KHN's 'What the Health?'
Episode Title: Life After 'Roe' Is ... Confusing
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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, July 14, at 10 a.m. Happy Bastille Day to those who celebrate. 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 Sandhya Raman of CQ Roll Call.

Sandhya Raman: Good morning.

Rovner: I hope you all enjoyed last week's special episode, my discussion with Surgeon General Vivek Murthy. This week, we'll try to catch up with the news that's happened since the end of June. And we will start with abortion or, as I'm calling it, "Life after *Roe*." Things in the states are — not to put too fine a point on it — chaotic. State abortion bans are being unblocked, blocked again, and re-unblocked faster than I can count. Just in the last 48 hours, Louisiana's ban was again put on hold, as was Utah's. But in Utah, a *different* ban, after 18 weeks, is in effect, at least as far as I can tell. Alice, how are patients and doctors, for that matter, supposed to know what's legal and what isn't from day to day and hour to hour?

Ollstein: Right. There's a lot of whiplash right now and a lot of confusion. And I especially have been hearing from folks in Louisiana where it's gone back and forth, different court rulings one day and the abortion clinics can reopen, [then] one day they have to close again. And because the patients book appointments weeks out, there's just so much chaos and uncertainty. So we are already seeing a high amount of travel. We are already seeing a high demand for ordering abortion pills online, including people doing that in states where they're not allowed to do that by law. And so all of this we predicted was going to happen. So I think what's interesting for us to watch is: Are there going to be actual attempts to prosecute people, or these laws are mainly designed to intimidate and have a chilling effect so people don't attempt these things in the first place, like traveling out of state, like ordering abortion pills online?

Rovner: I'm also wondering what it's doing to just access and access to other services. I'm seeing notes from abortion clinics — they're going to pack up and move. Eventually, these bans are going to take effect, so they're going to want to move to states where they can continue to serve patients, where it's legal. But then I wonder about women left in these states who, if Planned Parenthood picks up and moves — although I don't think they're one of the ones that tends to move — but women who are getting non-abortion services from some of these providers who are suddenly not going to have providers available.

Ollstein: Right. I wrote about this a few weeks ago, and it's just a real mix of abortion providers that are planning to move, or already have, to a different state. There are ones that plan to stay no matter what and just provide non-abortion care. Also, a lot of the people I talked to who plan to stay no matter what said that because of these exemptions for emergencies, saving the life of the patient, they are worried that if

they move, there won't be anyone left who knows how to do that, when this is really specialized training that they spent years and years developing. And not a lot of people have that training and they worry that if they move to a different state and somebody does have one of those medical emergencies, they'll be the only one with the ability to provide that care and save that person's life. But moving and staying also aren't the only options. You have people who have already been living full time in one state but traveling periodically to another state to provide abortions. That is set to increase. You also have people who live in one state but provide via telemedicine abortions in another state where it's legal, if they are licensed in both. And so I think you're seeing a real range of people moving, people staying, people doing the part-time thing, people doing the telemedicine thing. And it's creating a lot of upheaval. And there are concerns that it's going to create even worse maternal health.

Rovner: Outcomes.

Ollstein: Outcomes, and deserts in in places like Texas, where it's already a big issue.

Raman: Alice brings up a really good point with the specialized training because, you know, we see this now where there are people fleeing, but it also affects folks going to medical school or [becoming] another kind of provider, And they live in a state where they're not able to get that kind of training. Regardless of where they go after they finish their training, they won't have the expertise in that, even if they would want to work as an abortion provider or anything related to that. I mean, that's something that you wouldn't see for years from now, and it's already going to be affecting a lot of states.

Rovner: Yeah, I mean, OB-GYNs who specialize in high-risk pregnancies need to know how to terminate those high-risk pregnancies when things go wrong, even though their specialty is delivering babies and ... delivering wanted babies. I mean, they're not becoming, quote-unquote, “abortionists.” They're becoming obstetricians trying to deliver babies. But the point of having a high-risk specialist is that sometimes things go wrong. I told this story before: A bunch of OB-GYN residents reached out to me a couple of years ago when Iowa was about to ban abortion, and then that story went away temporarily because the Iowa state Supreme Court ruled that the Iowa Constitution protected abortion, which then the Iowa state Supreme Court has now ruled the other way. But there is a lot of concern among training programs. So now I'm going to add another layer of complication to this: The landscape for employers who want to offer abortion coverage is — not to put too fine a point on it — a mess. My KHN colleague Julie Appleby has an excellent roundup that basically comes to the conclusion that whether your insurance coverage includes abortion depends on way more than whether it's legal or illegal in the state you live in. This is just going to be one gigantic series of lawsuits, right?

