KHN's 'What the Health?'

Episode Title: Dems Agree to Agree, But Not on What to Agree On
Episode Number: 218
Published: October 21, 2021

Julie Rovner: Hello and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent for Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, Oct. 21, at 10 a.m. As always, news happens fast and things might have changed by the time you hear this. So here we go.

Julie Rovner: Today, we are joined via video conference by Tami Luhby of CNN.

Tami Luhby: Good morning.

Julie Rovner: Rachel Cohrs of Stat News.

Rachel Cohrs: Hi, Julie.

Julie Rovner: And Joanne Kenen of Politico and Johns Hopkins.

Joanne Kenen: Hi, everyone.

Rovner: So, no interview this week. We will get right to the news, and let's start on Capitol Hill, where Congress is back from its break and wrestling again with the social-spending bill that will represent President [Joe] Biden's domestic agenda, assuming Democrats can reach some sort of agreement. But while they are cutting the bill back in order to win the votes of holdout moderate Sens. Joe Manchin and Kyrsten Sinema, the Congressional Budget Office is out with its estimate of the bill that passed the House committees last month, and according to the CBO, a lot more people would actually get health insurance if that bill were to pass, right?

Cohrs: Yes, I think it was good to finally have some solid numbers just because we've been looking at so many different proposals over the past few months. So I think that was certainly good to have some numbers on the number of people who might get coverage, good to have some numbers on, you know, potential spending benchmarks. Obviously, the House bill is not going to be the final bill. If they get something done on these issues, it's going to be scaled back because it looks like the approach will be, for now, where they're trying to do a lot for a short amount of time and just hope that they can extend those benefits later on. So, these aren't final numbers, but they are useful benchmarks.

Rovner: And most of the numbers in that CBO report were about extending the extra subsidies for the ACA [Affordable Care Act] and figuring out how to expand Medicaid in the states that

haven't expanded it, right? I mean, there's a lot more in the bill, but that's sort of what this CBO report seemed to kind of focus in on.

Cohrs: Yes, that's true. And it didn't address the more kind of controversial issue of expanding Medicare benefits: vision, hearing, dental, didn't touch that. Was just kind of on these other two health care issues that, you know, have broad support, especially among House Democrats. But really, in the whole Democratic caucus, it's just a matter of how much they can do.

Rovner: And apparently, that's the sticking point. Now, they can expand some of these coverage issues. But it turns out that these Medicare benefits are pretty expensive to add to it, right?

Cohrs: It depends how you do the math. Yes, you can delay them for a while. There's some fancy budget work you can do to make them look less expensive. There's different options for making the benefits more generous or less generous to make sure that number kind of comes in where they need it to come in. But, as a whole, yes, it's expensive, though, as I think it came up in the hearing yesterday, it doesn't necessarily affect the solvency of the program itself. You know, it's really complicated how it's financed, but it's kind of different streams of funding. But yes, it's expensive.

Rovner: Yes. I think for people who don't quite understand that Medicare, the only part of Medicare that can quote-unquote "go insolvent" is Medicare Part A, and that's the part that funds hospitals and some nursing home care. Pretty much everything else is in other parts of Medicare, which take money from the general fund so they can't technically become insolvent. But the complaints about, you know, Medicare solvency always say, "We can't add things to Medicare because it'll make it insolvent faster," which it really won't. It just depends on how complicated Medicare is.

Kenen: One of the things that struck me on the CBO report is they were forecasting an erosion of employment-based coverage, and they did that 10 years ago when the ACA went into effect and they were really, really wrong on that. They had really, I don't remember the number from 10 years ago, but they had predicted …

Rovner: It was big.

Kenen: … a serious erosion of people who got their insurance through their work. It did not happen. I mean, the theory at the time was that people would, that employers would dump insurance and people would go into the exchange because they didn't have a job-based alternative. Actually, employers kept offering it. In a particularly tight labor market, like now, it's an important fringe benefit. It's something people want to get at work. It tends to be better when you get, you know, better coverage, lower cost; employer benefits tend to be richer than the ACA. You know, I can't tell yet if they're wrong. First of all, this bill isn't going to become law, as is. And secondly, we can't tell what the accurate reality versus the projection, but it

struck me that they're still saying that, they're saying that again, when it was one of the things they were most wrong about last time.

