KHN's 'What the Health?'

Episode Title: Waking Up to Baby Formula Shortage
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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 19, 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 Alice Miranda Ollstein of Politico.

Alice Miranda Ollstein: Good morning.

Rovner: Tami Luhby of CNN.

Tami Luhby: Hello.

Rovner: And Rachel Cohrs of Stat News.

Rachel Cohrs: Hi, Julie.

Rovner: Since we're an all-women podcast, I'm tempted this week to start with the news about pay parity for the men's and women's U.S. national soccer teams. But that's not *really* health news. So let's start with something that is, and actually it's something that we have not yet talked about on this podcast: the infant formula shortage. For those of you who have not turned on the news for the past few weeks, parents across the country are having an increasingly difficult time finding formula for their babies. And, no, moms can't just switch to breast milk. Honestly, that is not how it works. Go ask a woman in your household. This shortage stems from a bunch of supply chain factors, but it's been made worse by the FDA closure, for health reasons, of a plant in Sturgis, Michigan, in February. Tami, you've been following this. How did it sneak up and suddenly become a crisis?

Luhby: Well, actually, unfortunately, I've only covered the WIC [Special Supplemental Nutrition Program for Women, Infants, and Children] angle of it. I haven't been covering the formula. But what it does show is, it shows that there's a concentration of manufacturers for infant formula. And so when you have — the shortage existed prior to the plant closure. There were already problems surfacing last year. And then when you have a plant that — you only have a handful of manufacturers and then one of their major plants goes down, you all of a sudden make the crisis a lot worse.

Rovner: The Biden administration is suddenly jumping to use the Defense Production Act and to make it easier to bring in formula from other countries. I mean, why did it take until now? If you've been paying attention, you could have read about this formula shortage for the last two or three months at least, if not, and as you point out, Tami, even before that.

Luhby: This is why they're being criticized for not acting fast enough. The FDA is only starting to bring in the plants or announce when the plant will be able to restart, which will be another eight weeks, which is a problem. But … one thing to say — and, again, I've covered the WIC angle of this — nearly half of infant formula is bought by families on WIC, which is a huge amount. And …

Rovner: You should probably explain what WIC is. There are probably people who don't know

Luhby: Right. It's "women's, infants, and children." It's a supplemental food program to provide … nutrition for low-income families. To USDA's [the U.S. Department of Agriculture's] credit, they jumped in right after the plant closure and expanded the types and brands of formula that families on WIC can buy. Actually, because each state has a contract with one manufacturer and the WIC families are very, very limited in the single brand they could buy and even the types of formula and the sizes, etc. So the USDA jumped in and provided waivers to the states to allow them to allow families to have more variety. But, interestingly, not all states have taken up on this. Most have, but not all. And so last week, when, of course, the Biden administration was being criticized for not jumping on this fast enough, they were highlighting the fact that states can at least help these families. And we're urging states, the states that haven't done so far, to do more.

Rovner: Yeah, I mean, I knew that there were only a few makers of infant formula, that it's a very small industry. And so, if somebody goes down, you're going to have some kind of a shortage. What I didn't know until I read your story was that in each state, there's only one manufacturer that's authorized to provide to the WIC families. That was a big surprise. … Do you imagine that there's going to be some new looking at that after this?

Luhby: Possibly. But interestingly, CBPP [the Center on Budget and Policy Priorities] and some other left-leaning organizations which you would think would … obviously, they have WIC families in mind here. The problem is that infant formula is so expensive that doing it this way and setting it up this way is actually saves money for the government and allows this to happen and allows them to be able to get free formula. So will they look at it? Maybe. But, it is actually something that consumer advocates and advocates for low-income families actually support. But interestingly, one of the bills that's going through Congress that passed the House yesterday would allow the USDA to provide … make it easier for them to provide waivers to states in problematic times to open it up as well.

Rovner: Go ahead, Alice.

