KHN's 'What the Health?'

Episode Title: Leaked Abortion Opinion Rocks Washington's World
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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. And I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, May 5, at 10 a.m. As always, news happens fast, particularly this week, and things might have changed by the time you hear this. So here we go. Today we are joined via video conference by Joanne Kenen of the Johns Hopkins [Bloomberg] School of Public Health and Politico.

Joanne Kenen: Hi, everybody.

Rovner: Shefali Luthra of The 19th.

Shefali Luthra: Hello.

Rovner: And Jessie Hellmann of CQ Roll Call.

Jessie Hellmann: Hi.

Rovner: Later in this episode, we'll have the latest KHN-NPR "Bill of the Month." This time around, KHN's Paula Andalo follows a family that sought relief for high medical expenses south of the border. But first, this week's news. And, of course, this is the first week in 2½ years I did not put covid into the rundown — and the U.S. passes a million covid deaths. And it turns out that the White House Correspondents' Dinner may well have been a superspreader event. But this week we are going to start with abortion. Washington is still reverberating from the unprecedented leak to Politico of a draft Supreme Court opinion by Justice Samuel Alito that would not only uphold Mississippi's 15-week abortion ban, but would also completely overturn *Roe v. Wade* and its successor case, *Planned Parenthood of Southeast Pennsylvania v. Casey*. Now, this is, and I keep saying this, not the final official word on this. No opinion is official until it's released by the court, not leaked to a reporter. And this opinion is from February. So it may already have been revised or its purported majority may have splintered. All that said, though, it seems pretty clear that there are at least five votes on the current court to overrule *Roe*. And if this *is* the final opinion or something close to it, it could have ramifications way beyond abortion. But let's stick to abortion for a minute. Shefali, what would it mean if come next month, or later this month even, the right to abortion ceases to exist in the United States?

Luthra: So this would vary from state to state, but we know that there are 13 states in the country that have laws already on the books that are these so-called trigger laws. They would more or less ban abortion as soon as *Roe* is overturned. There are some nuances in how they function — some have a 30-day period, some require the AG [attorney general] or the governor to certify. Ohio is moving one of these bans as well. Separately from those 13 states, there's five states that don't have trigger laws, but they do have these laws that predate *Roe* that have not yet been repealed

that would also ban abortion. And the legal matters are a bit trickier here because there isn't much precedent for laws that have been blocked for so long coming back. There's a lot of debate over whether they'd have to be repassed, whether the governor could just start enforcing them. And in both Arizona and Michigan, there's actually the governors do not intend to enforce these bans. And in Michigan, the governor has challenged it in court. So it's possible that we have 18, 19 states banning abortion soon after *Roe* is overturned. It's possible it's fewer. The other thing we know longer term is that this very well could encourage states that have been in the middle — the Kansases and the Floridas — to go a bit further and impose new restrictions on abortion, especially in Florida, where the governor seems very serious about running for president.

Rovner: And in Oklahoma, I mean, they just — the governor has signed, what, two bills in 10 days?

Luthra: He has signed two laws. There is a third one that we are expecting could — it has to be done by the House again. But Oklahoma, it seems that they're really jealous they weren't the ones to pass Texas' six-week ban, and now they're doing everything they can to match their neighbor.

Rovner: And also, I mean, you sort of smile, but a lot of women from Texas have been going to Oklahoma, right?

Luthra: Yeah. And, I mean, the governor mentioned that when he signed the first of the bans he signed. He talked about how Oklahoma had become this sanctuary of the thousands of Texans who have fled the state for abortions. Almost half have gone to Oklahoma. And now they can't. And they're going to have to go to Kansas or to New Mexico. The Oklahoma clinics I've spoken to are trying their best to redirect folks to Kansas, but they know that that's probably not a long-term solution, either. In fact, I was talking actually to an Oklahoma clinic administrator on Tuesday morning, and she told me that on Monday night when she read the leaked *Roe* decision, it was while she was calling patients past six weeks scheduled for the next day to cancel their appointments because they knew this ban was coming.

