KHN's 'What the Health?'

Episode Title: Drug Price Bill Is a Go in the Senate
Episode Number: 257
Published: July 21, 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, July 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. Today we are joined via video conference by Shefali Luthra of The 19th.

Shefali Luthra: Hello.

Rovner: Joanne Kenen of the Johns Hopkins [Bloomberg] School of Public Health and Politico.

Joanne Kenen: Hi, everybody.

Rovner: And Rachel Cohrs of Stat News.

Rachel Cohrs: Hey, Julie.

Rovner: Later in this episode we'll have my interview with the new president of the American Medical Association, Dr. Jack Resnick, a dermatologist from the University of California. I can guarantee he does not sound like most of the other AMA presidents you might have heard. But first, this week's health news. And breaking just as we are sitting down to tape this, President [Joe] Biden has tested positive for covid. I guess this was something that we all knew was probably going to happen at some point. But what do we think from here, just as this is breaking?

Kenen: Well, first of all, I don't think any of us are surprised because all of us have really cautious friends and relatives who are boosted and masked and getting covid anyway. So ... Tony Fauci got it. This variant is incredibly contagious. We're not talking about it as a crisis, but it is really, really, really spreading. Now, Biden ... has one risk factor, which is his age. But as far as we know and ... we do get reports on his health, he has no other risk factors. He is actually very fit for his age, you know.

Rovner: And he's younger than Tony Fauci.

Kenen: Right. But is he 79? Is that right?

Rovner: I think so.

Kenen: But he's not overweight. He doesn't have diabetes, he doesn't have, you know, any severe health problems that the public has been made aware of ...

Rovner: And he's getting Paxlovid, the White House has said.

Kenen: He's getting Paxlovid. And he's double-boosted, he's had four shots. So is he sick? Yes. Is he likely to fully recover? Yes. Is the right wing going to then try to say every time he stumbles over a word that ... they've already been saying he's got dementia. Now, they will probably say he has dementia and long covid. But, you know, is he likely to make a full and rapid recovery? Yes. Is there some risk of long covid? Yes. Is it believed to be less if you're with omicron and double-boosted? Yes. We'll have to see how that ... could he have Paxlovid and get a rebound? Well, Tony Fauci did. So basically, we know the president has covid. We know lots of people have covid. We know he is likely to be fine in a matter of days. There are some uncertainties. And of course, we all know that his enemies will cheer it.

Rovner: All right. Well, obviously, more to come on this breaking news story. We will move on to what was our lead story, which is the continuing saga of "As Joe Manchin Turns." When we last picked up the story, the senior senator from West Virginia had decided that contrary to his earlier agreement, he really can only support a Democrats-only budget bill that includes legislation to allow Medicare to regulate drug prices and to extend this year's expanded subsidies for the Affordable Care Act for an additional two years. This is obviously a way-smaller package than the original Build Back Better bill that the House passed last year. Yet President Biden last Friday urged Congress to take up and pass the bill as soon as possible. And Senate Majority Leader [Chuck] Schumer has indicated he plans to do just that, with the bill on its way to the parliamentarian — even as we are taping this — to make sure it complies with these strict budget rules that would let the Democrats pass it with 51 votes instead of the usual 60. But while the Washington political pundit mob says this bill is barely a blip, in fact, it would represent the biggest change to drug prices in two decades and the biggest defeat for the drug industry that I can remember. Somebody remind us what's actually in this? It's not fully nailed down yet, right, Rachel?

Cohrs: So the drug pricing portion is pretty nailed down at this point. There are three main pillars of that bill. The first one, as you mentioned, would allow Medicare to negotiate drugs. Not a lot. Not a huge number of drugs right away, 10 in the first year. But again, which [would] ... break that firewall between the government and industry. The second big provision would penalize drugmakers that hike their prices faster than inflation. And that includes the commercial market, too, in a way, and those calculations. So we'll see if that survives parliamentarian review.

Rovner: I was going to say that's one of the things that the parliamentarian is going to be looking at.

Cohrs: Yes, definitely. And the third is a redesign of Medicare's prescription drug benefit, and that includes a $2,000-a-year cap for seniors' drug costs, which doesn't exist right now.

Rovner: When they did this bill back in 2003, the quote-unquote "catastrophic benefit" was that your drugs would be paid for, but you would have a 5% copay, which at the time seemed, if not *de minimis*, at least affordable to most people. But now 5% of some of these drugs that cost hundreds of thousands of dollars is way too much money for most Medicare beneficiaries.

