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 23, at 1 p.m., just in case the Supreme Court threw us the abortion decision this morning, which it did not. But 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: Hi, everybody.

Rovner: And Rachel Cohrs of Stat News.

Rachel Cohrs: Thanks for having me, Julie.

Rovner: Later in this episode, we'll have my interview with KHN's Noam Levey, who's helping launch a new KHN-NPR project on medical debt. And if you think you already know about medical debt, just you wait. But first, this week's news. And I will warn you, there is a lot of it. We're going to start this week with the Biden administration's crackdown on tobacco or, to be more specific, on nicotine. This morning, the FDA announced it was banning Juul, that vaping device that's proved so attractive to teens and even younger kids. To quote from the FDA's own release: "As a result, the company must stop selling and distributing these products. In addition, those currently on the U.S. market must be removed or risk enforcement action." Now, the FDA has been threatening this since the Trump administration and Juul has already said that it's going to fight back in court. Do we have any idea if the FDA can really do this or who's going to win?

Cohrs: I'm not the expert on this at Stat. But I know my colleague Nick Florko has been following this, and he noticed that the decision seems to center on toxicity data, which is interesting compared with other products that the FDA has allowed to be marketed. So I think it'll be interesting to see what that conversation looks like, a lawsuit — if there's different standards for different companies. But I think it certainly is just a really interesting test case going forward.

Kenen: To the laypeople the question has been: Are they a tool to help you quit traditional cigarette smoking?

Rovner: The idea being that vaping is less hazardous to your health than actually smoking.

Kenen: Is it harm reduction? Not that it's great, but is it better for you than the alternative? And then it got subsumed in a conversation about the marketing to kids and the amount of vaping going on, like, in middle school and where that leads. But there's a separate, more scientific discussion about what are the ingredients of these products? We had that spate of illnesses a

couple of years ago, right before the pandemic, and that turned out to be more marijuana and chemicals and things that weren't really supposed to be there. But there was just a study that came out last night or at least — I didn't read the whole thing, I just read a headline about it — about a harmful chemical. I will not try to pronounce the technical name that causes what's called, you know, popcorn lung, damage to the lungs. So just because they didn't cause lung cancer down the road, there may be other harms. You're still putting stuff in your lungs, and that's what the FDA is looking at. What exactly are you putting in your lungs when you vape with Juul? And of course Juul became a verb, right? Kids are Juuling. It's not just the smoking substitute debate. It's also, like, is this just another load of chemical garbage into a vital organ? And I guess you could still make them safer. I mean, I don't think the FDA ruled out that they couldn't be modified or, you know, as hazardous as identified ... that you have to have that chemical in it. I mean, they have not banned all e-cigs. Some of them have passed the safety ... now they could find out something about them and change. And they could also ... maybe Juul could reconstitute it so it does meet the standards that the FDA is creating.

Rovner: Well, the Juul ban was actually the second big tobacco action of the week. The FDA also announced that it plans to issue a rule by 2023 — so, next year — that will call for the gradual reduction in nicotine in tobacco products, even though it wouldn't phase in for several years. This would also be a very big deal, and I imagine it would be fought tooth and nail by the tobacco industry because it would make their products less addictive. Joanne ... you covered the bill that gave FDA this authority in the first place.

Kenen: Actually, the bill went to the Supreme Court.

Rovner: I was just gonna say, to regulate tobacco. I mean, can they do this?

Kenen: The idea was there was ambiguity about whether the FDA could actually regulate nicotine levels. And it went to the Supreme Court. I forgot what year. Roughly 2000. The FDA won, and they have authority to do this. Doesn't mean there won't be more litigation. I would be very surprised because the Supreme Court gave them the authority to regulate tobacco and the FDA included nicotine regulation. But when the rule comes out or maybe even before the rule comes out, I would expect ... there's fights about everything. I mean, we know that the FDA has the right to put warning labels on cigarettes, they've been doing for years. And yet when they did more graphic ones, there were three or four years of litigation about that. So I would be very surprised if there was not both a visible lobbying campaign, another quieter lobbying campaign behind the scenes that we don't see so well — as, you know, in terms of influencing individual lawmakers — and a legal battle. I would expect all of the above. And a public campaign and, you know, say, "Oh, it's all going to go on the black market and this is a bad idea. And you're not actually protecting public health." I mean, we've been hearing variants of this for decades. I don't think they'll stop now.