Rovner: I think one of the reasons they were so wrong back in 2010 was that it turned out that the coverage under the Affordable Care Act was definitely not anywhere near as good as most employer coverage. And I think the theory is now, because of these new subsidies, actual coverage is better. And if the coverage really is good enough to substitute for employer insurance, then many employers may feel more comfortable letting their employees get coverage on the exchange, if it's just as good. And I think that's kind of the … I mean, I suspect I'm sure the CBO knows that it was wrong in 2010, but it didn't play out. … Not the way they thought, right?

Kenen: We just told them.

Rovner: Yeah.

Kenen: In case they forgot.

Rovner: Pretty sure they already [knew]. But I also looked at that and I thought, OK, they were wrong because the coverage was really so, so much less generous than most employer coverage, and the whole point of adding these new subsidies is to make the coverage more generous and closer to …

Kenen: Right. But if you end up extending for only one or two years because of the fiscal …

Rovner: Right, then employers won't want to.

Kenen: It won't change. So, it's just a sort of point to note.

Rovner: It is.

Kenen: We can come back in 10 years.

Rovner: It's a serious nerd point, but we all know this dance so well.

Luhby: It actually does say that it would estimate a reduction of fewer than 100,000 people without insurance, but it estimates that it'll be primarily driven by fewer people taking up an employment-based offer. But yeah, I agree that most people want work insurance because it is generally better even than the ACA plans and certainly more doctors available than Medicaid.

Rovner: Yeah. So, ACA insurance, I mean, one of the big concerns is that ACA would crowd out employer insurance, and that didn't happen because it just was, you know, compared to most employer insurance, it was just substandard and it's better than it was. But we are yet to see how good. And of course, as we just said, this is not the bill that's going to pass. We know

because they're whacking it. Rachel, what's the latest on where they are? I keep hearing muttering about how we could get an agreement by the end of this week. That feels unlikely. It's Thursday.

Cohrs: Well, what I will say is that I think there has been real movement. Things have been heating up much more than I think they have in the past several months where we've seen lots of finger-pointing, lots of name-calling. But now we're actually seeing kind of the sausage-making horse-trading begin. And we're seeing real meaningful cutbacks to this package. I think it's optimistic to imagine that they would have all of the details worked out by the end of this month. However, I think what they're kind of aiming for is a framework, kind of an outline to work from where lawmakers feel comfortable moving forward with a separate infrastructure package. So, I think they gave themselves some wiggle room as to what they can call success on this issue, but we have seen meaningful progress. I think nobody really, really believes that they're going to meet this, have it passed both chambers of Congress by Oct. 31, but I think things are starting to move in a way they haven't been so far.

Rovner: Yeah, I know, I noticed they came out. I guess the Senate Democrats had a really long lunch on Tuesday and came out and basically agreed that they agreed that they needed to agree. Apparently for the many hours of talking, that was what they came out with. It's like we must agree on something. What is it? We haven't gotten there yet, but we must agree on something.

Cohrs: Right. But that is an important first step.

Kenen: But I think Rachel's right, it looks like the wheels have stopped. Like, if a normal car has four wheels, this bill has had 40 fall off. So, I think that sort of sense of chaos and out of control and futility, that dynamic seems to be shifting. I mean, we now can see a potential deal, although not a detailed one next week. But there does seem to be sort of a shift in realizing that they drove themselves right up to the cliff in a car without any wheels, so that there's a different feel. But, you know, it could fall apart again.

Rovner: It could, and I'm sure it will fall apart and come back together many times before they finish it, because that's how these things go. Well, meanwhile, there are also those annual spending bills for the fiscal year that started three weeks ago, which have now been punted to December. Senate Appropriations Committee Chair Patrick Leahy unveiled the Senate version of the bill that funds the Department of Health and Human Services this week. And, like the House version, it does not include the "Hyde Amendment," which bans federal abortion funding in most cases and has been part of the HHS funding bill in some form or another since the 1970s. But there's no way Hyde language is actually going away this year, even if the House and Senate Democratic leaders and President Biden would like it to, right? This is kind of progressive virtue signaling.

