

## **KHN's 'What the Health?'**

**Episode Title:** The Midterm Shake-Up

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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, Nov. 10, at 10 a.m. As always, and particularly this week, 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:** Sarah Karlin-Smith of the Pink Sheet.

**Sarah Karlin-Smith:** Hi, Julie.

**Rovner:** And Rachel Cohrs of Stat News.

**Rachel Cohrs:** Hi, everybody.

**Rovner:** Later in this episode, we'll have my interview with Carolee Lee. Yes, the former jewelry magnate. These days, she's working on women's health issues, particularly as they relate to inequities in research based on gender. But first, this week's news. And there is a ton. Election Day has come and gone. It was a better-than-expected day for Democrats even though they seem likely to lose control of the U.S. House. It was also a big day for supporters of abortion rights and Medicaid expansion. We will take these things one at a time. First, control of Congress, which we still don't know in either the House or the Senate. And in the Senate, it really is going to be possibly another Georgia runoff to determine which side is in charge. But what will it mean for health issues if Republicans take over the House, or the Senate, or both?

**Ollstein:** Yeah, I kind of think of the two buckets as legislation and oversight investigative work. I know that there is a lot of Republican eagerness to dive in on the latter. They've already signaled that they viewed the select committee on covid and all of its investigations into the Trump administration's handling of covid — they're very upset about that, and they want payback and want to focus on the Biden administration's handling of covid and to call Dr. [Anthony] Fauci and grill him and other health officials.

**Rovner:** I think someone said he should set up a cot on Capitol Hill.

**Ollstein:** Yes. Yes. And so that is a House and Senate possibility if they get the gavels. I also think just to expect a ton of focus on the impact of school closures that Republicans were really critical of during covid and learning loss and all of that. The legislative front is a lot more murky, and it really depends a lot on the majority. It's looking like, if Republicans do win a majority, it'll be a lot smaller one than they had hoped or anticipated. And so I think you're going to see the reverse of

what we've seen on the Democratic side, with the infighting and the struggle to get things passed and having to compromise with people along the different ideological spectrum and having different groups take hostages and make demands and tank bills. So it should be an exciting time on the Hill.

**Rovner:** I'm old enough to remember when the right wing that couldn't be controlled was led by Paul Ryan and Mike Pence, when they were both in the House, and underlings in the House, and tanked a lot of legislation all by themselves.

**Cohrs:** There is also an opportunity for some bipartisan deal-making, too — again, depends on the margins. But I think as our team has done some outreach to offices, they do want to highlight those areas. Like I know telehealth specifically is one of them that was unresolved. I think there are going to be some leftovers that don't really get taken care of this session on like mental health potentially, pandemic preparedness, like that kind of stuff that I think could potentially carry over depending on what things look like. But I think there certainly are opportunities for some, like more incremental — definitely not the scale that we've seen over the past two years — for some bipartisan progress.

**Rovner:** And we've mentioned this before, but if Republicans take the Senate, [Kentucky Sen.] Rand Paul is likely to become the chairman of the Senate health committee, which could be interesting.

**Cohrs:** He might. He's also up for one other one.

**Ollstein:** Yeah, there's still some debate about whether he would want that or he would want a committee that allows him to do more general oversight and hit issues across the administration. And so that's a little TBD.

**Rovner:** Yeah, a lot of this is TBD. Well, what does this all mean for the lame-duck session that starts next week? Is the fact that we don't know anything or that we know that the Republicans are likely to take over the House going to encourage ... Sarah, they left behind a lot of FDA stuff when they did the clean PDUFA [Prescription Drug User Fee Act] reauthorization. I know they were going to try to push some of that through in the lame duck. Is that still happening?

**Karlin-Smith:** That's my sense from talking to people, that they still plan to circle back to some of those FDA priority issues. One reason I think that it's likely is because [North Carolina] Sen. [Richard] Burr is retiring, and he would like to try and at least get some of his pandemic prep work done as a legacy issue for him. So I think it's part of compromises and negotiations there. You're likely to see some of the FDA policy stuff he was a big part of blocking come back. So I think we should expect FDA action. Of course, it's probably going to have to come in like a big kitchen-sink bill. And the dynamics of that always get more complicated. So you never want to guarantee anything in Congress until it happens. But I think it should be busy for the FDA health policy land the next month or two.

