KHN's 'What the Health?'

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Julie Rovner: Hello, and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent at Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, April 7, at 10 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today, we are joined via video conference by Tami Luhby of CNN.

Tami Luhby: Hello.

Rovner: Shefali Luthra of the 19th.

Shefali Luthra: Hello.

Rovner: And Jessie Hellmann of CQ Roll Call.

Jessie Hellmann: Hi.

Rovner: Thanks to Mary Agnes Carey for filling in for me last week while I went to dog obedience boot camp with my corgi. Let's jump right in because there is plenty of news for this week. We're going to start with the news that brought former President [Barack] Obama back to the White House for his first official visit since leaving office: improvements to the Affordable Care Act. This event was a little bit of a bait and switch. President [Joe] Biden signed an executive order that didn't really do much except order the rest of the government to improve the Affordable Care Act to the extent they can. But the actual news this week, and there was some, is a new regulation from the Treasury Department to fix the so-called family glitch. Tami, you wrote about this. Tell us what the family glitch is and how this regulation would make it go away.

Luhby: Right. So the family glitch has been a long-standing problem in Obamacare. Here's the issue. Workers who don't have affordable health insurance options through their jobs can qualify for subsidized coverage on the exchanges. A work-based policy is considered affordable if it costs the employee less than roughly 10% of his or her income for … single coverage. Now that's the key. But the law doesn't take into account the increase in premiums for adding family members to the policy, even if that pushes the cost above this 10% threshold. So in these cases, workers and their families aren't eligible for financial assistance to buy Affordable Care Act coverage on the exchanges.

Rovner: And often, those family policies will be really expensive because while employers tend to subsidize the individual coverage, they don't always subsidize the family coverage.

Luhby: Yes, and I have numbers from the Kaiser Family Foundation on that. So the difference is substantial. The average annual premium for a single worker was just over $7,700 in 2021, but it

topped $22,000 for a family, according to the most recent KFF study. And the problem affects lots of people. [KFF] also says that some 5.1 million people, the majority of them children, are affected. Now, the proposed rule would allow family members of the workers who are offered the affordable single coverage but unaffordable family policies to qualify for subsidies on the exchanges. And the White House says that an estimated 200,000 uninsured Americans would gain coverage and nearly a million people would see reductions in their premiums. And they say many families would be able to save hundreds of dollars a month. If this proposed rule is finalized, it would go into effect January 2023, so they would be able to enroll this fall. The White House declined to comment on how much it would cost, which is probably why it hasn't been done until now. But the Congressional Budget Office has previously pegged it at $45 billion over 10 years.

Rovner: Yeah, Congress has been talking about fixing this pretty much since the Obama Treasury Department first basically created it in the early 2010s, when it interpreted the Affordable Care Act to say that "yeah, you can qualify for subsidies if it's unaffordable for single coverage but not unaffordable for family coverage." The assumption has always been that it was going to require legislation and that that legislation would cost quite a bit of money. In fact, I was told by numerous staffers that they knew this was happening when they wrote the law, but it was going to be so expensive that they couldn't afford to do it and keep the law under the $1 trillion estimate that they had promised. Which is how it ended up in there in the first place. So the big question is: What makes the Biden administration think they can now just fix it by regulation? Or are they just hoping that nobody sues?

Luhby: That is probably the question. Plus, they also needed to have something to announce when Obama came to the White House. But this regulation has been — we know that they've been working on this for months.

Rovner: Yes. I mean, they've been signaling that they were going to do it. In fact, I've had it in the rundown for the podcast for the last three weeks.

Luhby: Exactly. So where it goes, we'll see. Everything about the Affordable Care Act seems subject to lawsuits.

Rovner: Yes. Yeah. We'll have to see who has standing to sue on this. It's hard to balance off in your head who'd be hurt — perhaps the insurance companies, although do they care if people get subsidies? I'm not sure employers care. It will be interesting to see how this plays itself out. While we are talking about the Affordable Care Act, it appears that several insurance companies are planning to stop paying agent commissions for people who enroll in special enrollment periods. That's on the theory that those who enroll outside the regular open enrollment window are more likely to be sick and expensive and therefore they'll run up premiums for everybody else. Even with generous subsidies, this is all just one giant balancing act between keeping premiums affordable so people will sign up and keeping people covered. Right? It feels like this is a symptom of this bigger issue with the ACA. Without a mandate, you need to have not only sick people in these pools.

