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, June 9, 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: Anna Edney of Bloomberg News.

Anna Edney: Hello, everybody.

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

Joanne Kenen: Hi, everyone.

Rovner: Later in this episode, we'll have my interview with Cori Uccello of the American Academy of Actuaries, who will explain the latest report from the trustees of the Medicare program and why we should care about it. Spoiler: We should care about it. But first, this week's news. And welcome to our 250th episode, everyone. We will start again this week with Congress and guns. They are talking. So there is that. The House on Wednesday passed a package of bills that would raise the age to buy automatic weapons from 18 to 21, create new rules for safe storage of firearms to keep them away from children, and ban large-capacity magazines, among other things. But that's clearly going to be a lot further than the Senate is willing to go. So, do we think a deal is going to emerge from the Senate? At the beginning of the week, they said, "Oh, well, we'll have something by the end of the week," and now it's getting towards the end of the week and they're saying, "Oh, be patient." I feel like we've heard this before.

Ollstein: Yeah. So ... I think the question is whether Democrats will want to settle for something really, really narrow just to say they did something and to break this years-long, complete logjam on doing anything related to guns. Or, if what they are ending up with in these bipartisan talks is so narrow and marginal that it just doesn't seem worth it. The House Democrats passed something that would be a lot more sweeping, raising the age of who can purchase certain weapons, especially given that the perpetrators of these recent mass shootings were very young, were under 21. And so they want to raise the age to 21. But Republicans in the Senate do not support that. And so I think it'll either be a much more narrow version that Democrats can say, "Well, this is a first step and we can build on it in the future." Or, as we've seen on so many other issues, it could just fall apart entirely and not pass anything.

Rovner: Yes. How many times we have seen that? I was going to make a joke about Lucy and Charlie Brown and the football. And then I realized that many of the people listening are probably too young to even know what that reference is to. And ... there's obviously other things that Congress is working on. You wonder, you know, guns have sort of rushed to the forefront because we had three [high-profile] mass shootings in a row in two weeks. But then the pressures of election-year legislating, I imagine, are going to take over before too much longer because they have other things that they have to do that they're presumably ... could get to. So Joanne, we've talked at length about the longtime congressional funding ban on research involving gun violence. That was something Congress actually did in the mid-1990s — I was there and covered it and how that ban on research was finally lifted a couple of years ago. Your extra credit this week is a look at what we've learned since that research was restarted. So, tell us what we know and what we still don't.

Kenen: Well, we don't know a lot. But at least we're in the process of learning. The Dickey Amendment that Julie referred to was actually a government ban, a ban on government spending, on promoting gun control. But it was interpreted to say you can't even research gun violence. And it really, at a time in the '90s when we clearly already had a big gun violence problem in this country, we stopped the science. I mean ... there has been some, it went into the privately funded, foundation-funded universities. But in 2019, $25 million was allocated. Biden has tried to get more. Congress hasn't given it to him, but at least there's $25 million a year and it's going half and half [to the] NIH [National Institutes of Health] and CDC [the Centers for Disease Control and Prevention], which then gets distributed to researchers around the country. We don't know that much yet because it's only been a couple of years, but at least there are avenues. And remember that gun violence makes headlines. It's the mass killings and they're traumatic and they've had a tremendous impact on our children and our culture.

Rovner: And our psyche.

Kenen: Right. All of us. But most of the killings are suicide — [it] is more than half some years, close to two-thirds. Accidents, children getting access to guns that they think are toys, domestic violence, urban violence. I mean, there's just lots — it's not one problem. So there's a number of studies going on, including screening patients for gun ownership and then giving them safety interventions, like safe storage. And, you know, we forget how many suicides are rural and there are some projects going on as part of this research into rural suicide, suicide with a gun, which is within the culture that's very pro-gun. So there's a number of things. It's not like we know the answers now and it's not like we'll know the answers next year, but we'll begin having some insights into effective interventions for at least some of these problems. And the story is by Chip Brownlee at The Trace.