Ollstein: Yeah. So on the congressional side anyways, now you're seeing a flurry of activity. But, we were all hearing from friends with babies weeks and weeks and weeks ago that this was an issue. And it was just interesting. Some reporters who were asking members of Congress about this a few weeks ago were saying that they answered that they had no idea what they were talking about. And I think it is reflective of having a very old, a very male, and a very wealthy demographic profile in Congress that is very isolated from these types of issues. And I think that it took some time for it to really bubble up and make an impact, even though it's impacting so many people around the country.

Rovner: Yeah, there was a very good piece in The New York Times about why many women can't breastfeed or don't breastfeed. And then a long Twitter thread about a woman who was traveling for business and needed to pump and got her breast milk basically confiscated by the TSA [Transportation Security Administration]. And I put that story up and I said, it's kind of a shame that this story even needed to be written, that people don't quite realize what mothers and families with infants go through in terms of feeding babies. It's just not that simple. So maybe this will shine a little bit of light on one of these things that mostly women encounter and men mostly ignore. All right. Well, let's talk about something that affects both women *and* men, and that's covid, which is still not over and still getting worse. Now, Health and Human Services Secretary Xavier Becerra just tested positive and, quoting The Atlantic's Pulitzer Prize-winning covid correspondent Ed Yong here, quote, "COVID can still hammer the health-care system even without sending a single person to the hospital." This week, we saw our first White House covid briefing with new covid coordinator Ashish Jha, whose voice should be familiar to those who regularly listen to the podcast. That briefing included the warning that one-third of Americans now live in an area with covid cases so high that they should return to masking indoors. I never stopped, for what it's worth. Also, the federal government is making another round of free rapid tests by mail available. I feel like they're talking at this point, but nobody's really listening. Am I the only one that feels that way?

Ollstein: Well, I …

Rovner: Rachel, you're smiling. Go ahead, Alice.

Ollstein: Oh, I mean, we're seeing the chasm between a recommendation and a requirement, or a mandate. We're now seeing an increased level of recommendations for indoor masking and urging more testing because we are in a surge. I think it's notable that a lot of the preparations that were underway were for a fall-winter surge. And here we are in May, seeing it already.

Rovner: And yet we've had surges the last two summers. I mean, it does seem that as soon as people start to travel and go places and mix again cases start to go up.

Ollstein: It happens. Right.

Rovner: Yeah. And we have this new more, more … every summer, we've had a new, more contagious variant.

Luhby: Right. And I live in New York City, which is one of the new — not one of the new hotspots, it's been a hotspot since omicron. And we just went into high-risk this week. But our mayor has said that he's not bringing back mandates, at least for now. And, gee, I wonder why we went into high-risk. And, gee, I wonder what's going to happen to the hospitals in a couple of weeks. But that's OK, because New York City's got to come back and the way to come back is to be in high-risk. So anyway, yes, I'm not sure, but I can just tell you from being around that there are some people wearing masks more, a few in my office. We don't have a mandate, of course. And I've noticed over the last couple of weeks that more and more people indoors are wearing it; as with Julie, I have never stopped. But, you know, we'll see what happens.

Rovner: Yeah, I'm just mys- … well, I guess I'm not mystified. I mean, we talked about this last week that there's a point at which the public just decides that this is over. And even if it's not, what does mystify me a little bit is the attitude of public health, which has kind of lost control here. I remember when they said you don't have to wear your masks anymore. They kept saying, but if it comes back, you'll have to wear them again. Well, now it's coming back. And everybody seems to be afraid to say you should wear your mask — or, they're willing to say you should wear your mask again, but nobody's willing to say you *need* to wear your masks again. And I see immunocompromised people and people with kids under 5 who are not yet immunized, who are, with good reason, kind of freaking out. We seem to have entered this every-person-for-themselves stage of the pandemic, which I don't feel works with a contagious disease.

Luhby: But even in places where it is required — I flew two weeks ago to Charleston and it's not required on the plane, but it is still required, technically, in LaGuardia Airport. And there were tons of people who are not wearing masks in the airport, and nobody was enforcing it. And the same thing with the subways. Some people wear masks, and a lot of people don't. So even in places where it is required, many people have moved beyond it.