**Rovner:** Basically, anything that passes still has to get by [West Virginia Sen.] Joe Manchin, unless it's completely bipartisan. Rachel, Alice, anything you guys are looking for in the lame duck?

**Cohrs:** I've been watching that there's going to be a lot of lobbying from physicians over the recent Medicare rules that have come out. It is going to be a bloodbath, and there's a finite pot of money that is left over from the gun reform bill earlier to address these things. So I think that's in place, certainly, like Sarah is talking about, all of the user fee talks, too. But I think it's also important to remember that the appropriations chairs here are both retiring. So I think they would like to make their mark and pass something longer. And I feel like [Missouri] Sen. Roy Blunt, as Alice mentioned, Sen. Burr — there are a lot of moderate Republicans who are really invested in health care policy heading out. So I think, my understanding has been that they're going to try and go as big as they can regardless of who's in control next year.

**Rovner:** And there's another Medicare cut they have to alleviate, right? Before the end of the year?

**Cohrs:** Yeah, that's a 4% Medicare cut, which is pretty steep. So, we'll see.

**Rovner:** Yeah. And hospitals are already advertising in a big way.

**Ollstein:** Just one other thing I'm watching is the fate of the pandemic preparedness bill that completely fell off the radar. Again, this is something Sen. Burr has been working a lot on. It did make it out of committee and then completely disappeared into the ether. It could be revived. There is not a lot of Republican interest in it, which is why I think they didn't call it up for a vote to date. But, again, if this is something that Burr sees as part of his legacy, will he try to muscle it through? That would also be a potential vehicle for getting some of the public health funding and other stuff related to long covid, which has really not been a priority for Congress. That would be a vehicle for that, as well. And so I'm watching that. But, again, so much depends on what happens with the remaining elections that haven't been called yet and who's in the majority. And it raises the stakes so much if Republicans do take the majority and Democrats see some of these bills as their last chance to get something done.

**Rovner:** So, yes. Well, back to the election. The things we *do* know. In South Dakota, voters told state leaders to expand Medicaid to those with incomes up to 138% of [the federal] poverty [level], something the governor and legislature had so far refused to do, even though the federal government will pay 90% of the cost. South Dakota is the seventh state to expand Medicaid by direct public vote, but it might be one of the last of the 11 states left that have not expanded. Most don't offer the option for citizen ballot measures, right?

**Cohrs:** So, yeah, I think that certainly is a dynamic we've seen, and it really comes down to the population centers, like Florida and Texas. There are so many people who might be eligible for these programs, but ultimately they're going to be stuck. And as we've seen, especially in Texas and both in Florida, too, I mean, just really strong Republican performances and just very little interest from these lawmakers. We've seen over this Congress financial incentives to, I guess, negate the budgetary argument against expanding Medicaid. But it's very clear that it's not a budgetary argument at all. It's a political one. And, yeah, they're kind of stuck essentially from here on out.

**Rovner:** Yeah. And [it's] worth noting that the three biggest states that haven't expanded, as you mentioned, Florida, Texas, and Georgia, all reelected very conservative Republican governors by large margins. All three, I think, of their opponents ran on expanding Medicaid, and all three of their challengers lost. So I don't think that's something that we're about to see.

**Ollstein:** Just quickly. So I was already getting press releases from advocacy groups saying "after the success in South Dakota, we want to launch a campaign in Florida to get it on the ballot." But unless groups are willing to spend, I mean, tens of millions of dollars, getting signatures is extremely time-consuming, extremely expensive. South Dakota has way fewer people. So it was a lighter lift there, and it would be a much heavier lift in Florida. Also, Florida and a bunch of other states have passed laws recently to make it harder. They've raised the vote threshold needed, or they've raised the signature threshold needed, specifically to make this more difficult to achieve. And so I think any sort of serious effort in these remaining states would have to have a huge budget behind it. And we just haven't seen that yet.

**Rovner:** All right. Let us move to abortion. Five states had various abortion-related voter initiatives on the ballot, and the abortion rights side won in four of them, with Montana still to be determined, I believe. Alice, you've been traveling around the country to states with abortion ballot measures. Is this what you expected?

