been tracking it, and I think the Wall Street Journal had a good scoop about this action that was coming. And I think there are questions about the relationship between medical debt and how well that predicts how likely people are to pay other debts in the future. So I think it does raise questions about how valuable that is, and I think it'll be interesting to watch as these new decisions play out, whether it takes a tool out of providers' toolbox, threatening collections for patients. So I think that'll be interesting to see how those debt collection tactics adjust.

Rovner: Yeah, I know we see with Bill of the Month pretty much it's a recurring thing that patients get all freaked out when they get these bills that they aren't technically responsible for. But they think, "Oh, it's going to ding my credit report, and I'd like to buy a house someday."

Cohrs: Exactly. And there's these companies — they're called revenue cycle management companies — that hospitals contract with to manage this debt collection process. Many times, they're very aggressive. So it's a step that restores some power to patients in having some leverage in this process to make sure insurers and providers are working out their issues and there's less of a threat to the patients and their financial stability in the future.

Rovner: It seems sort of in the spirit of the [No Surprises Act], even though it's not technically part of it.

Edney: It's also a step that recognizes the disconnect between medical debt and not being a responsible person who pays their bills. You can rack up debt and have no idea because the hospital billing system is so terrible. Or it can take you a very, very long time — as that's shown [through KHN's Bill of the Month series] again and again — to get these things resolved. So I think that that was a recognition that having medical debt does not mean that you won't pay your mortgage or something like that.

Rovner: Or your credit card bills.

Carey: And while this is going to help a lot of people, it doesn't help, if I understand it right, people with some of the largest bills that they've already accrued, right? And they're fighting off these debt collectors and so on. And that — progress is progress, right? That's great. But that's something to keep in mind here. If you've got this already existing debt and it's voluminous and people are pursuing you, this won't necessarily help you. I mean, other things might help you pay that off. But, again, this is a great thing to happen. But there's still a lot of people out there. And accruing medical debt, to Anna's point, is not like excess consumer spending, right? This is like something you didn't plan on, you didn't want to happen to you. You find out your insurance doesn't cover things or you're not insured. And, bam, it just can happen very quickly.

Rovner: Yeah, a little preview of a coming Bill of the Month: It's for nearly half a million dollars.

Carey: Oh my. Whoa.

Rovner: Yeah. It's pretty easy to rack it up really fast. Welcome to the spiraling cost of medical care. Well, I thought this week we really wouldn't have to talk about abortion. In fact, the ongoing confirmation hearing for Supreme Court nominee Ketanji Brown Jackson has had less discussion of abortion than any Supreme Court nomination hearing I can remember since the 1980s, which is

not that surprising, given that there are clearly already six anti-abortion votes on the court and her confirmation one way or the other isn't going to change that. But two more state laws got signed by governors this week: a Texas copycat ban in Idaho, except that the Idaho law would ban all abortions, instead of those after six weeks' gestation, like the Texas law has been doing. And even less noticed is a law signed in South Dakota that would basically overrule the FDA's easing of rules, allowing the mailing of abortion pills. Both of these appear to be among the leading waves of how anti-abortion states plan to deal with the likely overturn or significant weakening of *Roe v. Wade* later this spring or summer. Are we just going to see more of this as this decision nears? I know we'd been talking the last few weeks about how states have surprisingly not copied Texas right away, but maybe it just took them a few months. We're in March, when most state legislative leaders are nearing the ends of their sessions and actually passing whatever it is they're going to pass. Anna, I see you nodding.

Edney: Yeah, no — that's exactly what I was thinking was there was some timing there when the legislatures are getting into the last of their business, passing what they really want to get passed and that's part of it. And certainly they're emboldened by Texas. They've had a little time to see how it's played out and just to have an idea of whether it's something they wanted to tackle or whether it's something legally they thought they could go after, and certainly the floodgates are open.

