KHN's 'What the Health?'

Episode Title: Wrapping Up Summer's Health News
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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, Aug. 18, 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: Hi, Julie.

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

Kenen: Hi, everybody.

Rovner: So let us get right to the news because Congress is gone for the rest of the summer, but they left behind lots of health policy. And this week, we'll catch up on a couple of things we didn't get to earlier in the summer while news seemed to be breaking every hour. We're going to start with the Inflation Reduction Act. That's the budget reconciliation bill that is now law, after being signed by the president, who came back briefly from his own vacation in South Carolina on Tuesday. This thing has been literally over a year in the making. Now that it's official, let's have one last review of what's in it. First, drug prices. Just Medicare. Not the private sector, but still an achievement Democrats have been chasing for at least a couple of decades, yes? What exactly would this do?

Edney: It's not all of Medicare. They're not going to be able to negotiate every drug out there. So it starts with 10 in the first year and we're looking out to 2026 for people to start seeing some savings, and then 15 more the next year, 20 more the years after that. So there could be potentially a good amount of savings here, not as much as the Democrats maybe would have hoped originally. But it is something, it is a start. We'll have to see. Pharma obviously is very upset. This was a big loss for them. How will they fight this? They have a lot of time to do that, and they have a lot of time to go to court. So what this will look like once negotiations starts — if it starts — it could be interesting.

Rovner: Are they more upset about the negotiation or are they more upset about the limits on inflation increases?

Edney: That's a good question. I'm not sure which one they're most upset about. Certainly not being able to raise their prices more than inflation, which they do often and a lot, is something of a loss for them as well. With the drug price negotiation, you know, we're talking about it being small and we're talking about potentially ways that the pharma lobby could fight it, but it's also a foot in the door. And so it could become much, much bigger. On the other hand, also.

Rovner: Yes. As I misstated last week, I said that it was “the nose under the camel's tent.” I meant to say “the camel's nose under the tent.”

Kenen: I like the other way better, right! I think that we should remember that not just pharma, all of health care, every single sector, they are geniuses at cost shifting. So when you crack down in one place, they are really good at finding another place. They're not a money-losing sector, as a rule. Right? So right now, they're going to negotiate prices in Medicare. A lot of consumer advocates are worried that they're just going to raise prices out of Medicare. We don't know that that's what they're going to do. But the same thing with inflation — if you can't raise it by more than inflation, the consumer advocates are saying, well, they're just going to start higher. They're going to bake it into the starting point when they go to market. I mean, Anna’s more of an expert on the drug market than I am. But, yes, this is a huge achievement for Democrats. It's politically risky to wait for it until 2026. I mean, I understand there are budgetary and bureaucratic reasons, but politically it doesn't ... it's not great. I mean, ACA [the Affordable Care Act] — you pass a law and people don't see the benefits. It gives you a lot of time to attack. That's what we saw. We saw four years of attack. And this is harder to attack, lowering drug prices. But you pass a law, and you don't ... people don't feel it for four years. It is politically difficult.

Rovner: Although there are things that people are going to feel sooner, which is ...

Kenen: Yeah, the cap.

Rovner: The $2,000 out-of-pocket cap, which is one of those — like, I keep telling this story — that when they passed the Medicare drug law in 2003 and said that once you hit the catastrophic threshold, you would continue to pay 5%, that that wasn't a lot of money because there weren't a lot of drugs for which 5% was a huge amount. But now in the era of $10,000 and $100,000 drugs, 5% can be a lot more than a lot of people can afford. So that's going to go away. And there'll be a $2,000 cap, and there'll be a cap on insulin, at least in Medicare. And those things take effect sooner. I mean, not obviously before the elections.

Kenen: If you're talking about the negotiation is this crowning achievement that the Democrats have been seeking for since at least the early ’90s and maybe longer ... oh, but you have to wait for four years for 10 drugs. If you put it on a bumper sticker, it's going to look very muddy. ... I understand that it’ll help the high-cost people, the $2,000 cap is a big deal, right? I mean, it is. But a lot of people who are thinking a lot of things are going to change right away are going to be disappointed when they go out to pay their drug bill.

Rovner: But just exactly like the Affordable Care Act.