Rovner: Yeah, I mean, it's obviously never been anything like this before. I mean, Washington's biggest parlor game right now is who leaked this opinion, which is kind of predictably juvenile, but this can really seriously affect how the court operates going forward. I mean, this leak is a really big deal, isn't it, Joanne?

Kenen: Yeah, I think all of us are not big fans of horse-race reporting and process when it's just about finger pointing and polls, but this is different because … People are saying the leak reporting is a horse race. No, no, no — this is going to have political repercussions. And any of us would give to be a fly on that Supreme Court wall right now. This is extraordinary. And we don't know whether it came from the right or the left. There are coherent theories on both sides. It is probably, but not certainly, a clerk. We don't know for sure. We may not know for years. We may not ever know. How long did it take to find out who Deep Throat was? Forty years, or whatever. This is an extraordinary breach within the court. They must all be looking at each other very suspiciously right now. And there must be an extraordinary amount of anger, which we've actually seen boil up in public — in fact, during the oral arguments on this very case in December. There doesn't seem to be …

Rovner: There's some ill will among the court. I just want to point out, because I keep doing this, that if the February purported majority opinion in the Affordable Care Act had leaked in 2012, then it would have said that the Affordable Care Act was being declared unconstitutional, that votes can and do change in the process of writing these opinions. What happens is they hear the oral arguments, they take an initial vote, the senior justice in the majority assigns the opinion, and then that justice starts writing. And then they start trading opinions back and forth. And that's how sometimes you end up with concurrent opinions, because somebody who still agrees with the actual finding in the case may not agree with the reasoning. So they may write their own opinion, and then you can get multiple dissents, and they'll all quote each other. So, I mean, this is something where they pass things back and forth, and they really — I mean, there has never, at least since I've been covering the court, been a decision in process that's been leaked. A couple of times, there [has] been news of a decision that's been made leaked a day or a few hours beforehand. But this appears to be unprecedented.

Kenen: Yeah, I mean, two things about that. One is when Josh Gerstein, my colleague, who I should point out is, in addition to being an extraordinary reporter, is also an extraordinary colleague, a terrific person, very, very conscientious, who, as you can tell from his reporting … According to his reporting, the votes have not changed yet. It's still five on this decision, although that may be partly … some fluidity there may be part of the motivation for leaking it if it did come from the right. The second point is just in terms of changing *Roe* or changing abortion law, it's 6-3 and not 5-4. Because [Chief Justice John] Roberts is not siding with the three Democrats. Roberts wants to uphold Mississippi's 15-week ban, which is not in keeping with *Roe*. It's prior to viability. But he doesn't want to go as far as the Alito ruling, from what's come out so far. So the speculation centers on [Justice Brett] Kavanaugh. Even if Kavanaugh or one of the other five with Alito, even if one of them decides that Alito went too far or doesn't agree with the language, he's not going to come over and join the three Democratic or pro-choice … We're not supposed to call them Democratic, but they are. That's one of the problems with the court. If he or she, if one of them, decides they're not part of the gang of five with Alito, you have Roberts, who's currently a gang of one. You could have a 4-2-3, and they would have to take it from there. And the decision would probably …

Rovner: And whether Roberts could get one of the liberals, who right now would be a "we don't even want to uphold Mississippi" to say, "we'll uphold Mississippi if you won't strike down all of *Roe*." I mean, it's not to say that Roberts couldn't cobble together five votes. He apparently hasn't yet.

Kenen: Right. *Roe* is not going to come out of this intact. We don't know exactly what the opinion will say. Chances are anything [that] was written in February has changed. Alito is going to push it as far as he can to the first draft, knowing that he's going to have to modify it. So he came out clearly very strong. They pick apart language. The reason it takes so many months to write an opinion even when they've made up their minds is they discuss different legal approaches. They discuss language. Every word matters. So the document will look different in July. But as of Monday, it was still 5-1-3.

