KHN's 'What the Health?'

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Julie Rovner: Hello and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent at Kaiser Health News. And I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, May 12, at 10 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today we are joined via video conference by Joanne Kenen of the Johns Hopkins [Bloomberg] School of Public Health and Politico.

Joanne Kenen: Good morning, everybody.

Rovner: Alice Ollstein, also of Politico.

Alice Miranda Ollstein: Hi, Julie.

Rovner: And Sandhya Raman of CQ Roll Call.

Sandhya Raman: Good morning.

Rovner: No interview this week, but more than enough news to make up for it. I'm going to start with covid this week because we didn't talk about it last week and because there's news and I'm not just talking about the U.S. passing the threshold of 1 million deaths, as incomprehensible as that is. But it seems that covid is becoming invisible. Partly, it's that people just want it to go away. Apparently, demand for cruises is back to 2019 levels, even though they can still be superspreaders. And partly it's that so many people who are testing positive are doing so on home tests and not reporting it anyplace other than, sometimes, on social media. Hi, Bill Gates and Susan Rice. But while it seems that, thankfully, most vaccinated people who are getting breakthrough cases aren't getting very sick, hospitals are starting to report another upswing in admissions. And the statistics we have do suggest that new variants are even more contagious. Yet public officials and even public health officials seem loath to recommend going back to any required precautions, given the potential public backlash. Are we entering an entirely new phase of the pandemic here, where it's just sort of the underground pandemic?

Ollstein: What's been sort of baffling to me is that all of the rhetoric is about individuals assessing their own individual risk and making individual choices. But we are not being given the information that we need in order to do that. Not only are the reported case levels inaccurate because they don't include all of the rapid tests that are so common now, but a lot of places have stopped updating reports on cases or are just doing it so much less frequently. And so when you say, "Oh, I want to look up the rates in my area to make a decision about going to a big party" or whatnot, not only will the data you see be out of date, potentially by weeks, but it will be also artificially low because it won't include all of the people taking rapid tests. And so …

Rovner: They keep saying, "Well, you should look at … how prevalent it is in your area." Well, you can't really find out.

Ollstein: Exactly. Exactly.

Rovner: Yeah.

Raman: And another thing is that globally we've seen that the numbers have been rising really high in a lot of different countries. And they're probably rising in a similar way. But as you said, the home tests, if people aren't reporting what they're saying, it could be at a much higher level, on par with some of those other countries. And especially after we don't have the mask mandate in effect on transportation anymore and we've [got] to see the kind of the effects of that. And that's kind of been rising some of the rates as well.

Rovner: Yeah, I took the train to and from Philadelphia this week, and I would say about half the people were masked, which is, I think, pretty good. I think it's better than in a lot of other places. It's the Northeast Corridor.

Kenen: I've been on planes where I don't think even 10% were masked. So, I mean, I agree with what everybody else said, but I think there's two additional points. Things are getting worse, but they're not in crisis proportions right now. I mean, it's still … deaths ticked up for a couple of days and then they just dropped again. So is that just a one-day fluke? Obviously you have to keep watching it, but it's still around 350. And remember, just a few months ago, we were, like, 2,500. It's getting worse, but it's still in a much more — I don't want to say contained — but our hospitals are not filled to the brim and neither are our mortuaries.

Rovner: Yeah.

Kenen: One reason for that: Scientists are still looking at the latest subvariant of the subvariant of the subvariant. It's very, very, very contagious. But you know, what kind of disease does it cause? They're still looking at that. But one thing is that, by now, almost all of us have either been vaccinated or had either omicron or delta, recently, or both. And therefore, as a society, our immunity is pretty good right now. So either we're getting this new one — so mild that we don't know it — or we're rapid-testing and finding out that we have a mild case, but we're getting over it pretty quickly. That will not last forever. The hunch is that our immunity after having the virus is probably just a few months, and then it doesn't vanish, but it wanes. That leaves us more vulnerable. And as we know, we're in this boosting cycle. These vaccines are preventing deaths, but they're not preventing infections as well as we had initially hoped. So we're on a little, like, oasis right now, sort of an immunity oasis. I don't know if that really works as a metaphor, but you're stuck with it, because I just said it. So on this little bubble of immunity, oasis of immunity, whatever. But it's temporary. And what that really brings us up to is since we're not doing great reporting, since we are doing home testing, since all these things that the three of you just mentioned, we have to find some other way of keeping track. So we have to do more surveillance of routine blood tests to see the prevalence. And also the wastewater. It's really, really useful, but we're not doing enough of it or we're not coordinating it. It's the same old story, same old story, same old story. We have partial data, but not what we need.