Cohrs: I think, again, it's difficult to imagine Democrats and Republicans coming together for a kumbaya, for a, you know, comprehensive appropriations process at the end of this year after

all the spending that's going on by the Democratic Party unilaterally, essentially. I think there's more expectations for a C.R., a continuing resolution, which kind of keeps things where they are. Obviously, they can, you know, have tweaks on top of that. But I think these are Democrat-only bills. And, for government funding, they do have to get Republican support.

Rovner: In the Senate, right, they need 60 votes.

Cohrs: Yes, in the Senate, you are right.

Rovner: They need either 60 votes or no one wanting to filibuster it.

Cohrs: Yes, which I don't think is going to be the case. So, yes, good to know, like it is, I think virtue signaling is a good term for it. So it's a starting point, but I think there's a long way to go on that.

Rovner: I know, I'm sort of, and we talked about this a little bit last week, and we'll probably talk about it more next week, about how sort of abortion as a political issue is changing. And we're seeing that very much in Virginia, not just the governor's race, all the races. But I don't. … So, you know, in the past, you just could always assume there were never going to be the votes. Even, you know, when Democrats are completely in control for getting rid of the Hyde Amendment. But we'll see if that changes. But that's for another week. So, speaking of deadlines, the Biden administration has only until Nov. 15 to nominate someone to head the Food and Drug Administration. That's when current acting Director Janet Woodcock would have to step down if no name has been sent to Capitol Hill by then. Last week, The Washington Post reported a new leading candidate, Robert Califf, who was briefly FDA commissioner during President Obama's last year in office. Although Califf was approved by the Senate by a very large margin, he was criticized at the time for being too close to the drug industry, which is apparently why the administration thinks that Janet Woodcock can't get confirmed. And Califf was involved in the FDA's approval of an expensive new drug over the objections of its advisory committee, in this case for Duchenne muscular dystrophy. But it was an event that was strikingly similar to Woodcock's involvement with approval earlier this year of a controversial drug for Alzheimer's disease. So, my question for you guys is can Califf really get confirmed over Woodcock? And if so, what does that say about sexism in science?

Kenen: I think Woodcock also had the opioid issue against her. Some of the senators who were opposed to her from hard-hit opioid states — New Hampshire, West Virginia. So she's been at the FDA since, what, ’94 or something like that, ’92?

Rovner: ’86.

Kenen: I think she's been in her current job since ’94, I think, and at the FDA since ’86, something like that. So she's got a longer trail of things to dislike as he was there for, you know, less than a year. I don't think it's a slam-dunk, but I also think they probably did their homework before they leaked it, although I'm not sure about that. I haven't done any original reporting on

this, so maybe I'm wrong. With Woodcock, they made an assumption, they just assumed, “Oh, she did a good job during the pandemic, basically it makes sense to have continuity. The Democrats will go with this,” and they didn't ask anybody whether that was true. They might have sounded out some of the key Dems on Califf before they let the name leak, although I don't know that for sure.

Rovner: I would say, although I wonder because Califf was leaked last week and it's been a week and has not been named, I wonder if they floated it to sort of see how it would play, and maybe they weren't so happy with how it played.

Kenen: But we're really in a time-running-out mode now.

Rovner: I was just going to say, which leaves the question: Is there a Plan B, or are they trying to sort of jam Califf through saying it's either him who’s been, who was approved — what was it? I think it was 96-to-4 — or nobody, because Nov. 15 is coming up rapidly. I think everybody is still sort of mystified by how it is getting towards the end of October, and there is no permanent leader even nominated to head the FDA. That just seems so strange and bizarre.

Kenen: And as recently as 10 days ago, we were hearing other names, but they were all, like, grabbed out of the air.

Rovner: Well, speaking of the FDA officials there this week announced proposed regulations that would allow the sale of over-the-counter hearing aids, four years after such regs were ordered by Congress in a bipartisan vote and a year after they were actually due. These cheaper hearing aids could be available starting next year. But honestly, what took so long and how much would it help if Congress actually does add some sort of hearing benefit to Medicare?

Luhby: I mean, this is something that [Sen.] Elizabeth Warren has really campaigned upon. She mentioned in her campaign she's really been pushing. It is a bipartisan effort by Warren and [Sen. Chuck] Grassley. You know, so I'm not sure what took so long. Maybe they were busy with covid?

