KHN's 'What the Health?'

Episode Title: ACA Open Enrollment Without the Drama
Episode Number: 271
Published: Nov. 3, 2022

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 reporters in Washington. We're taping this week on Thursday, Nov. 3, 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: Tami Luhby of CNN.

Tami Luhby: Hello.

Rovner: And my KHN colleague Julie Appleby.

Julie Appleby: Hello.

Rovner: Later in this episode, we'll have my KHN-NPR "Bill of the Month" interview with KHN's Arthur Allen. This month's patient got a very big bill for a very old cancer drug. But first, this week's news. The Affordable Care Act's 10th annual open enrollment begins this week. In most states, it runs until Jan. 15 of 2023, although if you want coverage that begins Jan. 1, you have to sign up by Dec. 15. Those are pretty much similar things, but there are some pretty big changes for next year. Julie, you are our resident ACA specialist. What are some of the changes that people should be watching for?

Appleby: Well, one of them is not really a change. It's a continuation of something that happened in 2021 and 2022, and that would be the enhanced subsidies. So, if you remember, these were set in place under the provision of the American Rescue Plan [Act], I believe, and it was continued by the Inflation Reduction Act, which was approved by the Democrats this year. So basically, what it means is that people who earn up to 150% of the federal poverty level can get a zero-premium plan. Then there are sliding-scale subsidies for people up to 400% of the poverty line. And these subsidies are bigger than they used to be. And above 400% there's no longer "the cliff," as it was called, because people are required to pay no more than 8.5% of their household income for premiums. So that's a change as well that continues. But I think the biggest change is that more families may be eligible for subsidies, and this is what has been commonly known as "the family glitch." So under some new rules that were finalized by the Biden administration, basically, it expands the number of families who have job-based insurance that might be able to skip that insurance and instead get an ACA-subsidized plan. And it's all tied to what's considered affordable or not. So remember, under the previous rules, affordability was based on whether or not a

person's insurance at their job was affordable, and affordable was considered based on employee-only coverage. So how much it would cost that worker out of their paycheck in premiums, their share of the premiums for single-only coverage. But that didn't count how much it cost to add in the dependents, which is a lot more. As we know, family coverage is much more expensive, and employers tend to subsidize it less. So now both of those things are going to be taken into account. They will look at single-only coverage, but also how much it might cost for the person to add their family. And if that amount is higher than 9.1% of their household income, that family *could* decide to look into getting an ACA-subsidized plan instead. Now, not everybody would save money that way. So some of the experts tell me that people really should weigh the pros and cons of that before deciding. But that's one of the new options.

Rovner: Yeah, because there were stories about people who were making $30,000 a year and because the employer subsidized the employee's insurance, they would only have to pay $1,000 a year for their insurance. But if they wanted to add their families, that would be $10,000 a year, and they couldn't afford that. And then the family wouldn't be able to get subsidies on the exchange. And that is changed for now, although we don't know whether this is a permanent change, right? Because it's not something that Congress did.

Appleby: No, it's not. And it might be challenged in court. We haven't seen that yet, but it's possible. But what the experts tell me is that people who want to enroll for this coming year and feel that they would get a benefit and they do run the numbers, they should just go ahead and sign up, because anything that gets challenged will take some time. So they might as well sign up this year and see what happens. But yes, it might possibly be challenged.

Rovner: I also saw something about standardized plans. This is something we've had in Medigap for generations. But it's finally come to the ACA, right?

Appleby: It's finally come to healthcare.gov. There were a few states that were doing this. And what this means is that they've got some plans that if you're an insurer and you're offering Affordable Care Act coverage, you also need to offer now a standardized plan. And basically, these are plans that have the same copays and deductibles and cost sharing, so that you can more easily compare across insurers is the idea. And so those will be offered alongside of nonstandardized plans in the healthcare.gov marketplace, which serves 33 states. So it's kind of a big deal. And I went on yesterday just to look and see how they were doing this. And you go on healthcare.gov and then you click on a couple of filters and you look for something they're calling the easy pricing plans. So "easy pricing" are the plans that all have the same deductibles and copays. So they're a little bit separate from the others. But you could also see the nonstandardized plans as well. But that's new for this year for the vast majority of states.