Rovner: I found it interesting. Apparently, after the Idaho governor signed the law, he then put out a message that said he doesn't think that the enforcement method — which is this idea of "let's get around the Supreme Court by having people sue providers in civil court so there's nobody to then sue to block the law" … The Idaho governor is not sure that that is constitutional, but apparently he went ahead and signed the bill anyway.

Edney: Right. You almost just need the threat of the enforcement mechanism, not the actual ability to do it, because that is scaring doctors enough. I read a terrible story that was written in the beginning of March; it was on NPR and it just kind of made it into my inbox. But I saw that there was a woman in Texas who went into early childbirth, and the only thing … It was so early, the baby wasn't viable, and the only thing they could do was possibly was to terminate the pregnancy surgically, to save her life. But they were so scared in Texas, they had to find out ways to get her on a plane to another state while she was in the middle of this, and the doctors weren't even talking to her about it. They were texting it out on their phones so that they wouldn't be overheard by anybody else, like trying to help her out. And that's all it kind of takes as the threat of something like being sued.

Rovner: Right. Well, that's sort of the magic of these laws, which is that they have basically shut down abortions because it's basically an unlimited liability or a potentially unlimited liability if you get caught or reported or sued. And at the very least, you're going to get dragged into court. So I imagine we now have two states, and I know there's other states with this sort of thing in the pipeline.

OK, let's turn to covid. Depending on which numbers you're watching, the U.S. appears to have passed or is just about to pass the grim milestone of 1 million covid deaths. And I think it's worth

taking just a moment to absorb that literally 1 out of every 330 people in this country have died of this virus in just the past two years. How is that not the biggest headline of the week?

Carey: I have to say I remember being on the podcast when it was hitting 400,000 and thinking I couldn't believe it. Right? And now we're double that. I mean, we have this sort of fatigue, and I understand it about covid, right? Before the podcast began taping, we're all chatting about mask wearing or lack thereof and people's attitudes toward people who want to wear a mask or don't want to wear a mask. I mean, people are worn down. It's going into the third year. And I understand all that, and I'm feeling it myself. But to your point, look at that number. It's just nuts. And the fact that we've got variants on the rise and fights over funding. And are we going to have enough shots? Do we even need another booster? I mean, you could have podcasts on all those individually, right? But I just think there's this collective weariness that is understandable. But also it's just not over. It's just not, and we have to keep living with this.

Edney: And I think we've also collectively decided that if you die, it was your fault. You didn't get vaccinated, probably. And we're seeing that's not absolutely true.

Rovner: Or you're old, God forbid.

Edney: Or you have a condition that might make you immunocompromised. There are so many people that, even if it's someone who decided not to get vaccinated, there's so much misinformation, so many people that we haven't reached. This isn't just like a throwaway segment of the society that we can say like, oh well, 1 million deaths, like they weren't trying for themselves. And the under-5 set can't even get vaccinated yet. The CDC decided — and, obviously, I'm biased because I have a 2-year-old.

Rovner: Yes, you have an under 5 running around.

Edney: The CDC decided that all protections could be dropped pretty much before they even had a chance. And we're not, hopefully not, that far away from something — they at least might have something in the form of a vaccine. But it feels like that goes to what MAC was talking about. People were just tired, wanting to give up, want to win elections and in the long run. But I think that there's also been this idea that if you die, it's probably your fault. And on the Republican side, that even goes to like … They seem to be like, "Well, were they immunocompromised?" And I don't understand why that's even a question.

Rovner: Yes, because if you're immunocompromised, it's also your fault. There does seem to be this collective — it's all about, you know, it's up to you. They've taken this libertarian view of public health that it's up to you to protect yourself, and it's not up to the community to protect its vulnerable members, which is kind of where we seem to have landed after two years. Well, meanwhile, as Europe and Asia see cases of the BA.2 variant spreading rapidly, the Biden administration is ratcheting up its warnings about what will happen if Congress doesn't appropriate more money, so we won't be caught flat-footed again in terms of testing and treatment and vaccines. If another wave makes it to the U.S., as seems possible, if not likely. Anna, your extra credit this week is about exactly this. So why don't you tell us about it now?