Rovner: So I heard someone last week — and forgive me, I've forgotten who it was — posit that one reason Americans until recently knew so little about the 1918 flu pandemic is that, once it was over, everyone wanted to forget it and basically made it disappear from history. Is that where we are now? People just want to put this in the rearview mirror, whether it's over or not? I feel like history is sort of repeating itself a century later.

Ollstein: I think you can see that in the extremely muted and sparse coverage of reaching 1 million deaths in the United States, which would have been inconceivable even a year ago, even when we were well into this. And I think it's just something so hard for people to wrap their minds around. We on our site did some data visualizations and showed that that's like losing the population of an entire state.

Rovner: Or two of the very small states.

Ollstein: Exactly. Exactly. You know, it's like Delaware was wiped off the map or Montana. We sort of tried to help people visualize it. Just the fact that that was not the top story at very many places, if any, is very telling. This isn't over. And we've reached this devastating milestone, and there's been very little acknowledgment of it, including from people in power — Congress and the administration as well.

Rovner: You're anticipating my next question, which is that covid funding once again was supposed to happen this week and didn't.

Ollstein: Right. And so I have been talking to lawmakers who say, yes, it's this Title 42 issue that is making Democrats hesitant to move forward with this because it would open them up to the politically difficult vote on covid policy on the southern border. But also they're saying that's not the only issue. This is from Republican Roy Blunt, who is one of the top appropriators. He was saying, "Look, even beyond the Title 42 stuff, the administration has a really mixed message. They're both saying that covid is serious enough that we need tens of billions more dollars to keep fighting it but it's not serious enough that we need to do really anything else about it." And that's a tough message to sell to people in either party and especially tough to sell to the Republicans whose votes they need to move this forward.

Rovner: Yeah, that's such a good point. We're simultaneously trying to say it's serious and downplaying it at the same time.

Kenen: You could square that, though. I mean, they haven't. But you could square that. You could say, "OK, we're in a pretty good place now. We're better than we've been. We still have people sick. We need to take care of them. We need to do blah, blah, blah. But if we want to keep this semi-normalcy that we've attained, we then have to make sure we have the tools to keep it that way so we don't go backward." I mean, I think Blunt's code is really good. And he's a Republican who's fairly sophisticated about health. And he's not on the far right on a lot of health care issues. I mean, he's not someone who's going to have a knee-jerk reaction to, "No, I'm never going to spend another federal dollar." So I think that the point he made about the administration's mixed message is a really good one. But you also could unmix it.

Rovner: Yeah, well, but I think they've been trying. Go ahead, Sandhya.

Raman: Oh, to the boosters. Because, you know, as we were saying, that even if we are in more of a, if you say, a lull right now, that that waning immunity, especially for the large swaths of the population that has not been eligible yet for the second booster, you know, anyone that's an adult under 50, we … the administration has made pretty clear we don't have the funding to cover that. And, even if we go ahead with the aid package that they've been discussing, as the third time, that it would only be the … the 10 …

Rovner: $10 billion

Raman: … the $10 billion figure for domestic. And then you throw in the global piece. And it just gets very tricky to kind of look ahead.

Kenen: Well, the global piece has been a disaster from day one, right? I mean, somehow we thought that through some halfhearted border controls and flight controls, which were ineffective and not well thought out, and the idea that you're not letting people from other countries come in unless they were American and had been in that same country — Germans don't check passports? I mean, the whole travel piece of it was dumb from the start.

Rovner: Well, I think Australia and China are showing that that just doesn't work. Australia made a really valiant effort, and it still didn't work.

Kenen: Right. But the point is the variants have cropped up everywhere, including New York City, which has a fairly high vaccination rate. But this threat of variants emerging in parts of the world where there's a low vaccination rate is intensely high. And that is a danger because, one of these days, one of those variants is going to be the nightmare — or could be. I don't want to say that I know that it will be. But the possibility that you do have a variant that causes even more severe disease, that evades the vaccines, that just … [is] something we don't want. If we don't help vaccinate the world, we are at risk. And this country and this country's government continues to think that we're in some kind of a domestic bubble, and we're not.

