KHN's 'What the Health?'

Episode Title: Judge Takes Aim at the Affordable Care Act's Preventive Care Benefits
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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, Sept. 8, 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 Joanne Kenen of the Johns Hopkins Bloomberg School of Public Health and Politico.

Joanne Kenen: Hi, everybody.

Rovner: Sarah Karlin-Smith of the Pink Sheet.

Sarah Karlin-Smith: Morning, Julie.

Rovner: And Alice Miranda Ollstein of Politico.

Alice Miranda Ollstein: Hello.

Rovner: Later in this episode, we'll have our latest NPR-KHN "Bill of the Month" with Lauren Sausser. It's about a patient who did everything right before a cancer biopsy but still got hit with a whopping-big bill. So before we get to what we missed while we were away for the past couple of weeks, just a little breaking news from this week. On Wednesday, U.S. District Judge Reed O'Connor in the Northern District of Texas ruled that portions of the popular preventive services coverage requirement to the Affordable Care Act are unconstitutional. If that judge's name sounds familiar, it's because it's the same Judge O'Connor who ruled the entire Affordable Care Act was unconstitutional back in 2018, an opinion that was subsequently overturned by the Supreme Court in 2020. What is Judge O'Connor trying to do to the ACA now?

Ollstein: I've been tracking this case. It's actually been working its way around since 2020. And it finally got oral arguments earlier this year. And this is a group of Texas employers who say they have religious objections to the preventive care mandates of the Affordable Care Act, specifically the mandate that employers cover both STD testing and treatment, and the HIV prevention drug PrEP. And they say that they believe that doing so subsidizes or encourages behavior that they disagree with religiously. The Biden administration, defending the law, said you don't have standing, you're not harmed by having to cover preventive services. In fact, if you didn't cover these services, premiums would go up and costs would go up because treating these illnesses is a lot more expensive than preventing them. But Judge O'Connor, as was expected, ruled once again to chip away at the Affordable Care Act. So we don't actually know what's going to happen. Nothing has changed yet. The two sides of the case are submitting briefs and the judge will rule, maybe as soon as tomorrow, on the "scope of relief," quote unquote — you know, what sort of

legal remedy he thinks is needed. So there [were] really two pieces to the ruling that people should know about. One is that requiring employers to cover the drug PrEP for their employees violates the religious freedoms of the employers. The other is far more sweeping and potentially consequential. It's saying that the panel of people advising HHS [the Department of Health and Human Services] on what services *should* be covered itself doesn't have the legal authority to do that. And so that has the potential to wipe out everything, really. All of the ...

Rovner: All the preventive services.

Ollstein: Exactly. Exactly.

Kenen: This panel existed before the ACA. What the ACA did is said that if they give them really strong ratings, the highest ratings, these services have to be covered for free. Those are evidence-based. This is really a good kind of preventive screening of care you should get. It is there for free. Whether you have an Obama plan per se or — all of us, we get this free. But this includes, you know, mammography, colonoscopy, all sorts of preventive care screenings that, as Alice said, they're cheaper to prevent or catch early than they are to treat later. And they're also healthier for you. It is much better to catch an early cancer than a late cancer. People don't necessarily understand that they're getting it for free *because* of the ACA, because there's been a decade's worth of confusion about the ACA. But if this goes away, people will notice that they are now being charged for their colonoscopies and their mammography, and also many preventive screenings.

Rovner: But we've spent a decade explaining to people that these are now covered.

Kenen: Right, right.

Rovner: If this ruling is continued, it could be ...

Kenen: Right, so there is the subcategory where there's the religious element and then there's this larger category of preventive care. And at some point, Julie, you'll bring us back to what is this? Why is this a legitimate government body? Because it's not just like a random group of guys on a street corner.

Rovner: Yes. And there's basically, it's two different advisory committees, one on immunizations and one on general preventive care. And there's complicated things about the immunizations because that does go through somebody who is approved by the CDC [Centers for Disease Control and Prevention] director. And this is going to be a big fight. But I think a lot of people were surprised, given that this is the judge that tried to strike down the entire ACA, that he didn't go as far as some people thought he might in just striking down everything that had to do with the preventive care mandate. He actually sort of picked and chose his targets here.

Ollstein: So, in addition to this judge ruling on ... scope of relief, what we're going to be watching is: Is this going to go to the 5th Circuit, which has gotten way more conservative in recent years? And whether it's going to go all the way back to the Supreme Court. And, yes, the Supreme Court has upheld the Affordable Care Act several times, but it's a different court now. So it's really something to keep an eye on.

Rovner: Although the last time it was 7-to-2. The court hasn't changed that much.

Kenen: It's a fairly narrow issue about whether this federal advisory board is constitutional or not. And it's often described as a, quote, "volunteer board." Well, yes, they're volunteers, but they are nominated and screened, and they go through it. It is an HHS ARC [Advanced Research Corp.], which is part of HHS. So it's not like ...