Rovner: And tell people what The Trace is, because it's interesting.

Kenen: The Trace is a nonprofit journalism outlet that really focuses on gun violence. Julie and I were talking about actually making a conscious effort to include more of these really innovative, some terrific, reporting going on by these new — and some of them are a few years old — nonprofits around the country. So I committed to that this week. The actual headline — although

it'll be way easier for you to click on the Kaiser [KHN] website, because it's long trying to Google this one: "In 2019, Congress Pledged Millions to Study Gun Violence. The Results Are Nearly Here."

Rovner: All right. Well, in other continuing news on Capitol Hill, there is still a shortage of infant formula, even though the Biden administration is flying in formula from overseas. And the WIC [Special Supplemental Nutrition Program for Women, Infants, and Children] maternal and child health program is allowing a nationwide waiver of the usual restrictions on the types of formula that can be provided in each state. Anna, what's the latest on getting food for babies?

Edney: Yeah, you're right. There's been a lot of efforts to try and loosen restrictions, particularly on WIC, and also to allow some infant formulas that are made overseas and might not meet every last tiny little regulation in the U.S. to be sold here. But you know, there's this Operation Fly Formula and they have to actually get airlines to help and things like that to get it here. And parents so far do not seem to be feeling like there's a ton more formula on the shelves. Maybe a bit of good news — this is just from on high, and the experts who look at this from the data companies doing this — they think that maybe it hit "peak shortage" very recently. Given that the administration is trying to do a lot more stuff and maybe some of that's coming online. So, possibly, a bit of good news to look out for. The other thing is that the Abbott plant in Sturgis [Michigan] reopened just the other day and so they're going to focus on EleCare first, which is one of their specialty formulas — so a lot harder to find a substitute if that's the one you need. And they said we'll start seeing it on store shelves closer to the end of this month. So it's all hopefully good news. They opened under a consent decree, so the FDA is keeping careful watch on how they're doing as far as sanitation, given the state of the plant. When they went in there earlier this year, they had to hire a consultant, an outside consultant who is doing the same thing, making sure they meet every mark they have to to produce safe formula. And so those are the two, I think, the two key points on formula.

Rovner: Yeah. I consider you our expert on gross unsanitary manufacturing conditions.

Ollstein: Yes!

Rovner: You have looked at this across a wide variety of things! This plant ... was really, truly unsafe for what it was trying to manufacture. Right?

Edney: Yeah, certainly. ... When they went in there, they found the bacteria that has been linked to these babies — not the same bacteria, but they found a Cronobacter, which is the bacteria. They didn't find the same strains, but they found ... five different strains all over the factory in different places. And that's a very telling sign that it's potentially in the formula. It's very hard to test formula — [to] test one can and say, OK, it's all safe. It gets spread out. It's not an even thing. It's not blended into the formula. So when you find it in environmental samples, given that there was standing water on the floor and some practices that the employees were doing — not changing their gloves and things that they touched, outside areas, surfaces. ... Just given all of that, there was a reason that the FDA needed to go in there, as frustrated as people are with the outcome and how slow they were to respond to the supply side of it.

Rovner: You know, another issue that will continue, I imagine, for a while. All right. Well, let us turn to abortion. We had not one, but two Supreme Court decision days this week and still no sign of the big Mississippi decision that could overturn *Roe v. Wade* and end the nationwide right to abortion, although that right is already more of a theory than a fact, given how fast states are rushing to criminalize the procedure on Capitol Hill, where there are abortion-rights majorities, barely, in both houses, but not a supermajority in the Senate needed to pass anything abortion-related. Lawmakers are now looking to the Biden administration to take some actions, assuming the court does what the leaked draft opinion suggests it will do. Alice, what are some of those? I guess ... Sens. Patty Murray and Elizabeth Warren are leaning hard on the administration for some of these things.

