

KHN's 'What the Health?'

Episode Title: Congress Races the Clock

Episode Number: 275

Published: Dec. 8, 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 health reporters in Washington. We're taping this week on Thursday, Dec. 8, at 10 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today we are joined via video conference by Joanne Kenen of the Johns Hopkins Bloomberg School of Public Health and Politico.

Joanne Kenen: Hi, everybody.

Rovner: Anna Edney of Bloomberg News.

Anna Edney: Hi, Julie.

Rovner: And Sandhya Raman of CQ Roll Call.

Sandhya Raman: Good morning.

Rovner: No interview this week, but more than enough news. So we will get right to it. We'll talk about this Congress in a minute. But let's start with the makeup of the next Congress. Georgia Democratic Sen. Raphael Warnock won his runoff against former football player Herschel Walker earlier this week. That means Democrats will have a 51 to 49 edge in the next Congress, up from the 50-50 they have now, with Vice President [Kamala] Harris breaking ties. How big a difference does that one additional vote make?

Kenen: It's humongous. I mean, in a 50-50 Senate, the Democrats, or if it was the Republican Senate in a Republican administration, you can get things done. But you get things done more tediously, more slowly. Just things like reporting things out of committee. There are extra hurdles in the rules and in a tie situation.

Rovner: Right. And we should say that when it was 50-50, there were the same number of Democrats as Republicans on all the committees.

Kenen: But now it'll be like 11 to 9. It'll vary a bit by committee, but that 20-person committee that was 10-10 will now be 11-9. The Democrats, assuming they have unanimity on their committee, can get things to the floor more expeditiously. The Senate is a cumbersome place by design, but it takes some layers of cumbersomeness away from [Senate Majority Leader] Chuck Schumer.

Edney: I was just going to say, it also means someone like Sen. Joe Manchin of West Virginia isn't a key figure like he was before. When you're talking about things like nominations or other aspects of getting legislation through, he just doesn't hold as much power, which he actually said he welcomes, having some of the heat taken off of him.

Rovner: Not holding as much power. I think it was Chuck Schumer who said we can now stop having 50 separate presidents because any one of the 50 could have tanked anything that they were trying to do.

Raman: Anytime someone has been absent just for being sick, with all the covid absences, that makes a stop in the process. They just shift their timeline. So just even for that, even if everyone was on board before that, that had fiddled the timeline since the Senate was not doing remote voting. And it makes it easier for them to do any investigative subpoenas, anything like that, that might have been easier just in the House before.

Rovner: Yeah. So. All right. Well, meanwhile, this lame-duck Congress is on what I like to call the race to Christmas. In other words, can they finish all the work they didn't do last summer and fall in the next 17

days? Last I saw, there was still no agreement on a top-line number for the spending bills, which they will need to finish. Actually, they're currently set to expire Dec. 16. Any update? Or I guess we're looking at another short-term spending bill because it doesn't seem like they're going to get this resolved in the next week.

Raman: I think from the folks that I've talked to, some of the worry is that if we do either a super short-term bill, a couple-month bill, or even a yearlong bill, a lot of the bills that they have worked on that they want to tack on to an omnibus — in any part of health care, mental health, or anything else — those [will] get lost and maybe not be tacked on if we're doing a short-term bill. And they'd have to restart the process next year. And we also have a split Congress next year, which just further complicates the process. So I think we still don't know which one we're going to do, but that has been the worry that I've been hearing a lot from folks.

Kenen: If you were a House Republican, you don't have any reason to compromise now unless there's something that you really, really, really want that you don't think you can get next year, which may come down to a few things. They said, "OK, Dems, you get this; Republicans, you get that." But we're not exactly in a conciliatory, "let's make a deal" mood right now. So, yeah, I mean, there are people thinking, "Oh, all this stuff is going to get wrapped up in the end of the year deal," and I don't see it.

Rovner: Yeah. Well, first up in apparently the "Let's Get This All Done" sweepstakes is the annual defense authorization bill. Not to be confused with the defense appropriations bill, the defense authorization sets annual policy for the Defense Department. But like lots of other big end-of-year bills, the defense bill often includes things that are not strictly defense. One health issue that is defense-related is the covid vaccine mandate for members of the military, which Democrats have agreed to end. How did the anti-vaccine forces win this one?