Rovner: No, the tobacco wars are definitely not over yet. All right. Well, let's turn to the Supreme Court, which, as I mentioned, at the top, still hasn't issued its abortion ruling, although it did make it harder for states to regulate guns, which we'll get to in a moment. But first, the justices did decide a very confusing but somewhat important case about Medicare law and whose insurance

pays for people with end-stage kidney disease. Now, before we get into the weeds on this, and I don't plan to get too far into the weeds on this, it's important to remember that kidney disease, which is known formally as end-stage renal disease, or ESRD, is one of the few ailments that actually automatically qualifies you for Medicare, even if you're not yet 65. At issue in this case was an Ohio hospital's own health plan for its employees, which included no in-network dialysis care, effectively forcing anybody with ESRD directly onto Medicare rather than having Medicare be the so-called secondary payer to the employer plan. The idea here was to limit Medicare, i.e., taxpayers' exposure, and let people who can still work remain on their employer plans, at least at first. But by 7-to-2, the court ruled that since the plan didn't have different benefits for people with kidney failure and those without, didn't include in-network dialysis for anybody, that it was A-OK. And I can't imagine that that's actually what Congress intended here, was it? I mean, I can't help but think that there will be an effort to go back and re-clarify this, because it does seem to be a way for employers to basically dump their patients with kidney disease directly onto Medicare.

Kenen: I read the coverage, but I wasn't clear — are they dumped onto Medicare for *all* of their health needs or just their dialysis?

Rovner: No, I think all of their health needs. I think that was the idea. I think that was the whole point, unless I was misreading it. Because, as I said, I don't want to get way too far into the weeds. But I feel like this case can have some significant ramifications, particularly as we talk about Medicare solvency. ESRD is a particularly expensive part of Medicare because people with kidney disease need either dialysis or a kidney transplant, which many of them get. I mean, it's a good thing that they can now live much longer lives, but it comes at a price.

Kenen: Well, the also thing is, when this benefit was created, which was, I believe, in 1973 ...

Rovner: '72.

Kenen: '72? There weren't as many people who needed dialysis. And dialysis itself is a huge industry. I mean, it's dominated by two for-profit chains. It's an expensive thing and it's not an optional service. You either get a transplant, you have dialysis, or you die. I mean, those are your three choices. So dialysis is a much more common ... as a proportion of the population, not just that we have more people in the country, partly because there's a lot more diabetes and kidney failure. I mean, diabetes has become so common and people who have severe diabetes, this is a risk factor. There are other reasons that people do live longer. For a variety of reasons, more people live to the point where they need dialysis for their kidney failure. And we do a better job of keeping them alive through other health crises that cumulatively create the need for dialysis. So it's — I don't know what the entire bill will be for Medicare, but enormous, enormous.

Rovner: Yeah.

Cohrs: I think it'll be interesting to see how lawmakers respond to this. My colleague Bob Herman and I were talking about the decision after he covered it. And I think we realized that the CBO [Congressional Budget Office] doesn't score Supreme Court decisions. I mean, these can have really substantial ...

Rovner: But if they did ...

Cohrs: Right. It could have really substantial costs. So I think if lawmakers were to come up with some sort of fix or solution, I think that's something that's expected. We may see advocacy by these companies, trying to ask lawmakers to address this somehow. Then there could potentially be cost savings for the federal government associated with that, which is always a good incentive.

Rovner: That's right. Then they could use it for something else.

Kenen: Right. And then Medicare [does] cover dialysis for both people over 65 and people who are in end-stage ... they do it now. So there is a cost system, they have negotiated some prices. But I don't know how that changes, why they're the sole buyer of this service, where if someone doesn't have any place else to go. I it's all going to be Medicare, that also changes the market.