Ollstein: Sure. And I'll say that, you know, the ideas they outlined this week are not original to them or new. These are things that the advocacy community has been asking for, for months and months and months. But they are amplifying those asks. And, I mean, it's important to remember that the White House can't stop states from banning abortion if *Roe v. Wade* goes away. Only Congress can do that. And as you noted, they're not going to, not the current Congress. They can't. They don't have the votes. And so the things that advocates and now senators are asking the Biden administration to do — I mean, they would potentially help some people access abortion around the edges. But it's important to remember that sweeping protections can only really come from the courts or Congress at this point. And so, anyways, there are things related to FDA regulation of abortion pills. The Biden administration dropped some long-standing restrictions on them earlier this year but left some restrictions in place. And advocates are asking for those to be dropped as well. There are things related to enforcement of Medicaid's free choice of provider rules so that the states that have tried to kick Planned Parenthood out of their Medicaid programs will not be able to do that.

Rovner: Even Planned Parenthood that don't provide abortions.

Ollstein: Right. Exactly. Exactly. You know, we should all remember that federal funding for abortion is banned. And so this is about, you know, federal funding and state funding for non-abortion care. And then, people are asking the Biden administration to get creative, to see if maybe better HIPAA [Health Insurance Portability and Accountability Act] enforcement can prevent health care providers from reporting people to law enforcement that they suspect of having had abortions. That's already happening. There are potentially things they can do to protect the right to interstate travel. Already, people have to often cross state lines for an abortion, but that's expected to increase a lot going forward. And so there's a lot of things currently under consideration, but I think it's important to remember that none of them will provide the sweeping, blanket protections that *Roe* currently provides.

Rovner: And not that those of us who have followed this debate needed any more evidence, but an op-ed in The Washington Post this week, called "Even if Roe Is Overturned, Congress Must Act to Protect the Unborn," shows pretty bluntly how overturning *Roe* isn't anti-abortion activists' goal, but rather just the first step. We're already seeing quite the push for a full ban on abortion nationwide, even before the Supreme Court has technically pushed the decision back to the states. Right?

Ollstein: Right. I mean, for so long, Congress has been deadlocked to a point where they haven't been able to pass abortion restrictions or abortion protections. They've been trapped in a status-quo scenario. And, really, most of the action has been at the state level. So I think it'll be the outcome of the midterm elections that really decides what Congress could do going forward. Of course, there are people on the right who want to implement some sort of nationwide ban. But it's also a tough message on the right because for so long they've said we need to overturn *Roe v. Wade* because this decision should be in the hands of the states. And if you've been saying that for a long time, then to go back and say, 'Oh, no, actually Congress should pass the nationwide ban." It's a mixed message. And so both sides are really pouring energy into trying to win some of these races in swing states to tip the balance of power.

Rovner: So on the other hand, it's looking more and more like 1972, the year before *Roe*. Every day as California and New York are trying to hold themselves out as, quote, "abortion sanctuary states." Is that where we're likely to end up with abortion legal and available on the coasts, but not very much in between? Anna, this feeds into your extra credit this week from our fellow podcast panelist, Shefali Luthra. Why don't you tell us about it now?

Edney: That's right. And in The 19th news, it was: "Florida Could Be a Critical Access Point for Abortion, but the State's Own Battle Is Just Starting." I thought it was a great look at what you just mentioned, is that there's going to be this push-and-pull between the states and where it's legal and where it's not and travel. ... It was a good look and reminder at what travel can mean for an abortion, for a woman who might need to gather the money, not just for the abortion, but for getting out of state to go, and how putting time restrictions on it. And in Florida, there's a law about stopping it at 15 weeks. And so how that could make a difference for people from nearby the state, in other states that are going to end up with restrictions .... how hard it is to possibly get there by then, and then if you get there and someone thinks, well, this is probably a pregnancy past 15 weeks, what do you do? Shefali did a great job outlining what a practitioner that's been doing this for a long time is facing and what women will be facing when they've got to look outside their state. Like you said, it may be on the coast. I think what she was looking at was, well, Florida would be one that you don't know where [Gov.] Ron DeSantis is going to go right now and what his ambition might be.