Kenen: Exactly. And look what happened. Just four years gives you so much time to attack and weaken and undermine and confuse. It's way easier to attack something complicated than it is to explain something complicated. And this isn't anywhere near ... nothing is as complex as the ACA, in health care. But it's still complicated. Oh, there's these 10 drugs negotiated ... 10 only in Medicare, but there's this inflation thing. And then ... an out-of-pocket limit for some people, but not everybody, but not everybody will see it ... it's just another political mishmash.

Rovner: Alice.

Ollstein: Yes. And I think part of the challenge is that Democrats are already putting out ads right now saying we lowered your drug costs ... we are fighting to deliver relief. And, as Joanne pointed out, people won't be feeling that quite yet. And so they're hearing this message and then they're going to the pharmacy

to pick up their prescription. And it is not cheaper. The part that they're touting that does go into effect right away is another one of these difficult things, because it's the extension of the Affordable Care Act subsidies that people are already getting. And so, yes, they are avoiding prices going up, but it's not like prices are going to go down for their insurance premiums. And so it's politically challenging to sell people that a continuation of the status quo is this big victory for which Democrats should be rewarded. But I think it's an instance of even getting this much through Congress was an incredible lift and looked like it wouldn't happen at all at several points over the past year and a half.

Rovner: Oh, yeah. You just answered my, I thought, very artfully worded question that I didn't get to ask about how Democrats managed in this bill to avoid a gaping, self-inflicted wound by extending those subsidies. But this is really one of those cases where something not happening, meaning the subsidies expiring, which they were originally set to do at the end of 2022 — something not happening is a big achievement, which is kind of hard to translate politically.

Kenen: Yeah, that's another great bumper sticker. We avoided a self-inflicted wound. I mean, and the Democrats have never been great at explaining when they do something. I mean, they're just not as sharp as — as a rule, and there are exceptions. I mean, we all remember Barney Frank. But I think they're just not as good at getting credit for things that they think are important that they have achieved. They just aren't.

Edney: I'm curious this time, though, to see — and when we're contrasting with the ACA — I don't think you're going to have many Republicans out there saying ... bashing these things, as they did with the ACA, or trying to call it “Bidencare,” or whatever, like they did with Obamacare.

Rovner: Because Republicans want lower drug prices as much as Democrats.

Edney: Yeah, exactly. So will that change the calculus as far as do Democrats have a better chance at making this message heard and people accepting it?

Ollstein: I also think a lot of the messaging we're going to see is around the amendment votes that Republicans voted against, and Republicans [who] voted against the overall bill. And so. Exactly. So you're going to see a lot of ... it's not a great message to say we wanted to do even more for you voters, but the mean Republicans stopped us. But I think that is a message that is out there and could be effective.

Kenen: I don't think it's going to be as political as ACA. I mean, no way. But I still think when there's a health bill, there's a land mine, by definition. And I see several land mines. And whether it looks, in 2026, the way the backers envision it right now, or whether there are modifications that are give-backs to pharma or, you know, we don't know who's going to be in the White House in 2024, and whether it looks the way it's intended to look. Maybe it'll look better and maybe it'll be weakened in some way ... three or four years is a lot of time for stuff to happen.

Rovner: Mischief.

Kenen: Yeah.

Rovner: Well, I have one last political question before we move on, which is: Someone, I forget who, noted that every single Democrat in the House and Senate voted for this bill, and I honestly can't remember that ever happening before. Yes, many bills are passed with party-line splits, but not every single Democrat voting yes. Often you get at least a handful who vote no or who don't vote, or who get a Republican or two voting with the Democrats. I'm not sure this says that much about this bill, in specific. I think it says more about how the Democrats, particularly in the House, have basically no more conservatives in their ranks.

What used to be this big conservative coalition that we called it at CQ [Congressional Quarterly] that could sometimes outvote the rest of the Democratic Party really is no more — that both parties seem to have retreated more to their pole. And I wonder, on the one hand, that would suggest that it would be much harder to get anything done. On the other hand, we've seen this spate of bipartisan bills in the last month. Are they just going to sort of go towards low- hanging fruit? Are we becoming a parliament without having a prime minister?

Kenen: I don't think guns was low-hanging fruit. It wasn't the entire agenda that the gun safety advocates wanted, obviously, but there was more than people thought would get through. I don't think that was low-hanging fruit. It wasn't an impossible dream, but ... those are mixed metaphors. But, you know, I don't think it's all low-hanging fruit, but I do think you're right, Julie, that we're in this age of hyperpartisanship that, as many political observers think, is just extremely worrisome. And yet there has been this boatload of bipartisan stuff in the last two or three months. It's a lot.