Rovner: They did have other things to do.

Luhby: There could be other things that were going on. But, you know, I mean, clearly, the benefits that are going to be expanded in the reconciliation bill are still under debate. So we don't know if we're going to have a hearing benefit, although it is one of the cheaper ones, compared to dental. But I mean, it's, you know, certainly really important. I mean, there was a ’20 Commonwealth [Fund] study that showed that 75% of people who need hearing aids, you know, can't get them. Kaiser Family Foundation just came out with a report that showed that people are spending $914 out-of-pocket for hearing devices or hearing issues. So it's, you know, it's definitely a big need for seniors and it's a really, you know, expensive device. So if they can get it over the counter, it can really help a lot of people.

Rovner: Yeah, I was actually reading up on it, and I didn't realize one of the other blocks to hearing aids that the over-the-counter hearing aids would help is that it's not just that they're expensive, and they're expensive. My mom had hearing aids even, you know, from Costco …

Luhby: They're in the thousands of dollars.

Rovner: Right. They cost thousands of dollars, but you need to be seen by an audiologist in order to get, you know. And in a lot of parts of the country, there just aren't any audiologists. So even if you could afford it, you can't find somebody that can actually, you know, help you obtain them, which is another reason for the ability of, you know, to get them over the counter — the same way you can now get over-the-counter reading glasses, or you can go to an optometrist who can actually help measure, you know, make sure you get exactly what you need. So I think the idea here is to get something, but it is sort of shocking that it's 2021 and you still can't buy, you know, hearing aids for mild hearing loss, the way you can buy over-the-counter reading glasses.

Luhby: Right. And now many, many optometrists just tell you to go buy it over the counter.

Rovner: That's right!

Kenen: Unless you have astigmatism.

Rovner: Yes, which I do.

Kenen: I use the over-the-counter [ones] too.

Rovner: I'm actually wearing my real reading glasses right now, but I also have cheap drugstore reading glasses. All right, well, let's turn to covid. While we are waiting for the final calls from the CDC [Centers for Disease Control and Prevention] on those boosters, for those who got the Moderna and J&J shots, which is a confusing thing in and of itself, the White House seems to be preparing for a rollout of first shots for kids between ages 5 and 12. Now they got out a little over their skis on the whole booster thing, appearing to put the White House thumb on the scale of approving them before the FDA and the CDC got to weigh in officially. They say that's not what they did, nor is that what they are doing now. Rather, they are getting their ducks in a row, so they'll be ready, assuming the science agencies do give the go-ahead. But this is really hard to message without looking like they are interfering with the science, right? You know, I listened to the White House briefing yesterday and I got what they were saying, but then you watch the news afterwards and it just gets sort of garbled in the mix and it does make them look like they're saying, "Yeah, we're ready to start giving shots to kids!"

Kenen: I mean, I think they're not botching the messaging on kids quite as badly as they did with the boosters, which was probably their worst messaging moment since Biden took office. It was really a mess. I think they are being a little bit more careful saying, you know, we're ready when. … I agree with you it's not crystal-clear.

Rovner: But it's not as bad.

Kenen: I don't think it's as bad as boosters. I mean, I think it's more like we're lining up, we're getting the needles ready. You know, we're delivering stuff. We're making plans. I mean, I don't, I agree it's far from perfect, but I don't think it's quite as cataclysmic. I mean, the booster stuff was a mess. This is less of a mess.

Rovner: I do think it's important for the kids, for the smaller kids, because they don't want to do it. I mean, you're not going to have mass vaccine sites for little kids. They're going to try to send it to pediatricians' offices.

Kenen: They're going to do it in schools probably, too, though. And in children's hospital parking lots, I would imagine, and things like that. I mean, I think that with the kids, it cuts two ways. There are parents who are really, really, really, really ready for this. And they just, they're going to line up on Day One. And there are parents who are really afraid of it because kids are not little adults and they're more worried about how it will affect them in the future, etc. And even if the FDA says it's safe and the CDC says it's safe, there are parents who are going to be worried. So I think we're … with boosters, we didn't know what to think. You know, those of us who [wondered]: Do I need a booster? Do I not need a booster? Do you need a booster at 60? Do you need a booster at 70? Do you need a booster only if you have this disease, do you need a booster if you have that? I mean the booster science was murkier and the booster messaging was a mess. So, I think with the kids, it's a little clearer. I mean, there are parents who just have been waiting a long time, they're really worried about their kids and delta. Their kids are in school, and they really want them. So I think that for them it's sort of reassuring. We're ready. We got your needles, we got a plan. I think that's what they want to hear, and the people who are afraid are tuning it out.