**Ollstein:** We were making predictions on Tuesday, and I said I thought the abortion rights side would win everywhere but Montana. But it looks like they're going to win everywhere, including Montana. And I only said that because Montana's ballot initiative was a narrower question. It wasn't a complete outlaw abortion or allow abortion stark question. And so because it's such a conservative state, I thought people would go for that. But, yes, this has been a sweep. And if you count Kansas earlier this year, it's six out of six. So a really strong showing for the abortion rights side and really revealing of the divide between average voters and the candidates who represent them. I mean, normally they only get to vote for the candidates, and it's unclear why they're voting for particular candidates. And so especially in Kentucky, you saw Rand Paul win reelection by a huge margin, very easily. And the abortion rights side of the amendment fight got way more votes than Rand Paul's Democratic opponent. And so it shows that this is resonating even among Republican and independent voters, which is a lesson they're going to take going forward.

**Rovner:** That we're seeing ticket-splitting not between Democrats and Republicans, but between people voting for abortion rights when it's that question and people voting for candidates who don't support abortion rights and who've been pretty vocal about not supporting abortion rights, which goes to what I've been saying for years and decades, which is that the American public is extremely divided within themselves about what they think about abortion. I mean, I think they generally think if somebody ... challenged me to describe it, the American public, a majority thinks that abortion is bad but it should be up to the woman. That's kind of where the public ends up.

**Ollstein:** And a lot of these campaigns specifically were speaking to conservative voters and really framing their messages to appeal to them. It was a lot about preventing government interference in people's personal medical decisions. And so I think that that proved successful. And I think it speaks to what you were just saying, Julie.

**Karlin-Smith:** If you are a Rand Paul voter, you can see how you would get in line with that messaging. Even if Rand Paul on abortion wasn't in line with that messaging, his underlying political philosophy is.

**Rovner:** That's true. I mean, he calls himself a libertarian, even though libertarians I know disavow him as being a libertarian and partly because of his strong opposition to abortion. Both sides in the abortion debate came out with basically the same argument, that they should go on the offense, and both sides said that they won on offense. The Susan B. Anthony List was like, "Well, look at Texas and Georgia and Florida, where the strong anti-abortion, where all three governors signed abortion bans and all three governors were overwhelmingly reelected." And then the abortion rights people said, "Look at all these ballot measures where we won." It strikes me that what we've been talking about suggests that the public is more in the middle on abortion. And yet we've got both sides saying go to the mattresses. I mean, where does the abortion debate go from here?

**Ollstein:** I definitely thought it was interesting. And one note of skepticism about the argument you just cited. I mean, those politicians did well in states where Republicans did well generally. You can't say specifically that [Florida Gov.] Ron DeSantis won because of abortion. And, in fact, I wouldn't put it in the top couple of issues that he ran on. Like, yes, he did support restrictions on abortion, but he also supported a lot of other things Republicans like. And so I just think that Florida, Texas, these places where Republicans did well overall, I wouldn't say that's strong evidence that abortion restrictions are popular more broadly. I think a lot of other evidence from this week shows that they are not.

**Rovner:** But there did seem to be cases where the abortion issue brought along other candidates. I'm thinking Michigan, where the Democratic governor and the Democratic attorney general and Democratic female secretary of state were all reelected and all were in tough fights. And I know we saw lots of pictures on Election Day of students at both the University of Michigan and Michigan State [University] waiting hours and hours to vote. And a lot of them said they were brought out by the abortion referendum.

**Ollstein:** Absolutely. And not to mention flipping the state legislature for the first time in decades. A lot of those state House and Senate candidates ran on the abortion issue, too. I mean, I think Michigan's a good example because the choice was very concrete there. On the one hand, you had Democrats running on protecting abortion rights, and on the other hand, you had, especially in the state legislature, Republicans who had intervened in court to defend the 1931 ban there. Those races had very real and immediate consequences, and that seemed to really motivate people.

**Rovner:** Yeah, it was pretty black-and-white with that one, unlike some of the other ones. Like even Montana, where the question was whether to require doctors to provide medical care to infants born alive after failed abortions, which is already a federal law. I'm still unclear about why Montana thinks they need this, and it passed in a bipartisan way because it was kind of a statement bill. But we will leave that aside for now.

All right. Well there were more than just elections this week. The Supreme Court on Tuesday heard a case that could prevent Medicaid beneficiaries, as well as others who get government

benefits, from suing to enforce those rules. The case, which is a mouthful — it's called *Health and Hospital Corporation of Marion County, Indiana v. Talevski* — was really, really dry and technical to listen to. Ask me how I know — I listened to all two hours of it. But the court could rule that Medicaid patients and others who get benefits from their state via federal funding don't have an individual right to go to court. In this case, a daughter sued over her father being drugged and restrained against his will in a nursing home and then involuntarily transferred. This case has pretty much flown under the radar, given everything else that's going on at the Supreme Court. But people who follow Medicaid seem pretty freaked out by it.