Rovner: Yeah. And Florida has long been where people went in the South anyway because ... even in states where abortion is technically still legal, there's just not a lot of availability. But it's one thing to get in your car and drive three or four hours. It's another thing to have to get on an airplane and fly somewhere. And if you already have kids, which most women seeking abortions do, you have to get child care. You have to get time off of work. I mean, it's ... it is still a big deal. As people have been pointing out, wealthier women will probably still have access and poor women won't, although to some extent that's the case even already, even with *Roe* still existing on paper. I think one big difference between now and 1972, though, is the role of employers in health care and other types of employee benefits. The typical job in the early 1970s didn't even come with health insurance, much less family leave or any kind of paid leave for that matter. We're now seeing employers taking sides in the abortion debate, which is something different. Some are making it clear they'll help pay for abortions for their workers who want them, including travel

costs. Others are making it clear they won't. We've seen people segregate themselves by politics and where they live over the past couple of decades, with blue areas getting bluer and red areas getting redder. Are workplaces about to do the same thing? Is abortion going to create a "I want to work for this employer, but not that one"? That *would* be something novel.

Edney: Yeah. I think that there are certainly health benefits that people do look at. I just heard a story the other day about — this is a little different, it's on the spectrum of fertility benefits, and when employers offer those women seeking out that place to work because ... it could be $30,000 or more to do IVF. And so I think that it could become an incentive for some people. And I think what may be new a little bit is that if you're seeing employers deliberately going the other way, restricting access. There was a good story in Bloomberg Law that talked about some of this, maybe just protecting themselves, too. It may not be necessarily a debate they're having on moral grounds or anything along those lines.

Rovner: Yeah ... we will link to that story in Bloomberg Law, because that's sort of what got me thinking about this, although I had seen other things, too, where ... it just it looks like it's yet another place where the country is about to divide between pro-abortion rights and anti-abortion.

Kenen: But I'm not sure that people ... on abortion ... it's a medical thing that you don't anticipate and therefore you're not looking at a job as, possibly, you're going to have some kind of health problem that you don't know about yet. ... By definition, unplanned pregnancies are unplanned. And to choose a job based on something being unplanned and a subsequent time later that you're not planning on is sort of a tautology there. I think in terms of broader, not necessarily so much the abortion benefit per se, but as companies get more ideological and as companies get more red or blue, I think you may see more of that: "I don't want to work for this company because they are X," and "I do want to work for that company because they are Y." I think we may be getting into *that*. But the basic reality is that women of certain socioeconomic classes are going to be able to, not 100%, but many of them are going to be able to access abortion one way or the other. And many of those in need will not, because they're not going to be working for these companies. They're not going to know about it. I mean, Alice and I did a story a few weeks ago together on access to contraception, and I went to a Title X clinic in Texas. And ... of the four or five women who agreed to be interviewed, there's only one I could remotely see figuring out how to navigate and get to another state hundreds of miles away on an airplane with their four kids at home and no spouse or an ex-spouse who's not doing very much. The only one I could possibly see doing that is a college student, and she doesn't believe in abortion anyway, which is one reason she's in the clinic getting contraception. So it's not irrelevant to where the country is heading, but it is not the answer for many, many women — and men. Or *people*. Two people are involved in a pregnancy, whether they wanted to be or not.

Ollstein: I also think that a lot of this is aimed at messaging towards consumers rather than workers. And like you said, it's about projecting this is what this company stands for, so that consumers choose who to support and not support. Because an issue I've been hearing, too, is would this require workers to disclose to their employer that they're availing themselves of this benefit and traveling for an abortion? And should workers have to do that? This is an extremely

private thing. And so, logistically, there are questions about the utility of this. So I do think it's more about sending a message about the broader values of the companies.

