KHN's 'What the Health?'

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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 are taping this week on Thursday, Dec. 1, at 10 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today, we are joined via video conference by Alice Miranda Ollstein of Politico.

Alice Miranda Ollstein: Good morning.

Rovner: Rachel Cohrs of Stat News.

Rachel Cohrs: Hi, everybody.

Rovner: And Sarah Karlin-Smith of the Pink Sheet.

Sarah Karlin-Smith: Hi, Julie.

Rovner: Later in this episode, we'll have my "Bill of the Month" interview with KHN's Fred Clasen-Kelly. This month's story isn't about a big bill, but about what happens when there's an accident during surgery.

So we will start with the lame-duck Congress, which formally returned this week. We now know for sure that Democrats will be ceding control of the House to Republicans starting in January. So they have only a few weeks to complete a pretty long to-do list. What health items seem to be making the cut? I know a lot of other things have popped in ahead of them, like the railroad strike. Rachel, you're shaking your head. Do we have a list?

Cohrs: Yes. Well, there's a very long list of things that they'd like to get done. I think the first one they kind of punted to the end of the year was discussions over the FDA reforms related to the funding negotiations. They resolved most of that in September but did leave the door open to renegotiate some minor reforms but ones that a lot of these lawmakers have been working on for a very long time.

Rovner: And I should say, Sarah, these are the ones that fell out of the user fee bill, right? When they decided to just do a clean.

Karlin-Smith: Right, they did a clean reauthorization. And instead of doing a lot of policy reform along with it, they left that, with the goal of returning and negotiating, using the time to negotiate. And so that's one that's fairly likely to go on this, but not a 100%. And certainly I don't think everything people in FDA-land want also is going to get on, compared to I think there's some other stuff, you know, more like in the doctor pay space and Medicare and so forth, which it would be pretty hard for Congress to get out of doing, I guess. So the FDA stuff, I would put in that sort of middle category where we're probably going to be watching till the final minute.

Rovner: Please don't be Christmas Eve, but could be because it has been in the past. Sorry, Rachel, continue with your list.

Cohrs: Sara's talking about there are some cuts to Medicare that lawmakers are going to have to address somehow. There's a PAYGO cut that is about 4% for Medicare.

Rovner: Right. And this is a scheduled cut from a very old budget deal that they're likely to cancel.

Cohrs: Yes, exactly. And then there are some other, like, physician bonuses that date back to the Trump era, but they're kind of pay boosts for physicians that date back to covid discussions. And that's a little less than 4% right now but is still definitely an object of concern, something that lawmakers are thinking about. With the FDA funding as well, there's a possibility that they advance some sort of pandemic preparedness legislation, something on mental health. They are also talking about Medicaid funding for the territories, which is something that they're going to have to address. There are expiring programs for rural hospitals and safety net facilities, as well. So I think they're going to have to take a look at that. And as I am hearing in my reporting this week, they are also looking at the end of the public health emergency. So they are thinking about telehealth, hospital at home, and also the redetermination process for Medicaid. I think there are some Republicans who would like to see that process speeded up a little bit from the timeline that is laid out right now, which could save money. So I think there's a possibility that they do something on that, as well. But all of it's up in the air. As I'm talking to people, they are like, "I'll tell you what I'm hearing if we get an omnibus." Because if we don't get an omnibus, then none of this really matters. And I think it'll be a lot lighter on the policy. So we don't have clarity on that yet.

Ollstein: I mean, there's like a series of dominoes. And so the health policy decisions can't be made until further upstream decisions are made, like Rachel mentioned, like whether we even have an omnibus or if it's just a [continuing resolution]. These different health priorities are fighting over a pot of money, but people don't even know how big the pot is. So it's really hard to make these decisions.

Rovner: And just to be clear — I think it's confusing for some people — if they do an omnibus spending bill, that means they will finish the spending bills for the rest of the fiscal year through the end of next September. But if they do a continuing resolution, then they'll just kick it into next year, and then we'll have to keep negotiating. There seems to be an intense desire to get an omnibus to actually finish the spending bills, in which case that could serve as a vehicle for all of these things that we're talking about.

Ollstein: Exactly. Exactly. And with Republicans taking over the House next year, it's seen as the last possible vehicle for a lot of things. Another thing I'm tracking is the pandemic preparedness package that has been languishing in the Senate for months now. And the omnibus is also seen as the last possible train for that to hitch a ride to, although it's just very much up in the air. There's only so much money to go around. And, again, we don't even know how much that is.