**Karlin-Smith:** I was struck by the fact that, again, it's one of those cases where the precedent could go well beyond Medicaid in terms of people's ability to ensure that government programs are serving them the way they're supposed to, and that if it goes the way some people fear, you'd be relying on basically the government to ensure your rights and various programs are working. And I know from covering the federal government and various health agencies for a while, they're often understaffed, underresourced. They don't have the time to do all the enforcement they would like to do. So you have to assume that this would mean an environment where they wouldn't get that. They wouldn't be able to protect as many people. And also the people that argue that the government should be doing this enforcement, not the individual people, are also the ones that generally don't want to enforce the government to give them those powers and those additional tools to do it. So it could definitely ... It's a difficult situation. And some people have been ... I think one of the articles you shared, Julie, was saying, "This could be the end of Medicaid. It would be so devastating."

**Rovner:** Yeah. It's funny. Over many years, when Congress is passing legislation that basically beefs up protections for people, there's always this fight over the right to sue. It's what hung up HIPAA [Health Insurance Portability and Accountability Act] for a long time, the privacy rules about whether people would have individual rights to sue if their health records were inadvertently or purposely released to others. So it's this constant refrain that goes back like 30 years. But now the Supreme Court may call Congress' bluff, if you will, and make Congress say one way or the other when they passed all these requirements for nursing homes, for the protections for nursing home patients, who did they intend to have enforce it. Obviously, we won't get a decision on that for a while, and we will come back to it when we do. All right. I'm glad Sarah is here because I've been saving all my covid and other drug stuff. Where are we on the covid vaccines, both now and going forward? It feels like a confusing mess about who should be getting what.

**Karlin-Smith:** The bottom line is the recommendation right now is that people should be up to date on your covid vaccines. So they're trying to push for everybody to get the updated bivalent shot this fall, which means it was designed to both help people fight off the original strain of covid and be more adapted to the newer variants we're facing. Of course, some children still don't qualify for that. One thing I've been looking at is what happens next after this year, because Biden officials have really been pushing and saying, "OK, we're moving to like a flulike strategy for covid. You're only going to need a vaccine, we hope, like once a year." And when you dig into it a little bit more and you talk to FDA, you get a lot more resistance to that analogy to some degree. They're really not sure when people who are getting a vaccine now will need another one. And it might vary, again, depending on your health status, your age. Flu has a really predictable cycle in many

ways. You sometimes hear about early flu season, late flu season. There were certainly shifts in how much it impacted us during covid. But it's much more predictable compared to how covid has been, where we've had new variants pop up. Some last for a while. Some pop up in some areas of the world, not others.

**Rovner:** But like flu, we expect to see more covid in the winter, right? Because people are closer together and breathing on each other.

**Karlin-Smith:** I mean, that's the general expectation. But we've also ... if you look at the data, we've had big peaks in summer, at different times, and so forth. So it hasn't quite been as cyclical as people would like to think. So that's another question. And then there's just scientific questions that need to happen and things that need to be studied. Flu vaccines, one of the interesting things I learned in looking into this is flu vaccines, the way they impact you, your body doesn't develop a lot of immune memory. So next year, people can confidently say, "OK, if you want to be protected against severe disease, you need a new vaccine." With covid, we don't have that sense. We know that you actually do get a decent amount of long-term durable protection against severe disease even if your protection against infection wanes. So we need to get better answers as to really how often do most people get vaccinated and understand this technology going forward. And so I think it's going to keep FDA busy. It's probably going to keep companies developing covid vaccines busy because the requirements of how to do that keep shifting. And there, of course, was a lot of pushback to how FDA approved or authorized the last version of that. And so I think that's going to continue.

**Rovner:** With no human trials, right?

**Karlin-Smith:** Correct. So they didn't do human trials. And Pfizer just recently put out some human data on theirs. And you get different narratives as to how meaningful the benefit of the new vaccine over the old vaccine really is, depending on who you talk to. Again, I think the bottom line is people are saying it's not about thinking about the new versus old vaccine. It's just you need to be up to date, get a booster. But I think for scientists thinking about, like, what's the best way to protect all of us going forward, these are important issues. And it could be thinking about whether we need a new vaccine technology versus mRNA technology and so forth.