Rovner: So the perception is that if *Roe* is overturned, as this leaked opinion suggests it will be, that the abortion decision would go back to the states, that each state would be able to make up its own mind. But there are some things in this opinion that suggest that that may only be sort of a way station on the road to banning abortion nationwide. There's a phrase that Alito has in this opinion that said … talked about the state interest in potential life at every stage of development. That seems to be a nod to personhood or declaring that potential human life has some protections. That would eliminate the ability of the blue states to allow abortion. We also have to remember that even though Alito put in that decision that we're not going after contraception and gay marriage and interracial marriage because that's not really about potential life, it was Alito who wrote the Hobby Lobby decision that basically said that if you want to declare contraception to be an abortion, that's your religious belief and you can do that. So I'm wondering if this could have ramifications even beyond the huge ramifications we've all been talking about this week.

Luthra: Contraception feels like it's a really natural place, right? Because if a decision like this is …

Rovner: You mean to go after next.

Luthra: Yes, yes. I mean, this is a humungous victory for the anti-abortion movement. And every time one speaks to them, it's very clear that they do believe that, in particular, the morning-after pill is equally, to their view, heinous, right? And something that they would like to tackle next. And I just can't imagine not being so energized by this victory that you don't then go next for personhood in the states, for emergency contraception, and then longer term for hormonal contraception as well, right? It's just the logical place to go, especially when you have the court quietly signaling that this is an opening for you.

Rovner: So, what can Congress do? I mean, at the moment, we have a Democratic president who ostensibly supports abortion rights — he does support abortion rights; he doesn't like to say the word abortion — and a Democratic Congress, but paper-thin majorities. And not everybody supports abortion rights. I mean, could this be the thing that kills the filibuster in the Senate? No. I'm seeing people shake their heads.

Luthra: They already said no.

Hellmann: Yeah. So I was on the Hill this week asking people about this. And [West Virginia Sen.] Joe Manchin did not even consider thinking about getting rid of the filibuster.

Rovner: Of course, Joe Manchin is the remaining Democrat who is thoroughly anti-abortion. [Pennsylvania Sen.] Bob Casey being sort of the other one who is pretty anti-abortion.

Hellmann: Yeah, he's still saying this is one of the best ways to protect our democracy. This doesn't change his view on that. If he can’t get past him on this, then I don't see a path forward in the Senate to actually do anything about this. I think there's a recognition of that. But [Senate] Majority Leader [Chuck] Schumer did say he wants to have another vote soon on a bill that would codify *Roe*. They did a test vote on this in February. It failed. It's probably going to fail again. But they feel like they need to have some kind of messaging thing going into the elections this year.

Rovner: And they feel like they need to put Republicans who seem uncomfortable with this on the record again. I mean, they're on the record for February. It's not like we haven't voted on this in years and years. We haven't voted on this since last winter. I think people are paying attention in a way that they didn't, but there's nothing really effectively that Democrats can do, is there? Joanne, you're shaking your head.

Kenen: Well, I mean, they can spend more money on Title X, which is federal family planning, which they have not done. [President Joe] Biden's asked for more and so far has not gotten it. There are some coverage things because, remember, the Affordable Care Act did include expanded free contraception, not just in the Obamacare plans, but in the plans that most Americans get now. It's in Medicaid, it's in the ACA plans, it's [in] employer-sponsored insurance. There are some enforcement issues, there are some gaps, but a lot more women got covered. There's some FDA things, too, that advocates are calling for the FDA to remove even more restrictions, make it even easier to access telemedicine abortion. There are privacy issues that have been raised about phone apps. I mean, there are things around the edges that the federal government can do both for abortion, particularly the abortion pill … I mean, I don't see Congress creating an emergency "get a plane out of Texas" fund. You know, there are a bunch of things they could do, but there's nothing huge.

Rovner: Well, it's not just going to be Texas. It's going to be the entire South and much of the West.

Kenen: And the north, sort of the north-central part of the coast. It's about … approximate … According to an estimate I saw from [the] Guttmacher [Institute], it's approximately 40% of American women of reproductive age are going to live in a state that either has a ban or severe restrictions on abortion. And travel is not going to be practical. I mean, if you live right on the border and you can take a bus 20 minutes away, it's a big difference. And if you're living in a real contraception/abortion desert and you're trying to travel hundreds of miles and you have other kids to take care of or you have parents you can't tell if you're a teenager or if you can't take any time off work — there are all sorts of impediments to travel. Some women will be able to travel; some will not.