Cohrs: It's true. That would be a big change. And just to note that they haven't nailed down the ACA subsidies, like what that package could look like yet. That text is not before the

parliamentarian right now; it's only the drug part. And I think that's kind of in flux as to if there's any additional means testing or what the exact length would be. We don't know that yet. But Sen. Schumer did say Tuesday, kind of for the first time, that he is on board accepting Sen. Manchin's offer that health care is going to be the way to go for now.

Rovner: Yeah, I mean, there's still a possibility that they could do this bill and then come back in September and do another bill, right? They could either do another budget resolution or the rules of budget reconciliation are that you can do a spending bill and a tax bill and a debt ceiling bill. You can do three bills off of each budget resolution. And I've lost track, but I don't think they've done all the bills they can off the budget resolution they're working under.

Cohrs: Right. People smarter than me have looked at this issue. And the health care space does touch tax and spending. So they, I think, talked about a lot last year how many reconciliation bills they could do. That has never been done before, but they could certainly do a 2023 resolution. But it requires all 50 Democratic senators to be at a vote-a-rama overnight. And, you know, there are people out with covid. Sen. [Patrick] Leahy just had another surgery. I mean, it's going to be really tough going for them to even do this once.

Rovner: Yeah, this is the difficulty of having a 50-50 Senate. My bigger question: Is this yet another case of Democrats snatching defeat from the jaws of victory? Yes. They were asking for the sun and the moon and the stars in the Build Back Better bill, and they're really only getting the moon. But, wow, getting the moon is a really big deal and it's really popular and it's the fulfillment of a campaign promise Democrats have been making since basically the turn of the century. How do they always take these big achievements and make them look small? I'm looking at you, Affordable Care Act. Because they're just not *as* big as some would have liked.

Kenen: It's really hard to break anything through right now. I mean, the White House was complaining the other day that gas prices are going down quite rapidly. I mean, we don't know for how long, but right now they're down and ... there's no media coverage. There was huge media coverage of the soaring gas price and there hasn't been a drop-off. There hasn’t been equal coverage. And it's been really, really hard for the Biden administration to get publicity about the infrastructure bill, which they passed, which was also quite an achievement and had some climate in it, although not anywhere near as much as Biden wanted. Yes, this is a victory for Democrats. But, first of all, good news doesn't break through. And secondly, yeah, it's achievement, but we're down to “Build Back a Smidgen.” You know, when you set the expectations this high and ... it's a cliché already, it's Charlie Brown and Lucy and the football. I mean, we've had six months of Manchin smash-ups.

Rovner: More! It goes back to — it's almost a year. It was last September, wasn't it?

Kenen: Yeah, almost a year. Right. And yes, it's a big deal. But no, in the context of what President Biden and the Democrats set out to do, it's not a big deal. It's salvaging something from a large agenda that's been broken into a million pieces at a time of multiple crises in the country and the world. So, yeah, I mean, it's letting Medicare do drug pricing. It's a big deal, but it's going to be hard for him to sell it as a big deal.

Luthra: And I think the other part in there that we don't think about is when do people actually experience the impact of these changes? And we saw that with the ACA. We will see that with the drug pricing. We have seen that with the infrastructure bill. If you don't actually feel your life getting better, then it's really hard to internalize that this quote-unquote "good news" has actually happened.

Kenen: Plus, Republicans will pretend it's theirs. I mean, it's like the infrastructure bill. They voted ... most of them voted ... that *was* bipartisan, but most voted against it. And then, you know, there's a bridge going up in their hometown and they go and cut the ribbon and pretend it was their idea. So you're going to see Republicans saying, we have done this, and Americans don't pay enough attention to the news. It's going to be very hard to make this a victory.

Rovner: I was going to say, and then when it *does* happen, people don't remember what made it happen. There are all these ... if you go back and look at the polling on the Affordable Care Act, all these things that are really popular, people have no idea. All they heard when the Affordable Care Act passed [was] that it wasn't very big and it wasn't going to do very much. Then when it started doing the few things that it really does well, they're like, "Oh, this just happened." They have — they don't connect that to, you know, it's just, it's sort of the lag, you're right, between when something passes and when people feel the impact.

Kenen: Or why they ... where they think that impact came from.