Luhby: The insurers have always been very wary of special enrollment periods. They do not like them. I'm not surprised that they're going to try to limit the number of people who can enroll

during this period for that very reason … is that if you know you're sick and need coverage, you're going to enroll during the open enrollment. And if you are just sort of responsible and want to make sure that you have health insurance if you need it, you'll enroll in the open enrollment period. But who enrolls in a special enrollment period? People who all of a sudden need health insurance for some reason. So those are going to be the pricier people.

Rovner: Yeah, well, the agents are not very happy because now they're being told that "hey, if you go to the trouble of enrolling these people, you're going to do it for free." So I think that is a fight that will also continue to play out.

Luhby: But the White House and [the Centers for Medicare & Medicaid Services] have provided more money specifically for navigators year-round, so it doesn't have to be only the agents that are enrolling them. The navigators have more money now, and while they use a lot of it in open enrollment, the increase was designed to be year-round.

Rovner: Yeah, so we'll see how many people continue to get this coverage. All right. Well, let us turn to covid. It is still not over, people. Official Washington appears to have had another superspreader event: the annual Gridiron dinner, which last weekend brought together journalists, government officials, and various other A-listers to break bread and hold hands and watch skits and apparently give each other covid. Among those who went to the dinner and are now testing positive are Attorney General Merrick Garland, Commerce Secretary Gina Raimondo, and House members Adam Schiff and Joaquin Castro. And those are only the ones that we actually know about. Meanwhile, as Congress prepares for its two-week Easter/Passover break, it looked like a stripped-down covid funding package might pass before lawmakers leave. But now not so much. What's going on with the covid funding? Jessie, I thought they were going to do this. They got a deal, right?

Hellmann: Yeah. So things are moving really fast on this. There is a $10 billion agreement on covid funding, with some offsets that Republicans and Democrats could agree to. But kind of the last minute, Republicans decided that they wanted some votes on some amendments that Democrats just don't want to have votes on, particularly around the Biden administration's decision to resume processing migrants seeking asylum at the border. The Biden administration has gotten a lot of flak from this, especially from Republicans but even some Democrats. Which is why Senate leadership wants to avoid a vote on amendments like this.

Rovner: Yeah.

Hellmann: The path forward is really murky. Like you said, they're about to head out on recess, and, at this point, it doesn't look like there's going to be a vote on that before they get out of town.

Rovner: Now this was a $10 billion package, down from a $15 billion package the House had tried to put together, down from the $22 billion that the Biden administration says it needs to keep buying things like tests and treatments and vaccines. Tami, what made it into the $10 billion package and what didn't?

Luhby: Two of the things that didn't are global aid, which we can discuss. Some of the first important things is that there's not money for the U.S. to help other countries deal with covid. And then also one thing that I wrote about last week is there is no money to specifically refund the uninsured program. So right now, or at least since spring of 2020, people who are uninsured could get tests, treatment, and vaccines at no cost because the providers could get reimbursement from the federal government. And they've already gotten close to $20 billion, $19 billion, out of it, but now it's run out of money. And there are still places for the uninsured to get free testing and vaccines. But it's going to become much more limited going forward. So those are not in the $10 billion.

The main thing is it's giving $9.25 billion to [the Biomedical Advanced Research and Development Authority] in order to mainly spend money on buying more therapeutics like the oral antivirals, the monoclonal antibodies. And then it's also providing more funding to purchase vaccines and to maintain testing capacity. Because of course, right now, after the omicron wave, not that many people are getting tested. But when the next wave comes — if it does — the country has to be able to scale up quickly. And without the current demand, manufacturers would scale down without some government assistance. So those are the things that are in. Those are a lot of the main things — and some money. They're giving $750 million for research, clinical trials, and the development of vaccines for emerging variants.

How is this getting paid for? The reason it went from $15 billion to $10 billion is because Congress in the omnibus spending bill was going to take some money from the state and local funding that they had given states [through] the American Rescue Plan. But several Congress people were not happy with that, in thinking that their states were going to lose some funding, some previously promised funding. So that got nixed. And now they're going to be taking, again, unspent money — leftover relief funds — but it's coming from the Shuttered Venue Operators grant that was money that went to live music venues, theaters, and museums. It's coming from the Economic Injury Disaster Loan Advance Program, which was giving money for small businesses, the Aviation Manufacturing Jobs Protection Program. You know, all of these household names that we all know. But, yeah, this is leftover covid money. But already there are small businesses — because a lot of this money is going to small businesses — there are small businesses that are going to be protesting, that are protesting. They're losing this money. The Republicans are basically saying that this additional aid has to come from somewhere. They want it to be paid for. And so the money that's leftover is a lot of this relief money.

