

KHN's 'What the Health?'

Episode Title: News You Might Have Missed

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Frank Sesno: There is a threat to America's public health that is almost as insidious as the spread of covid itself. This disease of disinformation causes confusion, sickness, even death.

Female voice: When my dad died, I felt like I had a Category 5 hurricane deposited in my body. And it wasn't just grief — it was rage and fury, because I was able to connect the exact policy failures and leadership failures to my dad getting sick.

Sesno: I'm your host, Frank Sesno. And in this special series, I'll talk to people whose lives have been forever changed by covid myths and disinformation. We'll take a close look at what it is, who peddles this stuff, and we'll ask, "How can they be held accountable for their actions?" Subscribe to our fascinating series "Confronting our Disease of Disinformation" from the "Healthy You" podcast.

Julie Rovner: Hello and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent at Kaiser Health News. And I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, April 14, at 10:30 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 Margot Sanger-Katz [of] The New York Times [whom] we haven't seen in a while. Hey, Margot.

Margot Sanger-Katz: Good morning, guys. Good to see you.

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

Joanne Kenen: Hi, everybody.

Rovner: And Alice Miranda Ollstein, also of Politico.

Ollstein: Good morning.

Rovner: Since Congress is out for spring break and it's something of a slow news week, I thought we would spend this episode catching up on important health policy news you might have missed over the past several weeks and, in fact, we might have missed over the past several weeks. I want to start with Medicare. Officials at the Centers for Medicare & Medicaid Services have made it official: Medicare beneficiaries will only have access to the controversial Alzheimer's drug Aduhelm as something called "coverage with evidence development." What does that even mean?

Kenen: Means they're not convinced it works.

Rovner: I know, but what ... who's going to have access to it, I guess is my question.

Sanger-Katz: Well, it means that if you want Medicare to pay for this drug, you need to be enrolled in a clinical trial that is designed to evaluate its effectiveness. And that's pretty unusual. Generally speaking, the FDA is usually the agency that evaluates the safety and effectiveness of drugs like this, and then once they approve it, Medicare generally covers it for all patients who need it. It's clear in this case that CMS has made a determination that the FDA didn't fully evaluate the effectiveness of this drug and ...

Rovner: Or evaluated it and got it wrong.

Sanger-Katz: It's quite expensive, and so I think they were reluctant to just cover it for everyone. This drug is kind of interesting for a few reasons. One is that the evidence about its effectiveness is very unclear. There were multiple trials that had different findings. There was one trial that showed that it seemed to improve one measure of the progression of Alzheimer's, but others where it did not show that. It's also a drug that has a lot of safety concerns. There was a lot of evidence in all of the clinical trials that people who were taking it were at risk of having bleeding in their brain and other kinds of problems. And so I think all of that probably caused CMS to want to continue to study the drug. But this is a pretty unusual decision for them to make. They don't generally do this. There was a huge pushback from both the developer of this drug but also from certain patient groups, people who have Alzheimer's and their family members, who I think were excited about the possibility of a new treatment that might slow down the progression of this disease, which is quite devastating. And CMS basically held firm.

I had one other thought about this, which is it reminds me a little bit of what we're seeing with the vaccines, where there's this push-pull that's going on between the FDA and the [Centers for Disease Control and Prevention], where you have in our health care system, you have multiple agencies that sometimes are weighing in about these drugs. We've traditionally thought about the FDA as being the ones who decide about the science. Does this drug work? Is it safe? Who should it be approved for? And then letting medical professionals sort out the back end. But we've seen with the covid vaccines, where the federal government is doing a lot of the purchasing and the CDC is setting the terms for a lot of the distribution of these vaccines, that the CDC's decisions about who the vaccine is recommended for actually having as much, if not more weight than, what the FDA approval is doing. And I think this is another example where we're seeing another federal health care agency, CMS, have a big say in how this drug actually is going to be used out in the world. Medicare isn't the only purchaser of this drug, of course, but because it is a drug for Alzheimer's, the population that's affected is disproportionately in the Medicare population.

Rovner: So is there a way that ... The drug company obviously is very unhappy, as you've mentioned are some patients' groups, including the Alzheimer's Association. Is there a way to get this reversed or changed? Can they sue?

Kenen: I think they're expected to sue because everybody sues. I read something that litigation was expected. I don't know the status of it.

Rovner: I believe that this "coverage with evidence development" — that we're only going to cover it if you're in a clinical trial — is something that's not specifically in law by Congress, and it's not actually been challenged before because normally when you would do that, when you would ... when CMS would say "OK, we're going to let ... we're going to pay for this under some circumstances," the option was "we're not going to pay for this at all." So the drug company in question is usually happy to get that coverage decision for Medicare. This I think may be the first time where a drug company has been unhappy to get that coverage determination for Medicare. So I'm wondering if we're going to see some big court fight about whether the agency even has the authority to approve it this way or whether they actually need Congress to step in. It's funny. Last week, we were talking about the opposite, that the administration was deciding it could do things that the Congress had not given it authority to. I think Congress has thought that the administration has the authority to do this, and apparently some judge somewhere is going to decide whether or not they do. I imagine more fights about this drug as we go on.