Rovner: Yeah, but if they make it harder for the employer plans to basically dump people on Medicare, they would save a lot of money that now Medicare is going to have to pay.

Kenen: Oh, yeah. Yeah. Yeah.

Rovner: And they could spend that back. Speaking of that, let's talk about drug prices, which are still a thing, and just possibly a thing that Congress might still do something about before the end of this term. This is all still tied up in the talks over what I'm calling the teeny-tiny version of the Build Back Better bill. But now it seems members might settle, when it comes to drug prices, for only limiting the cost of insulin. Rachel, you're looking at this. Is that basically what's left on the table?

Cohrs: I would say no.

Rovner: Oh, good.

Cohrs: I think they're complementary somewhat, just because — and this gets really technical — but there may be some hang-ups on some portions of the reconciliation drug-pricing portions because of the special rules of that process. So I think they've chosen to pursue insulin legislation separately. And two key senators, Sen. Susan Collins and Sen. [Jeanne] Shaheen put out a bill text, finally — I think they've been talking about doing this for 2½ months — laying out this new mechanism for insulin pricing, both in Medicare and in the commercial market that would allow drugmakers to voluntarily choose, if they wanted to, to lower the list price, like the sticker price of their drug, to the negotiated price that they actually received last year, in 2021. And if they do that, then they're able to avoid all the rebates that they're paying to insurers and pharmacy benefit managers right now. I know that's a lot to take in. But the takeaways for me, from the bill text that we saw, were that it's certainly possible that this bill could help some consumers, depending on which insurance you're looking at. There's maybe 20% to 30% of people who use insulin right now who are paying more than the $35-a-month cap that the bill would create. So that could help those people. And it's also possible, if drugmakers participate and actually lower their prices, that people who are uninsured could also see some lower prices. So it's possible this could help people, but it's also a very pharmaceutical industry-friendly solution. Because why would drugmakers volunteer to participate in a program that would hurt them financially? You

know, that's the whole basis of the mechanism. So, interesting policy. We'll see. I think Democratic leadership in the Senate [are] hoping to bring this up for a vote shortly after the July Fourth recess.

Rovner: So they're going to do this separate from whatever else [West Virginia Sen.] Joe Manchin might allow them to do with some other drug prices and extending those Affordable Care Act subsidies that are going to expire if Congress doesn't renew them before the end of the year.

Cohrs: That's true. And it would have to be bipartisan, so they would need quite a few Republicans on board. We'll see if that happens.

Rovner: The insulin bill would have to be bipartisan.

Cohrs: The insulin bill, yes, the insulin bill would have to be bipartisan.

Rovner: The reconciliation bill wouldn't. That's the whole point of doing it in reconciliation. All right. Well, speaking of drug prices, there was an interesting study out this week in the Annals of Internal Medicine about the generic drug company launched earlier this year by Mark Cuban, the billionaire owner of the Dallas Mavericks and “Shark Tank” star. The study finds that had Medicare been able to take advantage of the prices that Cuban is selling the top 100 generic drugs for, which is cost plus 15% plus small dispensing and shipping fees, Medicare could have saved billions of dollars. Now, it's not like Cuban has invented something that’s all that novel. A similar study last year found Medicare is paying far more for generic drugs than Costco is, too — or that you could if you were going to Costco. Which raises the question for like the millionth time, why can't Medicare negotiate better prices even for generic drugs?

Kenen: Because ... Congress. Right? It doesn't make economic sense, by and large — there have been some holdouts — but basically the Democrats have favored this for many years. The Republicans have not, although a couple of Democrats have also quietly dug in their heels. That's one reason why it hasn't happened. I thought the piece on Cuban was really, really, really interesting because it's cheaper drugs! And we're not buying them!