Edney: I chose one from Politico by David Lim. It's "'We've Learned Absolutely Nothing': Tests Could Again Be in Short Supply if Covid Surges." There were a lot of great articles, I think, over the last week, highlighting all the things that we're not going to have if there is another surge. And, you know, testing very often, I think, gets left out of the conversation. It was something the Biden administration was very, very late to, and clearly it hasn't lasted all that long because if there is another surge and people do decide they want more of them, there are not enough that have been ordered. David talked to manufacturers. He talked to politicians and people in the administration, and it is interesting to hear them say, "If there's another surge, we really need to be able to have these resources." And they didn't do that before they decided that they would drop all of the protections. I mean, we're talking about treatments and even vaccines, if there might be fourth boosters, for some who need it. But I encourage everyone to read David's story just because testing sometimes gets a little forgotten about.

Rovner: And, of course, it's testing where we figure out what of the rest of these things that we're going to need. Meanwhile, what's anybody hearing about getting the actual money through Congress? The administration seems to be continuing its claim that the money doesn't have to be offset because we're still in a health emergency, and they point out that previous covid relief bills have not been offset. But the Republicans seem pretty intent right now on, you know, if there's going to be more money that they're going to need to find it and pay for it from somewhere. Are we just going to fight about this until we have another wave?

Cohrs: So I think the latest update — and I've been covering this, and I think it's worth noting, just stepping back and noticing that the White House did not sound the alarm before the vote happened. There was a lot of opportunity for them to start saying they were running out of money, and they didn't say anything until a week before the vote happened.

Rovner: Although they insist that they did. I mean, every time they now talk, they say, we asked in January and then we sent this letter, you know, two weeks later, blah blah blah …

Cohrs: They asked a very, very small group of people who they thought were going to be calling the shots. And it turned out to be a very costly miscalculation on their part. And I think there's, you know, maybe the first signs of realization that their strategy isn't working. Sen. [Mitt] Romney said yesterday — he, you know, told reporters on the Hill — that he was expecting some more information from the White House on potential — and I think Democratic leadership as well — on some potential pay-fors and some more potential information about what covid money is out there right now.

Rovner: Sen. Romney being one of the few Republicans who actually, I think, would like to cough up some more money.

Cohrs: The thing is, I think there are some of them out there. It's kind of a mystery why they haven't done, you know, more intense engagement with these individuals. Sen. [Richard] Burr, I think, might be open to it. It's possible they could get to 10 on this, but it's just taken until this point for the White House to concede that these Republicans aren't going to budge without some more information. So we'll see throughout the day, today, tomorrow, if that's enough, what

they're providing and if those pay-fors are going to be politically viable. But I think we just saw the first movement yesterday that maybe there might be some concessions going forward to break the stalemate.

Rovner: From everything we can tell, it looks like we're definitely not done with this yet, and they are definitely running out of money. Well, finally, on covid this week, another story I didn't see a lot of coverage of — I get there's a lot of other news — a full-scale trial in Brazil of ivermectin. Yes, the horse and dog [de]wormer that many touted as a treatment for covid. Well, that trial found that — drumroll, please — ivermectin did not reduce hospitalizations or help patients get better any faster than a placebo. So please, can my horse just have his [de]wormer back now? Is this going to finally stop the run on Tractor Supply stores for ivermectin?

Edney: No, no, I don't think so. I'm sorry for your horse, but the people who are taking it and seeking it out at the tractor stores aren't probably paying attention to studies on it.

Rovner: Particularly those from Brazil, I guess.

Edney: Yeah. Well, Brazil is the perfect place, probably, to do it because the president was so enamored with that drug and their ability … they made it very available.

Rovner: I guess the myth of ivermectin will continue as long as the continuation of covid does.