Rovner: So are we at the point yet where the ACA is ... it's routine? It's like, you know, we talk about Medicare open enrollment every year. Now we talk about ACA open enrollment every year. It is not that big a deal.

Appleby: Look, this year we had a record number of people enrolling — it was something like 14 million people, and a lot of that was tied to the enhanced subsidies. People got more subsidies and

so they were able to purchase coverage. And so I think it's become commonplace for them. But remember, also something like 40% of people were auto-enrolled. They don't go back in and shop, and most folks say you really should go back on and look around because your plan might have changed pricing. And the subsidies, remember, are tied to the second-lowest-cost silver plan. So as those plans go up and insurance is increasing — it's on average about 4% this year — the subsidies go up as well. But you might not, if you're getting a subsidy, you might not see that savings without changing plans. You might have to change plans. So they're saying shop around. But a good 40% of people are auto-enrolled and because that means they didn't go in and shop. So I think it is becoming pretty routine. People understand it, but there's still an awful lot of people who don't know about the open enrollment, and some of these other things that we were talking about today as well.

Rovner: Tami, you were about to say something.

Luhby: This is actually the first year that I didn't cover ... I covered the landscape report the year before, but I didn't write the Nov. 1, like, “Open enrollment is happening ...” because it [has] become, after 10 years, pretty much part of the landscape. And also we have the midterm elections coming up next week. And unlike in 2028 and in previous years, we don't hear a lot of Republicans saying that they want to repeal it. So ...

Kenen: Until yesterday! [laughter all around]

Rovner: Let me do my gracious segue. This is our last episode before Election Day. And I was going to say that this is the first election since 2008 where Republicans aren't running on repealing the Affordable Care Act. But then Joanne pointed out that that is not quite the case. In Arizona this week, Republican gubernatorial candidate Kari Lake not only called for the overturning of Obamacare, she went on to criticize the late Republican Sen. John McCain, who's still pretty beloved in Arizona for his critical thumbs-down vote preventing the gutting of the Affordable Care Act by Republicans in 2017. Lake is pretty much alone on this. Most Republicans, as Tami mentioned, have not mentioned the ACA on the campaign trail. Repeal isn't in any of the platforms put out by party officials, assuming that Republicans take over the House and/or the Senate. So what happened and what does Kari Lake think she knows that other Republicans don't?

Kenen: I was a little surprised by that, and she does not have a replacement plan. She says, let's ... we'll repeal it and we'll come up with something better. Well, the Republicans tried that for 10 years and failed. They failed when they had Trump in the White House and when they had control of both the Senate and House, they still failed. They had trouble getting it through the House. I mean, they finally squeaked it through the House, and they never got it through the Senate. So they're not talking about it anymore. I was surprised that Kari Lake did that. She's in a very, very, very tight race for Arizona governor. She is considered slightly the favorite, although it's certainly a margin-of-error race. Conventional wisdom is she's a little ahead, and she's a very dynamic, engaging candidate. And her Democratic opponent has had a lot of criticism for not being a great campaigner. But if you're a little bit ahead and you got all this momentum, I don't know why you ... call for taking ... repealing Obamacare, which is not going to happen. She's basically saying I'm going to take health care away from X number of people in Arizona and I'll figure it out later. So I

didn't know that politically, strategically — she's already got the base. She's an election denier. So I just didn't understand what she was thinking and why this helps her. What independent who hadn't made ... or undecided voter who wasn't for her is now going to be for her because she came out for Obamacare repeal? I don't understand the political thinking of it. I think she may win, but not because of this.

Rovner: Right. Or maybe she was just looking at the script from the last election.

Luhby: With the pandemic and the importance of health insurance and the enhanced ARPA subsidies for the last two years that are going to go on now through 2025. We have a record 14.5 million people signed up for coverage last year. The Affordable Care Act has become more ingrained in our country, and we don't know how many more people are going to sign up. But the Biden administration is providing a record nearly $100 million for the navigators to go out and try to help people enroll and to advertise the fact that this exists and that the subsidies exist. And this will also become more important because we do generally expect the public health emergency to end next year, and the navigators and the Affordable Care Act will become even more important when you have millions and millions of people who are going to lose Medicaid eligibility that they've had throughout the pandemic.