Rovner: I know. It's not even the pharma argument about how, you know, if you limit what you spend on drugs and we won't have any more innovation because we're not even talking about brand-name drugs, we're just talking about generic drugs here. And yet even that's not still on the table for what they ultimately might do in this reconciliation bill, right, Rachel? You're shaking your head.

Cohrs: No, I don't think so. Yeah, I think the negotiations would focus on brand-name, single-source products.

Rovner: Right. This is like really low-hanging fruit and they apparently can't even reach it. So. Well, speaking of low-hanging fruit, one thing that *is* moving in the Senate is the gun/mental health package. Now, it wouldn't do that much for gun regulation, mainly enhanced background checks for buyers between 18 and 21, making it harder for those convicted of domestic violence to get guns. On the mental health side, it's mostly money for community mental health clinics. But the biggest problem that the bill doesn't address is that there's a huge shortage of mental health clinicians. This isn't even something that the Congress is really addressing at all, is it? I mean, they

are saying that we're going to help people with mental health problems, but, at some point, just throwing money at it isn't going to help.

Cohrs: Yeah, I think that Congress is looking at broader mental health legislation as well. I don't know that that's going to solve all of those problems, but I wouldn't say that this bill is necessarily Congress' last word this session on mental health. I think that's a very interesting point, and it's very difficult to throw money at that problem.

Rovner: But, you know, it will be the first gun regulation bill gotten through the Senate in 30 some years.

Kenen: 1994, the crime bill and the assault weapon ban. And that lapsed. So ...

Rovner: Yeah.

Kenen: I mean, in terms of significant things, I think that '94 is the last big one. The other side won a few victories, including the liability protection bill; it was a pro-NRA bill. But I mean, I think that when we talk about gun violence, you know, we as a nation are traumatized and our children are traumatized by the mass shootings, and they have become a daily occurrence in this country. So to say it's obviously not all mental health. Most people who have mental illness are more likely to be a victim of violence than to be perpetrators of violence, and that shouldn't be forgotten. On the other hand, clearly, mental health has been a factor in some of these really horrible shootings. And don't forget, and we've talked about this before, more than half and in some years, closer to two-thirds of gun deaths are suicides. So one would hope that some of the provisions in this bill will address that. And domestic violence is also ... when you say gun violence right now, all of us think about the mass killings. You know, we think about Uvalde and Buffalo and Las Vegas and Pulse and Columbine.

Rovner: Right. The random shootings of strangers.

Kenen: And they're more common than they used to be, and they're horrible, and they've affected our whole society in many ways. But if you look at the numbers of deaths, and this bill won't, we'll never know if it stopped one or two, right? It's like public health, when you prevent something, you don't see it. So is there somebody who, because of their juvenile record, won't be able to get a gun and commit a mass murder? Maybe. But it would be hard to see it, because it'll be something that didn't happen. But we might see a decline in domestic violence. I would hope that we would see a decline in suicide. It's not going to go to zero. But people who take pills often survive. But people who shoot themselves in the head generally do not. So, gun violence is a lot of different things, and this bill certainly won't solve all of them or even address all of them. It doesn't. But in terms of how many people die a year, I think that people feel like this is not perfect but useful. Modest but not insignificant.

Rovner: A step that the Senate certainly hasn't been able to take until now, for as hard as a lot of people have been working on this. Well, while the Senate moves painstakingly slowly on this bill, the House is getting into its summer busy season. On Wednesday, the House passed its own mental health package, as Rachel mentioned, along with a bill regarding the new health agency,

ARPA H. And it would house that agency outside the National Institutes of Health, which is not what the administration wants. This is one of those interesting little spats with potentially some important impact, right?

Cohrs: Yes. Congress is essentially defying the administration. And [Health and Human Services] Secretary [Xavier] Becerra, who created the entity already and appointed ... I think it was a deputy director. So it's already in process. So I'm not entirely clear if Congress gives them different instructions what the resolution of that conflict might be. But I think it is a symptom of lawmakers not feeling heard. And congresswoman. Anna Eshoo is not backing down. So, yeah, we'll see.