Rovner: It's not a bunch of people off the street.

Kenen: Right. But they're not Senate-confirmed, but they're part of HHS, which is run by Senate-confirmed people. And there are many advisory boards in government that are legitimate. So there's this question about ... this judge is saying that this is not a legitimate panel to create policy, but it is part of a hierarchy. There is a screening process. They're qualified medical experts. They're not Senate-confirmed, but all sorts of agencies have advisory bodies that are not Senate-confirmed, and that doesn't make them unconstitutional.

Rovner: Yes. And we will get to talking about some of those advisory bodies in a little while. But before we leave this, I should point out that Judge O'Connor is not the only familiar name in this case. The lawyer representing the plaintiffs has been busy elsewhere in Texas, right?

Ollstein: Yes. Although that was what was the state's gambit before *Roe v. Wade* fell. And now they don't have to have that private enforcement. They can just go ahead and straight out ban abortion. But, yes, he is the architect of the six-week ban that was enforced by private lawsuits.

Rovner: Right. So this is sort of a piece of ... conservatives in Texas going after various federal health policies.

Ollstein: Well, also, a lot of former Trump administration folks were behind these pushes and there's a lot of judge-shopping, as we know. And so it's no accident that they found employers who have objections to this policy in the area of the country that Judge O'Connor presides over. They could have found them elsewhere, but they felt that this was their best bet. And, as we see from the ruling, that made sense to do.

Rovner: We're going to talk about abortion in a minute. But first, we have some more breaking news today. The Biden administration is formally overturning the Trump administration's public charge rule. Alice, remind us what that was.

Ollstein: It's a long-standing policy that considers what public benefits legal immigrants to the United States use and depend on when considering whether to give them more permanent status like a green card. And so what the Trump administration did is they vastly expanded what counts as a program that the use of which should penalize an immigrant family. And so it added things like signing up for Medicaid, even when they're eligible, and other health services, like nutrition assistance services. Before it was basically just cash welfare counted. And this vastly expanded all the other services that counted. And so the Biden administration is taking steps to roll that back and basically return it to what it was, pre-[Donald] Trump, where basically only if an immigrant family depended on cash welfare did it count against them. But not these other programs.

Rovner: Yes. Just a reminder that it takes a long time to unwind federal policies. We're now a year and ... more than a year and a half into the Biden administration, and they are just getting to this. All right. Well, let us segue officially to abortion. Lots of abortion news in the past couple of weeks as states keep passing and amending their various bans, as Alice already pointed out in Texas. But there has been some action at the federal level, too, as Veterans Affairs Secretary Denis McDonough last week announced that the VA would for the first time provide abortions to veterans and their dependents, although only in some cases. Alice, this was a long time coming and it feels like a microcosm of the entire administration's attitude here: "We support abortion rights, but we don't want to offend voters who don't." But it's really hard to stake out a middle ground, isn't it?

Ollstein: For sure. This feeds into the complaints of even this action. Why wasn't this ready to go the day the Supreme Court ruled? There are a lot of people complaining about that and wondering why. Like you said, federal policy takes a long time to change. They knew this was coming. Why weren't they ready to go? Whereas here we are months and months later. So, yes, basically this is a way to get around the "Hyde Amendment," although it really limits the circumstances in which VA doctors can provide abortions to just cases of rape, incest, and the life and health of the mother being at risk.

Rovner: Although prior to this, the VA policy was even more restrictive than the Hyde Amendment.

Ollstein: Absolutely.

Rovner: That's why they have the authority to do this as an increasing number of veterans ... this used to be ... when you talked about younger people on Medicare, you know, everybody saying, "Well, there are no women of childbearing age who get VA care. Why is this even relevant?" Well, there are now a *lot* of women of childbearing age who get VA, who are eligible for VA care. I believe it's more than a half a million. And so this actually does affect a lot of people and dependents in some cases.

Ollstein: Yes. And I went to a press conference yesterday where Sen. Tammy Duckworth [D-Ill.], who is herself a veteran, spoke about this. And she was pointing out that, look, a lot of people in the U.S. don't get to choose where, what state they live. They get sent here and there by the military. And so they are very likely to get sent to a state now where abortion is either completely banned or very, very restricted. And so, before *Roe v. Wade* fell, people could go outside the VA to get abortion care in these circumstances, but they couldn't get it from their regular doctor that they go to. And so this is trying to remedy that. This is something that she and other senators had been demanding of the administration for a while now.

Rovner: [00:11:19] And Sen. Duckworth, who rather famously was injured in combat in Iraq, pointed out that when she was in Iraq early on, when there wasn't a lot of supply available, they actually gave the women birth controls that would stop their periods because they had no way to deal with the sanitary issues of being a woman, she said. So the military didn't think much of messing with their reproductive abilities when it suited them but didn't want to when it didn't. I

thought that was rather ... she was pretty blunt about the whole thing. And if you haven't seen it, I will post a link to the press conference because it was worth listening to. Well, in the states, Michigan right now stands out as the source of a lot of action. Just Wednesday, a state judge said that the 1931 ban that had been on the books and is theoretically back in action because of the overturn of *Roe* is unconstitutional. That's not the last word on this law, though, right?