Well, while we are talking about Medicare, John Tozzi at Bloomberg had quite [the story](#) this week about how insurers are manipulating Medicare Advantage payments to their benefit. This follows some amazing reporting by KHN's Fred Schulte on overpayments to Medicare Advantage. Now boosting Medicare

Advantage payments to encourage more beneficiaries to depart Medicare's traditional fee-for-service program and join these private plans has been an important piece of the Republican health agenda for more than two decades. And Democrats used to complain about it, but boomer Medicare enrollees are voting with their feet, joining Medicare Advantage, and enjoying all the extra benefits that go with that extra money. And insurers are quite literally raking it in at this point. But at some point aren't taxpayers going to be left holding the bag for this? Medicare is not in great financial shape, and it seems that this is a way of drawing down Medicare even faster.

Ollstein: The politics of this are pretty interesting, as you alluded to. And when last year there was a lot of discussion about how Democrats wanted to pay for all of the health care programs they wanted to fund and the different benefit expansions, there was some interest just among progressives, people on the pretty far left, about really going after Medicare Advantage as a source of that funding, pointing to these overpayments and all the taxpayer money that goes to that and pushing for changes. But as we've seen, it really hasn't gone anywhere because people really don't want to piss off senior voters. And the insurance industry is also very powerful and has many lobbyists.

Rovner: And they don't want to piss off senior voters who are getting all these ... [All you have] to do is turn on the TV and see these ads — get all these things that you're entitled to. It's like, well, technically you're not entitled to that, but in some cases you can get it. But they don't know that.

Ollstein: I think some of these new reports, as well as the recent Medicare Advantage rate hike that just got announced, will provide more fodder for the progressives who have already wanted to crack down a bit more and will spur that discussion again, although I don't see it really changing the bigger dynamics around it.

Sanger-Katz: We've talked about this before on the podcast, but I think part of the problem with Medicare is that it's really a benefit that has a lot of holes and that puts a lot of financial burden on its beneficiaries for physician services. People are responsible for 20% cost sharing, with no cap at all. There're similar uncapped liabilities on the drug benefit, and people do have to pay a portion of their hospital care, as well. Medicare premiums are also pretty expensive and rising. And I think there's all kinds of things happening with Medicare Advantage, and I think this oversight and this good accountability journalism is really important. But part of the reason why Medicare Advantage is so popular is it's not just that they're giving extra goodies away. It's also that a lot of these plans are really lowering the cost sharing, the deductibles, putting a cap on how much people have to pay. And when you look at the income distribution of seniors who are in the Medicare program, a lot of them just don't have a lot of spare cash to have unlimited expenses should they or someone in their family get sick. And so Medicare Advantage is the way that they can insure against the risk of high health care bills. And I think it's a pretty rational choice. Congress over the years has chosen not to reform the traditional Medicare benefit design. There was some discussion during big budget negotiations in 2011, 2012 about making a whole package of reforms to Medicare to try to cap out-of-pocket expenses but then also change other things that would save money. That didn't happen. And so we now see more and more people going into these private plans because they have a better financial package for them. And I think, as Alice said, it creates a huge political problem because when you look at who is in these plans, they are disproportionately low- and middle-income people. They're disproportionately Medicare patients of color, people living in urban areas and suburban areas. These are people for whom these plans are really a much better deal. And because Congress is basically letting a lot of extra money go out the door to these private plans but they have not done very much about the traditional benefit, I think it continues to be a really attractive option for people who have limited cash to pay for their health care. So it's just there's these problems with Medicare Advantage, but I also think there's this understandable draw to these plans. It's not just about the advertising, not just about

Republicans wanting a private option. It's also that I think it's a rational choice on behalf of a lot of older Americans to choose a plan that is going to be cheaper for them to pay for and going to be cheaper for them when they get sick and need health care.

Rovner: And that's what Alice was talking about I think with the complicated politics at the beginning. The way Medicare Advantage used to pay, it really was wealthier seniors who wanted, you know, free gym memberships. And I think that was why it broke down on partisan lines: Republicans wanted more money for Medicare Advantage; Democrats wanted less money. But as you point out, Margot, the demographics of who's in Medicare Advantage have changed. And now there's a lot of Democratic voters who are in Medicare Advantage, and it's the only way they can basically afford to be in Medicare. So it has complicated things in a different way. But I think at some point as Medicare's financing ticks into the red again, there's going to have to be a reckoning on this.

Well, none of which is to say that all Medicare patients are what we used to call greedy geezers, a phrase I have not heard in a long time. A new paper in the policy journal Health Affairs from podcast pal Stacie Dusetzina of Vanderbilt, who helped us to understand drug pricing issues last year, finds that lots of Medicare beneficiaries, in fact, can't afford some of their more expensive drugs. Margot, this is your extra credit this week. Why don't you tell us about it now?