Rovner: And I think in a lot of cases, there are kids who are ready.

Kenen: I know kids who are ready.

Rovner: I heard a pediatrician, yeah, a pediatrician interviewed yesterday said I never had kids who've, you know, wanted, ever wanted to come in and get a shot. But these kids want to come in and get this shot.

Kenen: I have kids in my extended family who want that shot.

Rovner: Yeah.

Kenen: Very, very … I mean, I have a kid in my extended family, you know, two in particular, just, three in particular. They're talking about, when can I get it? I want to get it. I want to be able to do this. I want to be able to do that. You know, one of them has bad asthma. If you're like 9 years old in a pandemic that's 20 months old, that's a big chunk of your life. You can

barely remember pre-pandemic if you're a third grader, you know, some of them really want this.

Rovner: Meanwhile, this week on the vaccine front, with a few exceptions, looking at you Chicago police force and Kyrie Irving of the Brooklyn Nets, mandates seemed to be working pretty well. So well, in fact, that some organizations that were allowing people to either get vaccinated or get tested frequently, including workers in the city of New York, are now dropping the testing option, saying you just have to get the vaccine. Are we going to look back on this later and say, yes, of course, people should be required to protect themselves in their community? Or is this going to mark the start of yet another civil fissure that's going to divide families and states for generations?

Luhby: You know, in New York, it's already causing some concerns and issues. You know, there are people who don't want to do it and, you know, it's difficult even among our uniformed police and firefighters. You know, we just had firefighters come for an annual check in our building. They're not wearing masks, even though our building requires it. And, you know, there's that viral video that's gone on about the police, you know, taking somebody out of the subway station because they asked the police to wear masks because they weren't wearing masks, which are required. So yeah, I mean, you know, these mandates, the vaccine mandates, the mask mandates, they're required. But there are a lot of people in teachers and police officers and firefighters and others who just don't want to get it. I mean, they're in the minority, of course, but they're there and they have families and, you know, other people. So yeah, I think it is. It is causing a split.

Rovner: The In-N-Out Burger in Fisherman's Wharf in San Francisco. I didn't know there was an In-N-Out Burger at Fisherman's Wharf. They said they will not be the mask police or the vaccine police, and it's interesting to sort of see the way this divides. The U.S. has always had, you know, the whole libertarian streak of you can't tell me what to do with my body. And there are several historians who've written really good essays and books about how, you know, every time there's been some kind of an epidemic or a pandemic that we've had these same kinds of issues for generations, this is absolutely nothing new. But I feel like, with the advent of, you know, social media and instantaneous, anybody can talk to anybody, it just sort of makes it worse than maybe it was in the 1790s when they were requiring smallpox vaccinations.

Kenen: Well, that smallpox Twitter was really something.

Rovner: Yeah. Can you imagine if there was a smallpox Twitter in 1790?

Luhby: Well, I mean, we saw it in New York and with the measles here, I mean, we had a terrible measles outbreak before covid. And you know, and then there was the issue where the schools actually got rid of religious exemption, I believe, in New York for measles and some other vaccines.

Rovner: A number of states did that.

Luhby: Yeah. It caused a huge outcry again among a small group of people, because we're only talking about a small group of people, whether it be the covid vaccine or the measles vaccine. But you know, they're out there and, you know, maybe now the anti-vax movement is stronger now than it has ever been. It's again always existed and it's always been out there. But now it's got more force and probably more adherence.

Rovner: Yes, I think you're right. Well, I want to highlight a really interesting piece in The New York Times this week by sociologist Zeynep Tufekci about some of the characteristics of the unvaccinated. They're not just rural Trump voters, as we have, you know, many of us have painted them, but many are people without insurance and thus no source of medical expertise to turn to, people who simply don't trust institutions and people who are legit afraid of needles. I love this passage in the piece in particular, quote, "It may well be that some of the unvaccinated are a bit like cats stuck in a tree. They've made bad decisions earlier and now may be frozen part in fear and unable to admit their initial hesitancy wasn't a good idea. So they may come back with a version of how they are just doing, quote, 'more research.'" She says that's part of the reason why mandates are actually working so well that they let these people kind of save face by saying, "OK, you're requiring me to do it, so I will." Have we been approaching this whole thing all wrong?