Ollstein: That's right. So that could get appealed up to the state Supreme Court eventually. But really, people think the main game here is whether we see the courts order a[n] abortion rights amendment to be put on the November ballot because people see the back and forth in the courts as sort of not dependable, not permanent enough to provide protections. And so they're really looking to this constitutional amendment to be approved by a popular vote. And we could find out whether that's going to happen as early as today, whether it's going to be on the ballot. We don't know whether it will pass.

Rovner: They collected plenty of signatures, right? That's not the issue with whether it makes the ballot?

Ollstein: That's right.

Kenen: It's what in the old days we used to call "kerning." When Julie and I were in college, the old-fashioned printing — it's the spacing. When you look at the printed version of the ballot question, they ran words together. It's messy, but you can still figure out what they ... they don't have the spaces between words. So, yes, there's, like — I think it's just one line that is very messy, but you can figure out what the words are. And it's also just part of a line of a larger question. The state panel rejected it despite the many, many ... see, it's not a question of whether they got enough legitimate signatures. It was this technicality that, oh, it's mishmash. You can't understand it. So they reject it on that grounds. So it has to go to the court — what they ask of the court is ... we have the signatures. Yes, you can read the damn thing. Even though somebody screwed up the spacing in one line, it belongs on the ballot because what was it — 750,000 signatures? I forgot the number, but it was high.

Rovner: I think it was over 700,000.

Kenen: Yeah.

Rovner: Way more than they needed.

Kenen: Right. So that ... is the will of the voters to get a chance to vote on this, despite the messy ... and the messy spacing, which we have all been guilty of at some point in our life? But, you know, you could argue that they should have been a little bit more ... someone should have proofread the ballot measure.

Rovner: Yeah. I mean, when I read this the first time, it's like, wait a minute, they're not putting this on the ballot because of a printing error? I mean, that's essentially what's going on here. We're fighting over a printing error about whether abortion is going to remain legal in the state of Michigan. This is sort of what we've come to. I don't think this is what the Supreme Court had in

mind when they said they wanted to turn this question back to the states. But so it's now up to a court to decide whether this gets on the ballot, right, Alice?

Ollstein: That's right. So we're expecting that basically any day now; they have to rule soon because, you know, ballots get printed and mailed and whether this amendment is on there matters.

Kenen: And I think they have to print it intact with the mushy printing. I mean, I don't think they can change it at this point. But you know what it says. It's thought whoever didn't read it should have read it. But the court has to decide a larger issue about whether it's a legitimate ballot question despite the printing errors.

Rovner: All right. Well, since it's officially after Labor Day, let us talk about the sprint to the midterms. Since the Supreme Court overruled *Roe* in June, we've seen people suggesting that abortion could have an outsize role in determining whether Democrats retain control of Congress or Republicans oust them. But now it seems there's as much focus on state attorney general races as races for Congress. Alice, how did *they* become such a big deal?

Ollstein: They had already been gaining attention. Republican attorneys general made a big splash of banding together to sue the Obama administration. And then the same thing happened with Democratic attorneys general under the Trump administration.

Rovner: Over the ACA.

Ollstein: Exactly.

Rovner: Among other things.

Ollstein: Yeah, absolutely. And so now this state office, which often gets overlooked — it's down-ballot, it's not as sexy, people don't think about it as much — it's really getting a lot of attention because these are the officials who are deciding whether or not to defend state abortion bans in court, deciding whether or not to enforce them and bring charges, deciding to what extent to enforce them. And so they just have way more power than ever over this in a post-*Roe* country. And the Democratic attorneys general, they are the only Democratic campaign arm. So, like, not the Senate campaign arm, or not the House campaign arm, not the governor's. They are the Democratic attorneys general, the only campaign arm to require all of their candidates to be pro-abortion rights in order to get their endorsement. So they are really running hard on being pro-abortion rights right now. And it's seemingly really paying off. And so I did a piece this week about how they saw donations just skyrocket after *Roe v. Wade* fell and then also after the Kansas vote really lit a fire under people and made them feel that defending abortion rights was possible, even in red states. And so it's definitely something to watch because a lot of these races, particularly Texas, Arizona, Georgia, and Kansas, have the potential of flipping, whereas before *Roe v. Wade* fell those were seen as long shots for Democrats.

Kenen: And it's a part of a larger context of everything ending up in the courts, because Congress often deadlocks and can't get things done. Alice has been actually writing about this since her very first week at Politico; she sort of saw this coming. But sometimes they do work together. I mean,

the most famous one, I think, [was] in the late ’90s: The state attorneys general brought down the tobacco industry. That was — the whole regulation of tobacco was initiated by a very, very bipartisan coalition. Some of the opioid litigation has also been bipartisan. But we also see as social policy gets settled in the courts, we've seen the growing divide in our country also reflected in the increasing politicization of the state AGs. And their campaigns are now big deals because they're the proxy for all these other hot-button issues.