Sanger-Katz: Yes, she has an article in Health Affairs. It's called "[Many Medicare Beneficiaries Do Not Fill High-Price Specialty Drug Prescriptions](#)," which is a pretty descriptive title of what the paper found. But there's been research before that looks at what happens when drug prices are high and whether people actually take their drugs. But this is the first study that's really looked at these super expensive drugs. And the drugs that she looked at are for very serious health conditions: cancer, multiple sclerosis, rheumatoid arthritis. And what she found is that a pretty substantial portion of people who have Medicare who get these diagnoses and are prescribed a drug, like a drug for cancer ... when the drug is expensive, they just don't fill it. The study, I thought, was very clever because it compared two groups of Medicare beneficiaries. So you could imagine there are some people who just never fill their prescriptions for whatever reason. Or maybe they chose a different treatment or whatever. I mean, not 100% of people fill their prescriptions in any case, regardless of the cost of the drug. But what she did, and with her research team, is she compared people in the normal Medicare program to people who are poor enough that they qualify for Medicaid assistance paying for their drugs. So if you are poor enough, you get this additional help with your Medicare drugs so you don't have to pay the full price. And those people filled these prescriptions at a much higher rate. And so I think what this paper really showed is that the high cost of drugs is not just an esoteric concern. It is a problem that is causing seniors in Medicare who have serious life-threatening illnesses from filling the drugs that could help them with those illnesses.

And I think it's a very timely paper, of course, because Congress is thinking about drug prices. That Build Back Better bill, which is stalled in the Senate and who knows what its future will be, included a range of reforms that would take on drug prices. And one of the things that Congress wanted to do with that legislation, I think, would very squarely resolve this particular issue because what they wanted to do is change the Part D benefit design. So I was just talking about the benefit design for hospital and doctor payments. This is the benefit design for drugs, and they want to basically put a cap on how much anyone can be asked to pay in a single year. And so it would really insulate seniors who are prescribed these very high cost drugs from having this kind of unlimited financial exposure that they have right now. Doesn't mean that some of the drugs wouldn't still be too expensive. As I said, a lot of people in Medicare don't have a lot of money. But I think when you're looking at these really expensive drugs, this study is good evidence that protecting people on the high end could really ensure that more of them get medicines that their doctors want them to take for serious health conditions.

Rovner: Now, this is a perfect segue way into talking about the subject of drug prices, because it seems that the Biden administration is talking very quietly with governors of some of the states that want to take advantage of a Trump administration policy that would allow drug imports from Canada. This is one of those things that is extremely popular with the public, but not particularly practical from a “lowering drug prices” point of view. What's up with this? I mean, we've seen Democratic administrations going back to President [Bill] Clinton sort of dabble with this.

Kenen: It's not just a Trump administration policy. I mean, [Donald] Trump pushed ahead with it. But this idea has been circulating, sometimes with Democrats at the fore and sometimes with Republicans at the fore, for probably 20 years, 25 years.

Rovner: Oh yeah, more than 20 years. It was the '90s. Yeah.

Kenen: [Donna] Shalala was still [Health and Human Services] secretary at one point. So probably back to the '90s. It might have been even part of the Clinton plan in the early '90s. I don't remember. But I do remember being at a press conference with Donna Shalala a long time ago. I mean, the whole thing is we're much bigger than Canada. So Canada regulates drug prices differently than we do, but they do not want to get like rent a huge truck and put every drug in their country here so we, who don't ... regulate drugs, can take all their drugs. It's not something that is going to solve all the problems about drug costs that we have talked about here for ... since the podcast started four and a half years ago or whatever.

Rovner: It's not even something that's going to solve *lots* of the problems of drug prices. It mystifies me why this continues to be such a politically attractive, bipartisan idea when it seems obviously impractical on its face.

Kenen: Right. Because we were looking at Canada and saying, “They have policies that make their drugs more affordable; therefore, we want their drugs,” instead of saying, “Well, why don't we have policies that make our drugs affordable and let Canada keep their drugs?” I mean, is any state going to do this? I mean, [Ron] DeSantis has really pushed for it ...

Rovner: In Florida, right, where there's a lot of people who are buying drugs.

Kenen: A lot of seniors, and it's an ambitious governor. I mean, people do go to Canada to get personal supplies of drugs, that does happen. But it may end up happening in some state or another, although I'm still skeptical. But, I mean, I think it's possible that it'll go ahead somewhere, but it's not going to fix everything.

Rovner: Margot, you were about to add something.