Rovner: Yeah, just for those who have not been paying attention, the public health emergency required states to keep basically everybody who qualified for Medicaid at any point to stay on. And when the public health emergency ends, all of those people are going to have to be reevaluated to see if they're still eligible for Medicaid. And there is the expectation that when the public health emergency ends that a lot of those people are going to lose Medicaid, and some of them will be eligible for subsidies on the — actually, *most* of them should be eligible for subsidies on the Affordable Care Act exchanges. But that's going to be a big transition that states are gearing up for.

Kenen: And one other thing about that is there's a lot of economic uncertainty right now. We don't know, are we going to have a recession? Are we not going to have a recession? We could have a deep recession, we could have a small recession. People who lose their jobs, if we get to that point, the ACA becomes a backstop for people who lose employer-sponsored insurance, who become unemployed, and there are special enrollment periods. If anything happens to you outside of open enrollment period, this could become part of the economic safety net that people can turn to. Not that losing your job is a good thing, but at least you have the backdrop.

Rovner: You don't have to lose your health insurance if you lose your job.

Kenen: Yes, right, which used to be, you know, I mean, that's ... we have no idea what the economy is going to look like in a couple of months. But that's there in a way that it wasn't in our last really big recession, which was 2008, after the crash.

Luhby: As Julie said, the important thing is that with these enhanced subsidies through 2025, people at the lower end of the income scale will get pretty much free coverage, which will make it much easier for them to sign up, even easier than it was prior to the rescue plan ...

Rovner: Public health ...

Luhby: ... the American Rescue Plan, because prior to that, the subsidies were not that great for a lot of people.

Appleby: There's one other thing with the low-income folks, as well, iss there's this low-income open enrollment that is not tied to the open enrollment that's on right now. If you are below 150% of the poverty line, you can sign up actually every month. You don't have to wait for open enrollment. So that's also a little-known thing about the changes that are in place right now for folks to sign up for the ACA.

Rovner: And that's going to be really important as people are disenrolled for Medicaid over the course of the year.

Luhby: Mm-hmm.

Kenen: Just like the Republicans aren't campaigning on repeal, Democrats aren't talking about Obamacare as a positive thing right now, either. I mean, they're not going to say, yeah, well, you know, we might have a recession, but what got you covered on health insurance? I mean, it's sort of ... that wouldn't be great. But the normalization over the last two years has really solidified. I mean, it's not that we'll never hear some debate. There's another court case about preventive benefits and ... the litigation will just keep popping up. But it really has normalized in a way, it's settled down in the last two years, and there'll be debates about these subsidies again, and [these] enhanced subsidies in 2025. But that's a long way from now. It's just a really different feel this enrollment season.

Rovner: Yeah. Well, meanwhile, what used to be the big health election issue that Joanne and I will remember, before the Affordable Care Act, is back — meaning Social Security and Medicare. Republicans promising to cut entitlement spending and Democrats vowing to prevent them from doing that is an oldie but goodie, particularly in midterms where the electorate tends to skew older, meaning people who are already getting those benefits. Normally, cutting entitlement spending is kind of an empty threat for Republicans. The programs are really, really, really popular. But this year, there's worry that if Republicans take over the House or the Senate, they could actually accomplish their goal by tying it to the raising of the debt ceiling, which would basically blackmail President [Joe] Biden into either signing a bill that cuts entitlements or vetoing it and having the Treasury default. But the Democrats are bringing this up now, and so is President Biden. Why haven't they been bringing it up before now? This has been sort of a big, fat, over-the-home-plate pitch that they just haven't wanted to hit.

Kenen: I mean, this has been the most un-health care pandemic — I mean, abortion and reproductive health, obviously is health care, too. But in terms of traditional health care, in terms of cost coverage, who gets insured, how they get insured, this is the least health care election we've had probably since the early Nineties. And pivoting toward it *now*, I don't know that it makes much difference. I mean ... for the Democrats to go out in the last week and yell ... particularly explaining what the debt ceiling is and why, you know, it's complicated. We're in Washington. We understand the debt ceiling. We understand the gamesmanship. Julie and I at

least were around in 2012 when similar ... a similar dynamic. But there was a bipartisan deal cut between [President Barack] Obama, when Biden on one hand and [then-House Speaker] John Boehner on the other. But that's all ... we're in a different world. We don't do bipartisan deals anymore. But trying to turn it into a health care election in the last week — I don't know that that makes much difference.