Ollstein: I also think it's important to remember that a lot of the votes, particularly in the Senate, a lot of the Republicans who are most open to working with Democrats on these kinds of things are retiring. And the people who replace them might not be so inclined towards bipartisan collaboration. You know, I'm thinking of ...

Kenen: It's a small list.

Ollstein: There's a few people. I mean, [Alabama Sen. Richard] Shelby has worked on budget stuff. [Missouri Sen.] Roy Blunt has worked on stuff.

Kenen: Mental health in particular. [North Carolina Sen.] Richard Burr on public health.

Ollstein: Richard Burr, exactly.

Kenen: Pandemic and emergency preparedness.

Ollstein: Oh, [Pennsylvania Sen. Pat] Toomey, the other one on guns, for sure. And he's retiring. So I think that remains to be seen if is this an indication of where things are going in the future or is this people wanting some nice legacy items before they retire and we won't see more of this going forward?

Rovner: Yes, I think that's entirely possible. Well, that's something that we will obviously see down the road. So one of the things that did *not* make it into this reconciliation bill was more coverage of hearing and vision and dental care under Medicare, which currently has minimal, if any, benefits for those things that so many seniors need and use. But there is a tiny sliver of hope on the horizon in that the FDA this week issued its final rule, allowing the sale of hearing aids over the counter. This stems from a law passed by Congress in 2017, but, as they say, better late than never. Only an estimated 20% of the 30 million Americans who could be using hearing aids currently have them in large part because they are time-consuming and very expensive to obtain. The idea here is to encourage the development of cheaper, easier devices, although there's already been some complaints about the market being flooded with devices that basically don't work. So is this going to be sort of our case study into how well the free market works in health care?

Edney: Yeah, I think there was this argument and there was a lot of criticism of it from Sens. [Chuck] Grassley and [Elizabeth] Warren, who are behind this push for OTC hearing aids. But this argument from, I'll call it “Big Hearing Aid,” that there are basically five ...

Kenen: Big Ear!

Edney: Big Ear! [laughing] They are basically five companies —don't ask me the name them — that do most of the hearing aids that people buy and they were trying to push, actually, the FDA's regulations on this to make it so that maybe you would get the worst hearing aids on the OTC market and they wouldn't work so well and people would then need to come flocking to them with their prescriptions anyway. So I think that those worries maybe were a little bit inflated by the industry and we'll sort of have to see, once things are rolling, what comes out and if there is kind of more innovation. It's not really been a space where there's been a lot of change, where people still feel uncomfortable getting them sometimes if they're a little bit vain about how they might look or something like that. Totally understandable.

Rovner: And yet you are speaking to me with the earbuds hanging out of your ears even now. So I'm wondering if that doesn't fix the stigma somewhat. I mean, everybody is walking around with something in their ears.

Edney: Yeah, that's a good point. That may be changing things.

Kenen: Also, Bernie Sanders didn't get any of his priorities [in] what ended up being the ultimate reconciliation bill. But this is still a win for older people. And I could also see that you could do something where they're going to come down in price. If you still wanted to make it within Medicare, it costs a lot less. If you have these who say, well, we'll give people up to $1,000 or ... I don't know what they cost. I don't, I'm just making up a number.

Rovner: They cost about — I mean, prescription hearing aids, they cost $3,000 or $4,000 ...

Kenen: They cost up to $5,000, right. But these new ones, the OTC ones, there may be some way of making it even more affordable for lower-income ... I mean, there's, I don't know where they go with it, but I can see ... if he needs ... Bernie's going to come back at some of this stuff, if he can. And it's a different landscape now, and it's much more affordable to pay for people to get $500 ones than $5,000 ones. You know, I'm not an expert on the hearing aid industry at all, but I think that this is one where I can at least see a pathway that things would get better in a year or two. Like, you *can* do consumer regulation of products in a way that ... this kind of device, if there are really lousy ones on the market, you might be able to nudge it in the right direction. It's never truly a free market in health care. I mean, there's government regulation, oversight, and that could be expanded or modified or tweaked. You know, it's not just that you can't hear; there's spillover effects that are really bad for people. I mean, you're cut off, you're socially isolated. I mean, we've already all been going through this period of social isolation. You're alone. Your kids are 3,000 miles away. You can't hear them when they call you. I mean, it's a risk factor for depression, and it's also a risk factor for dementia. It's considered a really big risk factor for dementia. So getting people affordable hearing aids is probably more of a health achievement than many people realize.