Sanger-Katz: Oh, I just think, you know, if you think about our larger political environment, what the Biden administration is facing right now. Obviously, he's president. They're going into the midterms. The Democrats look like they're in trouble. And I think one of the most salient issues on the map right now is inflation and the high costs of everything. And there's not a whole lot, really, that a president can do in the short term that is going to affect inflation. A lot of that is going to come down to monetary policy from the Fed. Big long-term changes in the supply chain, et cetera. But I think that the White House is looking for levers that it can pull, where it can at least show voters “I'm trying to do something about this problem,” even if those things are symbolic. And even if those things are things that the policy experts will scream and yell aren't really going to make a big difference. You know, we hear discussion of a gas tax holiday because gas prices are high. They released a bunch of petroleum from the strategic reserve because gas prices are high. And I think this also fits into a category of policy change where if they could do it, I think the president would be able to stand up in front of the American people and say, “I know that you're dealing with these

high drug prices. I'm doing this thing for you." And even though all of us can explain all the reasons why it's not going to make a large difference, I think it does allow the White House to show that they understand that people are struggling with high costs and that they are trying to do whatever it is that they can do.

Rovner: It's a talking point.

Sanger-Katz: So I think if you're trying to understand the rationale, I think it's not a wonky rationale. I think it's a symbolic, it's a political ... it's just a desire to show the public that the White House feels their pain. And again, I think a lot of these changes that we've seen around the price of gasoline are in the same bucket of things that are just — they're not going to make a huge difference, they're not going to make a long-term difference. But they do make a show of caring about the problem.

Ollstein: I think you could say the exact same thing about the push to cap out-of-pocket costs on insulin. Most people pay less than \$35 a month out-of-pocket for insulin already. It would help a very small group of people, and it wouldn't do anything about the underlying cost of insulin. It would just shift the cost away from the patient, which is important and will help some people. But again, it's a very narrow and largely symbolic, like Margot said, effort to show that they want to do something and want to help people and aren't able to achieve these bigger, more structural reforms.

Kenen: When you hear [Joe] Biden talk about drug prices over the last couple of months, it's the insulin theme that comes up in his speeches. When he talks about health care costs, it often boils down to insulin. That's the talking point. Everybody knows somebody who has diabetes. These horror stories about people who can't afford insulin, there have been some deaths over ... it's not common, but there have been deaths of people who couldn't afford their insulin. And we've heard the Democrats talk about them. And Trump also had some insulin policies that didn't get enacted. Biden can sort of say, "Here. I've done this, it's step one, and I've gotten ... I've made insulin affordable for you." But, like Alice said, it's a cost shift. It's not the only expensive drug. I thought that article, the [Health Affairs piece](#) by Stacie [Dusetzina] was really shocking. You know, cancer drugs should not be a luxury item. And that's what they are so ... for that slice of the population that she was writing about. So lowering the cost of insulin doesn't make cancer drugs more affordable.

Rovner: All right. Well, one issue that it has not been a slow news week on is abortion. Hard to know where to start. I guess we will start with Oklahoma, where Republican Gov. Kevin Stitt, as promised, signed a bill that would make performing an abortion a felony subject to up to 10 years in prison, with only a handful of very narrow exceptions. Now, this is not the bill that copies the Texas ban that's now in effect that lets individuals sue people they suspect of having performed or abetted an abortion. This is a straight-up ban to be enforced by state officials. Alice, this is clearly and obviously a violation of *Roe v. Wade*, which is, for now, at least nominally, the law of the land. What is Oklahoma's strategy here?

Ollstein: Well, they're really throwing everything at the wall to see what sticks because they're also pushing a Texas-style ban with private right of enforcement, you know, empowering regular citizens to sue people for suspected violations of the abortion ban. And so they're just trying a bunch of different strategies at once. Of course, there will be lawsuits, but based on the trajectory of the courts and the anticipation that the Supreme Court will roll back or completely overturn *Roe v. Wade* just in the next few months, they are soldiering forward with this.

Rovner: And this doesn't take effect right away, right?

Ollstein: Right. But it does this summer.

Rovner: Is their theory that by the time it's supposed to take effect, the court will have said, "You can do this"?

Ollstein: Yeah, that's what a lot of states are banking on. And some states are moving forward with policies that would go into effect even earlier. So, basically, just daring the courts to stop them. You know, again, [it] worked out for Texas so far. Texas been able to basically ban abortion after six weeks in violation of *Roe v. Wade* for the past seven months. So, I think that it's important to remember about Oklahoma, specifically, is not only will it impact millions of people who live in that state, but it's been the main escape valve for millions of people in Texas who have been going to Oklahoma as the nearest abortion safe refuge. And clinics there have seen a huge uptick in patients from Texas. And so cutting that off would force people to travel even farther, would probably reduce the number of people who can afford or are logistically able to travel further. You know, Florida is just now signing a 15-week abortion ban into law today. The doors are closing, especially across the South, and the options are diminishing for people.

Rovner: And, obviously, all of these clinics in these other states are not capable of handling their own caseloads, plus the overflow from Texas. So basically, women are getting pushed into later and later abortions because you can't get an appointment for several weeks. And obviously every week that passes is another complication if you're trying to terminate a pregnancy.