Raman: It's already appearing like it's going to be. I mean, over the past few days, we had in Texas, the Texas Freedom Caucus, which is a bunch of conservative state lawmakers, had warned Sidley Austin, which is one of the biggest law firms in the country — they said that funding travel for your employees to get abortions doesn't fly. We're going to go after you for that. And they introduced a pretty wide-ranging bill that would penalize employers and individuals for reimbursing anyone to have an abortion out of state. And that’s just one company, and one state. You know, it's ...

Rovner: I'm fascinated that they're going after a law firm — and a big, powerful law firm.

Raman: Yeah, that's just one little slice of it. I mean, it depends. You work for a large company versus a small company. If they are going to reimburse you, do you already have the funds ahead of time to pay upfront? Because, as we know, a lot of abortion in low-income communities and just ... you might not have the funds to do it if you are a low-wage worker. And then there's the other layers of just, you know, IRS [the

Internal Revenue Service] sets the rates on what you can be reimbursed for gas and hotel and everything like that. And is the provider out of state, out of network? Have you hit your deductible? There's just so many layers and so many things that can complicate the situation even more.

Rovner: And there are states that require abortion coverage as part of insurance and states that ban abortion coverage as part of insurance coverage. And your employer may be in one of those states and you may be in a different state. ... It's making people and in-house lawyers, I think, start to rip their hair out.

Luhby: And one other issue that ... one of my friends who's in HR [human resources] told me is even for a company or an employer that's based in New York, for instance, where it's legal, they have dependents all over the country. And the dependents can often be young, you know, college-age or just after college women who may be in need of these services. So that adds another layer of complication, even for employers who might be largely based in states where abortion remains legal. One other issue, a story that I wrote about last week, was the privacy issue. So when the slew of employers started announcing that they're going to offer this, a major question was sparked, which is: Great — but then do I have to ask my boss, like, will you pay for me to travel for my abortion? You know, generally the answer is no. I mean, it's pretty certainly no, particularly if the benefit is administered through the company's health plan or a health reimbursement arrangement or an employee assistance program. The Health Insurance Portability and Accountability Act of 1996, otherwise known as HIPAA, protects the privacy of patients' medical activity for both care and travel. But some companies are discussing setting it up as a taxable reimbursement program. And that could potentially lead to some issues because the employer may want to verify the expenses, but then also has to maintain the worker privacy. So I think it is important that those who ... employees who want to be able to use this really understand what the benefit is and what will ... they'll be able to access.

Rovner: Yes, this has definitely not been made simpler by the Supreme Court — one of those places where it just raises so many more questions than it answered. So let's turn to the Biden administration, which was apparently caught unprepared for the overturn of *Roe [v. Wade]*, even though it only came a week ahead of when just about everyone on both sides thought it was going to happen. They're now trying to play catch-up. President Biden gave an impassioned speech last Friday and issued an executive order that didn't really seem to do very much, did it?

Ollstein: Yeah, and I think that has been even more evident in the follow-up actions we've seen to signing the executive order, because a lot of the executive order was directing various agencies to explore doing certain things, which sort of begs the question: Why didn't they sign the executive order the day of the ruling, have it ready to go? So the agencies have been exploring those things and came out with a couple of actions this week, but they are mainly aimed at reminding people of their obligations under current law.

Rovner: It does seem that the administration is starting to take some more concrete action. On Wednesday, HHS [the Department of Health and Human Services] issued a reminder to pharmacies around the country that failing to fill prescriptions for drugs that could be used for abortions but that are also used for other ailments, is a violation of the Affordable Care Act. This appears to be in response to a story in the L.A. Times about people with lupus and other autoimmune disorders losing access to methotrexate, which is the gold standard for many but can also be used for abortion. Who could possibly have seen people *not* seeking abortions being hurt by changing abortion policy? That's a rhetorical question. Alice, what else has the administration done?

Ollstein: So they also issued guidance telling hospitals and doctors around the country that they have the obligation to treat someone facing a medical emergency when the treatment is an abortion needed to stabilize the patients even — and they are saying that that's true even if the state has an abortion ban.