Rovner: Yeah. I'm reading about this Pregnant Women Protection Act that's bipartisan. It seems unlikely they'll do anything on abortion, but this thing might actually make it through, right?

Cohrs: I haven't heard a lot of conversations about it.

Karlin-Smith: I mean, it seems like my read on it — Politico did some good reporting on it — was it does have a lot of bipartisan support, but there are some key holdouts in the Senate, like [Kentucky Sen.] Rand Paul, who is worried that some of the protections that would be provided to pregnant women in the workplace would somehow also be then provided to women getting abortions, and then that would impinge on employers' religious liberty. So people who follow the Senate know sometimes just one player can find ways to really stymie something that's particularly popular. I mean, in this case, the Chamber of Commerce is pushing for this. A number of Republicans are pushing for this. If the Chamber of Commerce is pushing for this kind of benefit and people on the left are pushing for it, it's hard to see it not getting passed. But like I said, Rand Paul's objections at this point seem like a big stopping point. So they have to figure out how to placate him.

Ollstein: What I'm hearing most is people just saying this is just a traffic jam at this point. There's just too many things on the to-do list, too few days left to negotiate them. And that means that even things that are incredibly popular, even things that are bipartisan, could fall by the wayside. It's just the way it is. And that comes up even more when there are specific policy objections to some of these, which some people have, but even ones where really there's overwhelming support, things just fall through.

Rovner: Yeah. To be clear, this is a pretty minor bill. It gives pregnant women the same kind of accommodations that are available to people with disabilities, like being able to sit at work instead of stand. It's not some new leave thing. It's not expensive. It's literally just a clarification of accommodations for women when they are pregnant. And even that, as you say, is getting caught up by both the clock and by some substantive issues.

Well, one thing that is not on the list, at least for the moment, is doing more about prescription drug prices. In case you've forgotten, Congress took its first major swipe at the drug industry earlier this year. Rachel, you've got a really interesting story out this week about how that happened over the objections of PhRMA, the drug industry lobbying group that used to be invincible here in Washington but whose clout appears to be, well, waning. So tell us what you found.

Cohrs: The premise is pretty noncontroversial here, that PhRMA really did have a really big loss, biggest in two decades, and something they fought for a long time. But I think there is a lot of introspection about how they lost the entirety of the Democratic Party in Congress, about rising tides of populism, where big business in general has been falling out of favor. And there are fewer advocates who are willing to go to bat. And those advocates that were willing to work with leadership to water down that legislation weren't willing to go to bat for them in the last hours and minutes. When the financial services industry, private equity, venture capital were able to get major changes to this bill at the last second, we didn't see that PhRMA was able to do that. And I think there's so many different factors that contribute to that. Part of it's public opinion. Part of it is, like, Nancy Pelosi being really motivated before giving up her leadership post. But part of it is also just that PhRMA has behaved differently in this fight than they have previously. They realized they were going into meetings, and the lawmakers were taking meetings with them but they

weren't really listening. They're like, “That's a nice argument you have about research budgets, about innovation. But we don't believe that the consequences are as grave as you all are saying. And so we're going to go ahead with this anyway.” And I think it is a really pivotal moment for the industry. Certainly they are working to try and water this down through the regulatory process. They might sue. But I think there's also a moment where lawmakers are going to have to see the consequences of this, like we're taking a pretty big bite out of industry. We're going where we've never gone before. And do we face consequences? And I think that'll be an uphill battle, for the industry to try to explain to lawmakers the negative consequences of this bill as we see all the downstream effects. There certainly could be some. Some companies are already saying it's hurting their pipelines. But I think it is this watershed moment for industry that certainly makes them look weaker than they have in a very long time.