Rovner: So in the meantime, while we're trying to get out of this pandemic, there are a whole lot of flashing warning lights for the next pandemic. It appears that even if public health officials did want to reimpose precautions, they could get overruled by the court. We've already seen a [President Donald] Trump-appointed judge in Florida prematurely end the mask mandate for public transportation. And it wasn't even immediately clear that the Biden administration would appeal that ruling. I mean, how seriously have we harmed public health's ability to contain not just this pandemic but the next pandemic?

Ollstein: Since this is my extra credit, should I talk about it now?

Rovner: Yes. Why don't you go ahead and talk about it now?

Ollstein: So for my extra credit, which I will preview early, I have a piece by my colleague Krista Mahr about just this very issue, about how all of these lawsuits both directed at the [Centers for Disease Control and Prevention] over their policies — most recently, the mask mandate — that wiped it out on a national level, but also all of the state and local health departments have been inundated with lawsuits. And she's showing that not only is it hampering their powers through the actual rulings that come out, but it's also creating a massive chilling effect, where health officials are afraid to even impose these protections in the first place. And this just goes way beyond covid. And we've covered this before. I mean, this could touch things like combating food-borne illness outbreaks, closing restaurants that have salmonella, or cracking down on agriculture contamination. There's so much that public health covers. And if they are afraid to impose any restrictions at all over fear of lawsuits, that could really put a lot of us at risk.

Rovner: Yeah, I mean, people who don't want to wear masks now, that's like, "Well, why should I have to wear shoes when I go to a restaurant?" It's not that different. There are a lot of public health restrictions that Americans have accepted that I feel like a lot of people are no longer going to accept without question.

Ollstein: We've seen the opposition to the covid vaccine already spilling over into other immunizations. So, other immunizations have been required for public schools and other things. We could see more challenges there as well. It's a pretty scary trajectory.

Rovner: Yeah, well, that's a perfect segue way into our other big fight over bodily autonomy, which is abortion. The world has indeed changed since the leaked Supreme Court opinion showed that there were indeed five votes to overturn *Roe v. Wade*. I want to start with something that seems to be confusing people, even in the unlikely event that Chief Justice [John] Roberts manages to cobble together five votes to still not explicitly overturn *Roe*, but to allow Mississippi's 15-week ban to stand. That still effectively overturns *Roe*, right? Joanne, you're trying to make this point.

Kenen: Right. I mean, I tweeted about that. I mean, *Roe* is basically a viability … I mean, it's more complicated that. But if you really want to boil it down, *Roe* says you cannot restrict abortion before

viability, which in 1973 was about 27, 28 weeks. In 2022, it's around 23, 24. And there are a handful of documented cases, very rare, earlier than that — 22. I think there's one case at least of 21.

Rovner: I think there's a couple of 21 weeks.

Kenen: Including a set of triplets — really unusual. But, OK, so we're talking around 23 weeks the concept of viability. Fifteen weeks is nowhere near viability. Science has changed. Our ability to care for preemies has changed, but not 15 weeks. Fifteen weeks is three weeks into your second trimester, so that is not compatible with *Roe*. However, there's also a big difference between six weeks or zero weeks and 15 weeks. Almost all abortions in this country, about 90% — Alice knows this figure better than me and will correct me if I'm wrong. I believe about 90% of abortions are first trimester. More than half of them are now medication, which means they're before 10 weeks, very early. Mississippi at 15 weeks is blowing up *Roe* with dynamite instead of a nuclear bomb or whatever. But it's still blowing up *Roe*. On the other hand, it does preserve access for most of the abortions in this country. And Mississippi does have an — I read the statute this morning, and all I could see is more lawsuits in the future because it does allow for a post-15 weeks medical emergency. But then that's in the eye of the beholder.

Rovner: And it does not define what it is, right?

Kenen: Right. It doesn't say only for the life. It says medical emergency, and then it refers to severe fetal abnormalities, which is also not defined. So is the Mississippi [law] compatible with *Roe*? No. Does it leave a lot more access than we would under the alternatives? Yes. Are the pro-abortion rights groups — do they like Mississippi? No. Would they rather have Mississippi than the other options? Yes.