Rovner: This is not just theoretical. The attorney general in Alabama has already said that he wants to enforce Alabama's abortion ban against doctors at the VA that perform abortions under this new rule that the VA is trying to put out. So, we're seeing real-world consequences of the power of state attorneys general already.

Kenen: So just like ... they have to make the VA like an embassy, that it's not state territory, it becomes like federal territory.

Rovner: I think it *is* federal territory, actually.

Kenen: I don’t know. Then they can't. If it's federal territory, then they couldn't sue, right? Once you go through the parking lot, you're in federal territory, then state law doesn't apply.

Rovner: I'm sure we will have fights over this exact thing. All right. Well, let us turn to covid, where there has been much news over the past several weeks. The Food and Drug Administration [and] the CDC have endorsed a new vaccine intended to more accurately target some of the more recent variants. But there seem to be some communications failings around who should get them, when, and how often. Sarah, what is the latest here? I personally am confused. I went to the doctor last week and asked him, it's like: “I had my last booster in April. Am I covered in these people who should get another one?”

Karlin-Smith: So the new booster was approved for everybody 12 and up, and the CDC is trying to — and the FDA — trying to, like, reset things so everybody's no longer counting, am I eligible for two booster shots? Three booster shots? They're trying to simplify it and basically saying that if you had not had a covid shot within two months and you're over 12, you are eligible to get it. Now, most people seem to recommend, probably ideally if you had a shot two months ago, you're probably better off waiting longer than two months and stretching the interval out a bit to get the best safety and efficacy from the shot. Similarly, if you had a recent covid infection, you also probably want to wait a little bit longer than two months before getting the shot. So they're actually trying to simplify things and make everybody eligible. (Again, if you're under 12, you're not.) With the idea that they hypothesize that one reason booster uptake in the U.S. has been low is because it's been a bit confusing who's eligible and when. And so one of the things the Biden administration announced this week was they're trying to say, we think you ... now, most people will be able to just get one covid booster a year and they should be OK. There are some big caveats that go along with that that sort of rely on the fact that the virus will not shift as much as it has been in terms of development of new variants and so forth that impact how effective the vaccines are. Also, we just don't know a lot about, right now, about how durable these vaccines are. And the initial signals have been they're not that durable in terms of lasting protection over a year. So

that's a big question as we think about their strategy. And of course, there is also this third caveat that if you're in certain vulnerable populations, senior citizens, people who are immunocompromised and so forth, you may need more vaccines than just one a year. So, they're trying to switch to a simpler regimen, but it's really a question of whether the virus and, you know, it's actually going to let them do that going forward.

Rovner: I did see a lot of complaining on Twitter. You know, take that as it will. The policy that seems to be coming out of the federal government this fall is "you do you." As someone pointed out, that's not really what public health is. It's not like, well, if you don't feel like wearing a shirt and shoes when you go into a restaurant, you don't have to. Or if you don't feel like washing your hands, you don't have to. I mean, but that's what this starts to feel like. It's like, well, wear a mask if you're comfortable doing that or don't.

Karlin-Smith: I think you're making a reference to the New York subway masking posters.

Rovner: Yes.

Karlin-Smith: Which are quite interesting. Probably a topic for another time. I mean, I think the administration, when it comes to the vaccine boosters, is trying to be very encouraging and make a strong pitch that, again, not including people under 12, but that everybody should get it. You should get your flu shot. You should get your covid shot, get it at the same time. So I don't think they're lumping this into a "you do you" campaign. But, I mean, I do have questions about whether they're really going to be able to get the uptake we need to see in the U.S. We know flu uptake is not so great, but we do want flu shot uptake to be good. So we'll see whether they couple this messaging with any campaigns that really increase who's getting boosters this fall. One thing that I find interesting is they've bought enough vaccine for these boosters that it would cover about half the population — that does include under-12. But there [are] plans, I think, to eventually expand this bivalent booster for under-12. So if they actually got uptake to go up, would they wind up with problems where they don't have much supply? So that, is in my mind ... [the amount] they bought assumes they're not going to get good uptake, but they really want better uptake than we've seen so far.

Rovner: And this is the other big change that we're about to see, which is things — I mean, yes, this vaccine is free, but other things that people have been getting for free because of the public health emergency are starting to phase out because Congress has not felt like providing any more money for these things. So suddenly people are going to be asked to pay for or pay their copays for testing and treatment and things that had come with, you know, without. And I you know, I'm wondering what that does, particularly if there is another wave that we get in the fall. We don't know yet. And experts seem to be divided over whether they think that's likely.