Rovner: Yeah. And that's where you start fighting, although this seems like an odd way to run a pandemic, is to sort of constantly run out of money and then throw more at it and then run out of money and then throw more at it. We've talked about the government as a "bad business partner" many times before, and this seems to be fitting with that? "Well, we've got to go on spring break, so we'll do this when we come back." And a lot of these programs are going to lapse and then have to restart because that's the way Congress does things these days.

Well, also this week, the White House announced a new governmentwide effort to address long covid, which is estimated to affect as many as 20 million people who have lingering, often debilitating symptoms, even after sometimes mild cases. What's the administration doing here,

and how much of a difference could this make? I feel like this is a really big issue that's really flown under the radar.

Luthra: Well, a lot of the research right now is really not very good. It's a lot of small, self-identified people in these Facebook groups, where there hasn't been a really good opportunity to better get a truly randomized sample and understand if you get covid and you develop long covid, what are the implications. And we know that long covid is real, but we also know many people say that they have it and never had covid. And so this is a really good chance for the White House to fill in what's a very potent knowledge gap, right? And help us better understand how prevalent, how problematic this condition is, and then how we can best treat it.

Rovner: Yeah, it's this terrifying thought that we're going to have millions of people who are basically disabled added to the disability rolls who may never be able to fully go back to work. And there's kids with long covid. We don't know what that means to them as they grow up, we don't know. Obviously, we don't know how long long covid lasts because we've only had covid for two years, but it is clearly something that's more common than I think people would like to admit. In the coverage of this, people seem to be happy that the White House is making it a priority, but they worry that this is too little too late, that we should have jumped on this a lot earlier, as soon as we knew that this was going to be a problem. But I don't really see a lot of other countries jumping on it either.

All right. Well, kudos to The New York Times' Sharon LaFraniere, who in the White House covid briefing Tuesday finally got [Centers for Disease Control and Prevention] Director Rochelle Walensky to say that those extra boosters are not just available to people over 50 but actually recommended for them. This whole second booster thing has been yet another case of confused communications from the CDC. In fact, Walensky this week also announced she's bringing in a senior government expert from outside the agency but inside the Department of Health and Human Services to perform a thorough review and recommend improvements to help CDC regain its former standing as one of the nation's and one of the world's preeminent science entities. CDC has really fallen on hard times in public opinion and official opinion. Is this going to be enough, or are they going to need to strip it down to the studs and rebuild it?

Luthra: I'm a little sympathetic. I think the CDC has had a very, very difficult job for the past few years. The public at large has never had to see scientific consensus unfold in real time. And what we've experienced is the knowledge has changed. Certainly, mistakes have been made. But I think when you are an organization that has been as historically underfunded as the CDC and presented with this really mammoth task of trying to convey in real time a changing understanding of a virus that has changed, I could not do that. I'm curious what changes we will see. But I do want to just take a moment and say I don't think any administration could have done this well. It's just too difficult.

Rovner: Yeah. And the CDC has always been very cautious, of the agencies in HHS. They have a huge job, and they're responsible for all the things that make people panic, basically. So they've always been very careful and very circumspect, and it's been very difficult for them to get ahead of this. I will be interested to see what this review comes up with and what its recommendations are.

Because the CDC, both … obviously, under the Trump administration, it was pretty clear that there was politics involved. But under the Biden administration, the CDC has also had its stumbles, as I just mentioned, on recommendations for boosters and things like that. So it's not like the agency is … that everything was great when the administration changed. There's still work to be done there.

All right. Let us turn to abortion. Lawmakers in Oklahoma have been particularly busy this week. One bill is on its way for an expected governor's signature. Another is moving rapidly through the legislature, quite literally as we tape this show. Shefali, what are they up to out there?

Luthra: What are they not up to? So on Tuesday, the Oklahoma House of Representatives voted to pass a total ban on abortion that the Senate passed last year, and they found this ban and they have moved it to the governor. That would take effect around the end of August, 90 days after the legislature adjourns in May. So by the time it has an effective date, *Roe v. Wade* could very well be overturned. But they are not wasting any time. Today, they're voting on a Texas-inspired six-week abortion ban that would use that private lawsuit structure to essentially chill any abortion provider from providing these kinds of services after six weeks. That is very likely going to pass through the House today. It's already passed the Senate. The governor is expected to sign [it] as well. It could be in effect as early as tomorrow. And if that happens, the implications will be really significant, right? Because we know that thousands of Texans have been traveling out of state for care, and 45 percent have been going to Oklahoma, to say nothing of the Oklahomans themselves.