Rovner: We're so bad at doing preventive ... I mean, it's classic. A few dollars upfront will save a lot of dollars down the road.

Kenen: There should just be a law against how loud teenagers can listen to music. It's just ... federally, you know, just deal with it, like, don't leave it on the mothers.

Rovner: You were going to say something, Anna.

Edney: Oh, I was just going to say that the cost of the hearing aids is a huge deal. And one of the other positive things with this is that seniors or anyone with hearing loss wouldn't have to go to the audiologist to get it fitted [or] pay for that. And sometimes just getting to that appointment is really difficult if you're relying on family members to drive or public transportation in an area that doesn't really have any. So I

think that that's also a huge win. You *know* if you can't hear; you don't exactly need someone to tell you that.

Kenen: And you wouldn't be able to hear them if they tried to tell you, right?

Rovner: Let us move on to covid. It's been a big week for the Centers for Disease Control and Prevention. Last week, the CDC put out new covid guidelines that basically say, "OK, folks, you are on your own to protect ourselves. No more routine testing, no more quarantines in most cases, no more social distancing." And yet deaths are still running around 500 per day, which is way down but still way more than even the worst years of flu epidemics. Is the CDC just giving up at this point, or are they recognizing the reality that people aren't going to follow stricter guidelines anyway so they may as well, as some people have said, meet people where they are?

Edney: Both? Can I say both? I think that recognizing that is sort of giving up. But also it's probably right that people aren't paying attention anymore.

Rovner: Every place I go I feel like I'm the only person wearing a mask.

Kenen: You don't feel that way, Julie. You are the only person wearing a mask. I think that there are a lot of failures at the CDC, and we'll come to that in a minute. But they failed to really tell the population, the American public, that this is a dial, not an on-and-off switch. And we're dialing it down. But telling people right now: "Things could get worse. We understand where you are now. We understand that you've ditched the mask. It's worse than we'd like. But the health care system isn't falling apart. Doctors and nurses aren't as exhausted. We have vaccination. We have good drugs. Doctors know how to treat it better. Things are moving in the right direction. And we're sort of going to hit pause on yelling at you for the time being. But who knows what's next?" What's next might be better, right? Moderna's new shot, which attacks both the original strain and the early omicrons — I don't think we really know how well. Omicron keeps changing, too, so I don't think we really know how good it is against BA.5 and whatever comes next week. But that shot, which is a modernized, more targeted version. was approved in the U.K., and we think it will be approved here.

Rovner: It was this week.

Kenen: Yeah, we think it will be approved. People think that those kinds of vaccines will be available here [in] September, October. So one can hope that we are getting another, more effective tool. Do I think that we're going to see more waves? I think we're going to see more waves. We may be over the worst worst waves that — between the number of people who've had it and the number of people who have been vaccinated by now, we're not in the same situation as we were. And, clearly, people are tired of it.

Ollstein: Just briefly, it's been really interesting to me how long covid has completely fallen off of the discussion. And even as more research comes out that even a mild case where you don't get hospitalized can lead to long covid, more data about just the sheer number of people who have long covid around the country, who are unable to work, who are struggling to qualify for these different disability or other economic programs. This is the growing crisis in the wake of the crisis, and yet it's not at all part of the government's messaging around what the risks currently are. And you can't live your life wondering if every single interaction could lead to a debilitating, lifelong condition. But that's genuinely the case. It's not getting communicated, and it could be both an economic and a health system burden later down the road.

Rovner: Alice, was it your story that called it a mass disabling event?

Ollstein: Yes, although that is not phrasing that I invented. That is coming from the research.

Kenen: Right. I have seen some studies recently, and I don't know, Anna, if you've seen them and how good they are, that the risk does seem lower with omicron. And if that is true, that's really good news. But it's still not zero. And I think all of us know people and there's people who have symptoms for months and people who may have them for the rest … I think probably — I haven't surveyed the four of you, the four of us. But I think that we all know people who had several months of difficulty and they recovered. I think we all know — I know Alice and I know someone who's really disabled and her life is just really a struggle. I know someone else who has such bad digestive problems that there's really serious health issues there, although she's not that many months out. I mean, it takes lots of different forms. It manifests differently, and it manifests for different periods of time. And we don't know if it lasts forever or these people will recover. If the omicron risk is lower, terrific. I'm not convinced because I don't understand the science well enough. And we've heard … like if you look at long covid studies, they're all over the place. There really isn't a consensus on a lot of it. It's a lot of best guesses.