Kenen: And just think of the new slogans like, “What would Tesla do?”

Rovner: Oh, let's not go there. All right. Well, while we're talking about business, there's a bunch of interesting items in the news lately that I'm gathering under an umbrella I'm calling “Business News This Week.” Let us start with the Federal Trade Commission, which has announced an investigation into the practices of pharmacy benefit managers, those drug middlemen who either help bring down the price of drugs or keep them high, depending on which side of this debate you believe. According to the FTC's press release, the agency is requiring the six largest PBMs to provide information and records regarding their business practices. And this seems like it could be significant. Yes?

Edney: Yeah, definitely. It's been an area that the FTC has ... wanted to look at for a little while, and they just didn't have the right makeup on the commission. And now they do. And so, I think, in the drug price debate, PBMs emerged as ... pharma pointing fingers at PBMs and saying, “They're actually the problem. It's not our prices. It's these middlemen that we pay these huge rebates and nobody really knows where the money goes.” So figuring out that industry and seeing where does the money go, does it actually bring down costs for the health plans or the consumers? And getting any kind of handle on that, it sounds like they're going to be able to get a lot of documents and things that we don't normally get to see. So I think ... it could be significant also because ... a lot of the health plans and PBMs are now one. That's sort of changed in recent years, where you [used to have] the PBMs, Express Scripts, CVS, and some of the others, like, out on their own doing this. And now they're part of the health plans. So, how does that now lack of competition maybe affect what we're paying for drug prices?

Rovner: Which is actually the FTC's job to look at!

Kenen: But it's not just that they're part of the health plans, which is new because of all the consolidation in health care. But they're also — some of them own the mail-order pharmacies. So there's all these distorted incentives of, you know, I mean, a few years ago, as Anna just said, it was like they were the villain over there. “Over there! There they are! There they are, go get ’em!” And now, oh, they're us, so ... or what is us? Or who are you? Because it's so complicated now. I mean, consumers can't sort this out. We're having trouble sorting this out. So they were the boogeymen. There's this drip, drip, drip, drip, drip of consumer concern about pharmaceutical prices, which has been going on for years. But there were two burst-out drugs that made people really aware. One was the hepatitis Sovaldi and hepatitis drugs, which is already seven or eight years ago by now. And the other, remember, was the EpiPen, the price and the shortages. That's when they, you know, “Oh, it's not us,” EpiPen said. It was “It's those bad guys, those PBM things.” And it's different now. With my usual disclosure that I have a bee allergy and I carry EpiPens. ... Now I have a generic, right? I don't own the company. I just carry the EpiPen.

Rovner: I do not. I have no personal interest in this whole debate. But I am interested in seeing how it comes out. There is other FTC news this week. The agency last month filed lawsuits to block

hospital mergers in New Jersey and Utah, charging that the transactions would, quote, “eliminate direct competitors and incentives to reduce prices and improve care.” I have just one question about this. Where has the FTC been for the past two decades while every hospital in America has been merging with every other one? Anna, you kind of answered this on the PBMs, right? That it was really literally the membership of the FTC itself.

Edney: Yeah, I think that that is part of the answer here is that it's a different makeup so that the Democrats are able to do more in this sense than they were before.

Kenen: But also, antitrust oversight is divided, with some sectors overseen by the Justice Department and others overseen by the FTC. So there's not even a universe, there's not even one voice. There are many aspects of consolidation, and — was it, Anna, am I right, was it [that] hospitals are FTC and health plans are DOJ?

Rovner: I think that's right, but I'm not sure.

Kenen: I might have it reversed. There's two sets of rules. Well, two sets of ...

Rovner: Regulators.

Kenen: ... oversight. And regulators. Well, one is a litigator and ... they’re both litigators. ... It's very confusing.