Rovner: Yeah, and when you're in charge of an important subcommittee, you can do a lot of things that you would like to. Well, we'll see what happens with this in the Senate. But I'm sure we will talk more about ARPA-H as it starts to do things. Well, as I mentioned at the top, there's still no official word from the Supreme Court on the abortion case, but that doesn't mean there isn't abortion news this week. The latest state to flip-flop on abortion is Iowa, where just four years ago, the state Supreme Court ruled that abortion *was* protected by the state's constitution. But now, with different justices on the state high court, they've changed their minds. It makes me wonder, if the Supreme Court does overturn *Roe v. Wade*, could we see this happen in other states where abortion rights seem to be protected by state constitutions? And if there is an abortion rights backlash, could we see the reverse happen in some states, where you get new members on the Supreme Court and they decide the other way? You know, that maybe their state constitution actually does protect abortion rights. I mean, it seems that this is opening up a whole new venue to fight about abortion.

Kenen: I think there's going to be infinite venues to fight about abortion. If I'm remembering this correctly, Florida has some language that was perceived as protective of constitutional rights, and the court there just said, no, it isn't. I mean, none of us have read 50 state constitutions, since we're all sane people. There may be some other stuff that crops up in some of these states, but once there are enough precedents out there to say "This is not a right," and we know what the state legislatures look like in those states, they'll find ways of defining things to limit it. I don't see that even that protection in a red state, should it be upheld, will necessarily translate into a whole lot of access. It might prevent a total ban, but not necessarily.

Rovner: You know, I'm wondering if we'll just see in microcosm the way we have, you know, what we've spent most of today talking about things that, well, can the federal government do this? Will the courts might stop them? Now it looks like we could take it down to, rather than the U.S. Supreme Court, we can have state legislatures doing things and their state supreme courts may stop them.

Kenen: But many of them have shifted to the right over the last few years. Republicans have disproportionate control over not just ... I mean they've won more states, they're in power in more states. They've won control of the statehouses and ...

Rovner: They've worked hard on it.

Kenen: And abortion has been one of the reasons why, and they've been organized for 50 years on this. That's the reality. ... And it's not just Republicans taking over state legislatures; the Republican Party has also shifted to the right. So it's conservative, more conservative Republicans taking over positions of power in the states. I mean, because that's who was elected.

Rovner: Well, meanwhile, because it's June, Congress is starting work on the annual appropriations bills. And this week, the House Appropriations Committee released its version of the bill that would fund the Department of Health and Human Services. And for the second year in a row, maybe the third, the House bill drops the Hyde Amendment. That's 46-year-old language that bans almost all federal abortion funding. The House, which has had an abortion rights majority only since 2019, has twice passed its spending bill without the funding limitation, but it hasn't made it through the Senate. I imagine that whatever the Supreme Court does next week, dropping Hyde isn't getting through the Senate now either, right?

Cohrs: I don't think so. I'm not expecting that dynamic to change.

Rovner: Yeah, it's interesting that the House finally got around to — because it has a bare abortion rights majority — did actually pass the bill without the Hyde Amendment last year. But obviously that did not stick, and one would expect it not to stick this year, although I'll be interested, assuming that the House gets to vote on this spending bill in a couple of weeks, it will be after the Supreme Court rules to see how the votes fall out, if they're any different than they were last year. OK. One final news item following up from last week when we talked about all the science jobs that the president still has to fill. Apparently, acting science adviser and former NIH director Francis Collins has found someone to fill his current temporary job, if not his former one. President [Joe] Biden has announced his intention to nominate Dr. Arati Prabhakar — I hope I'm not mangling that name too badly — to become the next director of the White House Office of Science and Technology Policy. She's the former head of DARPA, the defense technology agency, on which the new ARPA-H that we were just talking about is based. She'd also be the first woman, the first immigrant, and the first person of color to hold the White House science adviser job. Anybody heard any opposition to her? I've only seen plaudits in my inbox.