Rovner: Which is next door.

Luthra: Yes. Who will also now have to go somewhere else for abortions. We're talking two-week wait times at a minimum for appointments. And two weeks is precious when six weeks is the limit. I think if any state could pass a Texas-inspired ban, there is none that could have a greater impact than Oklahoma.

Rovner: And of course one would expect that this would go back to the Supreme Court. I mean, we know that the Supreme Court's going to rule on this Mississippi case, and we suspect that they're going to do it at the very, very end of the term, which will be the last week of June or the first week of July. But could they be forced to maybe take another stand on the Oklahoma case?

Luthra: It seems that they've done a pretty good job of quelling all of the discussion around the Texas ban, and what folks have been telling me is that for Texas-style bans in particular, they don't really see much of a future in the federal courts anymore. And if we see legal challenges, it's going to be in the state courts. The Oklahoma state Supreme Court has in the past ruled against some abortion restrictions, so there's some hope that maybe they will step in here. But the fact that this law would take effect immediately does raise some complications, right? Because you have to stop providing services while you file that lawsuit.

Rovner: So, meanwhile, while red states in the Midwest and Great Plains and the South are tightening their abortion restrictions in anticipation of the Supreme Court letting them come later this summer, some states are trying to welcome patients from states where access is being restricted, like Colorado, right?

Luthra: Colorado is super interesting, right? It's already emerged as this hub for patients, right? You got a lot of Texans going to Colorado. They passed their own Reproductive Health [Equity] Act, which would sanctify abortion rights in the state. It's also a direct flight to get to Boulder or Denver from the major cities in [Idaho], and [Idaho], as we know, also just passed a Texas-style abortion ban. So there's going to be just a lot of pressure on Colorado, in particular, and I think it provides a really interesting model for us to see whether and how blue states are able to fill in the gaps. But the providers I've talked to there as well are just worried that they're already at their max. And they don't know how much more they can do without significant expansions in resources, in clinics, in providers.

Rovner: Yeah, I mean, you have to wonder whether there's going to be a huge migration of providers from these states where abortion is basically no longer going to be allowed to these states where it is allowed but there aren't enough providers. And there's just going to be this huge travel … that it will be something back to … which was true in the early 1970s, before *Roe v. Wade*, is that women who could afford to travel did. And it was not that hard to get an abortion by crossing state lines. Is that basically what we're looking at here?

Luthra: That seems more and more likely. And we've seen so many Texans travel, and the financial hardship is just so powerful. I have thought a lot about this one story collected by the Texas Policy Evaluation Project. The couple, they didn't buy any groceries for a week. They ate their scraps, and they couldn't buy dog food, either. So whatever scraps they couldn't eat, they gave to their dogs. And that was how they saved the money to travel. And I don't think we can overstate just what an arduous financial burden it already is. And as more states pass these kinds of restrictions, you're exactly right, it's going to be too difficult for some people. And those who can afford to travel will, and those who can't will try and self-manage at home — some safely, some not. Or they'll be forced to carry pregnancies to term that they didn't want.

Rovner: And speaking of trying to self-manage at home … What abortion rights advocates had considered their saving grace and anti-abortion forces their biggest threat if *Roe* is overturned is the abortion pill. Which you don't necessarily have to go to a clinic to get. But even that's proving harder for women to get, right? Thanks to both increasing cost and increasing regulation, it looks like anti-abortion forces are trying to stop that as well.

Luthra: Absolutely. We are seeing a big slew of bills that would ban telemedicine for the abortion pill, even though the FDA has endorsed telemedicine, medical experts have for a long time. Rachel Bluth had a really good story for California Healthline looking at doctors who try and get certified to do medication abortions over telemedicine. But, just, it's too difficult. So even though they are prepared to provide this care, right now they can't. And they're forced to stay within their own states more or less.

Rovner: And these are doctors who have gone ahead and gotten licensed in other states. I mean, it's not like just filling out a form.

Luthra: Yes. One thing that I think we should keep an eye on is if and after *Roe vs. Wade* is overturned if states like California and New York change their extradition deals with other states

essentially so that they would protect doctors who provide medication for abortions across state lines, knowing that they are violating the law in, say, Mississippi. Normally, the states would comply with other states' laws, but maybe they won't.