Rovner: Yes. There's just a lot of stuff we don't know yet. Well, I think one of the things that there is consensus on this is that the CDC kind of dropped the ball certainly at the beginning of the covid pandemic and again at the beginning of the monkeypox outbreak. So in other CDC news, Director Rochelle Walensky says she's going to support an overhaul of the agency as recommended by an outside panel that would make the CDC less academically focused and more operationally focused. CDC has gotten lots of criticism during both the Trump and the Biden administrations. Is this going to be a step in the right direction to getting CDC back where it needs to be to respond nimbly? I believe that's the word that people like to use to public health emergencies because they haven't been that nimble of late.

Edney: It's a good sign maybe that they're recognizing they might need to make some changes. We've all been doing this long enough that we're probably a little skeptical of those changes actually coming to fruition, but give them the benefit of the doubt. And I think, with what Joanne just said, I was thinking about the FDA because they're constantly in this pendulum swing of the public wanting them to be faster and then wanting them to be slower because then you have some drugs that get to market because of deaths and then that kind of goes away and then everybody wants them to be faster again. And so humble is probably a good place to be and in that sense. And hopefully the CDC is not in for that kind of ride, I guess is what I'm saying.

Rovner: Yeah, well, I mean, that's been the history of the FDA all the way back. If they're too slow, they get criticized. And if they're too fast, they get criticized.

Edney: Exactly. So hopefully … I was just thinking about CDC trying to … I mean, nimble, get faster — I think that's all very similar. And whether that would cause mistakes just on the other end, I'm not sure.

Kenen: Well, they've been making so many mistakes. It's like something has to change. They've just missed under both administrations. I mean, the messaging has been confusing and contradictory, and people don't understand it. And if it's not clear, then people … fuels distrust. It just opens the door to bad things. And I mean, look at the monkeypox response. Again? It's not killing people, but it's a serious disease. It's not killing massive amounts of people. But it's a bad disease. It's also very painful. And it can kill people in certain populations. And there are people at risk. And it's just been mind-boggling to watch.

Rovner: Yes. The CDC has been slow to respond.

Kenen: And the government and rest of the government, as well.

Rovner: Yeah.

Kenen: The only thing that surprised me about the CDC announcement yesterday is, "What took so long?" Like, it's been clear that they need an overhaul. She was appointed to do an overhaul. And what she's been setting up behind the scenes and how swift this is, we don't really know yet. But, yeah, the CDC's not been a paragon of excellence in a really trying time.

Rovner: All right. Well, we will clearly come back to this, too, but I want to move on to this week's abortion news. I want to talk a little bit this week about men and abortion. The Biden administration is reportedly going to expand its abortion message to men as well. I think a lot of folks just haven't thought it all the way through. But while there's been a lot written about parents of girls resisting sending them to college in states with abortion bans, I know several parents of boys who are having the same misgivings. They're worried that their teenage son could end up supporting a baby if he's not careful. Have we underestimated the effect of the overturn of *Roe* on the people who get other people pregnant?

Ollstein: I'd be interested to see more data coming out of the Kansas vote on that front broken down by gender. I think that given that a lot of states are set to vote directly on the issue rather than via voting for candidates, where it's a little harder to interpret: Why is someone voting for a Republican? Is it because of abortion? Is it because of taxes? It's hard to know. But I think we're about to get a lot clearer picture on where people are really at. Also, as we've talked about many times before, polling on abortion is notoriously unreliable. Tiny changes in wording can completely change people's responses. Both sides like to wave polls saying the masses are on my side. So I think that this could be really revealing in regards to the gender divide, how wide it is on this issue. It does seem like from the data we've seen so far that women are more fired up and motivated by the Supreme Court's decision and what's happening now in so many states. But I wouldn't underestimate … When I was on the ground in Kansas, there were definitely more women than men volunteering. But there were men out there knocking on doors, as well.