Ollstein: That's right. And then there are fewer and fewer states who have abortions available later in pregnancy. Florida was unique in that it allowed it up to 24 weeks, but now that's getting cut back to 15. Of course, there will probably be some court challenges and such, but that is what they're moving forward with right now. And so that's exactly right. People are attempting to get abortions earlier in pregnancy and are forced by delays and a lack of resources to go later and later. And then there are even fewer options and greater expenses then.

Rovner: And just a reminder that what we're waiting for the court to rule on, likely in June, is a 15-week ban out of Mississippi. So I think a lot of states are trying to ... they'll have a 15-week ban in place, assuming that that's what the court allows. And many of them are going to have even more stringent bans in place, assuming that the court is just going to do away with *Roe* altogether. There's a lot of activity right now. Well, meanwhile, deep in the heart of Texas — where, as Alice, you point out, women have been streaming to next-door Oklahoma for abortions they may soon no longer be able to get — we saw something completely different this week. While almost all of these laws are careful to spare the actual abortion patient from liability, a woman in the Rio Grande Valley was arrested last week and charged with murder for terminating her pregnancy — something that is not, in fact, a crime in Texas. At least not yet. This is a really, really confusing story because it apparently involves a divorce, a hospital, a Democratic district attorney who may have made a mistake, and a potential conflict of interest in divorce lawyers, and the charges were quickly dropped. But I'm wondering if this is the kind of story that's going to mobilize abortion-rights forces. Right now they say they're not coming for the women, but here's a case where somebody was coming for the woman.

Ollstein: And it is definitely not the first. Women have been prosecuted in various states, including so-called liberal states like California, for their pregnancy outcomes. And the concern from abortion-rights groups is that without better legal protections in place and without safe medical providers that people can turn to following an abortion, if they need follow-up care. I mean, that was part of the issue — this person in this case was reported to police by medical providers, by the hospital she went to. And so that puts a chilling effect on people seeking out care if they need it. And so this is really raising concerns that even though this is technically not allowed, these kinds of charges, there are all kinds of individual prosecutors with ideological beliefs across the country who may attempt this. And had the community not mobilized

and had this abortion rights group not raised money to make bail for this woman and get national attention on the case, there's a concern that this will only continue to happen.

Rovner: Yeah. This clearly was a story that I think made a whole lot of people sit up and take notice pretty fast. Well, meanwhile, red states are trying to make abortion harder to get. Blue states are trying to make it easier. In Maryland, the legislature overrode a veto by Republican-but-sometimes-abortion-rights-supporting Gov. Larry Hogan, which would not only extend the universe of abortion providers to advanced practice nurses and physician assistants, but would also require most private insurance to cover abortion as a benefit. I think that got left out of a lot of the descriptions of this. Is this the future, with red states banning abortion and blue ones making it more available? I mean, is that where we're going ... the rush to 1972?

Kenen: I mean, I think we'll see. You know, you might not see exactly the Maryland law, but I mean, I think that we don't know what the court is going to do. We've heard things in Texas that they want to outlaw a woman from trying to travel. I mean, there are huge legal questions about whether you can control some of these activities outside of your own state.

Rovner: I think that was Missouri [not Maryland] that you're talking about.

Kenen: Was it Missouri?

Ollstein: Yeah, that was Missouri. But in response to Texas.

Kenen: So I mean, I don't think we know the legal landscape. The best guess is that 26 states — Alice, could correct me, she keeps better track of this. I believe the best guess is that if *Roe* is tossed or substantially circumscribed, that 26 states would ban all or most abortions, or pretty much, depending on if it's 15 weeks — we don't know — but there'd be less access in 26 states, and the 24 remaining states plus D.C. would probably try to do everything they could to enhance access and to accommodate. But you see some companies saying they're going to help women from Texas to travel and tele-abortion and the abortion pill. And you know, there's a bunch of things that are being talked about. It's probably not realistic to think that every woman with an unplanned pregnancy that she wants to terminate in a no-abortion state will end up, you know, landing in New York or California and getting one.

Sanger-Katz: I think it's a little bit of an oversimplification to think about red states and blue states in this scenario. So there is like this range of estimates, somewhere between 21 and 26, depending on whose count you look at, states are expected to substantially restrict or ban abortion if they are allowed to. But even when you think about the states that remain, I think there is a range of what they want to do. You know, we talked about Florida. Florida is pretty much on everyone's list of states that would retain abortion rights. They just passed a 15-week ban. And you know, there are other states — Virginia, New Mexico, probably. Probably Alice has this list right at her fingertips! But there are a lot of other states, Wisconsin, that I think maybe are expected to keep some legal abortion in place but might pass more restrictions if they were allowed to or might just keep things the way they are right now, where there are some restrictions and where there aren't a lot of available providers. And then we do see some of these other states that are really making a point of outwardly embracing access to abortion, trying to recruit patients from other states to be able to come. I think Oregon's state legislature actually has set aside funding to help women from out of state, women from Idaho to come there, if Idaho bans abortion. And so I think there's going to be a fair amount of diversity. Part of what *Roe* has done over these last few decades is to [establish] some degree of standardization across the country, and that's of course an oversimplification, too, because there is a range of abortion restrictions and there's also a huge range in just the number and availability and geographic spread of clinics. So there are plenty of states where, technically, you are legally

entitled to an abortion until fetal viability, but you can't get one because there's no clinic in your state that you can drive to.