Rovner: It could be a very odd summer. Speaking of things that Congress would like to get done but has not yet — sometimes even the simplest things are not. The House last week approved a bill that would cap diabetes patients' out-of-pocket costs for insulin. But the Senate appears to want to go in a different direction. There's both politics and substance here. Democrats don't necessarily want to split off this albeit very popular issue from the rest of the drug price debate. They would like to keep that all together. But the House bill wouldn't actually lower the price of insulin; it would just pass the cost onto others. Jessie, what's going on with drug prices? Are we going to see something?

Hellmann: The Senate version, sponsored by Sen. Raphael Warnock [of Georgia], is supposed to get a vote this month. There is an effort by Sens. Jeanne Shaheen [of New Hampshire] and Susan Collins [of Maine] that would actually try to get at the list price by getting at the rebates issue. That text has not been introduced yet. Supposedly, it's supposed to come out sometime this month. But there are people who say even that doesn't go far enough in holding drug companies accountable for raising the prices of this 100-year-old drug. So we'll see what happens next. There's also some criticism that neither of the bills really helps people who are uninsured, and those are the people that are least likely able to afford insulin. And these are people that are most likely to ration insulin, which can lead to really serious health effects and death. We'll see what happens next with this.

Rovner: This is something that has bipartisan support, that President [Donald] Trump wanted to do and the Republicans wanted to do and Democrats have wanted to do. And there are, as you mentioned, there are bipartisan efforts to do this. And yet they just can't seem to push any of this over the finish line. Is this just the continued clout of the drug industry, or is it that they're just scattered here about the politics and can't figure out what to do?

Hellmann: So Pharma hasn't taken a position on this bill, which in my experience means that they don't oppose it. They might quietly support it because they think it might kill momentum for broader drug pricing reform, like Medicare price negotiation. I think the bigger question is: Can this get 10 Republican votes in the Senate? It's a political issue. This bill would be really great for Raphael Warnock, who's facing a tough reelection bid.

Rovner: And that's a seat that Republicans really want back, in Georgia.

Hellmann: They really want that. So is Sen. Mitch McConnell going to give his members permission to vote for this bill that would help Democrats? I don't know. Ten Republican votes are going to be hard to get for this.

Rovner: Sometimes the more popular something is, the harder it is to get the votes for it because it's so politically salient. Well, finally, this week, while most people retiring from Congress seem to be Democrats who are reading what they think is the writing on the wall about what seems likely in this year's midterms, we got news of another prominent Republican calling it quits: Fred Upton,

Michigan Republican, former chair of the House Energy and Commerce Committee — and I add, because I can, former sports writer at the Michigan Daily, my alma mater — said he'll step down at the end of this Congress. As chairman of the committee and/or ranking member, Upton helped steer through some pretty big health bills, including the 21st Century CURES Act and the bill that fixed the Medicare physician fee payment glitch and reauthorized the Children's Health Insurance Program. Upton joins North Carolina Republican senator Richard Burr as a legislator leaving with a lot of health policymaking expertise. They're both, at least when it comes to health care, centrist and very happy to do bipartisan deals. Are we seeing a real political shift here when it comes to how Republicans view health care policymaking? I just wonder with all these deal-makers stepping down if there'll be anybody left to make bipartisan deals with.

Luthra: I think it's Jonathan Cohn who has talked about the lack of real intellectual interest in health care as a policy issue in Republican politics at large. And so you're right, those voices were already incredibly rare. I can't think of anyone else. I'm sure if there is anyone, Jessie would immediately know the name, right? But the room for bipartisan health policy has been really slim for a long time, right? And it just seems that there's no curbing that trend.

Rovner: Yeah, those were two of the biggest names in terms of doing bipartisan deals. I guess Mike Burgess will still be there from Texas, who's done some bipartisan work. But when you think about Republicans who [are] willing to wade into the fray on health care — and, really, it's a hard issue, and a lot of members kind of shy away from it because it's such a hard issue. And these are guys who have really done the work over the years and who also, and this is not insignificant, have experienced staff who know the ins and outs of these things. Part of it, too, is members come in and they want to take on health care. And they have people who have zero idea how complicated it is, where the landmines are, who to talk to, who you need to avoid, whether Pharma really means that they're going to not oppose something if they don't say anything about it. There's a lot of places where you can get into a lot of really big trouble if you don't have somebody who's been doing this for a while. And just sort of makes me wonder what the … we saw a huge exodus of Democratic expertise walk out the door in the last six or seven years, people like Henry Waxman and George Miller. Now we're seeing sort of the counterparts on the Republican side walking out, too, and I just wonder what it's going to mean going forward for trying to do some of these complicated things, particularly like Medicare and Medicaid and drug prices and all those things that everybody talks about as being really important. Anyway, that's my lecture for the day.