They're saying federal law trumps state law. You are obligated to do this if your patient needs an abortion, even if your state has banned it. Now, we have been hearing from emergency physicians groups that this is not enough assurance and clarity for them. They're still afraid of being caught between state and federal law when there's this conflict. And there's still not a lot of clarity about who gets to decide what constitutes a medical emergency. Who gets to decide what stabilization means in different contexts? And I've heard the same with the pharmacy guidance as well. So still a lot of conflict ahead.

Rovner: So, meanwhile, the Justice Department is launching a reproductive rights task force that will bring together lawyers from across the department, among other things, to try to protect providers in states where abortion remains legal and women who travel to those states from being prosecuted by states where abortion is restricted or banned. The Supreme Court, in its majority opinion, said they were taking this issue out of the courts. But exactly the opposite is happening, right?

Raman: I think that the number of lawsuits that we've already seen and the ones that we're going to see is just multiplying. And I think that goes back to why, I think, maybe the Biden administration has not acted in some of the way that progressives and abortion rights advocates have been calling for, because they are in a legal pickle if they act too fast on something that will definitely be litigated. It could just work its way back up to the same Supreme Court, nine justices that just overturned *Roe v. Wade*. So I think that they're likely being cautious because some of the things that have been suggested are, like, new legal territory. This week, some of the House Democrats, it was Lloyd Doggett and Lizzie Fletcher — both Democrats from Texas — had asked the administration to declare a public health emergency ... a national emergency. And then other folks, I think Elizabeth Warren and others in the Senate, had asked to use federal lands to be a place where people could administer an abortion or have, like, a mobile clinic. And those are things that will definitely be litigated. And you don't know how they'll rule because it's all very new territory. So I think that that kind of puts them in a bind if even this is something that they're calling for. You don't really know how that will play out and if it could worsen the situation for them.

Ollstein: You know, Sandhya is absolutely right. But a lot of abortion rights advocates say it's still worth trying. Even if it is ultimately struck down by courts, it's still worth attempting. People are being harmed right now. This is an emergency and we do not see the same sort of hesitation on the right. The right has attempted many, many things to try to outlaw abortion, many of which were blocked by courts. But they tried enough things that eventually they got what they wanted. And so the left is looking for a similar aggressiveness that they are not getting from this administration.

Rovner: And we should point out that a lot of these lawsuits are not happening at the federal level because those bringing them know that if they were to get to the Supreme Court, they would likely lose. So they're bringing all of these various lawsuits in state courts and hoping to ... we're having 50 different litigation strategies going on. But meanwhile, the one place where something really could change, in Congress — Congress is looking at this. But, Sandhya, what are they actually trying to do, if anything?

Raman: Capitol Hill is trying 50 different things and hope something sticks, but very limited in what they can do because of the Senate filibuster and that they are not going to be able to get 60 votes on either side. But just like this week, there's so many things happening. There have been several hearings. You know, we had Senate Judiciary look at *Roe*, we had Senate HELP [Health, Education Labor & Pensions], House Oversight [and Reform]. Right now, while we're talking, a House Judiciary is also looking at it. And one of the big talking points, Republicans, is that they've been very much focused on: the physical violence that's been happening to pregnancy centers rather than, I think, what Democrats have been ... talking about is, like, the broader impact on reproductive health. And then tomorrow, Friday, we would have the House is going to vote on two big abortion rights bills. One, the Women's Health Protection Act. They have ...

Rovner: The one they passed already ...

Raman: The House has passed before, yes. The Senate has not been able to clear, like, a procedural vote twice. And then the other bill they're voting on is a right-to-interstate-travel kind of thing just to protect someone going from one state to another to seek an abortion. And that's a little bit newer than something that we've seen before. And the Senate actually is voting on a similar one around now, too. Or they're going to ask for a meeting and said that that will likely not happen in the next few minutes. But that's from [Sens. Patty] Murray and from [Catherine] Cortez Masto.

Rovner: I'm interested, though, I mean, that's kind of a different ... obviously, it hasn't been relevant before, which is why we haven't seen it. But I'll be interested to see, you know, particularly some of these Republicans who support abortion rights, Susan Collins and Lisa Murkowski and some of the Democrats who are not fully into abortion rights: Joe Manchin, thinking, and Bob Casey [Jr.] from Pennsylvania.