Edney: That's a good question. It seems like, at least from what I read, some quotes from some of the Democrats who are supporting it, is that it feels outdated given where at least the majority of the public and even those in power and how the CDC [Centers for Disease Control and Prevention] and others are treating covid right now. They feel like there's just no reason to keep it up. But I thought that the defense secretary made a good argument against getting rid of this mandate, because it also affects readiness. I mean, if you have a lot of troops who are getting covid and are out and are sick, then you do have an issue there that has less to do with the sentiment of the American public right now.

Rovner: On the other hand, I think some people were saying that they needed to get rid of it because it was hurting recruitment. So the readiness argument can go both ways. I guess this is a good place to point out the breaking news of the morning, that the FDA has approved the bivalent vaccine for young children, which I think ... There are a lot of people who don't want to get the vaccine, but there are a lot of people waiting to get the vaccine or to get their kids the vaccine. So we'll see if that sort of ups the uptake of people getting this vaccine. One item that sponsors had hoped to get into the defense bill that apparently didn't make it would have started to undo some of the federal bans on marijuana. This was originally added in the House as a way to make it easier for veterans to get medical marijuana, which is used by many as a treatment for PTSD [post-traumatic stress disorder]. Then the package got expanded to make it easier for banks to do business with legal marijuana businesses in states that allow it. But apparently the entire weed package got pulled, right?

Raman: It's been a contentious issue because it's still illegal under federal law and it varies state to state kind of drastically. And proponents were like, "Well, this will make financial transactions easier in states where it is legal." And there had been the big push from folks that said that this was necessary, especially in states where it is legalized. And I guess there was broader support initially. And then when it was getting pulled from negotiations, I feel like it just really unraveled because progressive Dems wanted to add on

more provisions related to, like, criminal justice. And then there were a lot of GOP objections that it just was not any of it was helping with. So it just is not coming together.

Rovner: Yeah, one thing about these year-end tack-ons, they pretty much have to be consensus bills in order to catch a ride on this bus. All right.

Well, next up, FDA. Anna, in the wake of the infant formula shortage earlier this year, an advisory group told FDA Commissioner Rob Califf in a report this week that the food regulation part of the FDA is basically toothless and leaderless and needs a major overhaul. It's likely that anything big, like making the food part of the FDA a separate agency, would need to be done by Congress. Is there somebody who's going to champion this report? It was kind of a big deal.

Edney: Yeah. I don't think the findings were entirely unexpected for anyone who followed the infant formula crisis closely. But having an esteemed group like this come out and say it was helpful, and there are people in Congress who do want to see a separate food agency. Congresswoman Rosa DeLauro [of Connecticut] has talked about that. But it's a tough sell, very hard to get something like that likely through Congress. The commissioner of the FDA, Rob Califf, has said we may just not wait. And he has potential, not to make his own agency, but he has potential to fix some of the leadership issues. A couple commissioners ago, I think it was that ... Things have been switched up, so in a lot of the centers at the FDA — you have a center that deals with drugs, you have a center that deals with food, center that deals with tobacco, etc. — you have someone at the top, a director, who reports to the commissioner. With food, you essentially have three separate people who report to the commissioner who are in charge. But that means essentially the staff feels like no one's in charge. They don't know who is making decisions, finger pointing. They aren't sharing information, as a part of this report. There's no desire to collaborate. They see each other as separate silos, that the infant formula crisis could have been entirely different if they had been talking to each other and headed things off beforehand. And also one of the things the report pointed out was there's a huge aversion to risk there. And part of that being that they just don't know who the responsibility lies with. So there's no one person to say, "This is what we have to do."

Rovner: Yeah. So I imagine that this is something that will probably come up next year in Congress.

Edney: I think so.

Rovner: This may be one of those things that ... They're going to fight about a lot of things. But I would think that there will be a lot of Republican support for this sort of thing, or at least for doing something about the FDA and the CDC and some of the other federal health agencies. All right.