Rovner: Yes, it is. But at least ...

Kenen: There's clearly — there's a lot of consolidation in the last few years that has had many ripple effects throughout cost and access.

Rovner: Yes, absolutely. Finally on the business beat in other hospital news, remember those rules requiring hospitals to make their prices public starting in January of 2021? We’ve talked about this a lot. Well, apparently, it is still not happening. And the federal government, while it has issued a bunch of warnings, only this week has levied its first fines, fairly small, for noncompliance. I know things are a mess due to the pandemic, but really? This is something that's been supported by every administration since President [Barack] Obama. Maybe we should turn this task over to the FTC instead of the Department of Health and Human Services, because they actually seem interested in this sort of thing. I mean, it does seem to be this giant red flag that’s like, “Hello, we have these rules!” And hospitals are just saying, “Yep, nope, not doing it.”

Ollstein: Well, like you said, the size of the fine really matters here because they've obviously decided it is way more lucrative for them to flout the rules and pay the fines if and when they arrive than to publish their prices, which could potentially cause people to seek care elsewhere. And, the irony is — we've talked on this podcast several times about the rules not even being that helpful for folks because the list price of these different services is not usually what people actually pay. It depends on what kind of insurance they have. And so we tell people to be smart shoppers, but we don't really give them the means to do so, even if everyone complied with these rules, which they obviously are not doing.

Rovner: Yes. All right. Another one we'll come back to. Well, finally, last but certainly not least this week, covid, which is still the most unwelcome houseguest that won't seem to leave. Congress still seems to be not in much of a hurry to replenish covid funding that the Biden administration has been asking for. And now the administration is having to move money from one covid need to another just to keep things operating. If we have another big surge this fall, which looks possible, if not probable, things could end not well, right? I mean, is there any indication that Congress is going to come up with any of this money?

Edney: I have not seen any indication that they're interested in coming up with this money. I think, just like a lot of the rest of the country has wanted to move on, now Republicans certainly have used that opportunity to not fund these types of things. And it's interesting because the CDC also has in a way tried to move on. And so how do you argue for funding when the numbers are showing or saying you don't need it, in a way?

Rovner: Yes, and the CDC is trying to downplay how things are going.

Edney: And we still do have a very hard time. I mean, it's become clear that we're not going to plan ahead. People thought that that would be something that would change in all of this. And we'd look at pandemics differently, but we can't even do it four months out or whatever.

Rovner: You're feeding into my very last question here, which is there's an interesting study this week in the latest issue of Health Affairs. A peer-reviewed study has confirmed what Charles Gaba over at ACASignups.net has been tracking for a couple of years now, that covid has killed more people in counties that tend to vote Republican than those that tend to vote Democratic. According to the study, majority-Republican counties experienced 72.9 additional deaths per 100,000 people relative to majority-Democratic counties. And it wasn't just vaccine uptake, although that was part of it. Apparently, Republicans are just less likely to support and comply with public health advice than Democrats are. Which, what does that tell us going forward, when we have future pandemics?

Edney: Yeah, the mistrust is huge. And particularly among more Republican-leaning counties, [Donald] Trump certainly helped that grow, and a strong dislike, if not hate, of [Dr. Anthony] Fauci and ... just people aren't listening as much to anything. Not that they were before, but they think that, well, health experts want them to wear masks forever and ever. And they're certainly bucking against that. And I think more so in Republican areas, which tracks with the ideals of the party generally in a way, when you're talking about individual freedom.

Kenen: The other thing interesting about that study — I mean we have seen both Gaba's work and others, we've seen this — but it was adjusted for other socioeconomic factors, or social determinants of health. And it was still, you know, how you vote. I mean, it wasn't the sole factor, but it was a biggie. And it was documented in a more rigorous academic way that voting patterns and death rates are related.