Kenen: Yeah, there's hundreds of miles. I mean, there's big parts of the country that are already abortion deserts, even if it's legal in the state that, for all practical purposes, there's no local access. But "local" being defined pretty generously. I mean, they are states that only have visiting doctors who are only there during certain periods of time. I mean, there's already been an erosion of access to abortion in a number of states, and there's also a bunch of laws on the books that have been stopped by lower courts that would be able to go into effect. You know, a bunch of states passed 20-week bans, not all of which actually went into effect. Again, Alice can correct me because she's more on top of the details. I haven't looked at this 20-[week] state ban; she probably has more recently than I have. But when I last looked, there were states that had 20-week bans, not allowed by *Roe*. Lower courts stop them. They would be able to, assuming the court goes at least to a 15-week [ban], they would go ahead and then the states might even do further. I mean, a couple of years ago, 20 weeks was the outer limit of what the anti-abortion activists thought they could achieve. And now we're talking about six weeks to zero.

Ollstein: So a couple of points that I think are important to keep in mind. One, I think there is absolutely more state-level activity on the anti-abortion side than on the pro-abortion, right side. There are many more states more actively working to ban and have strict abortion and passing laws right now than there are responses from progressive states to shore up protections. I mean, California is really out front on this. You mentioned Oregon, Washington state, Illinois. There are some states doing something. Some are passing weaker protections like New Jersey that got watered down before passage, although people there think it's better than nothing. Colorado also, as well, nominally put abortion rights into law without some of the other measures that people think is needed. But it's absolutely lopsided, and that has a lot to do with which parties control state governments right now. I will also say that even though there are a lot of groups right now trying to raise money so that if people need to travel across state lines, that can be fully funded. But I think it's important to remember that money is not the only reason that some people are not able to travel. It's definitely a big one. But, you know, I'm talking to these groups and they mention there are people with disabilities who can't travel. There are people who are immunocompromised and can't travel for covid reasons. There are people who have young children and can't get child care. There are people who can't miss work. There are people who are undocumented and are afraid of passing immigration checkpoints by crossing state lines or can't get on an airplane for that reason. And so these abortion funds that are raising money to help people travel — and, as Joanne mentioned, individual corporations are offering travel to their own employees. That will not help everyone who needs it. And you know, that's why these abortion-rights groups say the important thing is to make abortion available in the communities that people already live in, in a safe way, not just allow travel to this new patchwork-state future that we are rapidly entering.

Rovner: Oh boy, this hasn't even happened yet, and it's already a mess.

Kenen: Oh, it's already a patchwork. It's going to get ... the patchwork is going to be ... it's still going to be a patchwork. It just the limitations are going to be more stringent. We already have a country where there's unequal access to abortion that — not legally, legally it's the same — but, practically, there is already unequal access to abortion, depending on what county and what state you live in. That's a fact. That will be a wider gulf, and the travel programs will probably not eliminate that gulf. And telemedicine, the abortion pill, I mean, I expect states trying to obstruct that. I think it's now the most common first-term abortion, right, Alice? More women are doing [medication abortion] than surgical?

Rovner: Guttmacher [Institute] says it's more than half.

Kenen: Right. And that's a trend going up. But it's good until 10 weeks, I believe. So I don't see that, that also is going to be an easy thing for all women to access, particularly those in more marginalized communities with less access to technology, medicine, advice, all that stuff. I mean, it's not ...

Rovner: All right. Well, we're going to move on, but we'll definitely come back to this one. I also have a series of stories this week that I'm calling "This Week in Ominous Indicators." We've been informed that covid cases have now passed a half a billion worldwide, that U.S. life expectancy continues to fall even after we got the covid vaccine, and that teen fentanyl overdoses doubled in 2020. I assume all these things are kind of related, right, Margot?

Sanger-Katz: I guess I push back a little bit. I don't really like looking at life expectancy when you have these short-term blips that really cause big changes in mortality. I think ...

Rovner: Like a worldwide pandemic.