**Rovner:** I will add as an addendum. We talked about Rochelle Walensky at the [Centers for Disease Control and Prevention] testing positive for covid. Now Rob Califf of the FDA has tested positive. Pretty much every major health official and major White House official has now officially had covid, right? And I'm not sure who's still outstanding.

Meanwhile, there's something going on with drug shortages. They seem to be growing. One survey I saw found that 98% of community pharmacies reported shortages. And it's not just single-source drugs, which is what it used to be. The latest shortages seem to be affecting really common medications, like Adderall and amoxicillin. Are we missing a serious problem because it's growing kind of slowly and we're busy looking at other things?

**Karlin-Smith:** I think the drug shortage problem has been a continuous problem since as long as I have covered this area, which is more than a decade, and probably goes back. And it tends to

impact older products that are generic, where there are smaller profit margins. So it impacts companies' ability to or interest in investing in redundancy. Sometimes companies go out of the market because when there's too many generic players, they feel like they're not making enough money. There's a few unique covid-centric issues at play with these shortages. With Adderall, there seemed to be a big uptick in prescribing of the drug when we switched to telemedicine, and there are particular companies and startups that actually developed pretty much just to prescribe these types of ADHD [attention-deficit/hyperactivity disorder] medicines. And so that is seen to be a factor here, which is demand went up, and Adderall is a controlled substance. So it's not just regulated by the FDA. The DEA [Drug Enforcement Administration] gets involved, and there are very strict manufacturing caps. So when demand goes up, companies can't as easily just make more. So that's a problem there.

The amoxicillin situation seems to be more of a rising demand just due to different patterns in infectious disease outbreaks that are occurring now. We're seeing more waves of, higher counts of RSV [respiratory syncytial virus, even earlier flu season, and other respiratory viruses we weren't seeing when people were doing more of the covid prevention measures, taking those a little bit more seriously. We were also getting other benefits. Amoxicillin is an antibiotic. It doesn't address respiratory viruses, but sometimes you get secondary infections that go along with it. And in that case, we're really seeing it's the pediatric formulations that are being hit. And so I've seen ... what people are saying is you can usually find it in some formulation and maybe it can be modified, or you can find another antibiotic. So it's a little bit of a "how easy is it for you to get your drug" as opposed to it not being available. But going back to your initial question, Julie, I think drug shortages is just a longtime thing that maybe because it has become a little evergreen, it doesn't always get the attention it deserves because it's hard to figure out how to bring it back. But, again, particularly when you talk about older generic medicines, they are usually at any time hundreds of drugs on FDA shortage lists.

**Rovner:** I had a drug that I was taking go into shortage, and it wasn't generic. And there was only one manufacturer, and they stopped making it for like a year. And it's back. And my doctor's like, "I don't know whether I feel comfortable prescribing it because it could go away again." So I see ... lots of people affected by some of these.

All right. Finally this week, The Wall Street Journal had [a really interesting story](#) about how covid in general and long covid in particular is actually fueling inflation by lowering productivity for people who get sick or whose kids get sick and need to stay home with them and taking people out of the workforce, either short or long term, which is driving up wages. As we all know, there's kind of a labor shortage going on. David Cutler, a Harvard health economist, is quoted in the piece calling covid "a mass disabling event." I feel like we talk about covid and the economy like they're different things, particularly when we think about how people vote, but they're really more interrelated than people realize.

**Cohrs:** Right. I think this idea we've been talking about for a while in relation to long covid and the workforce. I think this piece just puts a finer point on it and uses more of the language that we hear more to discuss the economy. But certainly I think there are scientists, patient advocates who have been ringing the alarm for months and months now that this is going to be something that's



not going to go away. And if researchers aren't able to make some progress on these really stubborn issues of post-viral illness, which existed before covid, as well. But we're seeing it on a scale that we've never seen before, affecting a breadth of people that we've never seen before. If researchers aren't able to make some advances and relieve their symptoms, then I think there are really big questions about long-term impacts on the economy, on the labor force, on individual families and people. There's caregiving as well, which I don't know that this went into in great detail, but it's kind of a ripple effect that is certainly going to be something that we can hopefully see measured in dollars as we go forward. And I think that'll be really interesting to watch.