Luthra: To add on to that — right, I mean — the clinics in these blue states, they don't have the capacity to care for all these patients, right? Already the clinics in Colorado and New Mexico are working full tilt just to accommodate all the Texans. When you add in like five or 10 more states, it's not possible. And we've seen some action from blue states like California really talk about wanting to be this abortion sanctuary. But everyone I've talked to has suggested that what we've seen from blue states versus what would be needed to meet their new reality, there's a tremendous gap.

Rovner: So one wild card in all this are some big corporations that are actually — I mean, this is something that we didn't have before *Roe* in 1973 — that we have companies, including Amazon and Citigroup and Yelp and Uber and Lyft, saying they want to guarantee their workers access to reproductive health care, including money for them to travel. I mean, we joke about a federal travel fund. Amazon could put together a pretty big travel fund if they needed to. I mean, it's hard

to imagine an issue that's more divisive in society than abortion, but I feel like this is going to make it even more divisive than it is now.

Kenen: I mean, it is pretty extraordinary that they've offered to do this, but it doesn't solve the access capacity problem. But for people who are employed by these companies or perhaps their dependents, there could [be] travel, but it's a lot of people. But right now, they're something … approximately a little under 900,000 abortions a year, as of 2017, I believe, was the last … It's like 870,000. I'm probably off by about 10,000, but that's the ballpark. Which is way down. It's half from the peak in around 1990. That's still a lot of women who seek abortions. Most of them, the vast majority, are in the first trimester. Most of the later-term ones are because there's some kind of medical complication, not 100%. But, basically, abortion is an early-in-pregnancy procedure overwhelmingly. And the later ones tend to be because there's a medical thing. I mean, there's a medical problem.

Rovner: Or because they've run into problems getting an early abortion.

Kenen: Right, right.

Rovner: Increasingly.

Kenen: I've asked people for a story I'm working on how much of this drop is because we have better contraception, better access to contraception, and how much is it because in parts of the country, it's already pretty much impossible to get an abortion. And I was told that it's really hard to untangle that. It's sort of an inkblot. We don't know for sure. There are already large, many states, where there's very, very, very limited abortion access today. And it's going to go from very, very little to basically none. So there's not a simple answer. Even states that want to be abortion refuges, it requires capacity, it requires money. I mean, it's one thing for the state to declare it. It's another thing for states to set up a fund for out-of-state women. I mean, we don't know what the conservative states are going to do to try to prevent travel. We've discussed that.

Rovner: We've already talked about Missouri trying to. Yeah.

Kenen: And then also, I mean, I think that the abortion pill doesn't require the clinic capacity. It's nonsurgical. You don't have to go to a clinic and have a procedure. It became the most common form of early, I think, in 2020 or 2021, the most recent statistics. It did become the most common form of early abortion. So that is something that the women's health advocates and the pro-choice people are trying to really expand because you can accommodate more.

Rovner: Right. And that's what the other side is going to go after.

Luthra: And they're already starting to go after it.

Rovner: Exactly. All right. We will obviously come back to this more in the weeks ahead. There is, believe it or not, other news, other health news this week. Not nearly as all encompassing, but still very important. The FDA last week said it would move to ban menthol in cigarettes and cigars. Now, the FDA has been moving to ban flavors in tobacco, primarily to deter young people from starting to smoke, for several years now, since Congress first gave the agency authority to regulate

nicotine in 2009. But while banning flavors like bubblegum and unicorn — yes, that was an actual vaping flavor — is one thing, menthol is a whole different discussion that starts to touch on health equity issues. Jessie, you've been covering this. Why is banning menthol in particular so touchy?

Hellmann: So data shows that there are health disparities at play here. Most Black smokers say they prefer menthol. I think it's 85% compared to about 29% of white smokers who say they prefer menthol. So we've seen groups like the NAACP weighing in on this, saying the FDA needs to ban menthol. It's causing severe health disparities in Black communities. Tobacco is still one of the leading causes of preventable deaths in the United States, but it has been divisive. We've seen some groups in the Black community, like Al Sharpton's group, saying that this could lead to more overpolicing of Black communities. Critics of this argument will note that Al Sharpton's group and some others have received funding from the tobacco industry, which obviously their bottom lines would be severely impacted by a menthol ban.