Sanger-Katz: I think it's totally possible that covid is going to continue to kill a lot of Americans for a long time, and that will have a long-term effect on life expectancy. But life expectancy is like sort of the synthetic measure where they look at how many people died last year, and if they just assume that those rates continue forever for the lifetime of people who are born this year, that that's how long they're going to live. And I just think that's not realistic. I think we had more people die of covid in 2021 than we did in 2020. I think largely due to the delta wave and also due to, you know, the first few months of 2021 before Americans were vaccinated, when covid was still very widespread. You know, January 2021, February 2021 were real bad months even before the vaccines. So yes, covid is causing a lot of deaths. I think covid is causing a lot of preventable deaths. You know, the further we get into the present, the more the deaths really are due to a lack of vaccine. And the fact that there are so many Americans who aren't vaccinated is bad. Overdoses? I am dubious that there is really a strong covid component to these overdose deaths among young people. You know, if you look at the article that was published documenting this, it does seem like this is a change in the drug supply. As you know, a lot of these trends in overdose deaths reflect changes in the drug supply. So young people are taking pills, and it turns out that more of those pills seem to have fentanyl in them than they did before. And so they think that they're taking one thing and they're taking something that's very strong or they're taking multiple drugs together. And because there's fentanyl in one of those things, it's leading to a fatal overdose. So I think that is a huge public health problem. And the death of adolescents is just an enormous tragedy and something that needs to be fixed and dealt with. But I don't think it's necessarily all due to the pandemic. I think a lot of these mortality trends are kind of long-standing. I mean, even before the pandemic, we had peak drug overdose deaths. We had peak suicide deaths. You know, suicide is actually down during the pandemic. But some of these trends that are driving life expectancy may have been worsened by covid, and some of them, I think, may have just continued on their own trajectory regardless.

Rovner: Separately, in "Ominous Indicators," while life expectancy went down, sexually transmitted diseases are up — a lot. Alice, we've all been locked down for the past two years. How are sexually transmitted diseases going up so fast?

Ollstein: Let's just say people did not stay 6 feet apart. So I think this is really a story about human behavior and reduced access to health care. You know, routine testing, especially just the regular testing — that's not when you notice symptoms, but just the regular testing that can catch asymptomatic infections, which are really common for chlamydia and, you know, the early stages of a lot of STDs — that went away. Places during covid had to shut their doors. People who were doing contact tracing for STDs were pulled off that and reassigned to do contact tracing for covid. There were supply-chain issues with the test kits themselves and the labs that process them having to be diverted to focus just on covid and stop working on all that

other stuff. And the impact has been terrible. STDs are now at record rates. They've gone up and you see really scary consequences. You know, people think of STDs as something not that serious because if you do catch it early, you can just, you know, take some antibiotics and be fine. But when you don't catch it early, it can lead to serious and even life-threatening impairments, including infertility, as well as other risks. And, most troublingly, what's gone up the most is congenital syphilis — newborns born with syphilis, which is entirely preventable if the pregnant person gets tested and gets good prenatal care. And that's just not happening for so many people, and it's a real preventable tragedy. And so I wrote about how this is happening at a time when some of the budgets for these programs that provide STD testing and contraceptive services to low-income people are not getting the investment that people say is needed. So, trying to have an accountability angle there, too.

Rovner: Yeah, it's the federal family planning program that funds most of this testing from the federal Treasury. And it's all, of course, caught up in the abortion debate. But, you know, while they're fighting over abortion, this program that can help control sexually transmitted diseases basically isn't. So. All right. Well, now let's actually talk about covid for a minute, which frankly sounds a little redundant this week as we see cases rising again with yet another new variant. The Biden administration has renewed the public health emergency, Philadelphia is reimposing a mask mandate, and you'll still have to wear masks on public transportation at least until early May. Being tired and wishing this was over apparently doesn't make it so. And there actually also might be a lot more cases than we're seeing, right? I mean, I had seven negative tests last week, and except for the PCR test that I got, I don't think I've reported any of them. So, you know, I'm wondering, how bad is it that we're not even seeing?

Kenen: There are other ways to do surveillance. So if you're going to move to some, there are good public health and individual health reasons to push for home at-home, rapid tests. They're a good thing whether you have symptoms and you need to know — do I, you know, is this just my allergies acting up or do I have a cold or do I have covid? Would I recommend getting a PCR, too? But it's useful if you're going to be at a family gathering and you want people to check before they go, so you're protecting the at-risk people, et cetera. However, it means that we don't have a good picture. So, because people don't ... if you get a positive, most people don't report it.

Sanger-Katz: I did.

Rovner: Thank you, Margot.

Kenen: And there are a lot of positives. But there are other ways of detecting ups and downs of disease. And we're just not, you know — surprise! — we're not doing a good job.

Rovner: What a shock.

Kenen: Who knew?! Right. The wastewater [monitoring] is actually very promising. It's useful. I mean, we are getting data from it, but we're not getting the kind of comprehensive, systematic national data that we should be getting because most cities are not doing it and they're not reporting it to the CDC. Again, the usual list of things that go wrong. There are other ways that scientists can surveil and detect variants. And we're just, I mean, right now, Congress hasn't even passed the skinny, skinny, skinny, watered-down version of the next covid package. You know, it's a mess. So part of the way we watch caseloads is, sort of, "What's going on in the UK? And when is it going to get here?" And Israel has very good data as well. So we partly look, but we're not identical to them. I mean, we've had more covid here. Bill Hanage is an epidemiologist at Harvard. I think maybe we all saw this quote, but I'm going to share it anyway. When he was explaining our level of immunity at this snapshot in time, you know, may not last, versus a country like the U.K. where they have less covid, he said that we're more covid curious than other countries. So ... not

only is there a subvariant but there's a subvariant of the subvariant and it's, each one is getting more contagious. From what we know, they're not more dangerous, but they are dangerous to people who aren't vaccinated, to people who are vulnerable. So we do see an uptick. We never see ... there's no such thing as a "downtick." I mean, it's getting worse again, but we don't know how bad this one is. We might get through this without getting to crisis proportions because we do have, between all the people who got omicron a month or two ago, plus vaccination, we might have pretty good protection right now. But depending what the variation after that, the variant after that is, and depending when it comes, we're not out of this.