Luhby: And, you know, Democrats have certainly been talking a lot about Republicans wanting to cut Medicare and Social Security, but we haven't really seen, particularly Republican leadership, saying this.

Kenen: Rick Scott.

Luhby: They're pretty much drawing on ... right, they're drawing on a very old plan already from earlier this year that the Republican leadership have pretty much disavowed. They're drawing on one controversial senator's comments.

Rovner: Well, and Ron Johnson. Two controversial senators.

Luhby: No, that's the controversial senator.

Kenen: And Rick Scott. I mean, there's two.

Luhby: Right. And a very old plan from earlier this year. It's not like it's been a very big talking point. And this is what the Democrats and Biden are having to use as a scare tactic because this is what they think will resonate with voters. But there really isn't a ton of evidence now that a Republican-controlled Senate will do this.

Rovner: We will have to wait and see. I think a Republican-controlled House is more likely to do it than a Republican-controlled Senate. But again, there's a lot to shake out. Well, meanwhile, abortion is not turning out to be the magic bullet that Democrats hoped it would last summer. Studies out this week show the number of abortions is down, particularly though, not surprisingly, in states that have instituted bans or severe restrictions. A separate study finds, again, not that surprisingly, that women seeking abortion are having to travel further to get it. But at least in Michigan, one Democrat is trying to tie abortion and — what's emerging instead as the most pivotal issue of the year to voters — the economy. Our podmate, Alice [Miranda] Ollstein reports that Democratic Gov. Gretchen Whitmer is making the case that if Michigan voters approve a ballot measure guaranteeing a right to abortion, then the state could attract business from other surrounding states where abortion is now restricted or banned, which is most of the states surrounding Michigan. I don't know whether that's great politics, but I wonder if the claim is real, that businesses will relocate, in general, from states with abortion bans. We haven't seen that yet, right?

Kenen: We've seen some conversation about it. I don't know how much reality there is yet. But also, it's not just relocating. It's where people are going to locate in the first place. That might be more realistic. There's been talk about a lot of the companies — financial services and tech companies — that when California got so expensive, they started moving to Austin. Some of those people are telecommuting. Is the California-to-Texas pathway going to persist, or are they going to

go somewhere else because of the restrictions in Texas? I don't think we really know yet. I mean, this is all pretty new, but it's an interesting political take in Michigan.

Rovner: Yeah, I would ...

Kenen: I mean, you hear about people choosing colleges based on whether it's an abortion or an anti-abortion state for sons and daughters. You hear about, certainly, the practice of medicine, where people want to practice, where can they practice? I'm not sure we know what corporations are going to do. It's one of many factors a corporation would take into account, including things like taxes.

Rovner: Yeah.

Kenen: Labor law.

Rovner: Yeah. That's why people want to move to Texas. Companies seem to be more active in promising travel benefits for employees who need to travel to get an abortion and maybe where they're going to locate ... that seems to be the trend. Anybody seeing anything other than that? No. I didn't think so. All right. Well, in some awkward news this week, the Food and Drug Administration has told Politico that it opposes the advance prescription of the abortion pill because it's worried that patients may not use it correctly if they get pregnant. Now, one more time, this is not the morning-after pill, which prevents pregnancy and which reproductive health experts do recommend that women of childbearing age have on hand in case they need it, because the sooner you take it, the better it works. This is the actual abortion pill we're talking about, which can end a pregnancy up to 10 weeks. Now, on the one hand, this shouldn't be that surprising. The FDA has only approved the pill under some pretty strict conditions, and buying it in advance — particularly from overseas, where a lot of these pills are coming from — doesn't meet those conditions. On the other hand, the Biden administration has said repeatedly it wants to support women's ability to access abortion, and this doesn't actually do that. Could there be a backlash or is this just part of the abortion background noise of which there is so much right now?

Kenen: I mean, I don't think that the White House is going to tell the FDA overtly: Ignore your judgment about safety and science. Right? I mean, we may see this evolve. We may see ways of creating some kind of safety measures or packaging around it. The fear is that a woman would take this either too late in a pregnancy or that she could have an ectopic pregnancy or some other kind of dangerous situation that could be life-threatening. You know ... the FDA wants people to get medical advice before taking these pills because it's more than one. But, I mean, could this evolve? Yes. Is the White House going to just publicly tell the FDA to change its mind? No. Could we see it mutate? — that isn't exactly the word I'm looking for, but, you know — be modified over the coming months? Probably. But I don't know. I mean, it could, and maybe not. Maybe the FDA just says this is not something that you just treat yourself with it. Pregnancy is a big deal.