**Karlin-Smith:** I was going to say this goes back to just a fundamental debate we've been having this entire pandemic, which is: Do covid mitigation efforts help the economy? Because having people that are sick basically essentially hurts the economy. Or covid mitigation is hurting the economy. And there's been two schools of thought. And I think most public health people have said, "If you want to protect the economy, you have to control the pandemic." And in the U.S., we've taken the other frame a lot of the time, and here we are.

**Rovner:** Which is just sort of "let it rip." But now we have lots of people ... I mean, we've always had people with either long mono or long Lyme disease. I mean, there are several diseases where a percentage of people end up with long-term symptoms. But it seems like it's just a whole lot more people have long covid than have had some of these other somewhat or completely disabling ailments that researchers have been working on but haven't been able to do. I know that there's some concern in Congress about this. And I know that [Virginia] Sen. Tim Kaine was still having covid symptoms like a year and a half later. So, I mean, there's not only people who are worried about this, but there are people who have this. Might we see something in the lame duck or next year?

**Ollstein:** I mean, I mentioned that they're hoping that the pandemic preparedness bill could be a vehicle there. But it's really interesting. And Kaine, I interviewed him not too long ago, and he's been really frustrated at the lack of attention on this on Capitol Hill and has even said that there are others besides him who have long covid, who have not disclosed it publicly, and he's not outing them. But he said that they're there and they've thanked him for coming out and talking about it. But there is absolutely a stigma issue there. And people fear that if they disclose that they are struggling with that, that people will assume they're not able to do their jobs well, especially because brain fog is one of the main symptoms, although not one that Tim Kaine has. He has more neurological, tactile issues. But this has really not been a priority for Congress. And I think the inability to even continue the active covid funding for testing and vaccinations, if Congress can't even do that, the likelihood that they would do the more structural supports for long covid are not looking good.

**Rovner:** All right. Well, much is known this week and much is still unknown this week, so we will know more going forward. That's the news for this week. Now we'll play my interview with Carolee Lee, and then we will come back with our extra credits.

I am pleased to welcome to the podcast Carolee Lee, founder and CEO of Women's Health Access Matters, or WHAM. WHAM is a nonprofit that funds research into women's health, something that still doesn't happen as often as it should despite the fact that Congress required the National

Institutes of Health to include more women in clinical trials in 1993. Carolee Lee, welcome to “What the Health?”

**Lee:** Thank you so much, Julie. I appreciate the invitation.

**Rovner:** Now, I know you're helping fund research into women's health, but it's not just to improve the health of individual women. You're making the business case to do more women's health research. How would that help the economy?

**Lee:** This issue has been around, as you said, for a very long time. And it wasn't until 1993 when the Revitalization Act was passed by President [Bill] Clinton that women were mandated, for example, to be part of research and in clinical trials. So for a very long time, there's been almost like the life cycle of a cicada. It seems like every 15 years there's some noise about this and then it kind of dies down, then it kind of goes up again. And the truth is that we can't just be talking about women being understudied or undervalued or underrepresented. If you look at the data today, it is different than it was in 1993. So, women are 52% of the population, 51% of the workforce. They make 85% of the spending decisions, 80% of the health care decisions. And they own 60% of the wealth in the country. That data is different than 1993 or even 15 years ago. A group of businesswomen, along with myself, determined that perhaps there was a better way to be thinking about women's health, understanding that women are different down to the biological level. And what we thought could happen was that there was a business case that could be made by asking the question: “What would happen if we accelerated women's health research, particularly in four areas where women are disproportionately, exclusively, or predominantly affected by disease?” So, the four areas that we were focused on were areas that disproportionately, exclusively, predominantly, or differentially affect women, and they're brain health, cancer, cardiovascular disease, and autoimmune disease. And the question that we wanted to ask was: What would happen if we accelerated women's health research in those areas? Would there be an economic impact? And in order to answer the question, we engaged the Rand Corp., spoke with them and asked them what they thought of asking the question. And they were very, very excited by this because it is a totally different approach. It takes away the emotional drama about “women are understudied, women are undervalued.” It is about the economy. So what happens? If you add up those four areas, basically, and you invest \$350 million, you would get a return of \$14 billion to the economy. No one can push back on that.

**Rovner:** And this was obviously — it's not a particular medical research study. This was simply a “what would be the impact of including more women in studies of these ailments where women's biology tends to differ from men and men are the ones who overwhelmingly have been studied for these?”