Rovner: Yeah. We will definitely watch that space. All right. Well, I had other things that we do not have time to get to this week, so I will tuck them in in weeks to come. So that is the 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 the links on the podcast page at khn.org and in our show notes on your phone or other mobile device. Margot, you have already done yours. Alice, why don't you go next?

Ollstein: I wanted to get in a mention of this fight that's going on over Title 42, so I'm promoting a piece I did with my newly hired co-worker Krista Mahr about the fight over Title 42 and how it has derailed the other fight over covid funding in Congress. And so this is the CDC's policy that was enacted under the Trump administration to expel migrants who are seeking asylum at the borders of the country under the argument that it will keep the country safer from the spread of covid. Now, the Biden administration, for a lot of their initial time in office, worked to keep the policy in place, and in fact, far more migrants have been expelled under Biden than were expelled under Trump. But the Biden administration recently moved to say, "This policy doesn't really do anything for public health. We are getting rid of it." And that has inspired a huge backlash from Republicans, but also from a lot of moderate Democrats, especially those who are up for reelection later this year, who think this is a very bad move politically, and Republicans are absolutely pouncing on this. And so in our piece, we walk through not only how they've used it in Congress to try to force votes on it to derail the covid funding package, but also how there are federal lawsuits about it playing out. There are a lot of campaigns that have started focusing on it, using it in ads, et cetera. And so this is really something to watch, and it's something where it's definitely more of an immigration issue. But because it's coming under the covid umbrella, you have this very weird situation where both parties are accusing the other of hypocrisy. So you have Democrats saying, you know, Republicans want to get rid of every other covid restriction, mask mandates, vaccine mandates, but they want to keep this one in place? That doesn't make sense. And Republicans are saying: Democrats want to keep the mask mandate in place and have billions more to fight covid, but they want to lift this restriction. That doesn't make sense. And so we're just in this ugly round of finger-pointing right now.

Rovner: Yep, and we'll be back to it when Congress gets back. Joanne.

Kenen: Vox is doing a series on preparing for the next pandemic, and I chose a piece by Dylan Scott. The headline is "[America Needs More Doctors and Nurses to Survive the Next Pandemic](#)." It's not so much about, like, you can't instantaneously create more doctors. It's more about the steps we can take and the tools we already have but aren't using wisely for surge capacity. You know, how do we get everybody where they're needed, doing what they're capable of doing in an emergency situation? People who aren't normally allowed to do X but are perfectly capable of doing X. You know, how to get doctors, nurses, and nurse practitioners, nurse assistants — and, he didn't mention it specifically, but respiratory therapists. So things like that, people like that, how to let them do what's called practice at the top of their license without regulatory barriers that sometimes don't let them do things that they actually know how to do or making the supervision more flexible. So it's not that we need more doctors sitting around with nothing to

do. Obviously, we need more and more primary care doctors in this country. But how do we meet that surge need in a crisis?

Rovner: It's also how to get primary care without having more primary care doctors, which has been a theme for a while. Well, I've had a bunch of downer stories lately, so I thought I would pick something a little bit lighter this week. My story is from Politico. It's by David Lim and Lauren Gardner and it's called "[Mice Occupy FDA Offices After Food Left Behind in Pandemic](#)." And I suspect it is not just the FDA where this is happening, although it's so bad at the agency's White Oak, Maryland, headquarters that some workers have had to be transferred to temporary workspaces or asked to continue to telework. This is where I get to say that a dead mouse was once found layered in my overloaded inbox when I worked on Capitol Hill, helping me learn my lesson. So the one time I went to the KHN office during the pandemic, I threw out all the snacks I normally keep in my desk. As you might imagine, this story brought out the creative side in some of my colleagues. Alice here [tweeted it](#) with a wonderful limerick. I will read it. "There's mice at the FDA / Who like to frolic and play / Staff left food in their desks / And now it's a mess with a return-to-office delay." But my favorite comment came from KHN's Liz Szabo, who pointed out that the quickest fix would be a "Take Your Cat to Work" day. So we shall see what the FDA decides to do.

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. Joanne?

Kenen: I'm @JoanneKenen

Rovner: Alice?

Ollstein: @AliceOllstein

Rovner: Margot.

Sanger-Katz: @sangerkatz

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