Ollstein: Sure. Just to say, though, what Sandhya said about, you know, they're asking for unanimous consent so we actually won't get a roll call vote, in all likelihood. We won't get to know if Susan Collins, Lisa Murkowski and Joe Manchin are ready to vote for this. And I also think that the fact that the bill was introduced on Tuesday and is getting a vote on Thursday shows that there was not really a robust effort to cobble together the votes needed to actually pass it. They are trying to shine a light on this issue, but I think that speaks to how stuck they feel in actually making something like this law.

Rovner: Yeah. So mostly they're just yelling at the administration for not doing things that the administration can't do. So coincidentally, and the company insists this is a coincidence, the France-based pharma company HRA this week filed the first-ever application with the FDA for an over-the-counter birth control pill. This is something women's health advocates have been talking about for decades. Alice, you wrote about it. Why now and what difference might this make?

Ollstein: So the timing with the fall of *Roe* is somewhat coincidental. The pharmaceutical company has been working with the FDA for years, more than six years, to get this application done. In order to file an application to convert something from prescription to over-the-counter, you need to do years and years of studies on thousands of people showing that the average person can pick up this medication, read and understand the label and instructions, self-screen. You know, if it says this is bad for people with X, Y, or Z condition, are people able to be like, “Oh, I have that. I probably shouldn't take this then.” And then actually take it correctly. And so the company feels like they have this really good evidence that all of that is true, that this can be sold safely over the counter, and now it's before the FDA. And this is a slow process. It's been slow leading up to this point, and it's going to continue to be slow. We're probably not going to see a decision until well into next year.

Rovner: Yeah, getting Plan B over the counter, the morning-after pill, was a saga that took, I think, 13 years, if I remember correctly. The FDA takes its time with things like this. And obviously this is, you know, this is a big deal. I saw somebody on Twitter saying, well, you know, birth control pills are safer than Tylenol. And it's like, yeah, but Tylenol is really pretty dangerous. Maybe it shouldn't be over-the-counter. These aren't necessarily efforts to hold things back. This is the FDA being really concerned about drugs that can have bad side effects and that should be taken with the oversight of a medical professional.

Ollstein: Right. And I also, I think the biggest fight is going to be over whether this is over-the-counter for everyone or only people over a certain age. The pharmaceutical company and the advocacy groups pushing for this drug to go over-the-counter want there to be no age restrictions. They want this to be available to adolescents, to prevent teen pregnancies and whatnot, especially because putting it over-the-counter helps

people who are on their parents' insurance and don't feel safe telling their parents that they want to go on birth control. But I imagine that there will be a lot of pushback to making it available to everyone without any age restriction. So I anticipate that to be the area of the most fights.

Rovner: Just the fight we had over Plan B.

Ollstein: Exactly.

Rovner: Literally just the fight we had over Plan B for years and years and years. All right. Well, let's go back to Capitol Hill, because Congress is back, sort of. Majority Leader Chuck Schumer is still home in Brooklyn, quarantining with covid. And if Congress is back, so are the negotiations over the Build Back Better budget reconciliation bill, which I am now calling the Build Back "a Little Bit" Better bill. When we last tuned in to this saga, West Virginia Sen. Joe Manchin said he was enthusiastic about lowering prescription drug prices but wants at least half the money raised from that and closing some other tax loopholes to go to deficit reduction, so it's not further fueling inflation in the economy. What does that mean for the fate of extending the temporary subsidies for the Affordable Care Act — without which premiums will skyrocket and voters will find out about it just as they go to the polls in November?

Luhby: Well, yesterday's inflation number coming in hotter than expected at 9.1 does not bode well for the bill in general and adding anything beyond Medicare, drug price negotiations to it. And yesterday, Manchin was asked about this, and he said he was very, very cautious about passing anything beyond a proposal to curb Medicare drug prices. And, you know, he said it depends on if we can look at things and find a pathway forward that's not inflammatory. So, the loss of the subsidies may become very inflammatory to some people, but we'll see. The path is getting harder and harder as the CPI [Consumer Price Index] numbers continue to rise.

Rovner: Yeah, I mean, Congress is sort of between a rock and a hard place here — Democrats, in particular. If they don't continue these subsidies, there's going to be a bill to pay at the polls. And if they do continue these subsidies, it could, I mean, we are starting to see inflation in health care pick back up again. It had been slower than inflation and things like, you know, food and energy. But there was a big spike in health care inflation this last month or two also.