**Lee:** That's absolutely correct. And most of the data has been studied on 175-pound white male. And as you know and you've written about this, drugs ... I'm not a 175-pound male, and I should have a different dosage, as has been discovered throughout by FDA and NIH that is necessary. Not only that, yes, you have to be treating men and women as different subjects. We metabolize drugs differently. We're different down to the cellular level, and we express disease differently. So heart disease is totally different in men and women.

**Rovner:** So how did you get into this? You're not in the medical field, or you didn't come up in the medical field?

**Lee:** No, I'm not. But I'm a businessperson who had a particular interest in it because I ran a significant company that ultimately had 350 employees that were 85% women. And I understood very quickly firsthand what happens when women are not part of my workforce. And that stuck with me. And then very early in my career, I was asked to join the Breast Cancer Research Foundation almost ... a couple of days after it was started by the Lauder family. And for 25 years, I got very, very firsthand knowledge on research, how you build — even though my background is somewhat definitely in marketing — how you build an entity like this. And if you look at, for example, if you look at the curve of the effects of treatments on breast cancer, on women, 1 in 3 women will die from heart disease, 1 in 21 from breast cancer. That took a lot of preventive strategies to put in place, and it took a lot of marketing effort. So, no, my interest is, however, in science, and I serve on several boards, including the La Jolla Institute for Immunology and Brigham and Women's at Harvard.

**Rovner:** So you've got a brand-new study coming out about lung cancer. What did it find? And [especially] financially?

**Lee:** So lung cancer is interesting. It found the same things basically and mimicked all of the other studies. So this is the fourth in a series of four studies: as I mentioned, Alzheimer's, coronary artery disease, rheumatoid arthritis, and lung cancer. And lung cancer, similar to rheumatoid arthritis, takes women in particular out of the workforce at a much earlier stage. So what we found is that doubling the funding to \$40 million generates \$611 million of return to the economy. That is very similar, actually — if you look at coronary artery disease, for example, adding \$20 million to \$40 million also gives a significant return, a much higher return. All of these mimic each other in that the investment, according to Rand, is quite small, and their micro-simulation models account for 0.5%. It's a very small number that they're looking at, which create a very significant return. And when [Illinois Sen.] Tammy Duckworth and [U.S. Rep.] Jan Schakowsky [of Illinois] heard about this, for example, they were incredibly excited because they stand on the shoulders, as we all do, of [former U.S. Rep.] Pat Schroeder, [former U.S. Sen.] Olympia Snowe, all of the incredible women who originally were horrified by the fact that female mice were not even part of trials. So all of this data is now, I think, a different way to show what happens to our economy. Women drive economies.

**Rovner:** What — I mean, and you sort of got into this already — what has been the response from policymakers? And are there going to be efforts to increase this funding?

**Lee:** What we proposed to them and what has been proposed in the resolution by them is to “double the budget.” So it's taking those numbers that I gave you, that \$350 million — double it, and you get a return of \$14 billion. Well, if we can make that happen, and we intend to, that would be fantastic. Now, having said that, we're not an advocacy organization. We're not based in D.C. But I clearly understand that we're going to have to impact policy, business, academia, and women generally — and the population at large. If we're going to make this work, we're going to need every part of the ecosystem. It's not just one.

**Rovner:** Well, thank you for doing this, and good luck with it, as someone who's been following this since the late 1980s. Carolee Lee, thank you so much for joining us.

**Lee:** My pleasure. Delighted to be with you.

**Rovner:** OK, we are 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](http://khn.org) and in our show notes on your phone or other mobile device. Sarah, why don't you go first this week?

**Karlin-Smith:** Sure. I took a look at a piece called "[Clock Runs Out on Efforts to Make Daylight Saving Time Permanent](#)" by Dan Diamond at The [Washington] Post. There's a lot of puns and interesting use of language in this piece, but he sort of coins, or he says advocates have coined, this term "Big Sleep." And he talks about all the lobbying that has been going on around a Senate-passed bill that would make, again, daylight saving time permanent. But it's been stalled in the House, which is usually not where we see legislation stalled in Congress. But it's just really fascinating because it seems like sometimes we try to put issues into just a couple of sides in D.C., and there seems like many arguments coming from all over the place on how to best control when we have daylight hours, when we have dark hours. There's economic reasons for it. And different businesses have different reasons why they want light to be had at certain times. Then there's safety reasons: whether you're talking about kids waiting for the school bus stop and how it impacts car accidents to our actual health and getting our sleep rhythms and so forth in line. And an interesting thing I thought at the end was somebody suggested, "well, the only way to settle this might be to kind of split the difference and adjust the clocks by 30 minutes and then kind of satisfy everybody in the U.S. potentially." But then it's going to mess up maybe when you think about the rest of the world. And it's a fascinating issue as a parent of young kids, and it is a pain to deal with the time change because, again, their biological clocks don't understand why we're tinkering with this.