Now for a segment I'm calling "This Week in Drug Prices." First up, with federal covid money rapidly running out, people without insurance or without good insurance are going to increasingly be exposed to costs for covid tests, vaccines, and treatments. And these can get very expensive very fast. PCR tests can cost hundreds or even \$1,000 or more, although they shouldn't. What happens when people start to realize they could be on the hook for a lot of money?

Edney: I think they stop trying, certainly getting PCR tests, and we're already seeing that anyway with a lot of the at-home tech. But there also are treatments like Paxlovid that are going to be a lot more expensive for people, that they're not going to be able to get. It feels like a lot of the tools that the Biden administration has said that we have won't be available to everyone. Certainly there'll be what your typical health disparities are going to exist in being able to get treatment for covid. And those are quite often the groups that are more likely to get covid.

Kenen: I think we should point out, too, that this is worse in the states that have not expanded Medicaid. Not everybody is insured in states that have coverage, but obviously there are several million who cannot get coverage. In a dozen states — I think it's 11 states now that still haven't expanded. So it's not the only

issue. Paxlovid, there's a Medicare reimbursement issue because it's not fully approved by the FDA. It's got an emergency authorization and therefore Medicare isn't going to cover it unless someone manages to fix that. And that's really paradoxical because the people who need it most are 65 and over. So you've got the Medicaid, which is a political gap. It's conservative states or conservative legislatures. In some cases, there's a Democratic governor. But that part could be fixed if lawmakers in those states chose to fix it. The Medicare thing — Anna may know more about what it takes to fix it. The FDA could approve it, but they have to make sure they're scientifically going through steps to approve it. I don't know the fastest scenario that can be, probably it's is not instantaneous. And Congress could probably address it, but we're not seeing any movement there.

Rovner: Sandhya, is there any movement on the covid funding?

Raman: I was going to say this also ... I was thinking of it as like a ripple effect because there has not been movement on the funding. I feel like it's pretty pessimistic about them getting the \$10 billion, which was the last ask for the covid and mpox money. But I think that as we have fewer people able to afford testing, or soon it'll be the boosters and Paxlovid, we're going to have a lesser view of what the community spread is in the area if not as many people are testing, whether or not they have covid. And then looking ahead, it's projected that we're going to unwind the public health emergency for covid at some point next year. We've already announced that we're going to phase it out for mpox. So I think that will be another kind of tell because some of those authorities for CDC require them to report out the data on a state level ... is going to also slowly unwind. And then we're just going to have a much lesser picture of what the state of covid is, especially if we don't have some of this money to ease some of the gaps here.

Kenen: What we're going to have is the too-late indicator, which is when the hospitals start filling up. If that happens — so far, we're not done with this. But so far, this year has not been anything like next year. There are still some worrisome variants, whether they fizzle out or take off. It's not so far so good, but so far sort of semi-OK. It could get worse. We could continue muddling through. We still have almost 300 deaths a day or around 300 deaths a day. But this time last year we had a couple of thousand. Finding out that you have a spike by hospital admissions, or ICU admissions, or ER visits is too late to head it off. Then you're already weeks into an outbreak.

Rovner: And it's worth remembering that the whole point of this federal money in the first place is because this is a contagious disease and you want people to get tested and get treated and get vaccinated. We're trying to curtail something that is spreading through the air here.

Edney: When you're talking about it spreading and obviously it's changing as it does that. And we're seeing that the monoclonal antibody is not working as well. And the FDA and the European Medicines Agency have called a meeting in a week or so to try to talk about how to get those done more quickly as we try to update them, because you see more and more of them, they no longer have an emergency authorization because they don't work against the variants.

Rovner: All right. Well, of course, most people these days do have insurance, and employers who foot a lot of the bill for that insurance are fighting back. Breaking just today is that Mark Cuban's Cost Plus Drug Company, the "Shark Tank" entrepreneur's effort to disrupt the prescription drug market by selling some generic drugs almost completely at cost, is going to partner with EmsanaRx, which is a nonprofit pharmacy benefit manager created by an employer consortium, the Purchaser Business Group on Health. Together, the groups plan to make generic drugs at lower prices available to employees of those firms, cutting out almost all the for-profit middlemen. Now, this is so far a fairly short list of already generic drugs, but is this the kind of thing that could have a lot of impact on the drug market at some point? There's a lot of middlemen taking a piece now.