Karlin-Smith: One of the dynamics here is in some ways, I think, the industry's bluff has been called in a way that people were afraid to for a long time. So, one way to think about this is there's … This is a huge symbolic political lobbying loss, as Rachel documented. But there's a lot of questions about whether this is actually a pocketbook financial loss for the industry and whether this is actually the sort of loss of new drug development, as they would like you to believe. And what ended up in the Inflation Reduction Act has been watered down by the industry over a number of years. So while they didn't get a lot of, like, last-minute tweaks they were pushing for and they ultimately couldn't stave off this more watered-down approach, they really got a lot of big wins here in the fact that this is much smaller than people wanted, as Rachel also related. They got some significant changes to [Medicare] Part D that a lot more people will feel, at least initially, than the drug price negotiations that will … should positively help them if people recognize that and their ability. So I think there's this balance. And even if … in my reporting, you would see the pharma industry was saying one thing and then the financial analysts that cover the industry had a completely different take on how much the law would hurt them. Lawmakers in Congress read this stuff, as well. And there were even people in the industry, I think, who … Even publicly, Jim Greenwood at times sort of said — he used to be the longtime head of the Bio lobby — “You know, we maybe have to take a hit, right? We have to take some hit. If we can get it to be the least burdensome hit that we can, that might actually protect us better politically and financially in the long run.” So, it's a complicated dynamic in terms of what the actual business implications are in the midst of this huge political loss.

Rovner: I was going to say, it's also kind of a partisan thing because … People, I think, underestimated how much clout PhRMA had with Democrats. I mean, both Democrats and Republicans wanted to do something about drug prices. But Democrats, I think just because this was an all Democratic bill, made the judgment that it was better to have this than to please PhRMA, which is a watershed change.

Ollstein: What Sarah said about calling the bluff is really key here. What struck me most in Rachel's story was that the industry did not follow through on their threats to punish the people who voted for the reforms. They didn't try to fight them in the midterms. They didn't even stop giving them money.

Karlin-Smith: They gave [Oregon Sen.] Ron Wyden money.

Ollstein: They gave Ron Wyden money. And he was like one of the leaders of the whole effort that they hate. So I wonder if that will embolden lawmakers in the future to keep going against what the industry is asking for by seeing that there weren't the dire consequences that they feared.

Rovner: Definitely a space that we will watch. Well, we're going to move on to our next topic, which is Medicaid. It is still open enrollment for those of you on Medicare or an Affordable Care Act plan. The Department of Health and Human Services is reporting brisk enrollment for those ACA plans, in part because Congress renewed those additional subsidies that make health insurance free or substantially cheaper for a broad swath of Americans. But there's breaking news on the Medicaid front, which people sometimes forget was also a big part of the Affordable Care Act. The reelection of Republican governors in Florida, Texas, and Georgia make those states unlikely to expand Medicaid under the ACA anytime soon. And we will talk about Georgia separately in a sec. But there are glimmers in a couple of other holdout states. Alice, you wrote about that this week.

Ollstein: No, my colleague did, actually. But, yes, there is renewed hope for Medicaid expansion in a couple of the holdout states, specifically Kansas and North Carolina. Like we've talked about a lot, many of the states are seen as a lost cause. The remaining holdout states —they're never going to do it unless they're forced to somehow under current political leadership. And so advocates are really targeting the places where it does seem possible. It was striking to me, though, that Wisconsin was not on that list and the continuing hard opposition from Republicans there even with a Democratic governor pushing for it.

Rovner: Yeah. We should point out these are the holdout states that have Democratic governors but Republican legislators.

Ollstein: Exactly. Exactly. But we've also seen some interesting movement in Georgia. They're trying to do a work requirement. They're trying to do a partial expansion and put a conservative stamp on it. So I think it's really something to watch going forward. And this will impact hundreds of thousands of people and make a real difference, especially when we're coming to the end of the public health emergency and there's a lot of concern about people losing coverage. That will feed into this. Also hospitals being stressed financially, that will feed into this. You have a lot of rural hospitals closing their doors, saying that Medicaid expansion would help keep them afloat. And so the lawmakers in these states, even though they're very conservative, even though they're very anti-Obamacare, they're hearing those arguments, too.

Rovner: Well, I want to talk about Georgia separately because this was something that came as a big surprise to me. It seems that despite a denial by the Biden administration, Georgia will, in fact, expand Medicaid, but only to those who can meet an 80 hour per month work requirement. A federal judge ruled that the Biden administration rescission of a Medicaid waiver granted by the Trump administration was "arbitrary and capricious." And the administration didn't appeal the ruling, probably because they were afraid of losing. They were afraid this was going to go further up. This is a policy that's been struck down in other states by a long list of judges around the country. What's going on here, Alice?