Luhby: And we're also seeing rates — you know, the insurers are starting and states are starting to release rates. So the numbers are starting to rise again in the double digits. You've got the loss of the subsidies, plus the increase in premiums, which could be very bad news in November.

Rovner: So even with the subsidies, people will likely see their premiums go up. Or do the subsidies take away the premium increases?

Luhby: No, the subsidies will protect them.

Rovner: Oh, that's true.

Luhby: So if subsidies aren't there ...

Rovner: The premiums will go even higher.

Luhby: Right. They're not going back to what they paid in, like, 2021 or 2020. They're going to be going back to much higher premiums at least, you know, and we don't know exactly. They're not finalized yet. We'll see what the states actually do. But the insurers, because of inflation and labor costs and other things, and hospitals are pushing for more higher reimbursements and insurers are pushing for higher premiums.

Rovner: I remember — when this all fell apart in December — I remember everybody said, Oh, well, they can do it next year. Well, now it's July. And I'm starting to see you know, as you point out, Tami, these insurers are starting to file their rates for next year. And, at this point, those premium subsidies aren't there. So ... they can't do this on Sept. 30, in other words.

Luhby: And the states that run their own exchanges have been sending up flares for the last several months, saying, you know, we have to start notifying the members and putting out literature and such. And we can't just turn around and ... CMS [the Centers for Medicare & Medicaid Services] has said the same thing for the federal exchange. It's, you know, they did it in April of '21 when the subsidies came in, but it's going to be harder for them to do it now on a new rate year.

Rovner: Well, now they're saying they would like to do this before the August recess, but it is July 14. We have two more weeks.

Luhby: Yeah. That's basically what the exchanges are telling them.

Raman: It's not going to be pretty.

Rovner: Yeah. Well, also back this week, an even less welcome than Congress is covid — specifically, the BA.5 omicron variant, which is *the* most contagious version yet, possibly as contagious as measles, which is really, really contagious. The Biden administration has authorized second boosters for all adults instead of just those over 50 or at high risk. And the FDA on Wednesday, at long last, approved the Novavax vaccine, the first new covid vaccine in more than a year. The hope is that the availability of the Novavax shot, which is based on more conventional technology, rather than the mRNA technology of the Pfizer and Moderna vaccines, might convince some holdouts to get vaccinated. On the other hand, the Novavax vaccine, like the others out there, is based on the original version of covid, which doesn't seem to work as well against the newer variant. So where does that leave us with covid right now? You know, every place I go, people are still acting like it's over.

Ollstein: Well, I think that they're also taking cues from our elected officials on this one. You know, we are in a surge right now. We have a new variant that is more immune-evasive than the previous ones. And yet we don't really have any new strategies. We are basically doing what we've done before, in terms of making vaccines available, sort of halfheartedly, encouraging masking, but not requiring it. And there doesn't seem to be a big push to reach out to unvaccinated populations. I will also say that now that vaccines are available for very young children, the pace of those families getting those shots is low. We're hearing a lot of anxiety that families are not getting their very young kids vaccinated, even though that's a possibility now. So, I think that it's not surprising that people are not paying attention to the pandemic because it doesn't seem like the government is, either.

Rovner: Yeah, that seems to be a fair way to put it. Well, meanwhile, I thought we should catch up on some other important health policy news that we didn't cover because we didn't do news last week. First, on July 1, new price transparency rules took effect for insurers. The good news is your insurer is now required by federal law to tell you the prices it has negotiated for various health care services. The bad news is that even if insurers do comply — and we've talked at some length about how hospitals, whose requirement kicked in earlier, have simply been ignoring it. Many insurers seem to be doing so in ways that are still pretty untransparent for the average consumer by posting reams of user-unfriendly data. So how much difference are these rules are really going to make? I mean, in theory, you should be able to go figure out how much something is going to cost you before you get it. That's the idea. But in practice, maybe not. We have a lot of people who're waiting and seeing. All right. Well, along the same lines, although not part of a

new law. Also on July 1, the three major credit reporting agencies said that they'll stop including medical debt as part of your credit report. But there's a catch, and it's kind of a big one. Tami, this is your extra credit this week. Tell us what will and won't happen with medical debt and your credit.