Rovner: It targets Black communities in, I guess, both good and bad ways. I mean, on the one hand, they're disproportionately impacted by the bad effects of smoking. On the other hand, if they were to reduce it, they would be disproportionately helped by people stopping smoking. What exactly is it that the FDA wants to do? How are they going to sort of do this ban?

Hellmann: It would basically ban manufacturing of menthol cigarettes and the sale of menthol cigarettes.

Rovner: Yeah, we should point out that menthol is one of those — a long, long, long time ago when I smoked, I liked menthol because it cut some of the bitterness of the tobacco, which is one of the reasons why it's so popular, and it's one of the reasons why they've been so loathe to do this. I guess this is the second piece of something that's been coming. In some ways, I guess it's good that you're doing this really controversial thing in the middle of things that are even more controversial that are happening, maybe you'll sort of fly under the radar.

Kenen: The community policing issue … If you stop manufacturing it, if it doesn't exist legally anymore … I mean, I think people thought it was like the police were going to go after individual smokers. I mean, the FDA statement made very clear they're talking about distribution, manufacturing, sales, etc. So it's not like you as someone who's already afraid of the police or hate the police or tension with the police or … we all know what the problems are. It's not the individual person, although that is a perception. The big tobacco fights were in the 1990s, and that's where a lot of the regulation of youth tobacco … and menthol was talked about then, and this issue has gone on for years and years. Among the Black leadership, there's now a split. I mean, there are members, prominent members of the Congressional Black Caucus who are in favor of this. And that makes it a little bit easier to move ahead. It's how kids start smoking, the thing that's less harsh and easiest. And we've had significant gains in reducing smoking. There have been some spikes in some areas again or some hints of bad trends. And this is another way that kids start smoking.

Rovner: And we will see how this one plays out. So in news on another long-running controversy, drug maker Biogen is effectively throwing in the towel on its Alzheimer's drug, Aduhelm, which

somehow got approved by the FDA only to get severely restricted by Medicare and now by lots of insurers, as well. As awful as Alzheimer's is and as much as the world wants an effective treatment, there wasn't a lot of strong evidence that Aduhelm was that drug, and there was evidence that it could have very severe negative effects. [The] Biogen CEO is now stepping down, and it is, according to the company, “substantially eliminating” spending on the drug, meaning it's going to basically stop marketing it. I'm wondering what this means for the future of drug development, or is this just kind of an embarrassing and expensive interlude? This costs Biogen an awful lot of money. Are companies going to think twice about some of these drugs that they're working on, or are they just going to rush to be the one that maybe has a safer drug before they take it to the FDA?

Kenen: Well, the trials always cost a lot of money, and most drugs fail. That's one reason they're so expensive is that for every one that gets through, there's an awful lot that fail. Sometimes very early, stage 1 or early stage 2 of the clinical trials. So drug companies are still going to spend money developing drugs. I'm not sure how many of them are going to take a drug to the FDA for approval when there's this much uncertainty about the drug, this much of a price tag, and this much of a side-effect profile, because the side effects Julie alluded to — your brain bleeds! It was also extremely expensive, although they kept bringing the price down. But there's all sorts of out-of-pocket. You need brain scans. It’s not like a generic aspirin. It was a very expensive drug.

Rovner: Yeah.

Kenen: Whoever does finally come up with a treatment for Alzheimer's, it's going to be (a) something that's going to make a tremendous difference to patients and families — it's a terrible disease. It's also going to make some company a whole lot of money.

Rovner: Yeah. And I would say as much as the Alzheimer's community really, really, really wants a medication — and there is a lot of pushing for people to take this drug —I think it's now pretty clear that this is not going to be the drug. This was sort of a yearlong really expensive sideshow, and the search is going to continue.

Kenen: And, you know, the drug that eventually works might be built on this drug. I mean, some of the science here that is different than other drugs — it still might be scientific progress. I don't know enough about the biochemistry of Alzheimer's in this drug, but it still could be a step towards something that works. But this is not the solution.