Cohrs: I think they kind of needed a noncontroversial pick after Eric Lander's controversy. And as someone with actual experience running an entity like this, I think it'll be interesting to see how she shapes ARPA H as well, because I think that is part of her portfolio. You have the cancer moonshot and, I think, pandemic preparedness, as well, in the future was kind of under Eric Lander's portfolio before he departed as well. So I think there are some really prominent science initiatives that President Biden has made a big deal out of publicly that have just been stuck in limbo. So it definitely is progress to get people filling these slots, but there are still open jobs as well.

Rovner: Yes. Like the head of the NIH. But as someone pointed out, she has been confirmed by the Senate before, so one presumes that she shouldn't have too much getting through this time.

Kenen: Well that's no longer ...

Rovner: Yeah, that's not always a guarantee.

Kenen: I mean, look at the court, but this isn't the Supreme Court. I mean, she doesn't seem to be controversial. We have seen other people who've been confirmed in the past who don't get confirmed again or they were confirmed for a lower court and don't get confirmed. This one does not seem to be setting off firecrackers.

Rovner: Yes, I'm sure there will be someone who will complain. Maybe they'll fight about ARPA H over this nomination.

Kenen: They will because it's a money ... there's questions about how to structure, but it's also a question about which state gets it. It's a huge feeding frenzy because it can be a lot of money and jobs. So everybody wants states want to be the home of ARPA-H.

Cohrs: Yes, and my colleague Lev Facher actually pointed out that she was a critic of the plan to put ARPA H inside NIH. So she is actually on Anna Eshoo's side of the debate, against Francis Collins, who she's likely to replace. So that'll certainly be a dynamic that we'll see play out, I'm sure.

Rovner: All right. We will definitely watch this space. All right. Well, that is as much news as we have time for this week. Now we will play my interview with KHN's Noam Levey, and then we will come back for our extra-credit segment.

I am pleased to welcome back to the podcast, my KHN colleague and longtime fellow health policy journalist Noam Levey. Noam, welcome back to "What the Health?"

Noam N. Levey: Thank you. Good to be here.

Rovner: So, Noam is here today to tell us about a new project KHN is launching with NPR and our colleagues over the firewall at KFF on medical debt. And if you think you already know about medical debt, just give us a few minutes. Trust us. There is more. Before we get to some of the eye-popping details, tell us why you wanted to do this project. Don't we already know that medical debt is a serious problem in this country?

Levey: Yeah, I think we do. And Julie, I know I'm sure you've had this experience covering health care over the years. It's not hard to find a patient who's had trouble paying a medical bill in this country. But, you know, one of the things which always interested me was just how big exactly is this problem? Because you see statistics about the number of people who have a medical bill in collections. And I always felt like that's just maybe the tip of the iceberg, because there's so much more ways that people go into debt to try to pay a medical or dental bill. You know, lots of people put their bills on a credit card and then they don't pay the credit card off, or they borrow money from friends or family or, increasingly, people go on these payment plans with hospitals or other medical providers. So, I was really interested in trying to get a sense of just how big this problem is, because I think it's a lot bigger than a lot of people realize.

Rovner: And how did you go about doing that?

Levey: Well, so one of the things we did was do a nationwide poll with our colleagues on the polling side at KFF. And we asked people exactly this question: How much do you owe and how do you owe it? And, you know, that's where we got to these eye-popping statistics.

Rovner: And some of those included ... ?

Levey: One of the amazing things is that about 100 million people in this country have some form of medical debt. That's about 40 — that's 41% of adults — and more than half, 57%, at some point in the last five years. So more than half the country.

Rovner: That's really terrifying.

Levey: It is amazing. And, you know, the thing is, as I mentioned before, there are just myriad ways that people end up going into debt because of a medical bill. One in 5 adults, that's about 50 million people, are on some kind of an extended payment plan to pay off a medical bill with a medical provider. One in 10 have borrowed from a friend or family member who covered their bills for them. And about 1 in 6, that's 42 million people, put a bill on a credit card that they're paying off over time, which often means there's interest and fees on top of whatever that medical bill is.