Edney: I was just going to say until the next drug …

Rovner: Until the next drug, until the next magic elixir for covid comes around. So on a covid-related subject, President [Joe] Biden this week signed the [Dr.] Lorna Breen Health Care Provider Protection Act, which provides for up to $135 million in federal funding, mostly in the form of grants to hospitals to address burnout and encourage health professionals to seek help if they are suffering from mental distress. It's named for a New York emergency room doctor who took her own life in the early weeks of the pandemic in 2020. But a doctor writing in Stat News this week worries that the bill won't do much beyond leading to, quote, “more gimmicky and even more cringey wellness initiatives that do not even come close to addressing the root causes of the current mental health crisis [afflicting] health care workers.” I thought that was quite a colorful way to put it. I know I'm kind of a broken record on this, but I am truly and seriously worried about the mental health damage that's being done to our health care workforce by our failure to take even the most minimal measures to protect ourselves from the pandemic. What could Congress actually do if it wanted to? I mean, what is it that health care workers need beyond, as our writer so nicely put it, “cringey wellness initiatives.” He actually in that piece wrote about one hospital that gave all of its residents a can of Coke and a can of Pringles.

Carey: It was half a can. Half a can of Pringles.

Rovner: It wasn't even a full can. A mini-can!

Carey: I mean, the same writer went on to make some, I thought, pretty interesting ideas. Could Congress create more residency positions? Right? That is, I believe, goes through the Medicare program. … Could you pay residents more so they don't feel the financial pressures they currently

[face]? But to your broader point, Julie, I mean, our health care provider system, our health care workers in the hospitals, they are exhausted, they've been stretched thin. … They bear the brunt of all these political fights we're talking about. If people are not wearing masks and it spreads, or they're dealing with someone who doesn't want to get vaccinated and they feel like they're … But we also have some health care workers who don't wanna get vaccinated either. I know we've talked about that before on the podcast, but I think there are broad, systemic issues that we all have to be thinking about and all coming up with. But I did think this particular piece that you mentioned, the idea of more residency positions, greater pay for residents, those could be two steps in the right direction to alleviate some of this, some of these pressure points.

Rovner: Yeah, I know. One of the things that we've seen with this is a lot of people just retiring early. Baby boomers who were almost ready to retire. It's like, "I don't need this," and getting out and we're going to end up … a lot of the claims of health care worker shortages are more *claims* than anything else. But now I really think we're going to end up with a serious problem. Obviously, we have spot shortages in certain places and among certain specialties, but I really think this could decimate the ranks of health care workers — and not just doctors. Doctors, nurses, medical assistance technicians, I mean, this is everybody who basically works in the health care system who is exhausted from two years of just constant stress and really no end in sight. I mean, it feels like a more serious problem than anybody is sort of taking it.

Cohrs: Yeah, I think there's a challenge for Congress, too, that this isn't entirely Congress' problem to solve. You know, if you think about — because Congress is really good at throwing money at things, which …

Rovner: Which is exactly what this bill does.

Cohrs: Yes. But I think if you're actually thinking about what would help burnout, maybe staffing ratios improving. So and that's a decision that's made on the health providers' side. And maybe it's increasing … permanent pay of your staff who decide to stay instead of just relying on these travel nurses. But the facilities are reluctant to do that because it's kind of sticky. Like, once you raise pay, you can't really lower it back again when the demand goes down. So I think there are a lot of important questions for the health care providers [that they] need to take responsibility for, in terms of how they view staffing in their budgets. That's not Congress' responsibility to fix.