Rovner: All right. Well, in other news that broke while we were taping last week, the inspector general at the Department of Health and Human Services issued a report finding that private Medicare Advantage plans are improperly denying patients coverage of services that they could get if they were still in government-run Medicare. The report found, quote, “widespread and persistent problems related to inappropriate denials of services and payment.” Now, this is not exactly news, that private Medicare insurers are more likely to make patients wait or deny care or jump through hoops to get care. In fact, the report itself noted that the results were similar to what they found the last time they did this kind of audit in 2018. But as Medicare Advantage enrolls a larger and larger share of the Medicare populations — nearing half, by some counts —

the question is whether all those patients realize that while they may get extra benefits that they wouldn't in traditional Medicare, like hearing or vision or dental coverage, they might also have more trouble getting actual care when they really need it. Could these kinds of reports dampen enthusiasm for signing up for Medicare Advantage, or are those Joe Namath ads just too ubiquitous? “Get what you deserve.”

Kenen: Pretty popular. I mean, it's been growing across the country, red and blue states. It's pretty popular because you do get a lot of things. And it's not like traditional Medicare is a hassle-free world either. It's not just getting your X-ray or your MRI. There's also different financial exposures. It's not just gym membership. There are other benefits, and people are going to make that trade-off — vision and dental and things. And some of these plans are valuable to people. And it is complicated, too, because the word “inappropriate” was used here, meaning that these are … they were not unreasonable things. But remember, patients often do want things that aren't really necessary. We do a lot of overtreatment in this country. We do both overtreatment and undertreatment. So sometimes when your doctor says or your insurer says no — sometimes they're right. Sometimes they're not. Sometimes they just don't want to pay for it.

Rovner: That's right. And in the case of Medicare Advantage, I mean, they get a set amount of money. So everything they don't spend, they get to keep. So they have a different incentive to … on the one hand, in traditional Medicare, doctors and hospitals have the incentive to do more because then they get paid more. But in Medicare Advantage, the insurance company has the incentive to do less because then they get paid more. And it's, you know, we're still sort of seeking that middle ground where …

Kenen: We haven't gotten it right. The incentive to do the right amount of medicine for the right patients. We’re still a significant work in progress. We overtreat, we undertreat, we overpay, we spend too much. We don't do the right things for the right people. We're still a mess.

Rovner: It's the holy grail of the health care system: figuring out how to get the incentives aligned. That is the favorite phrase.

Kenen: The *un*holy grail.

Rovner: Yes, we may get there someday. All right. Well, that is the news for the week, or at least as much as we have time for. Thanks for sticking with us. Now we will play my “Bill of the Month” interview with Paula Andalo, and then we will come back and do our extra credits.

We are pleased to welcome to the podcast my KHN colleague Paula Andalo, who reported and wrote the latest KHN-NPR “Bill of the Month.” Paula, welcome to “What the Health?”

Paula Andalo: Thank you so much.

Rovner: This month's family had good insurance, but like so many ended up with big out-of-pocket bills anyway and, in the end, they sought relief in another country. Tell us who the family is and what happened to them starting, I guess, with Dad, who got sick first.

Andalo: Yeah, sure. This is the family Jesús and Claudia Fierro. They live in Yuma, Arizona. They began to have really bad luck with health beginning in December 2020, when Jesús was hospitalized with a very serious covid case. He was 18 days in the Yuma Regional Medical Center. He refused to be intubated, but he was in bed with medicines. He came back home, losing 60 pounds, with an oxygen tank to help him breathe. He recovered after two months, but he almost fell sick again when he received the bill — that it was almost $4,000 ($3,894.86).

Rovner: And this was his part of the bill? That was not the whole bill.

Andalo: Yeah, of course. The family has insurance through Jesús' work. He works with an international oil company, and they have good insurance. But the problem, you know, is the deductible, the copayments, the coinsurance. So they were still paying for Jesús' bill. But the situation became worse in June 2021.