Kenen: It would be interesting to see the age breakdown, too — older men and younger men. But as an n of 1 with friends who are also ns of 1, I have a college-age son, and I have not had a blunt instrument talk with him. I haven't embarrassed him. I haven't yelled. I haven't said "you always have to live in certain kinds of states." But I've had conversations with him. And I also know that my friends, that's the other n of 1, I have friends who also have sons of college age. And I know this is a conversation.

Rovner: I have an n of two, of friends who both have twin sons. So it's really an n of 4. Four boys looking for colleges right now who are rising seniors, and the parents in both cases are worried about states with abortion bans. I mean, suddenly the college potential application list is looking different. We've also seen anecdotal evidence, and I don't know whether anybody's done any good studies yet, about an increase in men seeking vasectomies in the wake of *Roe* being overturned so they can't get someone pregnant.

Kenen: There's a 1 in a 1,000 chance.

Rovner: We keep talking, and obviously we will continue to talk about the impact on women, which is obviously the most immediate. But men are involved in this, too, and it'll be interesting to see how it plays out. Another group of people who are starting to get more attention are minors. During the reign of *Roe*, the Supreme Court required that teenagers be able to seek permission of a judge to get an abortion rather than their parents. But if abortion is illegal, there is no more judicial bypass. In Florida this week, where abortion is still legal for now, we saw a pregnant, parentless 16-year-old denied an abortion by a judge who found her not mature enough for an abortion, although apparently that does leave her mature enough to be a parent. And then we saw that ruling upheld by an appeals court. Given that carrying a pregnancy to

term is multiple times more dangerous than having an abortion, I'm wondering if someone is going to sue on behalf of minors who are turned down by judges from terminating their pregnancies. Is this another line of “let's go to court”?

Ollstein: That's already happened because before the Supreme Court overturned *Roe v. Wade*, there were lots of states that passed restrictions for minors and had complicated judicial bypass scenarios that were very difficult to navigate. And there are legal groups that have been previously and still are dedicated to assisting teens through that process. And so I think like so many other things, this had already been happening sort of in a quieter way. And now it's really in the spotlight.

Rovner: Yeah. I think this Florida case has caught … Again, these things that have been happening all along but suddenly they end upon the front pages of newspapers.

Ollstein: And I think it's also worth looking at the laws states passed that applied just to minors as sort of a trial balloon or a harbinger of what could be applied more broadly. There has been so much anxiety about the idea of states restricting travel. That's already true for minors, and people have already been prosecuted for helping a young person leave a state in order to obtain an abortion. That was true when *Roe v. Wade* was still in place. And so I think it's also … Even if you don't care about what's happening to young people right now, you should care because it could apply to the broader population in the future.

Rovner: So on a related note, one of the reasons it's so much more dangerous to carry a pregnancy to term than to have an abortion is that the U.S. ranks so low in terms of maternal morbidity and mortality, meaning pregnant women are much more likely to die or be injured in the process of or as a result of childbearing in this country than in just about every other industrialized nation. One way Congress has tried to address this is by letting states extend Medicaid coverage for women giving birth up to a full year, up from just 60 days. And until recently, 60 days after you give birth, that day your Medicaid's over. This week, the Department of Health and Human Services formally approved expansion requests from Hawaii, Maryland, and Ohio, which brings to about two-thirds the total of states now having opted for the expansion, part of a program that's set to run for five years. But of the 17 states that haven't expanded maternal coverage under Medicaid, several have also not expanded Medicaid under the Affordable Care Act and/or have banned abortion, which leaves low-income women with new babies in not a great place. What happened to all those promises of making it more attractive for women with unintended pregnancies to carry them to term? You would think that these states that are banning abortion would be more anxious to extend maternal Medicaid coverage.

Edney: I think that we've seen that the rhetoric might not match the actions in a lot of these cases. When you're cutting off the potential for people to not carry a baby to full term but then not helping them, I think it's — once they do have that baby, I think it's very clear what this is about. It's clearly not about trying to support mothers and families and in many cases even babies. It's making it difficult. I mean, the maternal mortality rate in this country is just incredibly high compared to any other developed nation. And it is just really sad that that's where we are in a lot of those states. And when you have a baby, it's not just those few days in the hospital and, bam, you're better. You need to go back and be checked. And even past those 60 days, women are going to have mental health issues, particularly, that really could be helped and any other issues — C-sections and things. There's a lot of checkups that need to happen and things like that that can be missed because they can't go to the doctor.