Kenen: No, I think that the Kaiser monthly Vaccine Monitor has actually picked that up, and much of the coverage of that poll and other polls have picked that up. There's really, I mean, I've characterized it as the, you know, when I've written about it, as the anti-vax versus the vaccine-hesitant. And there's the ideologically opposed. The stereotype is the high school-educated Southern, white, rural Trump voter. And that's not the only person in the anti-vax, but that's sort of a handy way of thinking about it … when depicted, and there's truth in it. It's not 100%, but there's truth in it. And they're just ideologically "I'm not going to get this vaccine." Mandates seem to be eroding it. We'll know more in another month or two. But mandates do seem to be chipping away at that "I'm not going to get that vaccine no matter what," because there's always been an asterisk. They've always said, "I'm not going to get that vaccine no matter what, unless I have to to keep my job." So that's the anti-vax. And the vaccine-hesitant are everybody else she's talking about. That's it. It's the cat stuck in the tree versus the lioness. So the cat stuck in the tree is people, we've seen this since the beginning. "It was developed too fast. I'm afraid of the side effects. I heard it interferes with fertility," on and on and on. You know, the needle. The fear of needles is another one of them. You know, I heard so-and-so, something happened to so-and-so, and I don't want that to happen to me. I mean, the Colin Powell thing is … Colin Powell died of covid, yes, but he also was an 84-year-old Parkinson's [patient] and [had] a form of blood cancer, which destroys your immune system and means that you don't get very good protection from the vaccine. So, you know, his death may have been a tragedy, but it wasn't a tragedy that proves the ineffectiveness of the covid vaccine.

Rovner: No, actually, what it proves is that the only way to protect people who are immunocompromised is if everybody else gets vaccinated!

Kenen: Exactly right.

Luhby: But I'm not sure that that message is coming out to everyone.

Rovner: No, it's not.

Kenen: But there are people who want to hear it, and there are people who don't. I mean, that's again, that's that divide. What happened to Powell is going to fuel the hesitancy: “See?! It doesn't even work. Why should I come? Oh, why should I overcome my fears and concerns and anxieties? Because it doesn't work anyway?” I mean, that's not a good thing. And then there's the “I'm not going to take it. See, there's another reason. You couldn't even protect Colin Powell, right?” So I thought what she said was, you know, a good recap. I do think that it's not a new discovery. It's been in the data all along and it has been covered that way to an extent.

Rovner: To what Tami was saying, though, about how the anti-vaccine forces, you know, are sort of stronger than they ever were. I think they're also getting endorsement from some doctors. There was news this week from the GOP Doctors Caucus in Congress, which earlier this year actually did a PSA encouraging people to get the covid vaccine. But it seems that congressman Andy Harris of Maryland, who did get vaccinated, is also prescribing ivermectin to patients with covid, so he says, even though he's an anesthesiologist by training and specialty. I don't even know where to start with this. This all came out on a radio program that he and his wife were guest-hosting. But he said his concern was that he's been prescribing ivermectin, but he can't find pharmacies to fill the prescription for it because pharmacies have been told, really, you should not dispense ivermectin for covid. There is absolutely no proof that it works, and there are a lot of dangers potentially associated with it. I mean, so … but it's hard, now we have doctors who are actually out there prescribing it.

Cohrs: I think you see a lot of these, you know, debates ongoing. And there's a range, I think. My colleague Lev Facher had a really good story this week, just kind of laying out, kind of, there's all these debates over, you know, hydroxychloroquine, ivermectin and on kind of the other side where they're, you know, actually might be some evidence worth debating on, kind of, natural immunity for covid. This is definitely on the side of the spectrum that doesn't have a whole lot of evidence or any kind of supporting its use. But I think you see that just the bigger picture is that it's been highly politicized in Congress. There are all these, you know, ideas that a lot of Republicans have been pushing that don't make a lot of sense. But I think that kind of seeps into these, you know, maybe more valuable conversations to have about natural immunity, about the words we should use about kind of how that actually protects you. Should these people be vaccinated, that, sort of, you know, more meritorious conversation. I think, just the whole climate gets ratcheted up by all these other kinds of distracting issues as well. So I think it's just a continuation of that.