Ollstein: It's interesting that conservative elected officials who were very staunchly opposed to Medicaid expansion are now trying to find ways to make it work and to make more conservative arguments for it and to shape it in a more conservative way. I will say we all covered the work requirements back-and-forth under the Trump administration. It only went into effect in one state, I believe, and it had pretty disastrous consequences. A lot of people couldn't navigate the system for reporting that they were, in fact, employed and working. And a lot of people who should have gotten coverage fell through the cracks, and that's predicted to happen in other places, as well. And so it'll be really interesting to see if and when this goes into effect what the impact is there and if they're able to manage it better than Arkansas, which was the one place that tried it already.

Rovner: Yeah. Although I guess we should add that if this goes into effect in Georgia, it will make some people eligible who weren't previously, which is not what happened in Arkansas. Those were people who were already on Medicaid, because Arkansas had expanded previously. I guess this is going to be an interesting test of what — you're right — a conservative policy for expanding Medicaid. All right.

Well, let us move to abortion. A lot has happened in the last two weeks. Speaking of Georgia, Georgia's on-again, off-again six-week abortion ban is back on again after a ruling from the state Supreme Court. And in Indiana, a law so old that it was signed by then-Gov. Mike Pence requiring hospitals and clinics to arrange for the burial or cremation of all fetal remains has likewise been reinstituted after being OK'd by the U.S. Supreme Court in 2019 but blocked by an Indiana state court. How hard is it to keep track of all these things that are literally changing by the day?

Ollstein: It's extremely hard. If it's hard for us and it's our job, I mean think about what it's like for patients on the ground and providers. They don't spend all day refreshing PACER. And because you often have to make an appointment for an abortion weeks out, they don't know when they make the appointment if it'll still be allowed in the place where they've made the appointment by the time the appointment rolls around. And so you're seeing people even in states where it is temporarily legal for now still traveling to other states, if they can, just to have that certainty. So that's an aspect of it I really want people to remember.

Rovner: It's definitely messy. Well, another avenue that's being pursued by abortion opponents is aimed squarely at the abortion pill mifepristone. Last month, a group of abortion foes filed a lawsuit seeking to force the Food and Drug Administration to rescind its approval of the abortion pill, which dates back to the year 2000. The lawsuit wasn't filed in Maryland, however, where the FDA has its headquarters, but rather in the Northern District of Texas, which is home to the judge who ruled the Affordable Care Act unconstitutional in 2018 and ruled its preventive care services were unconstitutional earlier this year. Sarah, I know the FDA has rescinded approval of drugs before, particularly when they are shown to be dangerous, but has a drug ever been pulled because of a lawsuit?

Karlin-Smith: I don't want to answer that definitively because I don't know.

Rovner: I guess I should ask, "Have you ever heard of a drug being pulled because of a lawsuit?"

Karlin-Smith: You know, nothing like quickly comes to mind, I guess, is what I would say. I mean, this suit seems like a challenging one. They're saying that FDA didn't have the authority to approve the drug through the particular pathway that they used, not necessarily that they didn't have authority to approve the drug overall … is one thing that I think is interesting. And yet one thing I think conservative groups really push for with the abortion pill is more restrictions around its access. And I think the counterargument to their lawsuit is in order to have those restrictions that FDA put in place — it's a pretty tightly controlled drug, although FDA has eased access over the years, including very recently — I think FDA is saying, "We had to approve it this way to have those restrictions." So this seems a bit designed, again, to draw attention to the abortion pill, to create time and legal frustrations for FDA. But I'm not really sure this is something where they will actually be able to show the FDA didn't meet their legal standard for approval.

Rovner: Also, I mean, isn't there some statute of limitations for 22 years after a drug has been approved?

Karlin-Smith: Yeah, that's an interesting question. I wonder if … Sometimes FDA takes intermittent actions on the products … But, yeah, I mean, it just seems like something that's going to be a high hurdle for them to prove.

Rovner: But you're right, it keeps it in the news. Speaking of which, Alice, you wrote about another lawsuit aimed at the pill, but using an environmental law as justification. Huh?