Kenen: I think they think there'll be more in the fall. But does it constitute ... is it a wave or a "wavelet"? And is it something similar to the version we have now that there's a lot of immunity or do we get hit by another surprise? And we have no way of knowing.

Karlin-Smith: And how does it intersect with the flu season, which this year they're predicting to be worse than the past few years when we've had covid? So this may be the first year where flu

and covid collide in a bad way. And, you know, covid numbers still right now are much higher than flu numbers ever are in a bad flu season. And people say in a bad flu season, a lot of our hospitals are under severe stress. Now we're coming off a few really, really hard years of continuous covid stresses at hospitals. And so this could be a big test for hospitals in our health system of whether they can handle both at once if numbers don't go down.

Ollstein: There's a lot we don't know on this front, but we do know from other parts of health care that even small costs are a huge deterrent for people and cause a lot of people to avoid really basic health care. And so even a small cost for a rapid test or a shot or what-have-you may not seem that big to us. For a lot of people, it will mean the difference between them taking it and not taking it.

Karlin-Smith: And it seems like there's a communication challenge. It's going to be: Can the Biden administration communicate to people these updated vaccines are free while people are also being asked to pay for other things? Because even if they are still free, if people just get the wrong messaging, they may not seek them out. There was also something that happened: A professor at University of Wisconsin, I believe, was talking on Twitter the other day that CVS was canceling appointments for the updated vaccines for people that are uninsured. It seems like the attention got CVS to fix whatever kind of computer glitch they say was causing that.

Rovner: Yeah, it looked like a scheduling error.

Karlin-Smith: But the issue there is that while the vaccines have always been free to people at the point of service, if you have insurance, the places providing it have been able to bill your insurance for an administration fee. The government had been providing them a fee for the uninsured for a while, but that funding pool has run out. So the CDC is basically saying, as part of participating in this covid vaccine program, you are required to administer vaccines to the uninsured regardless of whether we're paying you to do that. But, you know, you could certainly see some actors in the health care space, if they're not being monitored closely, potentially not being as willing to help out the uninsured. So that'll definitely be something for good oversight to make sure we're helping the most vulnerable in our society.

Kenen: But one reason that pharmacies, and pharmacies within supermarkets as well, have become centers of affordable vaccination — because a lot of it is free or very cheap — is because you go in there and you end up buying something. So, I mean, it's part of their business model. They even give you coupons to come back. On your next visit, you get $10 off or whatever. So it's complicated. Also, I think you will see some states picking up some of these costs for at least low-income people and Medicaid or CHIP [the Children's Health Insurance Program] and so forth. But I haven't seen any states saying they're going to pick up the slack, but I would imagine that some states will because they do pay for other vaccines in accommodating this for some. I think you may see a blue-red divide, but I think some people will have access.

Rovner: As I like to say, every week, as tired as we are of covid, it's not over yet. Speaking of which, Congress is back, sort of. The Senate is back in session. But at least three members this week are out with covid. And Sen. Richard Burr [R-N.C.] is recuperating from a hip replacement

that he got over the break. The House isn't due back until next week, but Oct. 1 is right around the corner and that's when Congress either has to fund the government or come to some sort of temporary funding patch, which will obviously be more likely. How is the whole funding fight going? Did they resolve everything over the August break, as they always say they're going to? Alice, you're laughing.

Ollstein: Everyone is assuming that a CR [continuing resolution], a temporary patch, is what's happening. And the only question is what's in it? What can hitch a ride on it? Obviously, Republicans are pushing for just a very stripped-down CR that just continues current funding and nothing else added to it. Democrats would like a lot of things added to it, including $20-something billion for covid, which Republicans are opposed to, as well as funding for monkeypox. What is more likely than either of those to get included is more funding for the war in Ukraine. But there are a lot of other things that various lawmakers want to see attached, whether that happens when we really get down to the wire is the question.

Rovner: Yeah, I think we're still two weeks away from those decisions actually being made.

Kenen: So it'll be the night before. I mean, and then they often do a one-day patch and a two-day patch, a three-day patch while they ... So even the patch isn't really the patch, it's the pre-patch. So they ...

Rovner: Yes.

Kenen: We've obviously seen the exceptions, but they usually do try to keep the government open. I'm not picking up on a shutdown right now, but things could change. But I'm not hearing that right now. I know Alice [is] here on the Hill, I don't think ... that's not in the calculus a few weeks before the election. Congress is expert at kicking cans. And also one of the things that struck me when I saw that Burr had had his hip surgery, since it's his last term, he's retiring, and he has two legacy issues. And they're big. And one of them is very, very time-sensitive, which is the FDA user reauthorization fees, which Sarah is much more expert in than I. But he's ...

Rovner: And which was my next question.

Kenen: OK. Well, I did it for you. And the other thing is, you know, he and [Sen.] Patty Murray [D-Wash.] do have a bipartisan public health preparedness bill that, you know, he is a Republican voice on. And this has been a signature issue for him for a number of years. He's worked with Murray. He's worked with Sen. [Bob] Casey [D-Pa.]. They've done a lot of work on public health preparedness, emergency preparedness, bioterror, etc. Sarah can weigh in since she knows more.