Kenen: Including, I learned working on a story that I'm in the process of now, domestic violence is way higher than I had realized prenatally and postnatally that first year. And when we think about postnatal

care and maternal mortality, that is also a risk factor that the health system has to become much more aware of and do better screening.

Rovner: Even wanted babies, it's stressful that first year being a parent. I mean, it's stressful being a parent period. But, obviously, I have not done this, but I'm sitting with two people who have. So I know that it is not an easy thing.

Well, one more interesting Medicaid tidbit, which is really about voter behavior on ballot questions rather than candidates that Alice was talking about. Just a couple of weeks ago, as you mentioned, Kansas surprisingly declined to amend their constitution to allow an abortion ban. Earlier this summer, South Dakota voters, who twice turned back their own abortion bans, also turned back a requirement that would have required a 60% supermajority for a measure that's coming up this fall to expand Medicaid there. So there are two really red states, South Dakota and Kansas, that are voting against many really red ballot measures. What does that suggest? I mean, Alice, you were saying people's opinions on these topics are not necessarily linked to their opinions about the candidates.

Ollstein: Absolutely. And so I think that in the wake of Kansas' vote, you're seeing a lot of states really taking a look at what can be done to get something on the ballot in the next couple of years. But not only is that not possible in every state, but, as you point out, several states are currently looking at making it harder to get something on the ballot, even in the states that do currently allow it. And so I think that it's a trend to really keep a close eye on in the future. We've seen these very conservative states really surprise people, not just with votes on abortion rights, but with Medicaid expansion, with marijuana, with lots of things people don't associate with red states supporting. Criminal justice reform is another one. But I think that whenever there is a disconnect between popular opinion and the folks in power, you're going to see that tension, and you're going to see ballot measures being considered as a tool.

Kenen: And as an aside, every state that's had a ballot measure, including really conservative ones like Idaho and Utah, they have all approved Medicaid expansion in the red states and in most cases it has been above 60%. So even if South Dakota had voted for that, it might have won anyway. I think there's only one that fell below. I think Oklahoma was like 59. But they've won, and they won big. So it doesn't mean that a conservative who votes for Medicaid expansion then becomes a Democrat. Even not everybody in Kansas who voted for abortion rights is going to vote Democratic in the fall. The difference when you have a one-issue vote. But, yeah, what we know is that the parties are not, because of the way things have been gerrymandered and all sorts of other political things, the country isn't where the parties are. Well, this is another reminder.

Rovner: Well, finally this week, because we have Anna here, I know that you've been working more on tainted drugs because we don't have enough to worry about with covid and monkeypox. So tell us about your latest on what we shouldn't be taking from the drugstore.

Edney: Yeah, sorry to be the bearer of more bad news. There were two fronts on this in the last week and a half or so. It started last week. Merck said that its blockbuster diabetes drug — there's two, Januvia and Janumet — contained these chemicals that may increase the risk of people getting cancer if you take them chronically. They're called nitrosamines. The thing is they're finding more and more of these, in recent years, more of these drugs that are contaminated with them. And they're finding nitrosamines that they don't know anything about. These are completely new compounds, but they're in a family of carcinogenic compounds. So the FDA is making a guess and saying, “Look, these are drugs that everybody needs. We're not going to do a recall this time.” They've done tons of recalls of other drugs: blood pressure pills, other diabetes medications, metformin, things like that. They're not doing it this time because this is the only

drug out there. It's still a brand-name drug. And they're saying, “As long as they can keep it below certain levels, we’ll allow it.” And these are higher levels than they normally allow because they don't want shortages. So an interesting zone right now. And then just like a day or two later, the biggest drug containing these nitrosamines so far has been Zantac, which you may remember a couple of years ago had to come off the market because the active ingredient in it basically formed one of the nitrosamines we know something about. It's NDMA. It was used in rocket fuel at one time. So that might tell you enough it.

Rovner: And we should point out that it's not. I mean, you've done also work about factories where there have been adulterated things. But these are things that are forming naturally in the making of these drugs, right?