Ollstein: Yeah, this is a strange one, but I wanted to highlight it because this could be something we're hearing about in the coming months. This is a new strategy from anti-abortion groups, and there's not a lawsuit yet. So, it starts with a citizen petition to the FDA, which if the FDA either rejects it, or delays, or doesn't respond the way they want, which is almost certain, then they plan to sue. There's also state-level actions planned related to this. But, basically, they are arguing that the use of abortion pills is contaminating wastewater and groundwater, and they want to use various environmental laws related to wastewater to challenge the use of the pill. They want to make the use of the pill so burdensome [that] it's basically impossible for providers and patients. They want providers to issue … Sorry, this is going to get a little bit graphic. But they say that when you have an abortion at home with the pill — and, again, these are only used very early in pregnancy; it's not like you're delivering a baby — that that shouldn't be allowed to be just flushed down the toilet. It should be put in like a medical waste bag and returned to the doctor who prescribed the pills. Of course, with telemedicine, often that doctor is very far away. This is not really feasible. This is a method to restrict people from being able to use this method of abortion. And it's no surprise that there's so much attention on abortion pills. I mean, for one, they very recently became the most common method of abortion, period, in the United States. And also it's just a lot harder to regulate. Conservatives were very, very successful over decades at regulating clinics out of existence. But pills are a lot harder. They come in the mail to your home. You can pick them up from a pharmacy. These are abortions happening in private. You don't have protesters blocking the entrances like you do at clinics. And so there's a lot of efforts to find new and creative ways to go after this. And this is one of them.

Karlin-Smith: It reminds me a little bit of … Pre-*Dobbs*, there were some places that had provisions where they essentially said, like, if you had an abortion, you had to almost like provide a burial.

Rovner: The Indiana law that's going back into effect.

Karlin-Smith: Your story sort of touches on this, Alice, this idea of creating those visualizations, even in people's minds, is part of the tactic here. So they do have to think a little bit more about that biological aspect and that "fetal remains" concept and so forth.

Ollstein: Absolutely.

Rovner: It's a very clever strategy. Go ahead, Alice.

Ollstein: This is absolutely, like Sarah said, a PR strategy, as well as a legal strategy. Even if this doesn't go absolutely anywhere in court or in legislation, this is designed to chip away at public support and approval for the use of the pills and make people feel icky about them.

Rovner: Yeah. And they've been very good at that over the years.

All right. Well, let us turn to covid, which is still with us and still controversial. We learned this week that most of the people dying of covid are now vaccinated, which is not because there's something dangerous or ineffective about the vaccines, but because most people are vaccinated now, at least to some extent. We also learned that the elderly are dying in disproportionate numbers. To quote from a Washington Post story, today nearly 9 in 10 covid deaths are in people 65 and over. Yet the number of people who've gotten the latest booster is way down. Have we just decided as a society that we're going to put this in the rearview mirror? I think I ask this every other week.

Karlin-Smith: I mean, it seems like it to me. It seems like we've stalled in this not-so-great place for a while now, which is certainly a lot better than what people say is like the delta peak of 2,000 deaths a day. But we've been consistently for months in this hundreds of deaths per day, thousands of deaths per week, third-leading cause of death. It's not a good place to be. And it just keeps putting us in this place where you're playing with fire and hoping nothing worse happens in terms of variants. And the White House right before Thanksgiving tried to make another big push for people to stay up to date with their vaccines and said, in particular, they're going to try and focus on these vulnerable groups, like seniors and then other populations that are at higher risk of dying if they're not really not just vaccinated but really staying up to date or getting any of the medications. But I don't know … When you look around at society and how everybody's operating their lives right now, it doesn't seem like we're willing to take minimal steps to protect people, including … And I think there's this debate going on as to what do we owe different members of our society. And people saying, "Just because I'm 70, it doesn't mean I deserve no protection from an infectious illness." I mean, think about Anthony Fauci and what he is contributing to society as an 80-year-old. There are plenty of people who are older and are at a high risk that want to be … that have plenty left to …

Rovner: Like the president of the United States. Like him or hate him, he's in his 70s. So is Donald Trump, in his 70s. So there are a lot of older people. Although I worry that now we're a week past Thanksgiving and you wonder if there's going to be — there are so many people traveling and mixing. If there's going to be a spike, we're going to see it in the coming weeks, I would imagine, yes?