Rovner: Obviously, if these numbers are so big, most of these people have insurance, right? How is it that they have both insurance and medical debt?

Levey: That's one of the amazing things, is I think people thought before the passage of the Affordable Care Act in 2010 that our medical debt and affordability problem was fueled mainly by the fact that so many people didn't have health insurance. But, you know, 90% of Americans now have health insurance in large part because of the ACA. And I think it's important to note also that without the ACA, this problem probably would have been worse, because people who lack health insurance do have more problems with medical debt than those who are insured. But the remarkable thing about medical debt in America is, exactly as you said, it extends everywhere. And having health insurance is no guarantee that you're going to be able to afford what you get charged if you go to the hospital or the physician's office. And, you know, the reason for that, Julie, is private health insurance has undergone this fundamental transformation over the last couple of decades. And it's sort of like the frog in the soup pot. It slowly, slowly happened. And what's ended up happening is that many, many, many of us have ended up getting shuttled into these high-deductible health insurance plans that can require a thousand, $2,000, $5,000 or even $10,000 for a family plan. A $10,000 deductible that requires people to pay all this money out-of-pocket before their health insurance kicks in. That's just proven to be a recipe for disaster.

Rovner: So what does it mean to these people who are carrying this debt? I mean, we do our “Bill of the Month” project and we hear about the people with these gigantic six-figure eye-popping bills. But there's an awful lot of people who are struggling to pay off four-figure bills, right?

Levey: You know, one of the things which we did for this project was interview scores, more than 100 people, I would say, I've talked to over the past year for this project around the country. And I can't overstate just how much suffering there is out there. Yes. We hear these stories of, you

know, a $100,000 bill that end up on the morning news or in our “Bill of the Month.” But even a small bill can be devastating. You know, I interviewed one young woman, a medical student in Texas, who was pursued for years for a $131 bill for a rape kit exam that she had undergone after a sexual assault years earlier. I talked to an elderly couple, a retired couple in rural Virginia, who saw their retirement completely upended when she needed colon surgery and ended up with more than $700,000 in medical bills because her health insurance plan was exhausted. They had to declare bankruptcy. We talked to a family in Chicago. The mom is a nurse practitioner. The husband runs a small nonprofit, solidly middle-class, had health insurance. And when their twin boys were born 10 years ago, they came prematurely, and they ended up in the NICU [neonatal intensive care unit]. And the family got hit with about $80,000 in medical debt. They had to load up their credit cards, they borrowed from their family. They actually moved across country to be closer to family, to cushion the financial blow. And the mom had to take on extra nursing shifts when her kids were babies to pay down this debt. And we just don't hear these stories. I think people suffer in many cases in silence or they just ... [it] becomes something that we expect that when we go to the medical office or the hospital, we're going to get bills that we can't pay, and we're just going to have to figure out a way to get by. And there's just an enormous amount of that going on around the country.

Rovner: I know you and I have both traveled overseas and get a look at other countries’ health care systems and people shake their heads in wonder at the idea of medical debt because no other industrialized country, no matter how they organize their health care system, has this. ... And yet you've found that there's an entire industry now to collect medical debt.

Levey: There is. And you're right, Julie. I mean, nobody else does it this way. I still remember sitting in a doctor's office in the Netherlands a couple of years ago and interviewing the patients after they came through and asking them whether they were worried how much the visit was going to cost. And I joked with people when I got back that I might as well have been asking them what their pet penguin was like. I mean, they looked at me like I'm crazy. I mean, other countries don't even measure medical debt. It's not a question that the German federal government asks on its surveys of economic well-being. Meanwhile, as you said, in this country, it's fueling this entire industry that's dependent on people's inability to pay their medical bills. So, hospitals now and doctors’ offices and dentists’ offices are oftentimes directly shuttling their patients into these credit products. Some of them are credit cards, some of them are loan products. They oftentimes have interest rates at 5%, 10%, even higher sometimes. So essentially, the health care industry has now gotten into bed with the credit industry to move the people that they “care for,” quote-unquote, into debt more easily.