Rovner: I should point out, the FDA also says that you shouldn't buy any prescription drugs from overseas, and yet people do it all the time and they don't police it *that* actively. So I'm wondering if this also becomes part of that. There's a lot more people buying drugs from Canada and elsewhere than having those drugs caught in the mail on their way in, although occasionally they

do. Well, finally this week, a story that caught my eye about antitrust, of all things. This is one of those esoteric but really important tools the federal government can use to try to control health care prices by stopping anti-competitive mega-mergers. And in one tiny victory this week, the Justice Department announced that it had secured a guilty verdict from a nurse staffing company that provided school nurses in Nevada. Now, they had the firm pretty much dead to rights. They had emails to a competing firm that said things like, quote, "If anyone threatens us for more money, we will tell them to kick rocks!" And quote, "I am glad that we can work together through this and assure that we will not let the field employees run our businesses moving forward." So, yeah, pretty open-and-shut here, but this was actually the first successful criminal prosecution for a labor market antitrust violation. Is this a one-off, or do we think we might see more emphasis on the antitrust side, on controlling health care costs? Julie, this has been talked about over many years, about trying to stem over-consolidation, both on the insurance side and on the hospital side. But we haven't seen it used that much.

Appleby: We have not. There's been a lot of antitrust cases back and forth over hospital consolidation, for example, and the government doesn't necessarily have a great track record in winning those. They've won some and they've lost some. So this is a very interesting development, I think.

Rovner: I noticed this week the government did stop two large book publishers from merging. So that's also a sign. And anybody think we're going to be talking a lot more about antitrust in the months to come?

Kenen: Well, you know, that was something that HHS [Health and Human Services] Secretary [Xavier] Becerra, when he was attorney general of the state of California, I mean, that was his hallmark issue. He sued Sutter, which was an enormous, very powerful, and high-cost health care system in Northern California. And he won. And if we didn't have a pandemic and a million other things going on, this is an interest of his; this is something he has experience in, this is something he's had success in. But we're not seeing a lot of talk or action about ... partly the HHS doesn't do this.

Rovner: It's the Justice Department.

Kenen: Justice and FTC.

Rovner: Right. The Federal Trade Commission.

Kenen: I mean, he could make noise and he could talk about the role of consolidation and monopolization. And ... there are probably things they could do on a regulatory basis. They certainly could bully-pulpit. But we're not hearing or seeing it because ... we're not hearing or seeing that much from HHS. I mean, they're not running the pandemic response. So I think, under different circumstances, there might be more visibility. It's also confusing, right? I mean, you say antitrust and people want to run away. So it's complicated. Even for health care, it's complicated. And, in some ways, consolidation and efficiency is good, but too much consolidation becomes monopolization. And people argue about what that tipping point is. But we haven't seen it from Becerra.

Rovner: Yeah. If you think the debt ceiling is complicated, wait until you get to antitrust policy. So we will watch that space. OK. Well, that is this week's news. Now we will play my "Bill of the Month" interview with Arthur Allen, and then we will come back to our extra credits.

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

Arthur Allen: Thank you. Good to be here.

Rovner: This month's patient has cancer, which we all know is expensive to treat, but this is still a pretty eye-popping bill. First, tell us who the patient is and what kind of medical care he got.

Allen: Yeah. So his name is Paul Hinds. He's about 59, lives in Chicago, is a cybersecurity consultant. He had prostate cancer. When he met his girlfriend in 2017 — she's a doctor — she insisted that he get a checkup. She said she doesn't date anybody who doesn't take care of their health. He went in, and he had a very elevated PSA. He tried to drive it down by taking THC, but he was stoned out of his head for three months and couldn't get any work done. So he tried a few other things, always sort of under her guidance, to avoid the inevitable when you have advanced metastatic prostate cancer, which is basically chemical castration. And still the standard treatment is leuprolide, or Lupron — in his case, Lupron Depot, which is a drug that is slow-released.