Rovner: All right. Well, speaking of things that we have felt the immediate impact of, we're going to proceed to life after *Roe [v. Wade].* This week's theme is: Hey, even though we all knew this was coming, it seems that no one was ready for it to actually happen. I want to start with an interesting Politico story, mostly about congressman Jim Himes, a liberal Democrat from Connecticut, who said that the Democrats' main talking point, which was "Vote for a bigger majority in the Senate this November and we'll codify abortion rights," isn't going over very well in his district. I have to say it isn't going over very well in my Twitter feed either. It's pretty clear that there wasn't going to be much that Democrats could do in the short term after *Roe* got overturned. But couldn't they have had more effective talking points?

Luthra: It's pretty wild. I don't know. ... We knew that this was coming. Some would say for two or three months. Others would say since December.

Rovner: Yeah. ... I wrote a story in December, when they had the oral arguments, that said, "This is coming." And I don't do that when I listen to Supreme Court arguments. I mean, I'm very cautious about predicting what the court's going to do. But this was pretty transparent.

Luthra: But, yeah, this was really obvious. I remember talking to Democrats right after the leak, and it was just really stark how they didn't have any ideas of what to do. They just seemed really uncertain and lost. And they would talk about if we can get a few more senators, we could vote on these things. They didn't really have good answers for the fact that they will lose the House. I think you're right, they could have had better talking points, but part of that is not fully recognizing that it's hard to make the pitch to voters to bring more of them in when what people see is the same people in charge of the party for decades ... who never shored up protections to begin with. And

then to come back and say, if you ask us, if you vote for us this time, we'll get it right. That's a tough pill to swallow.

Rovner: It is.

Kenen: But I think that the political ground shifted dramatically in that we knew *Roe* was gone, but we didn't know all the details of how far they went. They went extremely far.

Rovner: Right. They might have done it in steps, which they decided not to.

Kenen: But I think what happened, and Jen Haberkorn has written about, was the first person I know who wrote about some of this who said, sometimes on the podcast, a former colleague of mine, and Jen was with the L.A. Times, and she wrote a story, maybe two or three months ago now — I can't remember — saying, you know, even in the anti-abortion world, the political debates, there were exceptions for health, there were exceptions for rape, there were exceptions for incest. That was pretty much part of the package. Not too long ago, we were talking about an 18- or 20-week ban being the outer limit of what they were going to look for. We're now at a total ban, an attempt to make it national, or a desire to make it national, not through the court, but through politics, through the elections. And we're seeing this really narrow definition of when a woman's life is even threatened. So we're really in a ... I think that, yes, the Democrats were ill-prepared politically and policy-wise with either a political or a policy response, other than "elect more Democrats." But I also think that some of the issues about medical care I don't think people anticipated. And Biden did take that EMTALA [Emergency Medical Treatment and Labor Act] step saying you have to give emergency care, but even then it's ambiguous. Doctors still face criminal prosecution and they can be turned in by somebody who overhears them in the emergency room. So, yes, the Democrats are often caught flat-footed. I mean, one side is life, and the other side is choice. They've always been behind the curve on language on this. They assumed *Roe* could ... was safe when it clearly wasn't. Abortion rights have been eroding in this country for years. Abortion access has been eroding for years. There are parts of the country where you already couldn't get one without traveling hundreds of miles, and they keep talking about it as a campaign slogan rather than something that is affecting women. And men — families — at this very minute across the country.

Rovner: So among the things on the table for Democrats this week is a very limited public health emergency declaration by President Biden attempting to protect abortion pills and efforts in the House and the Senate to make Republicans vote for contraception, assuming they support it. Both of these things could be pretty important, but they also feel like pretty weak tea for a very angry Democratic electorate that's not getting a whole lot of other things that were dangled in front of them, starting with climate change and student debt forgiveness. I mean, now they're starting to say, well, here's some of the things that we *can* do. A) Are they going to get any of them done? and b) are any of them going to be enough?

Luthra: No and no. I don't mean to be too sure of anything because nothing is sure. But, I mean, we do know that there are limits to what the president can do without Congress. We know that the votes in Congress are not there for most of these protections that people have lived with for

decades. But I think what we also have seen over the past month is that the administration has been incredibly cautious, right? They are very spooked about the possibility of facing legal challenges and losing in a court that they know leans conservative. And the criticism that they've gotten is that that fear of losing has meant that they're unwilling to try a lot of things that various academics have said could be worth a shot. And there are real criticisms about, for instance, the notion of putting clinics on federal lands. Can people be protected? Could those protections go away in a different administration? But I've been pretty surprised that they talked so much about safeguarding access to medication abortion pills the day the decision came down, and we have seen very little action on that front. I expected we would have seen something by now.