Rovner: All right. Well, let's cross the street from the Supreme Court to the Capitol, where the Senate, as expected, failed to advance a House-passed bill that would write the protections of *Roe v. Wade* into federal law. What was not as expected is that Pennsylvania senator Bob Casey, one of only two Democrats in the chamber who are nominally anti-abortion, announced that he would vote for the bill if it made it to final passage, which it has not yet and likely won't anytime soon. Casey is what both sides in the abortion debate call a squish, meaning his vote can't always be predicted. He has supported a 20-week federal ban in the past. But he also voted to advance this bill on another test vote back in February. Now, Casey isn't up for reelection again until 2024, but I'm wondering if this announcement represents the last vestiges of each party retreating to its corners, turning the abortion debate into a completely partisan fight. When I started covering abortion, there were at least a quarter of Democrats who were anti-abortion and a quarter of Republicans who were pro-abortion rights. And that is just not the case anymore. Now, you can count them both on one hand. Is this now another party fight?

Raman: I think there's some nuance on the state level because when we're in … Congress, there are a small handful of folks that … they kind of cross party lines. In the Senate, we only had [Sen. Joe] Manchin [of West Virginia] that voted with the Republicans. And then when there was the House vote in February, you only had Henry Cuellar that also voted with the Republicans — [he's] a Democrat. But I think when you go down to the state level, there is more of the crossover.

Rovner: The House vote was last fall, right?

Raman: Last fall, yes.

Rovner: The Senate vote was in February.

Raman: So if you think about a state like Louisiana that has a Democratic governor, he has been pretty passionately against abortion. And they have enacted some of these restrictions that are a lot stricter than a lot of other states. And even now, they've been considering some legislation that's a lot stricter than even a lot of other states are considering. And so I think if you look at that level, there is more, especially in some of the states where Democrats are a lot more moderate or conservative than other states. And even if you think about governors in the Northeast, where there's a lot of GOP governors, they're a little bit more amenable to abortion rights because that has been popular in the state. If you look at a state like Vermont, where they're kind of moving towards voting on the ballot this fall to enshrine that. The nuance is at the state level, I feel like.

Ollstein: Completely agree that there is a lot more crossing of the aisle at the state level. But I think Julie is right that in Congress you're really seeing a hardening along party lines. I think what Sen. Casey said when he announced that he was sort of changing his position here was really interesting. He said that the expected fall of *Roe v. Wade*, in addition to chatter from Republican lawmakers about considering a national abortion ban if they win power in September, for him completely changed the question at hand. Whereas before it was … he was saying, thinking, "I'm personally anti-abortion, I don't want to vote for something that expands access to abortion." But now he sees the question differently. He sees it as, "Do I want to give Republicans the chance to ban abortion nationally? No, I don't. I think people should make that decision for themselves." And so he was saying, "I am voting for this not because I think it's the best idea in the world, but because it would prevent Republicans from taking that step if they win power." Of course, the bill doesn't have the votes to pass at the moment, but that was really interesting to me. And then on the flip side, you had [Sens.] Susan Collins [of Maine] and Lisa Murkowski [of Alaska], who are the only Republicans that Democrats thought they had any chance of winning over to their side on this, not voting for it and saying they thought the Democrats' bill went too far.

Kenen: There's also the politics of Pennsylvania. We still don't know how much abortion will move voters overall in November. There's conflicting polling data, but I think that we do know it will affect some races. And Pennsylvania is really key because it's one of the few states where there's an open Senate seat that's in play. It's currently a Republican is retiring. Democrats would really like to pick that up. And also the governor's race is also there. So a Democratic governor who's not up for reelection, and that's also a tight race, with a very far right candidate suddenly in the ascendancy in the Republican primary. And I guess there's a favorite, but it's still not decided on the Democratic side. While the swing states aren't swing states anymore.

Rovner: And Pennsylvania is. Yeah.

Kenen: Pennsylvania, which was pretty Democratic that sometimes swung is now a swing state. And that's a state where I can see abortion … really affecting the Senate race in particular, governor, too, and some of the House races, because the swing voters tend to be … The stereotypical swing voter in Pennsylvania is a suburban woman outside of Philadelphia. And there are moderate Republicans, moderate Democrats. They do go back and forth. And I think that depending on turnout and other factors that — inflation's a big deal for suburban swing voters, too. But I think Pennsylvania, and Casey is part of the calculus of Pennsylvania, a clear Republican-Democrat delineation on abortion access in that state could be significant in November, more significant than in a number of other competitive races.