Karlin-Smith: Yeah, I think that's very likely. I saw yesterday or maybe even early this morning, there are some signs. Numbers are creeping up again, which isn't surprising. I'm just calling them the BQs right now because it's hard to track the numbers. But those variants seem to be, those subvariants of omicron seem to be taking over. That's starting to chip away more and more at our kind of medicine cabinet of what we have to offer. The last monoclonal antibody drug that was available under emergency use authorization got pulled by FDA yesterday because it doesn't work against these new variants. So, again, the White House likes to say, "We have the tools. Nobody should die from covid." Now, based on the situation, I think without more action, the question is: Will we still have those tools going forward? And, of course, the White House is pushing to increase the toolbox through better vaccines and so forth. And Congress isn't giving them funding. So it's not like the White House isn't trying at all.

Rovner: Another thing on that long to-do list.

Karlin-Smith: But, again, nobody I've talked to or seen talk about this thinks … Nobody puts covid funding high up on what's coming at the end of the year, and nobody sees any new big covid relief coming from Congress, either. Even Democrats — I think right before Thanksgiving, as well — they voted on a bill in the Senate to try and end the covid public health emergency. So I think that shows where some people's mindsets are politically.

Rovner: Well, another related problem that's still with us is covid-related misinformation. Speaking of giving up, Twitter this week announced it would no longer enforce its covid misinformation policy, which makes sense because there's likely no one left at Twitter to do it anyway, meaning half the staff is gone. But even if Twitter and Facebook and TikTok and all the social media sites could police misinformation, there are lots of more fringe places on the Internet where purposely bad information thrives. Is there any way to stop this while still preserving free speech? That seems to be the newest debate. It's, like, do you just let everybody say what they want? Or is there a line that you can draw that says, "no, this is this is wrong, this is anti-science, this has been proved untrue, and you shouldn't believe it"?

Ollstein: Well, one of my main hobbyhorses is that we're talking about private companies. Private companies have the legal right to regulate the content on their platforms. This is not a First Amendment violation. The First Amendment and the right to free speech is protection from government infringement on that right. The government can't dictate what you can and cannot say, except for limited circumstances. But Twitter can. They have the ability to. But, of course, a lot of people have made this a free speech crusade, and covid misinformation has gotten caught up in all of that. So. Welcome to my TED talk.

Rovner: I know. Well, there's this issue in California, too, which passed this ballot measure that says doctors can be punished for spreading bad information. And there's now a big backlash about that because who decides what's bad information that a doctor can or can't say? I mean, it obviously keeps … what we know about covid and how to treat it keeps changing. So things that a doctor would say now might have been misinformation two years ago.

Cohrs: The point that you brought up, Julie, was great, about the platform shopping at this point. And I think there is an evaluation by scientists, by public health people right now: Do I stay on

Twitter and be the voice of someone who is providing accurate information? Is it even worth being here anymore? And part of me wonders whether there's going to be even more of a siloing of people in their own bubbles, where … I think that can happen on any platform as you control who you follow and what you're seeing, but I think we could see that speeding up. And I just want to say that The Washington Post did hire a reporter from KHN to cover misinformation. I'm really excited. I think that's a really fascinating beat and something that is definitely worth tracking over time. So, congrats to her.

Rovner: And she'll be joining the podcast panel.

Cohrs: Yeah. Exciting.

Karlin-Smith: Well, to Alice's point, though, about the First Amendment, I guess the one thing is when you have a platform like Twitter, a business that is willing to do that regulation at times at least, that's one thing. But then you have these other platforms that clearly the businesses — whether they're businesses or not, the people running them do not care to do that or they sort of exist … And if the business and the entity wants this misinformation to spread and exists to do that, is there any government lever or regulatory lever to stop it? I don't have the answers to that, but I think that's a bigger question because you can usually sometimes get those people like Facebook or other corporations to buy in, at least to some degree. But it's these other places where a lot of people go to get radicalized.

Rovner: And at least with doctors, there are boards of medicine in every state that get to determine what is acceptable behavior for doctors to whom they have granted licenses. But you're right, for the general public, it's still … We're all thrashing around trying to figure out what to do. So. All right. That is the news for this week. Now we will play my Bill of the Month interview with Fred Clasen-Kelly. Then we will come back with our extra credits.

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

Fred Clasen-Kelly: Oh, thanks for having me. Appreciate it.

Rovner: So, this month's patient has Medicare. And when he had cataract surgery, he did not get an enormous bill, unlike most of our Bill of the Month patients. But he did experience an accident during surgery. Tell us who he is and what happened.