**Rovner:** Neither do my dogs, who still want dinner an hour early.

**Karlin-Smith:** It's a topic that seems lighter, and then you realize just how many serious impacts it has on the way we function. So it's a good story.

**Rovner:** And also how complicated the whole science of it is. Alice.

**Ollstein:** Yeah, I chose [a segment the PBS NewsHour did](#) on a really troubling study about alcohol-related deaths that came out from the CDC, finding that between 2015 and 2019, 1 in 8 [deaths among working-age Americans were related to alcohol]. So the numbers are staggering, and the impact on people in the prime of their life is really staggering. And this is more than are dying from opioids, which have gotten lots and lots of attention and public policy aimed at addressing this. And that's all necessary, too. And opioid overdoses have gotten worse and do need attention, but I think a lot less attention has been paid to alcohol. And it's just been really striking to me that it's gotten sort of normalized during the pandemic to talk about self-medicating with alcohol. We're definitely hearing that from a lot of people.

**Rovner:** Yeah, the liquor stores making deliveries.

**Ollstein:** Exactly. Exactly. And so I think that the alcohol industry is very powerful and its lobbying. It's been interesting for me to watch over the last few years as states have tried to legalize marijuana, that the alcohol industry has tried to fight that because they see it as a threat to their profits. And so I just think we should really be paying more attention to this from a public health perspective.

**Rovner:** I do, too. Rachel, you found a story even I hadn't seen.

**Cohrs:** Yes, it's a really interesting one, outside of our, I guess, normal purview. But it's a story in ESPN, and the headline is "[Review Shows Favre-Backed Drug Companies Overstated Benefits, Connections](#)" — and that's the NFL — by Mark Fainaru-Wada. And I think this story just has echoes of Theranos almost. Essentially the allegation is that these companies who were in business with Brett Favre were overstating their connections to the NFL, overstating how the drugs have been tested in their concussion treatments essentially. That's what they were trying to sell when they were trying to raise money with investors. And I think I had never really thought about concussion drugs as a market potentially. But I think that's a really interesting business opportunity and definitely something that could use more oversight from the business community, the sports community, the policy community. And so I thought this was just a really interesting story that had a lot of intersections with what we do, the safety of drugs and transparency in fundraising and clinical trials, but applied to sports. So I thought it was a great piece.

**Rovner:** And this is separate, we should say, from Brett Favre's other scandal about using covid money to build a volleyball court at a college where his daughter attends. So Brett Favre is the source of many interesting stories these days. All right. My story is an interactive from the Columbia Journalism Review called "[How Much Coverage Are You Worth?](#)" And it's not what you think. It's actually a tool to show how much visibility in the media missing people get based on their race, sex, and location. It turns out that missing people are not all equal. If you are older, if you live in a rural area, or if you are not white, you're likely to get only a fraction of the attention if you go missing than if you're a young, urban, white woman. I used the tool. And because I am, cough-cough, a little older, if I went missing, I would be worth 19 news stories. By comparison, a white woman in her early 20s would get 120 stories if she went missing and probably her own "Dateline" or "20/20" episode. I added that last part. But the interactive is a really interesting way to impart really important information about something that's been covered but people go sort of, yeah, yeah.

OK, that is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review; that helps other people find us, too. Special thanks, as always, to our producer, Francis Ying, who makes the weekly magic happen. As always, you can email us your comments or questions. Get those questions in for our "Ask Us Anything" episode, please. We're at whatthehealth — all one word — at kff.org. Or you can tweet me. I'm still at Twitter for now, @jrovner. Sarah.

**Karlin-Smith:** I'm @SarahKarlin.

**Rovner:** Alice.

**Ollstein:** @AliceOllstein

**Rovner:** Rachel.

**Cohrs:** @rachelcohrs

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