Rovner: Well, I want I want to stay on the Republicans for a minute. For years, the Republican position on abortion was overturn *Roe* and let each state decide for itself how to restrict or allow abortion. But we're seeing Republicans already talking openly about federal restrictions or bans should they take back control of Congress and the White House. In Louisiana, Sandhya, as you mentioned, a new law obviously awaiting

formal blessing from the Supreme Court goes directly after women rather than the doctors who perform abortions. Is this going to be the unified Republican position, or are they going to become as fractured as the Democrats about how to proceed forward, assuming … in the post-*Roe* world?

Raman: I think it's already pretty fragmented. I mean, we had, I think, National Right to Life said earlier today that … sent an open letter to states saying that they do not want to penalize women that seek out abortion care, that that's not where the penalty should lie. That's a large group on that front. And then you had groups like Susan B. Anthony List earlier this week saying that they didn't have a consensus on where the conservative movement is going, whether it's a 15-week ban, a six-week ban, or some other permutation. And even the polling has been … There's kind of a spectrum, so it's hard to just band behind one sort of thing.

Rovner: Yeah, it's like we're playing a game of cards and all of the cards have been thrown up in the air on both sides. And we're going to have to figure out where they come down.

Ollstein: I think it's pretty similar to what we saw happen with the Affordable Care Act, where when you're not in power, it's really easy to say, "Burn it all down, tear it out root and branch, ban it, get rid of it." But when you're actually in power and it's your responsibility and you will bear the costs of the repercussions of those policy decisions, it gets a lot more serious and a lot more divisive about the way to move forward.

Rovner: For the second time in five years, the Republicans have caught the car. And now what do they do?

Kenen: I think there's two different issues that there's division about. One is penalties. Do you penalize the woman or the doctor? And do you do civil penalties, or do you do jail? So that's one set of issues. And I'd be surprised if putting women in jail is where the Republicans end up nationwide. The second question is how far do you go in limiting abortion? And we have seen that change dramatically in just a couple of years, and we've talked about that in prior weeks on the podcast. We were talking about state by state. Now we're talking about federal. We were talking about a 20-week ban. And now we're talking about no abortion except when life is threatened. We had exceptions for rape and incest. We no longer have exceptions for rape and incest. So I think the divisions about punishment are all over the map. And I think they'll end up on the more moderate — moderate's not quite the right word — but the non-jail side for women at least. I mean, right now the energy is with the more radical ban abortion, all abortion. I mean, 20 weeks isn't part of the conversation. Fifteen weeks is barely part of the conversation. Could we end up at 15 weeks? That's still a possibility. It's no longer the most likely possibility. But even in Mississippi, where there's the 15-week law, the one that's being questioned, there's legislation already been introduced in the state to do six weeks.

Rovner: Yeah, to move that back.

Kenen: I forget whether it's six weeks or a total ban.

Rovner: I think it's six weeks. I think it's a "heartbeat ban."

Ollstein: Just to note briefly on the penalties piece, there's what's in the letter of the law and then it's how it's interpreted. And so we've already seen women be jailed for pregnancy outcomes, not even just abortion, but for pregnancy loss more generally. And it just takes an individual zealous prosecutor to decide that they want to bring criminal charges and incarcerate someone for having an abortion or for losing a pregnancy even if that's not in the letter of the law. And then a lot of these laws were written back when taking a pill was not invented yet. And so they were written in the context of surgical abortion. And so they say things like a person who induces an abortion can be charged, meaning the doctor doing the surgery.

But in this current moment, if someone is ordering a pill themselves and taking it themselves at home, are they inducing the abortion? Are you your own provider? It would be up to law enforcement to decide that. And so I think there's a lot of gray area on penalties that we're already seeing play out.

Rovner: And we're already seeing this impacting other types of care. There's a piece that we published at KHN and was also on NPR this week detailing how in Texas women suffering miscarriages are having difficulty getting needed aftercare because it's the same care in many cases as for abortion and we have pharmacists and health providers who are afraid of getting caught up in the Texas law that allows private individuals to sue people who "aid or abet" an abortion. So they can't get needed medication or needed procedures. I mean, this could have really serious ramifications given that 1 in every 4 pregnancies ends in a miscarriage.