Rovner: So he gets a shot of this drug that was invented in the early 1970s, and you'd have every reason to believe there would be a generic version of it by now. And then the bills came, as they say. How much was he charged?

Allen: The bill for the two shots was about $75,000, of which …

Rovner: Wait — say that again.

Allen: $75,000 for two shots of a drug that lasts for three months, Lupron Depot. That's what the hospital charged. The insurer paid about $20,000 of that, and another $8,000 was left in his lap. He paid some of it off and then went on a payment plan for the rest of it.

Rovner: So, how could this drug still be so expensive? I take it this is not a one-off thing.

Allen: Yeah, they've been very clever. The company that makes it in the U.S. now is AbbVie, which was split off from Abbott Laboratories, which had the original patent and which then combined with a Japanese company, Takeda, in 1989 to make this slow-release form, which started the whole patent clock over again. And there is at least one other drug in the U.S. that's very similar. There are several others that have the same effect, essentially, that are different chemically. But it's still the treatment of choice for reasons that are not entirely clear to me. And once his girlfriend realized that he could go on an oral drug and he pressed for that, he got it. And that drug he paid much less for.

Rovner: So as it turns out, the hospital didn't pay all that much for the drug. Why was that? I take it there's this program involved called "340B."

Allen: Yes, there's this program, 340B, which started in 1992. It was created because the idea was that there are hospitals that serve very poor populations that don't have the wherewithal to pay their bills. And so these hospitals get a discount on drugs, significant discount on drugs. The discount is based on what Medicare pays for the drug. So, in this case, Medicare, the amount that it pays for Lupron is in the hundreds. And 340B, I believe, reduced that significantly. We estimated that for these two shots of Lupron, the hospital would have paid in the neighborhood of $800. When I ran that by them, they said, "Oh no, it was more than that." But they wouldn't give anything specific. So then they charge this huge amount, and it's basically what the traffic will bear. I mean, it's part of their whole system of collecting money and paying for the unpaid bills and also for their profit. And it's very obscure. It's a black box.

Rovner: It is. So what eventually happened with this bill?

Allen: Well, so he paid the first thousand or so of it and then set up a payment plan for [the] about $7,000 remainder. He was supposed to make a payment of $666 a month, which he did twice. And then they announced suddenly that they were sending his bill to collection, and mysteriously — the mysteries of the billing department. And we called and asked them about it, and they said, "Oh, that was a mistake." And they said they're continuing the payment plan now. But this is just part of dealing with a serious disease in America, dealing with insurance and the way the system is set up.

Rovner: And the good news here is that he's back on the hook for six hundred and some odd dollars a month, right?

Allen: Yeah, exactly. Right. That's the good news.

Rovner: So what's the takeaway here? It's pretty hard to comparison-shop when you're in cancer treatment.

Allen: Yes, it is. And I mean it helps, obviously, to have somebody in your corner who knows their way around the medicine. And I think that helped him somewhat. But even so, even having this medical doctor who was helping him trying to find alternatives and eventually got him on this oral drug still took him forever. And it is legally required now for hospitals to list the prices that they charge for things. So theoretically, he could have gone on and looked — well, am I better off getting this treated at the University of Chicago or, I don't know, whatever the other hospitals in Chicago are? But on the other hand, his doctor practiced at the University of Chicago. So what's he going to do, suddenly switch? And I assume the other hospitals are not charging nothing for it either. So there are options for how to find alternatives. But the chances that you're going to make a significant and painless transition just based on price are very unlikely, I think, slim.

Rovner: Basically, this is a problem that policymakers are going to have to solve.

Allen: Right. Right. And they sort of nibble at it here and there. Like requiring that the prices be listed is one thing. And you can find list prices for drugs online, too. That's very easy to do. But, ultimately, if you have a doctor that you've been seeing and that you trust, I think you're kind of at the mercies of what other medical system they work for.

Rovner: Indeed. Well, Arthur Allen, thank you very much.

Allen: Thank you. Thanks for having me.