Rovner: Before we move on, because when you say, OK, he had covid in 2020, didn't his bills have [to have] been paid? Weren't most insurers not charging patients and hospitals not charging patients their share?

Andalo: That was the suggestion at the moment. Remember when all the relief packages were in place? The hospitals received money to pay or avoid the patients [having] to pay for these bills. But nobody never told him about this. And when he asks for help, he talked to people at the hospital, with his bill — and lately with his wife's bill — they said, no, you cannot apply.

Rovner: So, all right. So now let's move on. What happened to his wife?

Andalo: OK. So they were waiting for a table at a local restaurant and she fainted. I mean, something that could have been, you know, if the weather is hot or is cold or whatever, usually it's not a big deal in terms of a medical situation. But of course, they called 911 and she was transferred to the same hospital that Jesús was less than a year before and she spent almost 24 hours in the ER. They did on her the basic stuff, you know, the vitals. They told her that her magnesium levels were a little low, but she was sent home. And the funny thing was that they received a bill for almost the same amount that Jesús received for covid, but for less than a day in the ER. This bill was, you know, the treatment, but also it charged for a doctor that was out of their network. But, of course, nobody told them. So they never knew that they were treated [by] a doctor that was out of the network.

Rovner: So now they have two multi-thousand-dollar bills and then one of the kids gets hurt.

Andalo: Yeah, after all these dramas, or tragedies, Jesús Jr., who is a teenager, now 17, but at the moment, 16, was wrestling with his brother, also a teenager, 15, and he dislocated his shoulder. So the Fierros said, OK, we didn't want to come back to the same center because we put a foot in it and it's $3,000. So they decided to drive one hour to Mexicali in Mexico to visit Dr. Alfredo Acosta, that is a family practice doctor there. And well, Jesús Jr. was treated. They put the shoulder in place. Dr. Acosta gave him some ibuprofen for the pain. And basically it was $5.

Rovner: Now, this was a doctor that they knew. They didn't just sort of go to Mexicali and look.

Andalo: Yeah, usually they cross the border for medical care, but not for urgent care. That was this case. Though Dr. Acosta treated [them] in the past, the other kid for asthma and some visits. But this was the first time that they decided to cross the border for urgent care. In fact, Jesús Sr. asked Jesús Jr., "Can you deal with the pain for an hour?" … Of course, he said, yes. It's pretty unfair. Why [do] you have to do that?

Rovner: Yeah. It feels like this may be one of the few situations where it actually made sense for them to leave the country. They live near the border. They both speak both languages. It was a doctor in Mexico that they already had a relationship with, and it was a place that they're familiar with. But, in general, it feels a bit off that Americans with American job-based insurance should feel like they need to leave the United States in order to get urgent medical care. What's wrong with this picture?

Andalo: Exactly. When I talked to Dr. Acosta, he told me that between 30% and 40% of patients that he sees daily are from [the] United States. And he told me that the Fierros didn't feel that they are health tourists because they cross the border frequently. But there are people that go maybe for the first time and they don't know what doctor [to trust with] blocks and blocks of medical offices. So it's very challenging. I mean, Dr. Acosta is one of the good ones, but you need to know, you know. It's difficult. It's a very difficult decision. But the feeling is that the health system here exposes people.

Rovner: So the takeaway here is that if you live on the border and you go back and forth a lot, maybe this makes sense even though it shouldn't have to. But, in general, if you have an urgent care need, this is maybe not the best idea.

Andalo: No, definitely. And it's all about knowledge and information. You know, if you have knowledge, you have the power to ask basic things that is important to know. Be aware of how your health plan is, if you have one. Be aware of your deductible, remember that it starts over every year. So if you pay $3,000 one year, that doesn't mean that you are not going to pay $3,000 the next year. That is very important.

Rovner: I know. And if you pay $3,000 in December, you may have to pay it again in January.

Andalo: Exactly. And probably for a visit to an ER that you think, "Well, I was here for 10 minutes. It's never going to be $3,000." But it will be. Also, ask again, when you talk to people at the hospital, because the hospitals and especially these nonprofit medical centers, they have the duty to listen to patients and to their circumstances. And they have the bandwidth to work on a case-by-case basis. So please ask questions and talk. And if you need help, go to community health centers to advocate. There are people that can help you understand and navigate this crisis. But as Jesús said, they pay $1,000 per month for their health insurance. They don't have to live with this stress.