Luhby: OK. My extra credit is a Wall Street Journal story by — and I'm sorry if I butcher this name — Ayse Kelce, and the headline is titled "Medical Debt Is Being Wiped Off Credit Reports. What That Means for You." And so, as Julie said, the three major credit reporting bureaus — Equifax, Experian and TransUnion — have removed medical debt that went into collection but were then paid. Previously, these debts could remain on credit reports for as long as seven years. And this is important because credit reports are important when people apply for loans, go to rent an apartment, a lot of different things. And removing the traces of these debts, which [have] been paid, will make it easier ...

Rovner: That's the catch.

Luhby: Right. ... will make it easier for people to pass credit checks. So this is actually the first of a few steps that credit reporting bureaus are taking concerning medical debt. Starting next year, all medical debts of up to $500 will be removed from credit reports. Now, these two changes will eliminate about 70% of the approximately $88 billion in medical debt that currently shows up on the credit reports of 43 million Americans, according to the Consumer Financial Protection Bureau. And then another measure that's kicking in next year is that unpaid medical collection debt won't appear on credit reports for the first year, instead of just six months. And that will give people more time to work out the bills with their health insurers or their providers, because, as we know, it's not always that simple a process. And the provider may say, or the insurer may say, you didn't pay the bill and that's actually not the case. So the CFPB's director, Rohit Chopra, has been very critical publicly of medical debt collections by credit reporting agencies. And also, interestingly, the bureau's research has found that unpaid medical debt isn't a very good predictor of overall credit worthiness. And FICO, which has some of the most widely used credit scores, also found that paid medical debt is even less predictive of a person's ability to pay their loans or repay, more than unpaid medical collection debt. But one thing that I found most interesting in the story is that the reporter said that the CFPB has found that collectors often have so little faith in the accuracy of the data that they will delete debts from their systems as soon as consumers question the accuracy of the bill.

Rovner: Baby steps. Baby steps, baby steps, I think, both on transparency and medical debt. All right. Well, while we spent most of our time the last few weeks talking about the Supreme Court's abortion decision, that was not the only health decision that came down at the end of the term. First, the high court made it harder for prosecutors to go after doctors accused of overprescribing opioids or other controlled substances. And there was a complicated case about a program called 340B that requires drugmakers to provide discounts to some buyers who serve low-income and uninsured patients, in this case hospitals. Tami, you wrote about this case. What's the takeaway here?

Luhby: Interestingly, the justices actually said that HHS has acted unlawfully in the 340B case in how it was varying the rates. So, at issue was the department had set Medicare reimbursement rates for certain prescription drugs in this 340B program, and the hospital industry then challenged this. It's all ... revolving around a Trump-era rule that reduced the rates to safety-net hospitals. The 340B program requires manufacturers to provide hefty discounts on certain drugs sold to safety-net hospitals. But starting in 2018, HHS cut the reimbursement rate for hospitals in the 340B program by nearly a third, but maintaining the higher rates to other hospitals. The agency argued that the 340B hospitals were able to generate significant profits under the system. So the hospitals countered, of course, saying that the funding helps offset the costs of treating the uninsured and underinsured in low-income and rural communities.

Rovner: Which is kind of what it's for.

Luhby: Exactly. And they said that Congress never said that 340B hospitals should be reimbursed less for outpatient prescription drugs. Now we're talking big money here. This change in rates has cost 340B hospitals an estimated $1.6 billion in Medicare funding annually. And actually, of course, after the ruling, a trio of hospital and medical college industry groups said they look forward to working with HHS and the courts to develop a reimbursement plan.

Rovner: I guess the most important thing here, though, I guess, is what the court didn't do, which is that there was some concern that this was going to be one of those cases where the court really undercut the administration's ability to do things. I mean, to regulate things like this. And this was one of those cases where they could have taken a swipe at it and apparently didn't.

Luhby: Right. And they did later in the EPA [Environmental Protection Agency] under a different type of ruling. But, yes, there was a concern that it would limit agencies' ability to interpret congressional rules. And that did not happen here, even though it was a narrow ruling. And it said that HHS did not act properly, but did not say that they were unable to act. Yeah, it didn't limit the agency's power.

Rovner: Maybe they're saving that for the next term. All right. Well, that is the news. Now 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. Tami, you've already done yours. Sandhya, why don't you go next?