Rovner: Yeah, I think a majority of people have moved beyond it, which we're going to find out what happens in that case. Meanwhile, we learned by the administration's silence that the public health emergency will be renewed again come July because officials had promised a 60-day warning for ending it and that 60 days passed this week. Tami, why is it a big deal that the public health emergency is not yet ending?

Luhby: Well, one of —there are multiple reasons, but one of the major reasons, of course, that this group is very interested in is it means that people will not be kicked off of Medicaid starting in two months or so. As we all know, Congress two years ago as part of one of its coronavirus relief measures agreed to give states more money, more Medicaid money. But in return, states can't involuntarily dis-enroll folks until the end of the public health emergency. So that's one of the major issues. I'm sure my colleagues can speak more about it. But one thing that I wanted to also bring up is that there's also an emergency SNAP [Supplemental Nutrition Assistance Program] allotment. So people are getting more food stamps. Not in all states. Several states have already ended their public health emergencies and have stopped this beefed-up monthly food SNAP benefit. But in a lot of states still, people are getting more. And, of course, with high inflation and increased costs at the grocery store, once the public health emergency ends and this increase in food stamps ends, it's going to make it more difficult for low-income families.

Rovner: I moderated a panel last week where we talked about what happens when the public health emergency ends, and one of my panelists suggested, and I think he's right, that if they're not going to end it in July, which they're not, they're also not going to end it because it would be July, August, September, October … they're not going to end it in October, because that would be right before the election. So therefore, we know as of this week that it's probably going to extend now through the end of the year, just sort of by default in the way it works. I imagine that pushes off some hard decisions. But I wonder if the public health emergency — as we were just talking about [how] people seem to be over this — ceases to have this emergency feel.

Cohrs: I just wanted to point out, too, on the Medicaid side, that at any point a state could decide to restart Medicaid redeterminations; they would just be giving up some extra federal funding. And I think there's been some buzz about the fact that some states are approaching the time or have passed the point where they have so many people on their Medicaid rolls now that it's like the costs are outweighing what they're receiving, the extra they're receiving from the federal government. So I think that will be a really interesting dynamic. If we don't see the federal government act in a more uniform way, I think we have seen CMS [the Centers for Medicare & Medicaid Services] put out tool after guidance after press release about different resources for states. So they are very actively planning for it, even if there's not a mass movement. And I think that could have really important consequences for states. Mostly Republican states would, I think, have this desire to transition, this pressure with the state budgets, which you have to balance. So I think this isn't the end of the story on Medicaid redeterminations, and I'll be interested to see how different states handle it moving forward.

Rovner: And it's important to remember, I mean, we talk about kicking people off of Medicaid, but really what happens here, what the states are worried about is that they have to go in and basically reevaluate every person on Medicaid to see if they are still eligible. And that's going to be an enormous undertaking. And I think … I could see some states starting to do it simply because they know that that task is going to be so immense … a lot of them have laid off their Medicaid workers. They don't have a lot of caseworkers. They don't … actually have the staff to do these redeterminations. I think that's probably one of the reasons why the administration decided not to end the public health emergency quite yet, because they know that the states, they're still trying to help the states get ready.

Luhby: And one other issue that's important and especially for the end of the year, is what happens to these people, particularly the low-income people, is going to be very much tied to whether we see these subsidies come back again next year. And this is something that states are very concerned about. And there's a lot of movement and pressure *not* on Capitol Hill to extend the subsidies. But that doesn't seem to be having much impact on lawmakers, at least at this point. And I'm sure Alice can talk more about that.

Rovner: Yeah, these are the subsidies, the temporary, quote unquote, air quotes, “subsidies” for the Affordable Care Act that Congress, if they do not renew, will end and people will find out about it just before the election.