Rovner: All right. Well, Paula Andalo, thank you so much for joining us.

Andalo: Thank you.

Rovner: OK, we're back. 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. Jessie, why don't you go first this week?

Hellmann: My extra credit is a story from Politico. It's called "Oregon, Kentucky Dust Off an Obama-Era Policy to Expand Health Insurance." It's about the basic health plan, which I think people expected to be more popular when the ACA was passed, but it was only adopted initially by New York and Minnesota. But now these states are looking at it as a way to expand health care coverage to people who can't afford ACA plans but also don't qualify for Medicaid. These plans typically don't have premiums or copays or deductibles, so they can be a good value for people. It's just a really good look at affordability issues. I think there's a growing recognition that ACA plans can't be affordable for everyone, especially with some of the cost sharing that can go along with that.

Rovner: Yeah, it was a really interesting story there. See, there's so much in the Affordable Care Act that people don't know about, to paraphrase Nancy Pelosi. Shefali.

Luthra: This is an article from my co-worker Chabeli Carrazana. The headline is "Supreme Court Justice Samuel Alito Argued Abortion Isn't an Economic Issue. But Is That True?" The answer you can guess is no, it's not true. Samuel Alito talks a lot about in this leaked draft whether pregnant people actually need access to abortion. Do they have these economic protections? He talks about paid family leave and pregnancy discrimination protections and medical leave and insurance that covers your medical bills. And, as Chabeli writes, most of these are actually works in progress and many people don't actually access them. So if that's the argument you're relying on to talk about the role abortion plays in economic equality, your argument might be lacking a little bit. It's a great read. Everyone should take a look at it.

Rovner: Joanne.

Kenen: I read that article and, you know, the Constitution, as The New Yorker pointed out, doesn't mention anything to do with women. Forget abortion. [It] doesn't mention abortion, it doesn't mention women. And it was not written by women. But that is an aside. The piece I'm choosing for the extra credit this week is from Stat, [by] Mohana Ravindranath. And I should do a better job pronouncing her name because I actually hired her and worked with her at some point in our lives. She wrote a really interesting piece called "A Clash Over Online Adderall Prescriptions Is Raising New Questions About Telehealth." And basically more people, as we've discussed before, are getting behavioral health and therapy online. But there are questions, particularly about some specific companies and pharmacies are now … don't really trust that the patients have been adequately assessed and they're refusing to fill the prescriptions for Adderall, which is an ADHD drug.

Rovner: Yeah, that was an interesting story.

Kenen: Right. So you can get access to the therapist, but you can't then get access to the drug that the therapist prescribes for you. So, you know.

Rovner: But it also folds into the whole opioid mess and the people abusing drugs and the ease with which you can get drugs online. So we have many, many problems to deal with.

Kenen: She discusses all that. It's a very good piece.

Rovner: Yep. It's a good piece. All right. Well, my extra credit this week is from Mother Jones magazine. It's called "Meet Abortion Bans' New Best Friend — Your Phone," by Lil Kalish. And it's about how easy it can be for you to be tracked by law enforcement or pretty much anyone else, for that matter, if you're suspected of having sought or obtained an illegal abortion or any other medical service. Here's just one small factoid from the story, quote: "More than 2,000 government agencies — from police departments and prisons to public schools and housing authorities — use [these search tools] to extract and share data in investigations of all kinds. In an analysis of public records, UpTurn found that just 44 law enforcement agencies extracted data from 50,000 phones between 2015 and 2019, using their findings in prosecutions for sex work, public drinking, shoplifting, cannabis possession, and more." So this is just another example of how what's a great convenience can also jeopardize your privacy.

Kenen: That was a great piece. I read that one, too.

Rovner: Yeah. All right. Well, that is our show for this week. As always, if you enjoyed 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: @JoanneKenen

Rovner: Shefali.

Luthra: @shefalil

Rovner: Jessie.

Hellmann: @jessiehellmann

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