Raman: All right. My extra credit this week is called "The Great Veterinary Shortage" from Sarah Zhang at [The Atlantic]. And I thought this was so interesting because I think we all focus so much of our energy on just human health. And this is, you know, the other — something that I don't generally look at and I don't think a lot of people do either, but it looks at ...

Rovner: I do!

Raman: I do love animals, too. OK. So it looks at the vet shortage and the struggles that have been building to find care for your pet. And the vet shortage is evergreen, kind of like human providers, where there's never enough, especially in specialties — and that also that the pandemic worsened it. And so it's the perfect storm of just, you know, more people were adopting pets during the pandemic and also more people leaving the fields. And again, the specialty issue was similar to humans. The emergency vets were especially scarce, which requires specialized training. And she points out the vet techs are underpaid and that causes another issue. And then there's just there's burnout among vets that's a lot higher than a lot of other fields, which is something I didn't know. And so I thought that was something really interesting and definitely has a lot of parallels to just the stuff that we look at about humans.

Rovner: Yeah, a couple of weeks ago, a reminder, my extra credit was a piece about veterinary mental health because it is a really serious burnout issue. Alice.

Ollstein: So I have a piece in NiemanLab which is sort of a media analysis piece by Laura Hazard Owen about the horrible story that surfaced this week about the 10-year-old in Ohio who had to travel to Indiana for an abortion after being raped. And when the story first came out and the source for the story was the abortion provider and there were not yet other sources confirming the story, a lot of conservative activists and officials, as well as a fair number of mainstream media voices, rushed to question the veracity of the story. And now we have more corroborating information. An arrest has been made in the case, and those folks who said the story didn't appear credible have sort of had to eat their words. But this piece I wanted

to share is about how in a post-*Roe* world we are going to encounter a lot more stories like this. And we need to be better prepared as reporters and think differently about sourcing. When it comes to a child sexual assault victim, it makes sense that folks are not going to share additional details that could put the child in further danger. There is a lot of privacy protections around something like this. It was also problematic that The Washington Post fact checker labeled the abortion provider an "activist." She is a doctor who provided a medical treatment. So I think it's just important to really think more carefully about how we report these stories and how we question stories that are inevitably going to surface more now.

Rovner: Yeah. And perhaps local reporters have ethics, too, and they have levels of editors, just like those of us at the national level, and things don't get into papers like The Indianapolis Star without being checked. So I think a lot of people who are really quick to say, "Oh, yeah, this probably didn't happen" — now that the alleged assailant has been arraigned in court, are saying, "Well, now, an alleged assailant has been arraigned in court."

Ollstein: I also have seen initially a lot of people said, "Oh, well, law enforcement hasn't confirmed, so we can't trust it." And now that law enforcement has, I think — and this piece also advocates — that we should be just as skeptical of what law enforcement says as we should be about every other source. They do not have a stellar across-the-board track record when speaking to the press. Some tell the truth; some lie. And we should vet everybody's claims, including law enforcement. So, I just wanted to add that.

Rovner: Yes. The old journalism adage, you know, if your mother says she loves you, get a second source. My story is the latest in our KHN-NPR series on medical debt by Noam N. Levey, who we had on the podcast last month, in case you missed it. It's called "In America, Cancer Patients Endure Debt on Top of Disease." The story is specifically about a mom of two adopted daughters and four other foster children who survived a bout of breast cancer but has been left with more than $30,000 in medical debt — *after* her insurance paid. One debt collector called her while she was still in the recovery room from her double mastectomy. More generally, though, this story is about how people with cancer are among the most likely to end up with medical debt. They were nearly half again more likely to report, as part of the project survey, that they had used up most of their savings, more likely to have spent children's college funds or their own retirement funds on treatment, and more likely to have declared bankruptcy or lost their home to eviction or foreclosure. In other words, cancer patients in the U.S. may have better-than-average medical prognoses compared to those in other countries, but their financial prognoses are much, much worse.

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, as always, to our producer, Francis Ying, without whom there would be no podcast. As always, you can email us your comments or questions. We're at whatthehealth — all one word — @kff.org. Or you can tweet me. I'm @jrovner. Sandhya.

Raman: I'm @SandhyaWrites

Rovner: Tami.

Luhby: @Luhby — L-U-H-B-Y

Rovner: Alice.

Ollstein: @AliceOllstein

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