Luhby: Right. But also it means you have people who could get really good subsidies, those especially making below 150% of the poverty line, if these subsidies continue. So that all of those Medicaid — well not all of those, but many of those Medicaid folks would be able to be more seamlessly transferred to ACA coverage if the subsidies are continued in 2023. But if they're not, you're going to see a lot more people who are uninsured because they can't afford marketplace coverage.

Rovner: Rachel, Alice, any movement this week? I guess I ask every week: What's going on with the subsidies, anything? I'm seeing shaking heads.

Ollstein: No, no movement that we're aware of. A lot of meetings, a lot of talking, not a lot of action, is what I would say. Memorial Day was sort of this unofficial deadline that Democrats set to try to get their reconciliation package back on track. And we're almost there and there is not really a sign that they're going to make that. And once we get into the summer, a lot of people are off campaigning. It just gets harder and harder and harder. So a feeling of despair is definitely setting in.

Rovner: Well, there's nothing like a deadline to motivate them to get going.

Ollstein: Or not.

Rovner: Yeah. Or not. Let us move on to abortion. There is still no official word from the Supreme Court, but there is still lots and lots of activity elsewhere. We spent a lot of time the last couple of weeks talking about the anti-abortion movement and what it's trying to do. So this week, I want to focus on the other side. First, let's talk about how abortion-rights groups might try to fight back on the legal front, assuming *Roe [v. Wade]* is overturned. Politico had a wonderful story about all the possibilities this week, which I will post in the notes. What are some of the legal grounds for those trying to preserve abortion rights in the wake of not having *Roe* anymore?

Ollstein: So the experts I talked to and the legal groups I talked to said that state constitutions can really provide some meaningful protections here — not only the state constitutions that have explicit language around abortion rights, which several do, including some states you wouldn't expect, that are pretty conservative. But also some state constitutions have language around the right to privacy that attorneys think can be used to make arguments to get abortion bans struck down or blocked. So that's one area they're looking into. A few others that really interested me — one is progressives trying to use religious freedom arguments and flip that on its head, because that's so often been used by conservatives to support abortion bans. But because some religions, including Judaism, allow for abortions and even require them in some circumstances, when there is a threat to the life or health of the mother that Jewish plaintiffs and Muslim potentially, too, can bring cases saying that these bans infringe on their religions.

Rovner: I find that incredibly fascinating.

Ollstein: Yeah.

Rovner: And, well, we'll be interested to see how that proceeds. I guess they're also looking at some of these, and we've talked about some of these before, some of the states who are trying to restrict the mailing of abortion pills and restrict the movement of women from their states to other states where they could get abortions. Well, I'm going to come back to you, Alice, because while we're talking about protecting abortion rights, you write about states trying to boost their numbers of abortion providers in anticipation of a flood of patients traveling from other states. But that's not turning out to be as easy as it sounds, either, is it?

Ollstein: Right. So the states that are more friendly to abortion rights are just bracing to be completely inundated with patients traveling from other states after this decision comes down. And, currently, they are worried that they just don't have the capacity to serve everyone. And that

will impact not only the people coming in from out of state but also in-state residents, people who live in New York and California who think this doesn't really affect them because of the laws in those states. If they can't get an appointment because the local clinic is completely overwhelmed, then of course that will impact them, too. And so there's worries that that'll cause delays, push people to have procedures later in pregnancy than they want, which becomes more risky the later it goes. So the idea that a lot of states are moving towards right now is to allow more kinds of medical workers, not just M.D.s to be able to do abortions, both medication abortions, just prescribing someone a pill and giving it to them, but also early procedural abortions that use like a vacuum aspirator. And so a lot of states already allow nurse practitioners, midwives, and other so-called advanced practice clinicians, APCs, to do those procedures. But more states are considering it and moving towards that. And so we have a map of what the laws are and all the states in our story. And people say it's an under-the-radar, but potentially extremely impactful thing that states could do right now.