Rovner: Yeah, we got a really strong statement from Attorney General [Merrick] Garland and then not much since then. I would point out in response to Jen's very good piece about the rape and incest, when I ... I've been doing this so long that when I started covering the Hyde Amendment in the late 1980s, there were no rape and incest exceptions. They actually ... they had been there originally. They were taken out for several years. So the anti-abortion movement has been up and down on this particular issue. The Democrats failed to get those back, not because there weren't a fair number of Republicans who supported them, but because there were a fair number of Democrats who didn't. There used to be a very large contingent of very conservative, mostly Southern, pro-life Democrats. There was not a majority that supported abortion rights in the House until 2019. You know, people talk about why didn't they codify this when they could have? It's like, when exactly would that have been?

Kenen: It almost took down the Affordable Care Act.

Rovner: Yes, and that's right.

Kenen: I mean, at the very last minute at the very last night, it was that small band of anti-abortion rights Democrats who put it in danger in the House, which some people thought were about to pass single-payer. No. I mean, but also those restrictions you were just talking about on Hyde, they aren't the same. I'm not diminishing the importance of Hyde, but limits on Hyde aren't necessarily limits on all abortions. That's federal dollars versus access for people who aren't on Medicaid.

Rovner: Right.

Kenen: I mean, rape and incest has been ... most of the anti-abortion talk and bills and state things that even weren't in compliance with *Roe* and were struck down still allowed [exceptions for] rape and incest and health of the mother, usually health of the mother, sometimes only life. But now it's very hard to create a line ... where do you go from threat to life to threat to health? I mean, if you don't treat a health problem, it can become a life-threatening problem. And where is that line? So ...

Rovner: Yes, as we're hearing in many real-life anecdotes every single day.

Kenen: Yes. Yes. Yes.

Rovner: All right. Well, meanwhile, the winning side is also making unforced errors. We talked briefly last week about that sad story of a 10-year-old in Ohio who was raped and whose family had to take her to Indiana because she couldn't get an abortion in her home state. Well, Indiana's Republican attorney general, former congressman Todd Rokita, went on Fox News and accused the Indiana doctor who performed the procedure of failing to file the necessary paperwork and announced he was investigating her. Well, it took an Indianapolis news station less than a day to confirm that the doctor did, in fact, file the necessary paperwork. And now a lawyer for her is preparing to sue the attorney general for defamation. Meanwhile, when asked about that case in a Senate hearing last week, the head of the anti-abortion group Americans United for Life denied that an abortion for a 10-year-old who'd been raped was an abortion at all. Is that how the anti-choice movement is going to handle these hard cases? That it's only an abortion if you're doing it for purely elective reasons?

Luthra: I think they're in a really tough spot on this, because banning abortions for all cases is sort of the natural extension of the logic they have endorsed for decades. But people don't like that. And they're struggling to come up with a good answer that allows them to build on their victory while trying to maintain this narrative that they really care about the health of all, is sort of the way they've been trying to frame it — the parents and the fetus. And I don't envy that position. That just seems like a very difficult needle to thread and I don't think it's necessarily possible.

Rovner: Yeah, the reason that both sides are stuck here is because, if you look, the one consistent thread from public opinion on abortion over the 37 years I have been doing this is that Americans think abortion is generally a bad thing, but it shouldn't be up to the government to decide whether or not it's allowed. That's, in general, that abortion is more allowable earlier in pregnancy and more problematic later in pregnancy. But generally, Americans are quite ambivalent when it comes to abortion. They don't like it, but they don't think it should be banned. That's essentially where the public is. And that gives both sides problems in trying to fashion, you know, a majority position. And I think we're seeing both sides floundering around right now. I mean, as someone pointed out last week, it's not just that the Democrats weren't ready for this to happen. The anti-choicers were not ready to get everything they wanted at once, and they're having a little bit of trouble finding their footing.

Kenen: Well, also, the anti-abortion movement had different factions, and the faction that is now dominant just four or five years ago was considered the fringe. I mean, there are people who are in the anti-abortion movement who since early on opposed abortion on moral grounds and believe it should be illegal, but who also did see that lots of things are wrong and you have to make choices about which is most wrong. Not everybody who has been advocating for tougher abortion laws would want a 10-year-old rape victim to have to have a child, but some do.

Rovner: Clearly.

Kenen: It's, you know, which dog caught the car?