Rovner: Well, as I like to say, one of these weeks we won't have to talk about covid, but this is not that week. OK. That is the news for this week. Now we'll play my interview about the Medicare trustees' report with Cori Uccello, and we will come back for our extra credits.

I am pleased to welcome to the podcast Cori Uccello of the American Academy of Actuaries. Cori has long been one of my go-to experts on the financial condition of Medicare. And not just mine — one of the nation's go-to experts. I couldn't think of anyone better to help us unpack the latest report from Medicare's trustees and why we should care. Cori, welcome to "What the Health?"

Uccello: Thank you, Julie. It's an honor to be here.

Rovner: So let's start at the very beginning. Who are Medicare's trustees, and what do they do?

Uccello: So the trustees are government officials, with two public trustees. But the public trustees' positions have been vacant for the past several years. And so what they do — every year, they come out with a report that gives an overview of the financial status of the Medicare program. And this report gives information to policymakers and the public regarding the sustainability of the program and whether changes might be needed to ensure that the benefits promised will indeed be able to be covered.

Rovner: What does it normally … People talk about the report … They usually compare it to the previous years. It's, like, OK, the insolvency date is moved back or it's moved up. First of all, it's not all of Medicare that we worry about going insolvent, right?

Uccello: That's exactly right. The Medicare program has two trust funds. One of them is the Hospital Insurance Trust Fund, or Part A, or HI — it has many names. But that's the one that people focus on. That covers inpatient hospital care and post-acute care. And it's financed primarily through payroll taxes. And that's the one that will be depleted in "X" amount of years. And so the "X" is what people are looking for. In this year's report, it's projected that it will be depleted in 2028. And in last year's report, it was two years earlier. So in one sense, we've gotten a bit of a reprieve. But on the other hand, this is still a big deal, and two years isn't a long time. And if the economy gets bad, it could actually come forward again. So there's a lot of uncertainty. And in this year's report, the trustees actually went out of their way to highlight how uncertain these projections are because of covid and the economy.

Rovner: Yes. I wrote a story, I think, in 2020 suggesting that the insolvency date could be pushed up because so many people were out of work and so they weren't paying payroll taxes. And so there wasn't a lot of money coming into the Medicare trust fund. But now we're seeing that it's been pushed out. Do we have any idea why the financial situation looks marginally better?

Uccello: So there are two main reasons. One is payroll taxes are going up. The lower unemployment rate, higher wages contribute to higher payroll taxes coming in. Higher revenues coming in will improve the trust fund. The other main difference that I'll highlight is there was a technical change, an improvement to how Medicare Advantage payments are allocated between the HI trust fund and the other trust fund. And so less now is coming from the HI trust fund, which improves that portion of the program.

Rovner: So this really does get … You really have to be an actuary at some level to understand some of this.

Uccello: It is a bit complicated.

Rovner: Just to reiterate, the other trust fund — the SMI [Supplementary Medical Insurance] trust fund, or the Part B trust fund — can't technically go broke or insolvent, right?

Uccello: That's exactly right. It's solvent indefinitely because every year its revenues are increased in order to meet the increasing expected expenditures. But that means beneficiary premiums go up, general revenues have to go up. So even though it's solvent, it's still placing an increasing burden on beneficiary household incomes, on the federal budget.

Rovner: And on taxpayers.

Uccello: And on taxpayers, who pay general revenues.

Rovner: So when people are talking about the Hospital Insurance Trust Fund, which is the one that we're really looking at with these trustees' report or the one where we're concerned about. Looking at these reports, they often talk about Medicare going broke, but that's not really what would happen, right?

Uccello: So that's exactly right. The program will not go bankrupt forever. What will happen in 2028 is that the revenues coming in … So revenues will continue coming in through payroll taxes, but those revenues will only cover 90% of the expected expenditures under that program.

Rovner: So, therefore, something — I guess benefits would have to be cut? Or taxes would have to be raised, one presumes.