Edney: There are a lot of middlemen, and the pharmacy benefit managers have even their own middlemen now. And so I think that there were a lot of questions around Mark Cuban's company when it started up, and I think it's only been a year or so.

Rovner: I think it was last February they started.

Edney: Yeah, yeah, less than a year. And it's growing. I mean, slowly, but we're seeing today in this announcement that it's going from not just being sort of a consumer market, but employers might be using it. And it did start with an extremely small amount of drugs, and we're not up to a huge amount, but it is 1,000, and that's more than 100, I think, that it maybe not started with but got to fairly quickly. And so it could have potential to disrupt the market. It is generic right now, though. So what's unknown is how something like this could handle brand-name drugs, which you have a harder time paying out-of-pocket for them. So people probably wouldn't price-shop as much, but maybe there's innovation there that we just don't know about yet.

Rovner: Yeah, well, this addresses, I guess, the \$10 drug whose sticker price is \$100. But it won't address the \$4,000 drug whose sticker price is \$5,000.

Edney: Exactly.

Rovner: Well, also in the employer drug space, my KHN colleague Julie Appleby has an interesting [story this week](#) about a not-so-benign plan by employers to recapture the coupon discounts that many brand-name drugmakers intend for those who don't have insurance or who don't have an insurance that's good enough for their copays for those \$5,000 drugs. This could turn into a real free-for-all. This could also disrupt the drug market, right?

Edney: Certainly. Maybe in a way that doesn't work that well for patients. Depending on what happens. I mean, clearly, the drug manufacturers are not happy that employers are tapping into this program. And so if they start lowering the amount that the coupons can offer or even taking them away, that's not a great scenario. But kudos for the employers for trying something. I mean, they also need to lower their drug costs. So I think we'll see where this shakes out.

Rovner: Yeah. I think we're going to see more attempted disruption there. All right. Well, let's expand this discussion this week to other news about why health care costs so much. Item one: providers pleading poverty. The American Medical Association president, Jack Resneck, is on Capitol Hill this week lobbying for Congress to avert a possible 8% cut in Medicare payments to doctors, which Congress is likely to do eventually because the cuts are part of a now decade-old budget agreement, or half the cuts are. Meanwhile, hospitals are complaining that they're losing money from a combination of inflation, labor shortages, and sicker patients. Yet my colleagues over the firewall at [KFF report](#) that at least for the three largest for-profit hospital chains, operating margins actually exceeded their pre-pandemic levels. Is it even possible anymore to figure out when providers actually do need more money and when they're just complaining? Joanne, were you about to say something?

Kenen: We do know that this is a fight that happens every year. Providers usually, but not always, win. I mean, things do get modified or postponed. One of the problems is ... Looking at some of these things, as Julie just pointed out, these big for-profits are doing great. Some of the smaller hospitals, and community hospitals, and rural hospitals, and safety net hospitals are not. Same thing with medical specialties. Some of them bring in way more money than others. It's a crazy system. So under the current system, it's not well fine-tuned about targeting money to the sectors within a sector that needs it most. Do I think they're going to end up with an 8% cut? No. But, I mean, the end-of-the-year dynamics are weird right now, post-election. So I've been surprised ... Sometimes when I have expected cuts that they should go through — everybody knows that they were there for a reason — and they get halted. And sometimes when you think they're

going to be halted, they do go through. But the providers are pretty powerful, and they usually get a lot of what they want.