Clasen-Kelly: We wrote about Jerry Bilinski, who's a retired social worker who lives in Fayetteville, North Carolina. He suffers from diabetes and has had problems with his vision as a result. He moved to North Carolina to be near his grandkids. And so part of the reason for going in for a cataract surgery to improve his vision is so he could spend more quality time with them and travel with them.

Rovner: Now, cataract surgery, it's super common, right?

Clasen-Kelly: It's one of the most common procedures in the Western world. I think there are about 4 million of them performed in the United States every single year. Under light sedation, the

procedure usually takes 20 to 30 minutes. It's not considered a very serious surgery, if there's such a thing as not serious surgery.

Rovner: But in this case, he woke up and found something odd.

Clasen-Kelly: Yeah. He woke up and noticed that he had a cut on his forehead and didn't exactly know how or why that had happened. His wife took him home. He took a nap post-procedure and woke up, and his pillow was covered in blood, he says. That only added to the mystery. I think that one of the things he felt is somewhat vulnerable since he was sedated and didn't know what happened to him. And so it was one of those things that he could have let go. But something told him he needed to dig deeper.

Rovner: So he dug deeper. Did he ever find out exactly what happened?

Clasen-Kelly: He had this procedure in the spring, in May. And to this day, he does not know exactly what happened. He went in for a post-op meeting with the doctors and did not get the answer he was looking for. He asked the doctor what happened and was told that he had some adverse reaction to anesthesia, but that's basically as far as she went. And he describes a rather brief meeting where she basically walked out without telling him what happened and didn't really give him what he was looking for. And so he went up the chain, talked to an executive who he felt also did not give him the answers he was looking for. And so he filed a complaint with the police.

Rovner: And the police said “not our problem.”

Clasen-Kelly: Police said this is more of a civil matter and not a criminal matter. So he took the affidavit that he gave to police and sent it to the North Carolina Medical Board for further investigation, which is a step that experts recommend someone take if they're not satisfied or suspicious. But those investigations often take months.

Rovner: And I assume it's still ongoing.

Clasen-Kelly: It is very much ongoing, according to him. When we contacted the medical board, they said they could not confirm or deny that an investigation was ongoing.

Rovner: Now, one of the things you discovered in all this is that there's nothing in his medical record about it. It says that the surgery went without complication. Why could that be an issue?

Clasen-Kelly: This is really a mystery to him. And I think one of the things that really makes him upset is he went through a lot of work requesting and paying for copies of his medical records. These are very thick files. And when he combed through them, when he looked at this procedure, the records say there were no complications. And he says clearly that's not true. And so the reason that's significant is that under standards of professional care across the country, doctors are supposed to inform patients either verbally or in writing when something goes wrong during a surgery or another procedure. And so because of that, he feels very much like he wasn't treated properly or that the doctor wasn't straight up with him.

Rovner: So what's the takeaway here? If something bad happens to you during surgery or any other medical procedure, what should you do, and who's responsible? I guess in this case, there wasn't an additional bill, but sometimes there can be, right?

Clasen-Kelly: Oh, there absolutely can be. So what we did is we went to a bioethicist and asked them their opinion and asked them to review some of the details of Jerry Bilinski's case. This expert said that he found the cut on the forehead completely bizarre and said that he would withhold payment until he got an answer that was satisfactory as to what happened. One of the issues in the U.S. health care system is when mistakes happen or there are adverse things that happen to patients during procedures is that it's really up to the medical provider whether to provide a rebate or financial relief. It's also up to them whether to issue an apology. Many times, they don't even though that is what's recommended by medical ethics experts.

Rovner: And a lot of medical malpractice experts, too.

Clasen-Kelly: Those, too.

Rovner: Yeah, that seems to be the new thing. I mean, it used to be don't admit wrongdoing and now it seems to be if you apologize, most patients will say "OK" and walk away, right?

Clasen-Kelly: Yes. And that's, again, that's part of what has created a sense of betrayal in Jerry Bilinski is that he just feels like they were not honest with him and that not only has hurt his feelings. I think it's also made him suspicious of their motivations for keeping it secret.

Rovner: Well, we will see what happens with this. Fred Clasen-Kelly, thank you so much.

Clasen-Kelly: Thank you for having me on this great platform.