Rovner: Exactly. All right. Well, moving southward, it used to be that California was a place where all new health ideas were born. If it happened there and it worked, it was likely to spread. Well,

when it comes to abortion restrictions, that title pretty clearly belongs to Texas. Texas, of course, is where *Roe* has been effectively repealed since last September, when the Supreme Court declined to block a six-week ban that lets ordinary citizens tattle and take to court anyone who aids or abets an abortion, which could include receptionists and Uber drivers. That pretty quickly shut down most abortions in the state, even the ones that were still legally allowed. Now, Texas is trying to push that envelope even further. We talked last week, and, Joanne, you just talked about how the Biden administration is setting up potential conflicts for doctors by reiterating that EMTALA, the Emergency Medical Treatment and Active Labor Act of 1986, requires doctors to at least stabilize patients with medical emergencies, even if that requires an abortion. Well, Texas Attorney General Ken Paxton is suing over that, saying the federal government can't require doctors to violate state law. This could end up right back at the Supreme Court, right? And I guess it's going to test that whole anti-choice talking point about how abortions in medical emergencies aren't actually abortions.

Luthra: I'm surprised it took Ken Paxton a whole day. Like, of course, there was going to be a lawsuit. Of course it was going to come from Texas. And this is what the Biden administration is afraid of, that this will go to the Supreme Court and they will lose. And then the administrative state will be further weakened and weakened, as we've seen over the past year. I think you're right that this definitely complicates the narrative for the anti-abortion movement, that they care about the health of the pregnant person. Because if you aren't allowing doctors to determine this to be a necessary treatment for people who could otherwise suffer severe health consequences, how do you say that you are, in fact, caring about the pregnant person's health or well-being? You are absolutely right that we are going to be spending a lot of time, I think, in Texas over the coming months and years just to see how far things go and to go back even further. I mean, *Roe v. Wade* came from Texas, even well before when Joanne was referencing that the outer limits were the 18- and the 20-week bans, Texas was a pioneer. In 2013, they passed the omnibus bill that led to half the clinics in the state shutting down. When we think about what the future of the anti-abortion movement looks like, we are going to be spending time in Texas.

Rovner: So let's stay in Texas for a minute. Texas colleges and universities, particularly public ones and ones that draw a lot of out-of-state students, are scrambling to figure out how to handle the ever-changing state of the law. Shefali, Texas thinks itself as a haven for young people with its low taxes and big opportunities in tech and other high-paying professions. This could have a real impact on people's decisions to move there, right?

Luthra: I've already heard from doctors in neighboring states who say that they are getting patients from Texas who are planning to move out of state. I have talked to folks I know socially who live in Texas who are planning to move out because they are concerned about the well-being of their children. Austin has changed dramatically in the past few years. We've all been there pretty recently and we've seen the massive mini-San Francisco. This is going to be really tricky because at some point you will see a tension between the social norms that, generally, more liberal socially tech employees and young people want and what is available to them in Texas. And I think this is going to be a real challenge for how the state thinks about its economic development moving forward.

Rovner: And Texas anti-abortion forces want to go even further, trying to build cases not against just abortion clinics, but against abortion funds and those who contribute money to them — in addition to the threats we talked about last week against employers who want to help their employees leave the state for an abortion. How much of this is bluster and how much of this might they actually do? I mean, this is Texas we're talking about.

Luthra: Texas abortion funds already aren't able to pay for patients to go out of state at all. They are too afraid of what things look like in the post-*Roe* world because Texas is enforcing its pre-*Roe* ban. I think it seems very possible that when the legislature reconvenes, which obviously does not happen until next year, they do look at penalizing corporations that pay for folks to go out of state. Even a few years ago, I think there would have been real questions about whether they could get the votes. But anything seems possible now. And once you win on this signature issue, there is pressure on a lot of these states to keep being leaders in the effort to restrict access to abortion. This is a really natural next step for them. And there's a decent chance that, at least in the short term, they could succeed, even if in the longer term, they face legal challenges.

Rovner: Well, meanwhile, it's not just Texas. Around the country, a lot of things that were predicted to happen if *Roe* were to fall are happening despite the people who were predicting them being told they were being overly dramatic. As you will hear in my interview with the AMA's Jack Resnick, people seeking methotrexate for cancer or psoriasis are being denied unless they can prove they're not planning to use it as an abortion pill. Women with miscarriages are being made to wait until they are septic before they can get care, lest that can be mistaken for an abortion. And clinics that are performing abortions are getting overwhelmed. Shefali, you wrote about that. How bad is this all going to get before it comes to a head?