Rovner: When you're selling things that are as expensive as cars, you’d better have the financing like you do for cars.

Levey: That's exactly right. Although, you know, one might say that there should be something of a difference between selling somebody an SUV and taking care of them when they have cancer.

Rovner: Yeah. Well, Noam Levey, I’m looking forward to the rest of this project. Thank you very much and thanks for joining us.

Levey: Thank you, Julie. Good to be with you.

Rovner: OK, we're back. It's time for our extra-credit segment, where we each recommend a story we read this week we think you should read, too. Don't worry if you miss it; we will post the links on the podcast page at khn.org and in our show notes on your phone or other mobile device. Joanne, why don't you go first this week?

Kenen: I picked a story from an organization called Fern, the Food and Environmental Reporting Network, by Nancy Averett, and it's called "Back Forty: How to Protect Farmworkers From Heat-Related Kidney Disease." It's a coincidence that we're talking kidneys twice in one episode, but it turns out that excessive heat — and they're out in it for hours, including the hottest parts of the day — puts even young and healthy farmworkers at risk for serious kidney disease. So it used to be only seen in Central America. It's now seen in the U.S. They don't understand why it hits some populations more than others, but they're exposed to greater heat for longer, hot, hot, hot seasons. It is being seen more. And there were also some very small studies, but some very simple interventions, including just wearing a wet headband, that seemed to have helped — kept the core body temperature lower and protected them. So it was something I knew nothing about. Seems really important and getting worse and maybe had solutions. So it's a good piece.

Rovner: And maybe keep some people off of Medicare in addition to not having them end up needing kidney dialysis or worse. Rachel.

Cohrs: Yes, so the story that I chose this week is headlined "Facebook Is Receiving Sensitive Medical Information From Hospital Websites," which is published by The Markup and co-published by Stat as well, by a team of four reporters who just had this really fascinating investigation on whether Facebook tracking tools are actually collecting information from the websites that patients will use, like the patient portals to make appointments and that kind of thing and maybe ask questions. And I think there is this really fascinating gray area as to whether that sensitive medical information is being transmitted to Facebook and how they might be using it to target ads and whatever they might be using that data to do. And I think it was really just a meticulous, well-done investigation that showed that there are some really prominent medical centers that we're talking about: Johns Hopkins, UCLA, NewYork-Presbyterian that have these tracking tools. And I don't know that patients would be necessarily expecting when they're making their appointments that their data could end up in places that they weren't expecting. So I thought it was just really well done. And it's just a really fascinating issue going forward as more scheduling happens on patient apps, patient portals, and websites as opposed to a phone call or in the office.

Rovner: And I should point out that this is separate from the taking the information from the check-in software that we talked about last week. So, I mean, there's an awful lot that's going on behind the scenes with your medical information that you think is being protected by HIPAA but isn't always. I'm sure we'll see more. It was a very eye-opening story.

Kenen: Well, also, once anything is downloaded out of the hospital, HIPAA is only within the health system. Once it's outside of the cyber equivalent of the four walls of the hospital, it's just out there.

Rovner: Yes. All right. Well, my story this week is an AP story from Jennifer Peltz called "At Westminster Dog Show, New Focus on Veterinarians' Welfare." And yes, I have spent my free time this week watching the dog show, but the Westminster Kennel Club is doing something new this year, giving a contribution to a charity that focuses on the mental health and well-being of the nation's veterinarians, who are suffering the same and in some cases even more burnout than health professionals who care for humans. A study we talked about a couple of years ago showed that veterinarians had a higher rate of suicide than the general population, and that was before the pandemic cut off most of them from face-to-face interaction with their human client and increased workloads from people getting pandemic pets to keep them company while they worked from home. When we talk about health worker burnout, we need to remember to address all health workers.

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, as always, to our producer, Francis Ying. We honestly couldn't do this show without him. 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. Rachel?

Cohrs: @rachelcohrs

Rovner: Joanne.

Kenen: @JoanneKenen

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