Rovner: But it's funny —here in Maryland, the Democratic legislature passed a law that not only authorized advanced practice nurses and physician assistants to do abortions but appropriated money to help train them. And then the governor, the Republican but pro-choice governor, vetoed the money, said he wasn't going to spend the money because he didn't want to. He's trying to "preserve the status quo." I'm interested to see the people who are trying to straddle this middle line on abortion. "It's OK for abortion to be legal, and it's maybe OK for more people to be allowed to offer it. But I'm going to draw the line at training them to do it." And I imagine that we may … There's a lot of blue states, but there's also a lot of purple states when it comes to this issue. I'll be interested to see. And then, of course, there's the issue of doctors not wanting to have their turf trod upon. That's also going on, isn't it?

Ollstein: Right. So some state medical societies have pushed back against this, saying … And it's interesting, they're saying: "We support expanding access to abortion. However, this sets a bad precedent of infringing on doctors' territory and is a slippery slope, blah, blah, blah." There again … Many states have been doing this for a long time. There have been studies showing that it is not a safety risk for these early abortion procedures. And a lot of medical groups actually support allowing these other kinds of medical workers to do this. ACOG, the American College of Obstetricians and Gynecologists, supports this. The World Health Organization supports this move. But it is interesting because you get into these scope-of-practice fights. We've seen this with everything from flu shots to ordering an X-ray or whatever, or prescribing opioids.

Rovner: Nurse anesthetists and anesthesiologists have been at each other's throats for literally decades.

Ollstein: Right, right. So, scope-of-practice fights is nothing new. What's new is this fight in the context of this coming large need for abortion services and fears of a shortage of providers. And I will say when it comes to training, that's another huge issue, too. You talked about Maryland, but a lot of states are worried about training. It's one thing to allow the workers to do it, but making sure that they get the training and funding is not the only barrier there. There's just so few in the whole country trained abortion providers to teach other people. And the most fascinating thing I learned this week that I put in my story was people are trying to come up with creative ways to

teach this work and teach this training. And one of the methods is having nurses and midwives practice doing an abortion on a papaya. Yes, a papaya, the fruit, which apparently is very similar to a uterus early in pregnancy. And they stick the vacuum tube in the papaya and get all the seeds out. They also use it as practice to insert an IUD. I was just fascinated by this. You can see a video link in my story.

Rovner: Well, speaking of the medical community and its mixed signals on abortion, we're not hearing as much as I would have thought from groups like the American Medical Association and ACOG. A couple of years ago, the AMA filed a lawsuit against two North Dakota abortion restrictions that it said required doctors to commit ethical violations by having to tell women things that were not technically scientifically accurate. And the AMA and other medical groups did file a brief with the Supreme Court opposing the overturn of *Roe*. But I feel like organized medicine has been pretty quiet on the abortion issue as it has blown up over these past few weeks. Any idea why? I imagine it's because they are themselves divided about this.

Cohrs: It could be. Or the decision isn't final yet.

Rovner: Yes, that could be part of it, too, that they're … down there writing stuff up. … I've covered this for a lot of years and I've covered the AMA when it's been very in favor of abortion and very much not in favor of abortion. And there was a big scandal in the early 1990s, I guess the late 1990s, about quote unquote, "partial birth abortion." And the AMA had actually endorsed a bill banning it and then it removed its endorsement. So there's obviously lots of different opinions here, but it seemed to me that in the last couple of years, the medical community had been a little bit more concerned about threats to their — I don't want to say autonomy, because that's a rather loaded word in this context. But, you know, threats to their professional judgment, as it were. And actually, while we are on the subject of criminalizing medical treatment, Alabama last week criminalized prescribing of puberty blocking drugs and hormones to transgender minors. The law was quickly blocked by a federal judge. But there seems to be this growing trend of lawmakers just plain practicing medicine without a license. I mean, has the pandemic and the overruling of public health made legislators less reluctant to leave doctors to practice medicine?