Rovner: Yeah. That’s a good way to put it. Well, we talked about, last week, some of the dangers to the health care workforce, but this week I really want to talk about nurses who are not OK. Even before covid, we were in a nursing shortage as the nation's nursing workforce

aged and retired and weren't replaced fast enough by nursing schools who had trouble finding enough teachers, even though there is plenty of demand from students. Covid has made it that much worse. Now we have burnout and suicidal thoughts and lots of labor unrest, adding to what's already a not-so-great situation. Are we going to find ourselves without the people we need to care for the sick when we're not really paying attention? There's also an inflationary aspect to this. A lot of nurses are quitting full-time jobs to become travel nurses because they can get paid way more and just basically adding to health care inflation and subtracting from, basically, continuity of care.

Luhby: Right now it's a huge issue. I mean, it was an issue prior where you saw … I was actually hospitalized for a cat bite last year during the surge of covid in New York in the spring. And almost everyone, well not everyone, but multiple people who took care of me were travel nurses and were making a lot of money, which was interesting. I did not even, I wasn't even aware of that trend until covid. But no, it's a big problem. I mean, health care used to be one of the fastest-growing jobs in the U.S. and now we have, last month or in August, actually, a record number of health care workers quitting their jobs — 534,000. And you know, there is a lot of burnout. I have some people in my family who are nurses and they're exhausted. And shockingly, you know, they're not getting necessarily the help or the consideration that they need to keep going.

Rovner: You know, there's all this, this talk of quote unquote, “the Great Resignation,” where the pandemic has made people sort of really rethink their relationship of work to home to job. And I'm wondering if maybe it's time for a shake-up in health care, too? I mean, people in health care have been sort of overworked and underserved for a very long time. Maybe it is time to sort of change the way we view the health care workforce or we're not going to have a health care workforce.

Luhby: Well, I mean, this is one of the things that Biden is saying. I mean, you know, the health care workforce is many different people. I mean, you've got doctors who are making tons of money, you know, nurses who are sort of maybe in the middle and then you've got a lot of other health care workers who have long not had great jobs where they've not made a lot of money. And, you know, this is one of the things that Biden is trying to address in the bill. So we'll see if that actually happens.

Rovner: It's all the nursing home and home care workers.

Luhby: Yes.

Kenen: Respiratory therapists, they were very much in demand and, you know, they were saving people's lives. They don't get paid well.

Luhby: And this brings in again also the vaccine mandates because, you know, you have so many places that are requiring vaccine mandates. And, you know, in New York, there's a vaccine mandate in nursing homes and stuff and some nursing homes have already been

struggling. They were struggling before the pandemic. The pandemic made them struggle even more. And now the vaccine mandates are, you know, a third blow. So it's going to be very difficult.

Kenen: But I think the other thing … there were a couple of really good articles this week at The Washington Post and elsewhere on the nursing crisis, the nursing shortage, the resignations, the burnout, the abuse, the mistreatment. One thing I didn't see in those stories is nurses tend to be, it's a disproportionately female profession. And these nurses may well have kids at home who are homeschooling because they're, not now, but over the last year and a half, and dealing with that's a factor in the Great Resignation, too. I mean, women who do not have the support they need have for child care for when schools were shut, when schools were shut on and off, and kids were quarantined. That's probably an extra stress on many of these nurses on top of all the things unique to the nursing profession 20 months into a pandemic.

Rovner: And the fear of taking home a contagious disease to your unvaccinated child.

Kenen: Yes, there's lots of lots of things. And the disparity of pay between the traveling nurse and the staff nurse is very big. And then there's the small, smaller, poorer hospitals who can't even compete with the bigger, richer hospitals or the rural versus urban on the traveling nurse. The pay disparity is also quite large. So traveling nurses to, like, relatively prosperous academic medical centers are making a lot of money.