Rovner: It's useful to remember that the provider taxes that were supposed to pay for the Affordable Care Act one by one all got repealed. It took several years, but eventually they got their way. Well, also this week, in the fight between hospitals and insurers, the Centers for Medicare & Medicaid Services issued new rules on prior authorization, which is when doctors have to get specific permission to provide a medical service. This is something that they've been fighting about since the late 1990s during the debate over the Patients' Bill of Rights that Joanne and I covered. When I talked to Jack Resneck, the head of the AMA ... I mean, it was the first ... What is your priority? I guess his first priority was to stop the Medicare cuts, but the second priority was to do something about prior authorization. And I guess it's the government programs because the Affordable Care Act took care of it in private insurance. But I know doctors are saying that this is going to be a huge help, particularly in Medicare. I know a lot of doctors don't take Medicare, and some of that is because of the way it pays. But some of it is just because of the hassle of dealing with the Medicare bureaucracy. Will this prompt more doctors to actually take Medicare? Hard to say, but at least it fixes one problem. All right.

Finally this week, in private equity in health care, I bring you clinical trials. We now have companies that for a fee will bring drugmakers and others better, faster clinical trials with a more diverse population. One benefit: These firms get paid regardless of whether the drug or device is eventually approved. So it's not like they're investing in the drug or device itself. In a similar vein, insurance behemoth UnitedHealth is finding a way to keep more of the insurance premiums it collects by buying up provider groups. Are we heading toward the point where the entire health care system is going to be controlled by big oligopolies? It's starting to look that way.

Edney: Yeah, I agree. It definitely is starting to look that way. And in talking about private equity, I was surprised that clinical trials were something they would be interested in. I'm curious to see how it plays out. I mean, I think it was [Rachana's story](#), the company — it was KKR — that had started a clinical trial company, and they had already closed a few sites because it wasn't working out. So I am curious to see how this goes and the ability to make cuts in the way that they do to get more profit. I guess it's harder to see in the clinical trial realm, but certainly, yeah, they're trying to take over a lot of parts. And like you said with UnitedHealth, as well, it seems to benefit maybe everybody but the patients when you have as many pieces of the pie as possible.

Rovner: Yeah, well, that's basically what we're seeing is all the consolidation and integration and call it whatever you like. All right.

Well, let's turn to abortion. It's not just a U.S. thing. Sandhya, tell us where you've been this month and what you wrote about.

Raman: So I was at the largest international conference on family planning, in Thailand. And so my story is "[At International Conference, Dobbs Dominates Debate](#)." And this is my dispatch from the International Conference on Family Planning. In years past, this conference, which had 125 countries this year, has mostly shied away from focusing on abortion. And that shifted after the U.S. had the *Dobbs v. Jackson Women's Health Organization* ruling earlier this year. And so I looked at a lot of the global implications. Even if it's a U.S. policy, it has ramifications worldwide. I talked to people from around the world. And in Latin America, they've been moving a little bit more liberally on abortion rights. But there are impacts even in Mexico, where a lot of patients are going from the southern United States to get abortion access. And then in a lot of African countries, there are worries about foreign influence that affect whatever abortion policies they have and just changes related to U.S. aid that might fund their family planning or health centers and how that might play out. And then even in Europe, there are changes that you can possibly watch for there, as a lot of the governments have shifted a little bit more to the hard right this year and in recent years. So in

Poland just a couple of years ago shifted their abortion policy dramatically and rescinded access. So they're things to watch where things can go in either direction, just kind of spiraling based on one thing in the U.S.

Rovner: Well, we've talked a lot about women who aren't having abortions having trouble getting medical care because of abortion bans. Selena Simmons-Duffin over at NPR has [a story](#) about doctors actually doing more dangerous procedures to avoid being suspected of performing abortions on women, for instance, who are already miscarrying. But this is a new one for me. [In Alabama](#), a woman is suing the county government for jailing her for exposing her fetus to drugs, except she wasn't actually pregnant. Can you now be swept off the street just for looking like you might be pregnant? This strikes me as pretty ominous.

Edney: Yeah, that's terrifying.

Raman: This is a really interesting case. I mean, her daughter reported that she was pregnant, which is why they thought it was the case. And they said that there were amphetamines in her system, but they did not do the pregnancy tests to verify. And then the sheriff and the investigator when she was released said she could still be charged if she were to get pregnant in the next few months. So it's an unusual case. But I mean, it could open up some of the new questions that have been emerging in the last few months over just how this plays out, with changing laws on abortion and questions on implementing these personhood laws that we have in different places across the country and who can challenge those laws. And so I think it'll be interesting to see how this moves and if there are similar cases elsewhere.