Ollstein: I view the trans battles a little differently because I think we saw a few years ago a lot of attempts to really go after trans adults fall flat, with the bathroom bills, etc. And the right has found a lot more success in raising fears around trans youth and children and really leaning in on that front. And I think that limiting medical care for trans youth could lead to limiting it for adults as well. But I really think that they've been more successful in playing on people's fears about children and teens than past attempts to do the same.

Rovner: Although, I will say, for years the abortion debate was also about minors. I mean, there are so many laws about whether minors needed to get the permission of a parent or permission of both parents or notify a parent or notify both parents and who could go to a judge, and when. There was at least a decade of the abortion debate being basically all about minors. So, I'm wondering if the transgender debate is doing the same thing there. They're going, as you say, Alice, they're going after minors because there seems to be more sensitivity to that.

Luhby: Right. Although one thing that's also interesting here is this is happening especially in states at the same time where they're talking about parental rights and parental judgment when it comes to schools and other things.

Rovner: So it seems …

Luhby: Yes. So parents have rights and, you know, better knowledge and more responsibility to their kids in some aspects of life. But not in all.

Rovner: Yeah, we are ever going to be in the culture wars. Well, finally, another update in that case of RaDonda Vaught, the Tennessee nurse who was convicted in March of, quote, "criminally negligent homicide and gross neglect for a medication mistake that killed a patient." The judge in the case sentenced her to no jail time, to have her conviction expunged after she served three years of probation. The judge noted that she had no previous criminal record and has already lost her job and her nursing license and will never practice on patients again. Still, this case seems to be casting a chill over an already overworked and overstressed health care workforce who now have the added worry of being prosecuted for medical errors. Does this lack of jail time relieve some of the fear, or is there still a worry that people will stop reporting medical mistakes for fear of being prosecuted? That seems to be the big issue in this case. Will mistakes that could be rectified — systemic mistakes that could be rectified — now go unreported because people are terrified about being convicted of murder?

Cohrs: There was a really interesting opinion piece that ran this week … pointing out the disparities. And I think there has been this interest in protections, like liability protections, for physicians versus nurses. And I think this case certainly drew attention to that. And we have had this swirling conversation during the pandemic about liability, about scope of practice, about who is responsible when things go wrong. And certainly I think there has been a lot of conversation and a lot of discourse, a lot of concern about this case and what happens when mistakes happen. I think there's also a conversation about accountability and equity and different practitioners in the health care space and providers. And so I think that this case illustrates that very well. And I can't speak to how people will feel about this sentencing decision. But I think it certainly calls a lot of attention to this disparity in protections for nurses.

Rovner: Yeah, that was a really good piece, in Stat; I'll link to that one, too. Alice, you were going to say something?

Ollstein: Yeah. So, having friends in the nursing field, one thing I've been seeing is not only fears that people won't report medical errors, but the workforce has been so battered by the pandemic and feels so hung out to dry by the public and elected officials and everyone, their own employers. We've seen a lot of strikes this year. And people fear this could be just either a final straw or one more reason if someone is considering leaving the field to do so. And so I've seen a lot of fears of this exacerbating the current shortages and poor morale in the field as well.

Rovner: Yeah, I think that's definitely … this particular case seems to have touched a nerve for an awful lot of people. 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 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. Tami, you picked first this week, so why don't you go first?

Luhby: OK. Well, my story this week is headlined "States Have Yet to Spend Hundreds of Millions of Federal Dollars to Tackle Covid Health Disparities," by Phil Galewitz, Lauren Weber, and Sam Whitehead of Kaiser Health News. And the story really interested me because Congress has been funneling hundreds of billions of dollars to states and municipalities over the past two years to help them cope with the health and economic fallout of the pandemic. But there have been serious questions raised over whether state and local governments have the ability to actually allocate and spend this money. And so this story shows that those concerns are not unfounded. It looks at $2.25 billion that the Biden administration was investing in covid health disparities. The CDC awarded the grants last spring, and Kaiser Health News looked a year later, found that little of the money had been used. Several states are notable: Missouri's health department had not spent any of its $35.6 million. Wisconsin, Illinois, and Idaho, as well as California, have not used a ton of their grant money. So the public health agencies have said that they need to hire more people or that it takes time to work with the nonprofits to put the money to use. Or they have internal, state, long budget processes. … People say, I need the money. But then actually getting the money out the door is a different issue. So the Biden administration now wants Congress to give it billions more to fight the pandemic. But the Republicans are pointing to unspent money, like what Kaiser Health News looked at, to justify their opposition to giving more money to the administration.