Rovner: We will definitely come back to this issue. All right, that is the news for this week. Now it is time for our extra credit segment where we each recommend a story we read this week we think others should read, too. Don't worry if you miss it, we will post the list on the podcast page at khn.org. And now in the show notes on your phone too. Tami, why don't you go first this week?

Luhby: Well, mine makes sense to go first because it continues the conversation we were just having, which Joanne highlighted, which is a story in Modern Healthcare by Jessie Hellmann called “Rural Reckoning: COVID-19 Highlights Long-Standing Challenges Facing Rural Hospitals. Will It Create Momentum for Change?” And, you know, it goes over the fact that rural hospitals were having major issues before covid. They were having issues with payments and staffing, and many of them were closing. And now, of course, covid is only exacerbating this, of course, making nursing more expensive and, you know, and having more people quit and leave. So this is just a good piece. He highlights two different, you know, several different hospitals in there explaining what their problems are. And, you know, we'll see, you know, what happens. There are efforts to try to help them. There was an extra $8 billion, I think, or $8.5 billion in the March relief bill that was directed specifically for rural hospitals. And you know, it remains to be seen.

Rovner: Well, I'm going to exercise the moderator option to go next because mine also builds on the discussion that we were just having. It's a KHN story from freelance health reporter Giles Bruce, which appeared in the Chicago Tribune, and it's called “Hygienists Brace for Pitched Battles With Dentists in Fights Over Practice Laws.” And it's about something I have covered a

lot over the years, something called scope of practice. The idea is that every health professional should be able to practice to the top of their license, meaning the most sophisticated things that they are trained for. Except the top of a dental hygienist license is the bottom of a dentist license, and the dentists and other health professionals don't want the economic competition of lesser-paid professionals. As a result, we see lots of legislative fights between dentists and dental hygienists and doctors and various forms of advanced practice nurses and so on. And the people who tend to lose out are those who can't get any services at all, which is why a lot of these bills get introduced to allow things like dental hygienists to practice without a dentist in nursing homes. But, seriously, one of the ways other countries deliver more care at less cost than we do here in the U.S. is they'd let less expensive professionals do more things. Just a thought. Anyway, Joanne.

Kenen: This is a piece by Sam Quinones, who many of us have read his book "Dreamland," which was the very readable and very sad book on opioids. And now he's got a book out on fentanyl and meth. And there's a very long but very good excerpt in The Atlantic. It's called, the headline is, "I Don't Know That I Would Even Call It Meth Anymore." And it talks about how what is now sold as meth is a different chemical composition than the meth that was bad enough a few years ago. This one seems to be … he talked about, you know, rapid decay, that your … it just does terrible damage very quickly. It seems to be sparking severe mental illness. It is a factor in some of the tent cities in L.A. and other places. It is very cheap to make. It is very easy to smuggle. It is very abundant. It is very dangerous and it's a very long article. I learned a lot from that article, and his new book is called — it's a much longer title than "Dreamland" — "The Least of Us: True Tales of America and Hope in the Time of Fentanyl and Meth." So it's a weekend read. Sit down on Saturday afternoon. But it's good.

Rovner: Yeah, a heavy weekend read. Rachel.

Cohrs: OK, so my story is in the U.S. News & World Report. It's headlined "Debt After Death: The Painful Blow of Medicaid Estate Recovery" by Sarah True. I just thought this was a really insightful and important portrait into how Medicaid estate recovery impacts generational wealth issues, and just as, I think, as reporters, you know, we're all thinking about how to cover health equity better. And I think this was just a shining example of just a really complex and kind of wonky policy topic that she just really brought to life with great anecdotes, you know, great photos. And it's just a really such a sad impact on these families who, you know, have just dealt with the loss of a loved one. So yeah, I thought it was very moving and it's a very important issue to think about.

Rovner: It is a really important issue, and I think it's been undercovered. It pops up every couple of years, but at some point someone will really pay attention. All right. Well, 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 ace producer Francis Ying. Also, as always, you can email us your comments or questions. We're at WhatTheHealth, all one word, @kff.org or you can tweet me. I'm @jrovner. Rachel?

Cohrs: @rachelcohrs

Rovner: Joanne.

Kenen: @JoanneKenen

Rovner: Tami?

Luhby: @luhby

Rovner: We will be back in your feed next week. In the meantime, be healthy.