Rovner: Yes. And I was going to just sort of ... by way of filling in a little bit of background.

Kenen: It just seemed funny to have your hip replaced ... it's usually an elective procedure. And I mean, in his case, there may have been a pain issue that needed to be addressed. It just struck me as funny timing that this guy has like a few more weeks to pass this law he's worked for and he's not around right now.

Rovner: Yeah, well, one of the things that Congress thought it was going to get done but didn't before the summer break, was that bill to reauthorize the user fees that fund much of the drug review staff at the FDA. This is a bipartisan program. Sarah, remind us again why it got stuck and when it might get unstuck.

Karlin-Smith: Burr is a big reason or perhaps *the* reason why it's stuck. Essentially he and Patty Murray, the co-leads on this in the Senate, had come to an agreement and then when the bill got marked up, there were a number of amendments added to it that Burr was unhappy with and he changed his mind and said, "You know what, I don't I don't want to deal with adding all this policy on to this FDA user-fee bill. Let's just do a clean bill." That's certainly not what the House passed. That's not what Democrats wanted. Even, to some degree, obviously, there were things Burr wanted added to this bill as well. So now we're in this bit of a stalemate where they have to figure out how to move forward. There's been some sort of, I would call them, rumors of sorts percolating over the past week that maybe they could just attach a clean user-fee reauthorization to the CR. I have also heard, could they just extend the current user-fee program a little bit in the way a CR extends government funding a little bit?

Rovner: I think they've done that before once or twice.

Kenen: I think so, too. Somebody told me that I was wrong. But I mean, there's also things you could do temporarily. Congress does temporary reauthorizations all the time.

Rovner: Yeah.

Karlin-Smith: And the big thing is, is that if you don't get this done by the end of September or even ahead of that, FDA has to warn staff whose funding is reliant on these user fees, you know, we may have to furlough you, maybe may have to lay you off. That just creates big ramifications for the FDA in terms of its ability to hire, retain staff, do its work. I don't get a sense that Democrats want to do a just clean user-fee bill on the CR because they have some leverage here, I think. And they don't want the clean bill. They want to get something bigger than that ideally. But we'll see what happens. And like you said, Burr, being at least semi out of commission makes it a bit harder for them to get this done.

Kenen: I mean, he has staff and he has a telephone, but it just seems that his actual presence affects the dynamic in the next few weeks.

Rovner: Yeah. All right. Well, we will obviously talk about this more as we push closer to the midterms, but that is the news for this week. Now we will play my "Bill of the Month" interview with KHN's Lauren Sausser. Then we will come back with our extra credits.

We are pleased to welcome to the podcast, my KHN colleague Lauren Sausser, who reported and wrote the latest KHN-NPR "Bill of the Month." Lauren, welcome to "What the Health?"

Lauren Sausser: Thanks for having me.

Rovner: So this month's patient did everything we say patients should do in advance of a scheduled medical procedure and got hit with a huge bill, anyway. Tell us who she is and what kind of medical care she needed.

Sausser: I spoke to a woman named Dani Yuengling, and she's 35. She lives in Conway, South Carolina, which is near Myrtle Beach, and she needed a breast biopsy. Her mother had been diagnosed with breast cancer when Dani was an adolescent. Her mom eventually ended up dying from breast cancer, actually. And it was last year that Dani self-diagnosed a lump in her breast. She ended up getting a mammography, I think it was in January. And then that determined that she needed a biopsy. The biopsy was scheduled for Valentine's Day of this year.

Rovner: So she knew she had a high-deductible plan and could potentially owe several thousand dollars. So she set about doing her due diligence. How did she try to figure out how much she was going to be on the hook for this biopsy?

Sausser: Sure. This was the part of the story that I found so interesting and frustrating, because here is an example of a patient who really, really did try to follow a lot of the advice that we give patients. She contacted the hospital and tried to get an idea of how much this was going to cost. The people at the hospital couldn't tell her. They said that the price of the procedure was contingent on the biopsy needle that they needed to use, but they wouldn't know what needle to use until the procedure was underway. So that was a dead end. She then went on the hospital's website, I think it's called the patient payment calculator, and she was having trouble entering her insurance information. But the calculator lets you look up prices for different procedures. So what she did was she said, Well, let's just assume that I had no insurance at all. What's the worst-case scenario that I could possibly owe? So on the website, the patient payment estimate her showed her that someone who was uninsured and getting this breast biopsy at Grand Strand Medical [Center], which is in Myrtle Beach, would pay about $1,400. That's the hospital where she was getting the biopsy done. And she thought to herself, OK, great. That seems reasonable to me. She also went online and just did a simple Google search, which indicated it might be closer to $3,000. Again, she said, that seems reasonable. That's within my budget. These are numbers that I can deal with. So she went to get the procedure and thought that with her $6,000 deductible through her Cigna health plan, that after all was said and done, she might owe between maybe $1,500-$3,000 for the procedure.