Edney: Yeah, as far as Zantac. With Januvia and Janumet, the Merck ones, we don't have a lot of information yet. Merck still doing its analysis, so it's trying to find out exactly how it's formed. Is it doing something naturally, or is it the manufacturing process, they're somehow introducing it because of the chemical reactions they're allowing to happen? And so with Zantac, this has been going on for a while, but there are some court cases. There is some big litigation that's getting close. And so investors freaked out. Sanofi, GSK, some of the generics like Teva the other day. Their shares went way down. So people are starting to take notice. The first trial on Zantac was kind of out on its own. There is a big multidistrict litigation with like 1,700 cases within it. This one in Illinois was supposed to start very soon, but it settled with a lot of the generic companies, not the brand companies. The person who took this Zantac was on a generic, ranitidine. And so we're waiting until mid-next year to see some of these trials starting. But investors were already freaking out about it, thinking it might be about $45 billion in liability for these companies.

Rovner: Well, that's plenty to worry about, I think, for an August week. Thank you all, ladies, for catching us up on the news. Now it is time for our extra credit segment where we each recommend a story we read this week we think you should read to. 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. Alice, why don't you go first this week?

Ollstein: So I have a pretty depressing story from MedPage Today by Cheryl Clark, and it's about the number of migrants crossing the southern border who are experiencing really horrible injuries from falling over the border wall. The Trump administration in 2019 raised the height of the wall in a lot of these high crossing areas from 18 feet to over 30 feet. And since then, there has been a massive increase in hospital admissions in the San Diego area of people with just really debilitating injuries. And it's straining the hospital system. And folks are taking a lot longer to recover. Some never recover. And it's taking resources away from all the other folks in the hospital who also need to be treated. And I lived on the southern border and studied migration. And there's this whole philosophy of prevention through deterrence. And it was the official U.S. policy to make it so harrowing and dangerous and deadly to cross the border that the idea would be people would be deterred. But it's also so harrowing and dangerous for people to stay in their home countries that we're seeing that they aren't deterred, that they are going to keep trying to cross, and making it more dangerous is having these major health care repercussions now.

Rovner: So immigration policy is also health care policy, as it turns out. Joanne.

Kenen: There's a story in Harper's called “A Hole in the Head” by Zachary Siegel. And it is about whether deep brain stimulation surgery, which is used for Parkinson's and some related diseases, whether that is going to be effective to treat opiate addiction. I came away skeptical because the author was skeptical. There are ethical questions. There are scientific questions. There's … what is addiction? What is its cause? Is

it something in your brain, or [are] there social factors? Or what combination? But it was a very interesting article. It's only been done on four people, as far as this article was aware. It's very experimental still. There's also a feeling like it is worth trying because we have a massive addiction and overdose problem and maybe they'll figure out this in combination with other things or this for certain people. Right now, it's not ready for prime time. It's four patients, two of whom have not had great outcomes. But it was an interesting read.

Rovner: Anna.

Edney: Mine was in Stat by Tara Bannow. It was "Parents and Clinicians Say Private Equity's Profit Fixation Is Short-Changing Kids With Autism." And it's a fascinating and frustrating story, just seeing private equity enter health care more and more over the years and finding where reimbursement is a sure thing and exploiting that. And that's what this story goes through, a certain treatment for autism that is one of those sure things and private equity has found it and seems to be stripping away the one good treatment that parents were relying on. And now there are a whole host of problems, with feeling pushed to do more than people can and for having cookie-cutter treatments and for clinicians getting burned out. The story, it's long. Read it over the weekend. But it details all of these problems, and it's quite illuminating.

Rovner: Yes. The government can't fix the health care system, but apparently neither can the private sector. It's what we tend to walk away with. My story is actually about public health. It's an op-ed from the Los Angeles Times. It's called "The CDC Loosened Its COVID Rules. Who Fills in This Public Health Vacuum?" It's by Wendy Netter Epstein and Daniel Goldberg. And it's about how in that open space left by the CDC essentially giving up on covid, covid advice is now mostly coming from doctors instead who are actually not trained in public health for the most part. And I read from the story here, "Public health officials are better equipped than doctors to make policies that protect communities and the vulnerable among us. With schools starting across the country, these officials should set clear rules that guard public health as a goal bigger than any one person's individual risk." So, again, the whole public health versus individual health, which goes back to what public health is. It's a really interesting read, and I wish them good luck with it.

So 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, who makes the weekly magic happen. As always, you can email us your comment or question to whatthehealth — all one word — at kff.org. Or you can tweet me. I'm @jrovner. Anna.

Edney: @annaedney

Rovner: Alice.

Ollstein: @AliceOllstein

Rovner: Joanne.

Kenen: @JoanneKenen

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