Kenen: And miscarriage is extremely common. But there can be complications. There can be infection. It can be really dangerous. Sometimes it's addressed surgically. Sometimes it's addressed with medications. Sometimes both. Basically it has to do with whether there's some tissue still in the uterus, and that can become dangerously infected. So this is not abortion.

Rovner: No.

Kenen: I mean, this is a pregnancy that doesn't exist anymore.

Rovner: The even more confusing part is that miscarriage medically is known as a spontaneous abortion, as opposed to an elective abortion.

Kenen: Which is really confusing if you interview someone in Spanish because the language is even more similar. And then an ectopic pregnancy … I mean, by definition, it's not viable. I mean, an embryo cannot develop in the fallopian tube. But it can cause the woman to hemorrhage, and it can rupture and bleed and kill a woman. And that's a real threat. And it was a very good piece, the KHN-NPR piece was very, very good. So not just the miscarriage, but there have been bills introduced to forbid abortions in the case of an ectopic pregnancy. I mean, none of them become law because someone doesn't understand basic biology. But, yes, that is a life-threatening condition. I have had it, and I was in the hospital several times. It was complicated. It's life-threatening. If my husband wasn't home, I had to have somebody on call every hour to get me to the hospital and take care of my other kid. It's traumatic. It was a planned; it was a wanted child. And, yeah, the idea that you can let women bleed to death because you don't understand what a fallopian tube is, that it's not a uterus. It is a life-threatening condition.

Rovner: And we're also seeing this impact — I mean, not just obviously after-miscarriage care, but family planning, contraception. The thing that everybody says can prevent abortion. Joanne, you and Alice together have your extra credit this week. Why don't you tell us about it now?

Kenen: Alice and I wrote a magazine piece that ran this morning about access to contraception, both about how it could be restricted further in this post-*Roe* world we're in and some of the things that politicians are already saying. But most of the piece looked at the gaps in contraception access now, that there are many women who still have trouble accessing contraception. There are many, many hurdles. There are also a lot of policy solutions that are not being utilized maximally. There are things that are possible to do that some states are doing that are not done. So, Alice and I had amazing access — the providers were very open, and the patients were very open — to a Title X clinic in San Marcos, Texas, that's on the brink of closing. It looks like they found a way to keep it open for a while, but not definitely. If you're saying, "No, you cannot have an abortion," and these women don't want abortion. They're coming there so they can avoid an abortion. The woman I spoke to, all but one of them already had a couple of kids. There's one college student, and

there was everybody else. Some of them had four children already. They did not want a fifth. And if you take away their access to free contraception, then they have no choice. They either have a child they don't want, or they try to get. Traveling is not easy. These organizations that are helping women travel to states where abortion is legal for now, it's not going to be obtainable for lots of women. So choice is abortion, but choice is also childbearing. Do you want kids? How many kids? When do you want kids? How far apart do you want your kids? All of that is also an aspect of choice. So, Alice and I wrote about the reality of these women and the federal, state, and health care system choices.

Rovner: All right. Well, we still don't know what the abortion debate is going to do to the rest of the legislative agenda. Spoiler alert: It's going to interfere big time. But we had our first indication of a dog that didn't bark this week as the House Energy and Commerce Committee's health subcommittee unanimously approved a bill to renew the various user fee authorities at the Food and Drug Administration. "What does that have to do with abortion?" one might reasonably ask. Well, the fact is that abortion can become part of almost any health-related legislation. In this case, anti-abortion forces could try to use the FDA bill to go after the FDA's approval and regulation of the abortion pill, mifepristone. Interestingly, no one did, at least at this very first markup. It was all very … a lot of very thoughtful conversation about ways to improve the FDA process. There was — as far as I could tell, I watched most of it — no partisan rancor. Is it just this bipartisanly popular bill is unique, or are we going to see this blow up more after the Supreme Court makes this abortion decision official?

Raman: I mean, at the hearing yesterday there were other bills that also went [through] markup. And, you know, they had their large mental health package as well that went off without a hitch. And I guess it's hard to say. They'll likely have their full markup next week.

Rovner: And with the full committee.