Luthra: It's not good. I have been thinking for the past week about one clinic that gets 1,000 calls a day. That's just staggering. They do not have the bandwidth for this many patients. They are capping at 35 a day when they can book people. And they told me there, if we booked everyone who called, we would be full until October. We are seeing wait times double and triple in Illinois. We are seeing them to 3 to 4 weeks in New Mexico, in Colorado. There is a movement toward building out new clinics in these states to try and absorb the overflow. We have heard that the clinic from Mississippi is moving to New Mexico. A clinic owner I talked to from Oklahoma and Texas is planning to open up sites in New Mexico and Illinois. But these things take time and it's a really bad market for hiring. It's going to take a few months before they're able to get off the ground and start seeing patients and see the ones who are able to travel. And in the interim, we're seeing longer wait times. We saw in Texas what happened, which is people are pushed later into pregnancy. More often they require second-trimester procedures instead of the first-trimester option of medication. It makes this more expensive. It makes it more invasive. It makes it take more time from the provider. And it's just a really incredible domino effect. And one thing that I've been thinking about is, I mean, the clinics, a lot of them, they did know that this was coming, but there was only so much they could do. They didn't have the money to hire folks in advance. Some of them were trying to physically get bigger. But that's hard.

Rovner: And some of them, I mean, you know, the ones who are moving, some of them wanted to stay as long as they could. And we're still seeing that in some states where, I think, Louisiana is

going back and forth, you know, abortions available today and not tomorrow and again the next day and not the day after. I mean, you know, Texas' full trigger ban hasn't gone into effect yet. Some providers are hanging on because they feel an obligation to their patients to try to do that.

Luthra: The Shreveport clinic in Louisiana has sort of boomeranged with what's legal. The other thing that I think really caught providers by surprise was the fear from patients about what would be defined as an abortion. And this concern that if I take the first pill for a medication abortion at your clinic in a safe state and then come home for the second state, is that getting an abortion in a state that has criminalized it? And doctors don't have answers. They don't know what to tell patients who ask about this. So it limits patients' options further. And in many cases, ones who would have wanted medication can only get surgery now.

Rovner: All right. Well, meanwhile, one thing that the government did seem somewhat prepared for, the new three-digit mental health hotline, 988, went into effect on July 16. It merges a series of existing mental health crisis lines for those contemplating suicide and for veterans, and connects to more than 200 crisis centers around the country where people experiencing mental health emergencies can reach out for crisis de-escalation and local mental health resource referrals. I feel like this is one of those things like the Americans with Disabilities Act, which took effect also in the middle of a summer that will be remembered more for its impact in retrospect than it is right now. Am I the only one who thinks that, that in 20 years they'll say, wow, there was a time when we didn't have a three-digit number for mental health crises, but right now it seems to be sort of overlooked.

Cohrs: Yeah, I mean, I think right now there's still some questions. I know there was like more funding and the gun safety bill, but about how much capacity they'll have from state to state. And I think trade-offs, the trade-off seemed at a really great breakdown about in the lead-up to the introduction of this hotline. So I think there's some wait and see. My colleague Theresa Gaffney did some great reporting sitting in a call center that first day and the feeling of encouragement and momentum that that call center was experiencing, specifically. But I think the resources, the support, how it plays out across the country, I think there's also really dangerous consequences if it isn't supported well. So certainly if it's a successful effort and there is more support for people who need it, I think that would be seen as a really significant achievement. If it's something that Americans really do adopt as just as natural as calling 911, but it's just unclear what the future looks like. And we'll just have to wait and see.

Rovner: A tiny bit of hope in a week of a lot of really bad news. All right. That's the news for this week. Now we will play my interview with AMA President Jack Resnick. Then we'll come back with our extra credit.

I am pleased to welcome to the podcast Jack Resnick, the newly inaugurated president of the American Medical Association. Dr. Resnick is a dermatologist from San Rafael, California. The first AMA president from California in 15 years and the first dermatologist in the post in nearly a century. In his "spare time," and I'm using air quotes here, he teaches both medicine and policy at UC-San Francisco. You are a super busy person, so thank you so much for dropping by.

Jack Resnick Jr.: Thanks, Julie, for having me. I really appreciate the opportunity.