Rovner: Yes, definitely. The limits of federal power over something that's basically a state and local problem, which I think has been a continuing theme of this all along. Rachel, why don't you go next?

Cohrs: All right. So my piece was headlined "The COVID Testing Company That Missed 96% of Cases," in ProPublica. It was written by Anjeanette Damon. And I just thought this was just incredible reporting. The reporter worked in Nevada for a long time, it was really evident. They have incredible public records, and [she] just illustrated how this one contractor got integrated with schools and Nevada and how public health officials' warnings and concerns about the positivity rates being incorrect, and conflicts with other tests happened just because I think there was this really quick transition. There were tight budgets, which the story goes into, and some gaming of the federal government's uninsured program to … just really incriminating public records that just made this story so incredible. And I think there are great questions about how, where else this might have happened, maybe not to this degree, but when there are these companies that are stood up so fast that may not be run by public health officials, you know, people who just saw an opportunity for profit, how that actually impacts people's lives. So I thought it was just a great example of public records reporting and just really well done.

Rovner: And also this continuing question, maybe this is why some states haven't spent their money because they would rather not spend the money at this point than misspend the money, which is what happened in this case. Alice.

Ollstein: So I chose a piece that came out in the JAMA Health Forum this week by David Cutler, who's a Harvard professor. And it's about the economic costs of long covid. And this is something

that I think has gone really under the radar. Obviously, researchers are still trying to wrap their minds around what long covid is and how many people have it, and is it permanent or what, and what the symptoms are. And just so many unanswered medical questions, but we're already seeing this growing economic impact. And I think a lot of elected officials are really sleeping on this. And I'm glad that this researcher is pointing out that potentially millions of people are going to be unable to work. And so what are they going to do? What supports will be available for them? And how will this impact the economy as a whole? How will this impact certain sectors where a lot of workers have been infected and maybe permanently disabled? So I think very worth paying attention to.

Rovner: And David Cutler, of course, famous for the underlying economic work that led to the Affordable Care Act. He's been a leader in this movement for several decades now. Well, my story, my extra credit this week is from my KHN colleague Michelle Andrews. It ran in Fortune and it's called "The Frequently Long Waits for Insurance Prior Approvals Frustrate Doctors and Patients Needing Treatment." And, proving once again that everything old is new again, it seems that one of the big annoyances that drove the debate over the patients' bill of rights in the late 1990s still hasn't been fully solved: that insurers still slow-walk treatment approvals to the detriment of patient health. Michigan is now the latest state to pass legislation, putting a limit on how long insurers can take to act on prior authorization requests. Eventually, when it's fully in place, it will be seven days for non-urgent requests and 72 hours for urgent ones. But the dozen or so states that already have these laws can't really reach most people with employer insurance, because, as we discovered in the debate over the Patient's Bill of Rights, those plans, most employer plans are regulated by the federal government, not by the states. And while insurers have promised to work on this issue, they've been promising since 2018 and it is still not solved yet. So we will continue to watch that space because nothing in health care is ever really solved.

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 this week to our producer, Lydia Zuraw, filling in for Francis [Ying], who is taking some well-deserved time off to visit family. As always, you can email us your questions or comments. We're at whatthehealth — all one word — @kff.org. Or you can tweet me. I'm @jrovner. Alice?

Ollstein: @AliceOllstein

Rovner: Rachel.

Cohrs: @rachelcohrs

Rovner: Tami.

Luhby: @Luhby — L-U-H-B-Y

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