Rovner: OK, 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. Rachel, why don't you go first this week?

Cohrs: OK, so my story is in The New Yorker, and the headline is "How Hospice Became a For-Profit Hustle," by Ava Kofman. And I thought this story was a great examination of a space that I have been interested in [for] a long time, I've reported on in tangential ways. But I think just the idea of profiting off of this like incredibly vulnerable time in people's lives and in families' lives and what profit means in that period of time. Like whether it's more time with nurses or more time with providers who are licensed in different ways, I think the incentives are kind of questionable, and I think this piece did a really great job of talking with a salesperson who worked with a hospice company, which is a strange concept that's kind of counterintuitive, to look at how it's expanding, as well. Because there's finite growth of people that need hospice medically. But just looking at how they're trying to expand the base of the people they could serve was pretty eye-opening, so I thought it was really well done and worth a read.

Rovner: And people might remember that my KHN colleague Markian Hawryluk did a story last summer about private equity getting into hospice. So it's definitely something that is growing. Alice.

Ollstein: So I chose an incredible and really devastating story from ProPublica by Lizzie Presser, and it's about states that have parental consent laws for teens who have abortions and how a lot of these states, if the teen can't or doesn't want to get that parental consent, they can go before a judge and make the case. And this is supposed to be … This is pitched as allowing a judge to impartially weigh in. But in practice it gives these judges the ability to bring their own biases to these cases. And in this case a judge who clearly had anti-abortion views decided that this teen in question, who was profiled in the story, was not mature enough to have an abortion but mature enough to give birth to twins. And just the devastating picture of her struggles after being denied the abortion she sought and having to try to raise those twin babies in poverty, just really, really gutting. And they made the point that these parental consent laws are not just in red states. They are in blue states, too. And so I'd be really interested to see if reporting like this changes anyone's minds on it.

Rovner: Yeah. Sarah.

Karlin-Smith: I looked at a piece from The New York Times called "Jail is a Death Sentence for a Growing Number of Americans." It focuses in particular on Houston but points to a trend throughout the country where more people are dying in jails. And jails — just to set the stage — it's important to remember jails are where you're held while you're awaiting trial or further proceedings. You have not necessarily been convicted of a crime. You are presumed innocent.

Rovner: Jail and prison are not the same thing.

Karlin-Smith: That's a big thing you learn I feel like when you start looking at the AP style guide for journalists. But so I think that's important to think about in this context. And you have people … Their lead story is about a person who wasn't given the insulin he needed to live as a diabetic. So people being placed in crowded conditions with other violent people and just points to a lot of problems going on with the criminal justice system, including backlogs of people just awaiting trial and awaiting hearings who for whatever reason are not able to be out on bail. There have been pushes again to release some of these people who have been held for a very long time because of these backlogs if they're nonviolent and likely wouldn't serve any time to begin with. And in different places, like in Texas, not a lot of political will or interest in doing that. So, it feeds on the problem … because they're not necessarily looking to solve it. And some of the ways that might help avoid some of this stuff. But it's just a really interesting piece. And I think it's always important to look at how we treat the most vulnerable people in our society in terms of health care.

Rovner: And people who somehow never get onto the to-do list of things to do.

My story is from Rachel's colleague at Stat Lev Facher, and it's called "Resistance to FDA's Opioid-Disposal Plan Raises Concerns About CADCA, a Powerful Advocacy Group." And it's about how there are so many companies making money off the prescription drug industry that don't actually make or sell prescription drugs. It turns out that the Community Anti-Drug Coalitions of America, which is the group in question, is opposing a plan to have patients use pre-paid envelopes to send back unused opioids, which would be a good way to keep them from being misused by others. CADCA says it would prefer that people use special "drug deactivation devices" that coincidentally

are made by a company that's a major donor to CADCA and a sponsor of some of its activities. Yes, unused opioids that can be stolen or sold are definitely a problem, but it's easy to see why drugs are so expensive when there is so much moneymaking opportunity, it seems, around every corner of the drug industry.

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. We're at whatthehealth — all one word — at kff.org. Or you can tweet me — still at Twitter for now. I'm @jrovner. Sarah.

Karlin-Smith: I'm @SarahKarlin.

Rovner: Alice.

Ollstein: @AliceOllstein

Rovner: Rachel.

Cohrs: @rachelcohrs

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