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

Luhby: My extra credit is an issue that we've heard a lot about, mental health care. The Washington Post has been doing several really strong stories on this lately. It's a Washington Post story by Rachel Zimmerman headlined "A Psychiatry Wait List Had 880 patients; a Hospital Couldn't Keep Up." And it explores both the long waits patients with mental health issues have to endure, but also what some therapists are doing to try to help these patients until providers can see them. The hospital referenced is Massachusetts General Hospital, and at one point it had 880 people on its waitlist this summer and actually asked physicians to stop referring patients for non-urgent care. The story explains that the backlogs are common around the nation, with more people seeking counseling during the pandemic. For this story, the Post reached out to more than 300 health care providers, as well as patients and policy experts. And that's a lot of people. More than half described long waits for care. The piece also looked at some unorthodox workarounds, including one provider who created a 12-step support group that she livestreams weekly on TikTok and Facebook while hosting on Zoom. And others have reached out to clergy and people like soccer coaches to serve as de facto therapists for children and adolescents. It also included the voices of patients about the devastating effects that the provider shortage and long wait times have had on them and their families. So it's one of the latest stories on what's been a major problem in the U.S. It's long been a problem; the pandemic has exacerbated [it[and has brought more of it to light.

Rovner: Yeah, and actually my extra credit last week was another one of The Washington Post's really good stories about mental health care. Joanne.

Kenen: This is also about mental health because this is about substance abuse. As regular listeners know, I've been trying to find stories from some of the startup nonprofits around the country that don't get as much attention as the major media. And this is from Mountain State Spotlight, which is a nonprofit media outlet in West Virginia, and it's by Ellie Heffernan. And the headline is "Stigmatize, Blame, Then Restrict: How This West Virginia City Responded to the Opioid Epidemic." And basically West Virginia's one of the hardest-hit states. This is in Parkersburg, West Virginia. They set up a lot of centers and facilities and treatment places, some of which were great and some of which were not so great, which is true everywhere. And then they decided that every single bad thing in town was because — all crime, all homelessness, all everything — was because the town had opened these centers. There's zero data supporting that. And the town basically shut many of them down. So they're basically treating them as criminals, not patients.

Rovner: This is still a problem and still a hard problem to solve. Julie.

Appleby: I'm looking at another story that's about a long-running problem in the United States, and it's maternal deaths. And there's a really good piece by April Dembosky in KQED. And it's titled "'Fourth Trimester' Focus Is Pushed to Prevent Maternal Deaths." The fourth trimester, obviously, is after the person has had the baby. There's these groups, maternal mortality review committees, that are looking for clues about what contributed to the deaths of these new moms. And so she dug into this report, the latest of which came out in September by the [Centers for Disease Control and Prevention] and found that 84% of pregnancy-related deaths were deemed preventable. And that's a shocking enough statistic. But she dug into it a little bit more and looked at what were some of the reasons. Mental health conditions were the leading underlying cause of maternal deaths between 2017 and 2019, with white and Hispanic women most likely to die from suicide or drug overdose, while cardiac problems were the leading cause of death for non-Hispanic Black women, according to the CDC report. And really the bottom line, one of the people she interviews talked about it, is that the typical six-week postnatal checkup is just way too late. I mean, six weeks after birth, a lot of these problems are already there and women have died before then. So people have had to go back to work. They're missing these appointments. And so it really digs into a lot of what some of the problems are and what some of the solutions are. And I can recommend reading that one.

Rovner: Yeah, April's been doing a lot of work on maternal health, and all of her stories have been really good. My story this week is from Modern Healthcare. It's called "Elon Musk Bought Twitter. Should Healthcare Professionals Be Worried?" by Caroline Hudson. And it points out that, like many large industries, health groups have a major presence on Twitter, and it's often a big part of their information distribution strategy. And the change in ownership and possibly a change in who and what is allowed on the site has a lot of people worried about whether they want to stay and, if not, if or how they'll be able to replicate that kind of reach that they have now. The story concludes it's pretty much too soon to say for sure, but it is definitely something that will have major ramifications for health information. And I'll have more to say about Twitter in just a moment. But for now, 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 questions or comments. Get those questions in for our "Ask Us Anything" episode, please. We're at whatthehealth — all one word — @kff.org. Or you can tweet me. I'm planning to stay on Twitter, at least for now, although that decision is obviously subject to revisitation. But for now, I'm @jrovner. Joanne.

Kenen: I'm also a "for now." We'll see how things evolve. I'm @JoanneKenen

Rovner: Julie.

Appleby: I'm still on, @Julie_Appleby

Rovner: Tami.

Luhby: I'm still on but don't tweet that much anyway. And I'm at @luhby

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