Kenen: But you can see it going in the other direction, too. You can see that every woman arrested on a drug charge is going to end up being given a pregnancy test. We're in a murky era.

Rovner: Yeah, we are. Well, and we could have seen this coming. There's also a new report this week detailing just how much more it's costing for pregnant women to travel to other states for abortions from states that now ban them. And, of course, getting the extra money often takes extra time and results in the need for abortion later in pregnancy. But isn't this part of the anti-abortion strategy?

Edney: Yes, to make it cost more. I mean, there's ways they're doing it and trying to even take away tax breaks for businesses that will help employees travel for an abortion if that's a benefit that people really start using. And I read the article on NPR that you were referencing, and the one thing I hadn't really thought about is now when you have all these states with potential restrictions to make it harder coming up and things, if you are going to get an abortion, a lot of women are thinking about what state would I go to that is safest, maybe not closest. Or maybe what state can I get an appointment in quickly enough. And so it's costing more just in that sense, too. You're not just looking next door like maybe a lot of people think.

Rovner: Yeah, anecdotally, but I've seen people who are worried about getting pregnant because they know they might have a high-risk pregnancy, worried that they'll be able to get, I mean, not an abortion. These are women who want babies worried about having potential complications dealt with. It's a real fear out there because doctors obviously don't want to go to jail. I mean, doctors don't know where the lines are, either. So it is a continuing mess, as Joanne says. All right. That is the news. Now 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. Sandhya, you've already done yours. Anna, why don't you go next.

Edney: So my extra credit is in The Washington Post: "[Drugs Killed 8 Friends, One by One, in a Tragedy Seen Across the U.S.](#)," by Lenny Bernstein and Jordan-Marie Smith. It's a look at Greenville, North Carolina. And it's obviously an extremely sad and poignant story. It starts off with four friends in their prom photo, and three of them have died from drug overdoses in pretty close succession. And the family in this town has been devastated by drug overdoses. So I think it's a story, too, that's hard to read, but it's keeping a light on something that maybe is easy to get a little bit numb to right now.

Rovner: Yeah. Joanne.

Kenen: My extra credit this week is a piece in the Columbia Journalism Review by Becca Andrews, and it's called "[Anonymous Woman](#)." And it's about two things. One is about the harassment and in some cases things like having their homes broken into, having their car brakes tampered with, that women who work for abortion rights organizations ... Or, in this case, they were profiling a woman who works for an organization that raises money to help women travel to abortions. So, part of the story is about the extent of the terror they're living in and why. And the other part was how to cover this and when she could grant these women anonymity and also some trouble that workers in the abortion groups have reported in getting their stories understood accurately. And some of them were volunteers or began as volunteers. They don't always know how to deal with the media. So it's both an abortion story and a journalism story.

Rovner: Well, mine is also a little bit offbeat. It's from, of all things, a new entry from the Associated Press Stylebook, which governs how much of the media writes or says what they write or say. In a revision published on Tuesday, the AP now says: "Do not use the term 'late-term abortion.' The American College of Obstetricians and Gynecologists defines late term as 41 weeks through 41 weeks and 6 days of gestation, and abortion does not happen in this period. Instead, use the term 'abortion later in pregnancy.'" This ends a grammatical battle that I have been waging since the mid-1990s, when David Grimes, who is a prominent OB-GYN researcher and former head of the CDC's abortion surveillance branch, chewed me out once for using the phrase "late term." The fact that it's medically inaccurate is in all three versions of my book, "Health Care Policy and Politics A to Z." But I've not been able to fight the dictates of the AP. So thank you, AP, for coming around. Better late than never.

OK. That is our show for this week. As always, if you enjoyed 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](http://whatthehealth.com) — all one word — at kff.org. Or you can tweet me. I'm still at Twitter for now, where I'm [@jrovner](https://twitter.com/jrovner). Joanne.

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