Rovner: So just a couple of weeks ago, I got to sit down with U.S. Surgeon General Vivek Murthy to talk about his recent report on health worker burnout. Obviously, doctors who already had burnout issues have been among those most disproportionately affected by the pandemic and the associated growing mistrust of the medical profession by the American public. How serious is this burnout problem becoming and what's the AMA doing about it?

Resnick: I think it's really serious and I'm glad to have the opportunity to talk a little bit about it. You know, I feel like I'm coming into this role at a time when the profession of medicine has really lived through 2½ very difficult years. And having watched my colleagues around the country during that time period, I can say, quite confidently, I've never been prouder to be a physician, to be part of the AMA. And we're in a different place than we were 2½ years ago, right? People are not sleeping in their garages or in tents or having to wear trash bags to work.

Rovner: Doctors, you mean?

Resnick: Doctors. Yes. But physicians really have put their lives on the line and, as you alluded to, have been battling misinformation and sometimes even threats of violence and working to hold together a health care system that has just been stretched too thin. So we are seeing increasing burnout. When we talk to and survey physicians around the country, about 1 in 5 of them is reporting that they may retire in the next two years. We're seeing even higher rates among our colleagues in nursing. So I think it's something to be worried about. And that's really why we at the AMA have been thinking about how the nation can renew its commitment to physicians. And that's why we have a recovery plan that we're thinking about for America's physicians.

Rovner: So tell us a little bit about that recovery plan.

Resnick: It has a few pillars, and I'd love to make sure we get to two or three of them. There are five in total. One of them is really focused just on burnout as its core piece. And part of this is thinking about mental health and the stigma around mental health to make sure physicians who have depression, who are at risk of suicide, actually are comfortable getting the help that they need, particularly in these difficult times. Another piece is around dysfunction and health care, and those two pillars are quite closely tied together because a lot of the things that create that dysfunction and create burdens that get in the way of our ability to provide the care to patients that really drew us to medicine as individuals in the first place are ... those are really the things that drive burnout. So there are a lot of examples. When I travel the country talking to physicians now, one of the big ones is prior authorization.

Rovner: Which sounds odd in the midst of a pandemic, it's like, well, doctors are worried about getting permission from insurance companies to treat patients.

Resnick: Yeah. You know, and when I went into medicine, I'm — I haven't been doing this that long — I'm two decades into my career as a trained physician. And when I started out in practice, prior authorization was something insurance companies had kind of created for brand-new, really expensive drugs or really expensive brand-new tests where the evidence wasn't entirely clear yet

and they wanted to take a second look. You mentioned in the opening, I happen to be a dermatologist. I now have to fill out prior authorization forms for, like, generic topical cortisone creams that have been around since the 1960s. And that's not just an isolated example. The average physician is doing 41 of these prior “auths” a week, and most of them get rejected when we first send them in. So then we have to do appeals and wait on hold and talk to somebody who's, oftentimes at the insurance company, never even heard of the disease we're treating or the medicines we want to use. And so, yeah, it sounds like a funny thing to be talking about in the middle of a pandemic, but in reality, it's one of those things that is driving physicians nuts because they really are struggling to get their patients the care that they need. And it's getting in the way. And that's no fun when you went into medicine to help patients in the first place, so that's a big piece. Another pillar for us around the recovery plan is really around fixing Medicare and the way that it pays physicians. And we're in a time of substantial inflation. Practice costs have gone up, especially for people in private practice and in small and mid-sized practices. But we're also seeing a larger health care system has been reported on really having to pay far more for staffing and rent and supplies and everything else. And the Medicare payment system has been frozen for 20 years. So physicians just can't invest in their practices to be able to get patients access to care, update to new electronic health records, work on improving quality metrics and reporting. So we really need a system that just automatically sort of keeps up with those practice costs and allows us to innovate and create cool new payment models and supports those models that actually work for physicians and patients. So that's another piece.

Rovner: Yeah. I've been covering physician burnout as a problem for a lot of years, as you say, things like prior authorization, you know, frustrations with physicians with Medicare. Those are nothing new. But medical misinformation strikes me as a relatively new phenomenon. Obviously, physicians can and do disagree about medical evidence and its strength or weakness. But one of the AMA's reasons for being is to establish baseline behaviors for the medical profession, including following science and evidence. What can you do about doctors who are demonstrably misinforming their patients? We've been reading about this all around the country.