Rovner: And the good news was that the biopsy was negative. So no cancer.

Sausser: The biopsy was negative. That was great news because actually Dani was 35 when she got this procedure done, which was the exact same age her mother had been when her mother was diagnosed with breast cancer back in the late '90s. So this was a really stressful time for her and obviously there was a huge sense of relief to find out that she did not have cancer.

Rovner: But the bill, not so much a sense of relief.

Sausser: Not so much. In fact, she was downright shocked when the bill came. So, to keep it simple, Grand Strand billed Cigna, which is her insurance plan, almost $18,000 for the procedure — that included lab work and pharmacy and all the supplies they needed. The insurance

company's negotiated rate automatically lowered the bill to about $8,400. The insurance company paid about $3,300 of that. But Dani Yuengling was billed the rest of it. She got over a $5,000 bill for this breast biopsy when she was only expecting to pay, like I said, you know, $1,500 to $3,000. And her initial thought was, well, something is certainly wrong. So she called the hospital. The hospital said, no, these charges are correct, but we'll give you a discount. And they automatically reduced what she owed by about 30%, which left her with, I think it was around $3,000-something.

Rovner: Which is still a lot, but at least not the $18,000 that she was originally charged.

Sausser: Yeah, she was still really frustrated and she was ... she just couldn't understand. Like I said, she had done all that homework. She asked for an itemized bill. The charges were really high, and she was literally losing sleep over it. So she decided to put it all on a credit card and just hope that the whole thing went away. She also kept calling the hospital's patient advocate, and the hospital eventually said, "We'll conduct an audit of your bill." They outsourced that audit to a company called Parallon, which actually, since publication I've learned, is owned by the same parent company that owns the hospital. And eventually the audit determined that the charges were appropriate.

Rovner: Surprise.

Sausser: Yes, that's basically it.

Rovner: So one of the big ironies here is that if she didn't have insurance, if she hadn't have had insurance, she would have been charged an enormous amount less. But she didn't actually have access to that cash discount, did she? I mean, the thought was, well, rather than put it through insurance, she could have just paid cash.

Sausser: It gets a little confusing because the people at Grand Strand Medical Center — and I should say that Grand Strand is owned by HCA, which is a huge for-profit hospital system in the United States — they contend that the patient payment estimator that she used online was wrong and it was just spitting out wrong numbers. And they blamed it on a glitch, and they said the glitch needs to be fixed. They said the actual price that an uninsured patient would pay for the procedure might be as high as, I think they said, $11,500. So they contend that the online estimator was just wrong, that Dani Yuengling got the wrong price, and that, in fact, someone who is uninsured would pay a lot more than that $1,400. That's not the case at every hospital. We reached out to the closest hospital to Grand Strand Medical, which is Conway Medical Center, which is actually closer to where she lived, and an uninsured patient at Conway Medical Center would, for the same sort of breast biopsy, would owe about $2,100. So, yes, if she had been uninsured and gone to a closer hospital, she would have owed a lot less.

Rovner: So the federal No Surprises Act that took effect this year should help patients like Dani in the future because they can go directly to their insurance company for an estimate. What else should they do to avoid being caught in this same situation?

Sausser: Yeah, that's a great question. I learned something in reporting this that I didn't realize. I thought that when Dani had gone to the hospital before her procedure and asked how much this

is going to cost, I thought that the federal No Surprises Act obligated the hospital to give her that good faith estimate. It turns out that they're only obligated to do that for patients without health insurance. And Dani had health insurance. The federal law requires the health plans to give their customers good faith estimates. But — and this is a big but — that part of the law is not being enforced. So there's literally nowhere she could have gone, either to her health plan or to the hospital, where she would have been entitled to a good faith estimate. That makes things really hard. She could have shopped around. If she had called, for example, Conway Medical Center, like we had reached out to, they apparently have lower prices for uninsured patients. She could have paid cash there and paid less. And, more generally, I spoke to some experts who suggested that all patients, whether you have health insurance or not, should look into cash prices for outpatient procedures.

Rovner: And particularly if you have high-deductible health insurance.

Sausser: Exactly. Exactly. Because a lot of times there are discounts baked into cash prices that hospitals are willing to pass along. The flip side of that, though, is ... let's say you go to a hospital and say, “I don't want to bill my insurance for this breast biopsy; I just want to give you $2,000. Here you go.” None of that money is going to be applied to your deductible. I broke my elbow last year. Let's say you break your elbow a few months later and end up with huge hospital bills. You know, you're sort of at square one in terms of your deductible. So it might not make financial sense in the long run, obviously, because we can't predict the future. But yeah, there were a few things she could have done. Again, it's an extremely frustrating situation because she did do quite a lot and she still ended up being sort of screwed.