Uccello: Well, something has to give, but there's nothing in current law that says we cut benefits or we raise premiums. So what instead would likely happen is that payments to providers, to those hospitals, to those MA plans would be cut or delayed.

Rovner: Basically, I mean, we've been here before. I've been covering this so long that I've seen reports where the insolvency date is like two or three years away and Congress usually steps in. I mean, what can be done to fix this for the long term? Or is this just going to be a continual putting Band-Aids on it until it doesn't look like it's going to run out of money?

Uccello: Well, I think part of the problem here is that it's human nature to not address problems until they become imminent. And that makes it difficult to put in place long-term solutions, as opposed to Band-Aids. And one of the reasons why I've been saying that just because we have two more years and this isn't an issue until 2028, it's actually an issue now. And the reason is it takes a long time to implement changes. And if we want structural changes that will actually improve the program moving forward, those can take six years to work out the details and implement and give beneficiaries, providers, etc., give them time to adapt. Even if we want to simply reduce payments to providers — I mean, that's a straightforward change — that could take two years. So we're not really talking about a lot of time here, and it's just not in the nature of policymaking these days to make these big kinds of changes. But we should. We should really be thinking about those right now.

Rovner: So this is another urgent thing that Congress ought to add to its health care to-do list, right?

Uccello: Absolutely.

Rovner: We'll see if they do. They've only been talking about drug prices for, what, 20 years? I'm sure we will come back and talk about this again, but this has been hugely helpful. Cori Uccello, thank you so much for joining us.

Uccello: Thanks so much for having me, Julie.

Rovner: OK, we're back and 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 our podcast page at khn.org and in our show notes on your phone or other mobile device. Joanne and Anna have already done their extra credits. Alice, you're next.

Ollstein: So I chose a piece by my colleague Rachael Levy about internal discussions in the Biden administration about how to measure when they can officially declare the pandemic under control. And specifically, there are folks that were pushing for the metric of 200 deaths a day from covid or less. And that message, they felt, was too grim. They didn't want to say that 200 deaths a day was OK, but ironically, 200 deaths today is also wildly optimistic. We are way above that currently. And so there was a reticence to say that that is an acceptable amount of death, but also we are way above that now and that would be a massive improvement if we were able to achieve that. And so now we're just in this weird place where we are not officially declaring the pandemic under control, but a lot of government actions are sending that message in different ways. So I recommend the piece.

Rovner: Yeah, it was very thought-provoking. Well, mine is by my colleague Sarah Varney at KHN. It's called "Misinformation Clouds America's Most Popular Emergency Contraception." And it combines three different topics we've talked about lately: birth control, medical misinformation, and private equity in health care. How? I am so glad you asked. So, as I've been trying mostly in vain to communicate for most of the last decade, the morning-after pill, called Plan B, is not an abortion pill. And in fact, according to a growing number of studies, it doesn't even work to stop a fertilized egg from implanting in a woman's uterus. But the misperception continues that the pill *can* stop that and therefore stop a pregnancy, which is still not considered an abortion by the medical community because pregnancy does not begin until after implantation. But it is considered an abortion by some religious people. Well, in many countries, the labeling on Plan B has been changed to make it clear that it only works as a contraceptive, but not here in the U.S. Why not? Well, it seems that the patent for Plan B has been sold to a private equity firm that hasn't bothered to ask the FDA to change the label. Will they when states start banning the pill for causing abortions? Which it doesn't; the abortion pill is a whole different drug that works a whole different way. Anyway, maybe the company will seek a label change, but it's another example of how private equity isn't in health care to improve health as much as it is to make money..

Kenen: But if they stop selling it, they won't make money.

Rovner: Yes. Hence, they might actually have to come forward and do this, but we shall see. All right. 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]. 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. Joanne?

Kenen: I'm @JoanneKenen

Rovner: Anna?

Edney: @annaedney

Rovner: Alice.

Ollstein: @AliceOllstein

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