Rovner: That's true. Congress can't. This may be one of those things that needs to be fixed at a more granular level or at least needs to be fixed together. All right. Well, in one more update of a bill that we talked about just last week, apparently the House is not going to just follow the Senate and vote to make daylight saving time permanent. In fact, health experts are rallying around the position that if we're going to stop changing the clocks twice a year, we really should make standard time permanent instead. Is this whole effort now dead or might we get an actual debate and decision on it? I can't decide. You know, there was, in fact, a House hearing before the Senate voted. Are they just going to thumb their nose at it? Or are we going to actually look at — what is not obviously in the context of other things going on in the world —not *the* most important issue, but an issue that affects everybody in the United States.

Edney: I don't know if we'll actually get a debate on it. I think that as soon as the Senate passed it, the response was — to the Senate actually doing something — was most people saying how horrible it was because they didn't want to wake up with it being dark outside. And then there were people— which I didn't know — bringing up, I think it was in 1974 where this was actually done, and everyone hated it so much that they immediately reverted back to changing the clock.

Rovner: I was in high school. I do. I actually remember it. I didn't think it was so terrible.

Edney: But I wonder if that is at all impacting the House's decision to move or not.

Rovner: I will be amused to see if this actually comes up for a serious debate. But there are, I mean, there, you know, a lot of these sleep experts have now been able to say, you know, changing the clocks twice a year is not great for our health, and we should probably do something different. Although they do seem to think that permanent daylight saving time is the least best change. So we will see how this plays out, too. All right, that is the news for this week. It is now 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. Anna, you've already done your extra credit this week. Rachel, why don't you go next?

Cohrs: Sure. So mine is a piece in The Guardian and the headline is "'Betting Against the NHS': £1bn Private Hospital to Open in Central London," by Julia Kollewe. I just really thought this piece did a great job of examining the implications of a big, fancy, like, Cleveland Clinic location in central London. I mean, there were details about views of Buckingham Palace; it captured the attention of these really name-brand U.S. institutions moving abroad to health care systems where there's this dual-track, public-private options for people and the potential that they'll be pulling staff and only performing really profitable services that help these other facilities operate. So I think it was just a nuanced story. This trend of U.S. hospitals opening international locations — I know Kaiser Health News has done great coverage of that issue as well — but I think this is just a great case study and an example of these clinics seeking profit abroad, where the health care systems aren't structured the same way the United States' is.

Rovner: Yeah, I know most of them have been in places like Dubai … where there are a lot of rich people and maybe not that much medical expertise. This one, to plunk it down in the middle of London, where the British are extremely possessive of their national health system, strikes me as super interesting. MAC.

Carey: So my pick comes from our KHN colleague Liz Szabo. The headline is "Covid's 'Silver Lining': Research Breakthroughs for Chronic Disease, Cancer, and the Common Flu." And it's — it could be indeed a silver lining if all these billions of dollars that have been invested in covid vaccines and covid-19 research could yield medical and scientific dividends for decades, right? Helping doctors battle these horrendous diseases that have been with us forever: cancer, influenza, cystic fibrosis, colorectal cancer, melanoma, this kind of thing. There's a lot of science in it, but Liz unpacks it beautifully — just to simplify this idea that harnessing the vaccine technology to help fight other

diseases would indeed be a silver lining to covid. Covid is a horrible thing. It's been just a huge tragedy. But if some good could come out of it in this way, that would be terrific.

Rovner: I also have a KHN story this week from Sarah Varney, and it's called "As States Impose Abortion Bans, Young Doctors Struggle — And Travel Far — To Learn the Procedure." And it's about the effort to end abortion by cutting off the supply of abortion providers. Those doctors-in-training who want to learn to do the procedures, but who are encountering increasing difficulties. And it could have serious side effects. Many of the procedures used for early abortions are the same ones used for other non-elective abortion, pregnancy complications, including miscarriages and other problems that threaten the life or health of the pregnant woman. It's a part of the abortion debate that really ought not to go ignored, and it's a really good story.

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 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. Or you can tweet me. I'm @jrovner. Anna?

Edney: @annaedney

Rovner: Rachel?

Cohrs: @rachelcohrs

Rovner: MAC.

Carey: @MaryAgnesCarey

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