So that is the news for this week. Now it is 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'll post the links on the podcast page at khn.org and in our show notes on your phone or other mobile device. Shefali, you have this week's story I wish I had written. Tell us about it.

Luthra: This is by Caroline Kitchener, the very excellent abortion reporter at The Washington Post. And she wrote, "With Roe Endangered, Democrats Divide on Saying the Word 'Abortion.'" And she gets into detail about Joe Biden's real inability to say the word "abortion" whenever talking about abortion laws, right? His framing of "reproductive health" and sometimes "women's health" — although abortion affects not just women, anyone with a uterus can get an abortion. But she really delves into the polling that seems to be driving Biden's decision, the frustration among advocates,

the potential implications, the debate around messaging. One thing I want to note that I think we've really seen maybe start to shift in recent weeks is the president hasn't said "abortion," but the vice president has. And maybe there's something there, but it's an issue that is of interest to so many of us. Julie, you wrote about it a few years ago, too, and I'm really glad that Caroline wrote the story.

Rovner: Yeah, it was a really good piece. Jessie?

Hellmann: So my extra credit this week is a story from Kaiser Health News and NC Health News. It's called "$11M for North Carolina Work-Based Rehab Raises Concerns." So, as the title suggests, it's a work-based program. People don't have to pay anything. They get free treatment and housing and meals. But in exchange for that, they have to do some kind of work. This organization is associated with places like thrift stores and laundromats. And in exchange for getting treatment, they have to work at these places. But there's ethical questions, legal questions, or questions about whether this is even effective. As we know, addiction treatment can be really expensive, especially for people who are uninsured. And I think this raises interesting questions about … How do we get care to those people? Where do you draw the line? So I would definitely recommend giving this a look.

Rovner: And, Tami, you have a rather unique extra credit this week.

Luhby: I do. Mine is from Health Affairs, and it's titled … I don't know how to explain … It's "Health Care" — two words — "Is Now Healthcare" — one word, by Alan Weil.

Rovner: The editor in chief of Health Affairs.

Luhby: Yes. And it's a little unusual, but it's a piece that I have to say I spent a lot of time on. So last Friday, Alan came out with his bombshell post that the journal was changing its style on health care from two words to one word. And now this is an issue that we've actually discussed a lot internally at CNN, as I'm sure a lot of journalists and health policy people all over have.

Rovner: Two words. I will die on this hill.

Luhby: Yes, several years ago, my editor ruled firmly that it is two words. So Alan explained that their primary motive was financial, as all important decisions in health care are, since it pays authors by the word. The journal now expects to save $3.46. And if other journals follow suit, the aggregate savings throughout the health care sector would be $89.23. And Alan said that they're very excited to do their part to bend the health care cost curve. They also gave how much it would affect overall health care spending. But the decimal point was too small for me to be able to tell you. I thoroughly enjoyed this post, and I also … It helped me realize two things: One, that Friday was April 1. And that also I'm a real health care policy nerd.

Rovner: Yes, I admit I was also initially taken in by this. I will point out that not only was this an April Fools' joke, but one of our senior vice presidents, Larry Levitt, who tweeted that KFF was finally going to throw in the towel and merge with Kaiser Permanente — that was also an April Fools' joke. Health Affairs is not making health care one word. KFF is not merging with KP, just to keep things straight.

So my extra credit this week is from my KHN colleague Krishna Sharma, whose day job is being part of our crack social media team and who helps us promote the podcast. The story is called "Losing Sleep Over the Pandemic? Work Flexibility May Be a Boon for Night Owls' Health." And as a night owl who really, really, really hates to get up early, I really identified with this story. It seems that the pandemic and work-from-home created a natural experiment studying sleep patterns and that there's at least some evidence that people like me who work later and get up later actually sleep longer and better. There's a lot more research to be done, but if nothing else, this should give a boost to all those studies that suggest that high school shouldn't start nearly as early as it does in most places because teenagers really can't get up at that hour of the morning. I guess I'm just a very old teenager at this point.

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 — @kff.org. Or you can tweet me. I'm @jrovner. Jessie?

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Luhby: @luhby

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