Raman: With the full committee. And then, it's early. I think that sometimes there have been health fights even in the past few years where you think things could go smoothly — it's a bipartisan program, there's support on both sides. And then something comes up. And the situation we're in now is so unpredictable and unprecedented that it's hard to say.

Rovner: Yet yesterday's markup felt extremely polite to me. It was all about, "I have an amendment that I'm going to withdraw, but I want to raise it for discussion because it's something I hope we can address down the line," which is a very traditional markup thing. It's a sign that you would like to amend the bill, but you're willing to work out a compromise with the authors of the bill. And you don't want to blow up the bill. And it's what happens when everything is greased. It looked like the markups of old, and indeed they had, at least on the user fee bill, they had a roll call, and it was unanimous. So we will see how that moves along.

All right. There's a little bit of non-covid, non-abortion news this week. It seems that a combination of covid-19 relief measures, Medicaid expansion, and other state expansions have boosted insurance coverage and created record-low uninsurance rates. But there's still no movement towards extending those extra ACA subsidies that got us to this point. And Democrats are going to be in a very bad place if premiums skyrocket for next year and people find out just as they go to vote this fall.

Ollstein: There's been no progress that I've seen on any kind of revival of the effort to get the health expansions that were part of the Build Back Better package that ran aground in December back on track. There's the widespread assumption that Democrats would be insane to let their ability to pass something through reconciliation with just a simple majority vote, that they would just let that go and not use that.

And so there is an assumption that they will try to use it before it expires in September. But we haven't seen what that could be or signs of success and progress yet. But we are we are highly attuned to any rumblings.

Kenen: And Medicaid, Medicaid expansion.

Rovner: Yeah, and the Medicaid expansion. Sandhya, any inklings of anything that's happening yet?

Kenen: There's no sign.

Raman: I have not seen anything there. I feel like with Medicaid, the thing that I had been watching was what had been happening in Missouri, where their session ends this week. But state lawmakers have been trying to pass legislation to trigger a constitutional amendment to make them specifically appropriate money just for expansion and add a work requirement. And that had been kind of a big battle in the state because they had already experienced a lot of pushback after the state had gone ahead to start implementing expansion. And so I've been kind of watching the states this week and seeing where that happened. But since their session ends tomorrow, it's not as likely that anything would change in the near future.

Rovner: We will obviously keep an eye on this as things move forward, too. All right. Well, that is the news for this week. Now it is time for our extra credit segment where we each recommend a story we read this week we think you should read, too. Don't worry if you miss it, we will post the links on the podcast page at khn.org and in our show notes on your phone or other mobile device. Joanne and Alice have already done theirs, so, Sandhya, why don't you go next.

Raman: Yeah, so my extra credit pick this week is called "End of COVID-19 Emergency Endangers Substance Use Treatment," from my co-worker at Roll Call Jessie Hellmann. And it looks at how the [Drug Enforcement Administration] has allowed tele-prescription of opioid use disorder drugs and more flexibilities there. But as we were talking about before, the public health emergency, whenever that ends — it could be this year, it could be any time as long as we get the 90 days' notice — when that ends, you would need to do some of that in person again. And so that could reduce access for rural and underserved folks that are having access to opioid use disorder medication, especially when we have record deaths from drugs. So DEA is working on their role still to kind of permanently make that the case. And she just kind of looks at that and what can be done there.

Rovner: Yeah, there will be much more to talk about the end of the public health emergency, but not this week, although my story also sort of relates to that. My story is from my KHN colleague Hannah Norman. It's called "Travel Nurses See Swift Change of Fortunes as Covid Money Runs Dry." So remember how just a few months ago we talked about how travel nurses were making two and three times what staff nurses were making at the same hospitals if they were willing to temporarily relocate. That was so 2021. 2022 is having your contract canceled midorientation, as happened to one nurse who had just moved her entire family, or being told midcontract that your hourly rate is being cut. In many cases, this is an actual breach of contract. These travel nurses sign contracts. But it is happening anyway, and it is quite the cautionary tale of the ups and downs of the health system. And it's one that's likely to spawn its own trail of litigation that we will keep an eye on.

All right. 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 — @kff.org. Or you can tweet me. I'm @jrovner. Sandhya, your Twitter handle?

Raman: @SandhyaWrites

Rovner: Alice?

Ollstein: @AliceOllstein

Rovner: Joanne?

Kenen: @JoanneKenen

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