Rovner: What happened with the bill?

Sausser: She paid it. She put it on her credit card. That audit determined that the hospital believes it charged her appropriately. She has filed a complaint with the Centers for Medicare & Medicaid Services. I don't know what's going to come of that. It's still pending. But that's another avenue that patients do have. You can file complaints with the federal government regarding your medical bills.

Rovner: We'll let you know what happens. Lauren Sausser, thank you so much.

Sausser: Of course. Thanks for having me.

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: This is a piece from ProPublica by Marilyn W. Thompson and Jenny Deam. And the headline is “‘The Human Psyche Was Not Built for This.’” And we've all read stories, of course, about states that have abolished mandates for vaccines and other things. And we've all read about crises in hospitals. So some of the story’s familiar, but this is really deeply reported inside a hospital juxtaposing ... when Montana went from a Democratic to Republican governor. Public

health requirements were basically rolled back and abolished. And then how the repercussions in a hospital that really went into crisis mode, that literally did not have enough ICU beds, that had to go to crisis care standards, which is agonizing for care providers who were trying to save lives. And also they were state lawmakers' relatives or state officials' relatives in the hospital. They were smuggling in ivermectin and hiding it in milkshakes. And it's a really beautifully written, deeply reported encapsulation of a lot of what went wrong last year.

Rovner: Yeah. Sarah.

Karlin-Smith: I looked at a piece by Helen Branswell at Stat: "Study Raises Concerns About the Effectiveness of the Monkeypox Vaccine." One of the reasons I picked it is this came out right before Labor Day weekend and, I think, didn't get a lot of attention. But it has an important public health message for people getting the vaccine, which is essentially there is a study and it's still in pre-peer review and so forth, but that suggests that the immune response people are getting to the monkeypox vaccine may not be as strong as we need. And this goes back to how FDA originally cleared this vaccine, which is [to] go through an unusual process where they use the animal role and basically relied on efficacy and animals and then tested again this immune response in humans and believe it should be effective. But we don't really know how effective. We don't know is it going to prevent infections? Will you maybe get infected but they'll be milder? And so forth. And again, like I mentioned, I think it's just important for people who are taking this vaccine to realize that if you need it and are at high risk of monkeypox, you do probably want to get this vaccine and get that protection. But you also have to be aware that it may not be perfect. It may not totally protect you from getting infected. So you have to think about what other precautions you might want to take in your life to lower your risk. Just as, and I think we've sort of not been great about this in the U.S., you know, you have your covid vaccine, but there are situations certainly where people would recommend you wear a really good, high-quality mask indoors, for example, even though you're vaccinated. So it's just getting out that message to people that the availability of this vaccine is not a silver bullet in and of itself. You have to think about your whole range of protectiveness.

Rovner: Or as I like to say every week: It's all about public health communication. Alice.

Ollstein: I chose a piece in The New Yorker by Yasmin Rafiei — I hope I got that name right. It was a really devastating look at the impact of private equity buying up nursing homes specifically, although this is an issue throughout a lot of different health care facilities. But it looks at this one particular facility in Richmond, Virginia, where things just got so bad after this private equity firm came in and there was this profit motive and they just slashed staffing, which was really at the root of all of these issues. And people were going for days without getting bathed and were suffering in all of these ways. Deaths from covid went way up, as well as deaths from other causes. Again, a very thoroughly reported, really depressing look at the impact of what happens here. And this is on a lot of folks' minds as parents age and they look into what kind of care is available to them. So this is another factor that people need to take into consideration.

Rovner: Or, as I like to say, "This Week in Private Equity in Health Care." My story is from my KHN colleague Sarah Varney. It's called "When Does Life Begin? As State Laws Define It, Science,

Politics, and Religion Clash." This is a topic that I first explored in 2005 during the debate over the morning-after pill and again in 2011, when states first started to debate granting, quote unquote, "personhood" to fetuses. The bottom line, of course, is that no one agrees on when life begins, although it is medically accepted that pregnancy begins not at fertilization, but rather at implantation. And that's for fairly practical medical reasons, one being that pregnancy tests don't turn positive until implantation, but also because as many as half of all fertilized eggs never implant, which would be problematic if we called every lost fertilized egg a miscarriage or an abortion. What's so interesting about Sarah's story, though, is that it explores how the medical and legal community has been able to basically agree on what constitutes the end of life, which is almost, although not quite, as thorny a medical, scientific, religious and ethical issue as when life begins. Might we be able to eventually do the same thing for when life begins? Well, we clearly haven't so far. So the struggle continues.

Kenen: It is a great piece. I read that. Yeah, yeah, it's very good. I just tweeted it. Yeah.

Rovner: It was really good piece, very thoughtful and something I'd never really looked at before. All right. That is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review — that helps other people find us, too. Special thanks, as always, to our producer, Francis Ying, who makes the weekly magic happen. 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. Alice?

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