Resnick: You're right, part of our founding as an AMA all those years back was really trying to get snake oil out of health care. It is a big part of our history and so it's incredibly frustrating to us as physicians. And we have seen so much of this during the pandemic when we see not just misinformation but disinformation, because some of it's on purpose. And it really is a part of what we refer to as anti-science aggression that we're seeing around the country. The reality is the vast majority of physicians look at good science, look at good evidence, communicate that to their patients and their communities. And again, it's another thing I've been quite proud of during these last 2½ years. Not only the physicians that you get to talk to and that we see on television and hear on radio and have national leadership roles. But physicians in their own communities, in their practices, talking to individual patients about vaccines, on social media, correcting the record. So there's a lot that our profession can do. We actually just adopted policy at a recent AMA meeting around a whole set of things to fight back against disinformation. But it is a part of reclaiming the mantle, of holding up physicians for their expertise and holding up science and rebuilding that respect.

Rovner: Are doctors ready to sanction their colleagues for, basically, misbehavior?

Resnick: There are times when that's necessary and there are processes in place for that, right? So whether it's state medical boards that are responsible for regulating physicians in the states, whether it's specialty boards that accredit us. So I think that's a piece of this, for some of the more extreme examples. But that's really in the disinformation space where you see people purposefully going out and spreading disinformation, which is very different than ... people try to blur the lines here between disagreements over science, which is part of who we are and what happens all the time, versus once we know and have 20 studies that ivermectin doesn't work for covid, that's not a disagreement in science anymore. The evidence is there. It's quite solid. So we look at those things a little bit differently.

Rovner: So, like the rest of American society, medicine in the U.S. no longer speaks with a single voice. Now, with the overturn of *Roe v. Wade*, we are literally seeing legislators with no background in medicine, effectively practicing medicine all around the country, threatening to put doctors in prison for providing medically necessary services to their patients. I know in recent years the AMA has been a little bit more outspoken about threats to physician autonomy. But how does the organization reckon with the history that it was the AMA that got abortion made illegal in the United States in the first place in the 1800s?

Resnick: Well, there's a lot of complicated history there, and we've reckoned with that history. And again, this is an organization that existed long before I was born or in practice. So whether it's around health equity or reproductive health, there are certainly things in our history that I wish had been different. But I'd say things are more than a little bit different. The AMA has been leading now for several years on keeping government out of the exam room. This is incredibly important to me as a physician. I love what I do. I love getting to take care of patients. But medicine is hard, and it's hard enough without members of Congress or governors or state legislators or others trying to sit in your exam room with you and second-guess all the decisions that you're making. So we feel incredibly strongly that decisions around things like reproductive health really belong ... taking place in health care between a physician and a patient sitting down together doing shared decision making. We strongly oppose the criminalization of medical care and, whether it's abortion, whether it's taking care of transgender teenagers, that's all part of health care. And so we've been involved in the courts for years in a number of these cases. We briefed in the *Dobbs [v. Jackson Women's Health Organization]* case that recently, really unfortunately, overturned nearly a half a century of reproductive health rights in this country. And we're going to continue to have doctors' backs, we're going to continue to have patients' backs, and we're going to continue to oppose these efforts for government and politicians to get into the exam room and between doctors and patients.

Rovner: On a practical level, how can the AMA help doctors who are caught between state abortion bans on the one hand and federal laws like EMTALA on the other hand that may require violation of the state laws?

Resnick: I can't sugarcoat how difficult this is right now. And I'm hearing from colleagues around the country in emergency departments who are facing pregnant patients with an ectopic

pregnancy or with miscarriage that's gotten complicated and needs additional care or with an infection during their pregnancy. As you said, we are having to think about the consequences for them and for their patients of what is really basically, at the end of the day, health care. And this puts us in a terrible position where we have our medical ethics, on the one hand, of doing what's best for our patient, but also having to consider those consequences. Physicians and emergency departments are having to call hospital attorneys who are literally telling them things like, you know what, we have to wait until this patient is sicker to be able to say they're really at risk of death — when you could have taken care of their topic more simply in the first place without having to do that waiting.

Rovner: I mean, that's a violation of medical ethics, isn't it?

Resnick: Absolutely a violation of medical ethics. So we're incredibly appreciative that the administration and HHS [Department of Health and Human Services] have clarified that the EMTALA rules preempt state law and demand that you take care of and stabilize a patient who's in front of you, even if they conflict with state law. But at the end of the day, physicians are still in a very difficult position because the state may still try to enforce that law, in the meantime. And that's going to be litigated. And there's not a magic answer that we can give people. In the meantime, we think to the extent that states don't pass these laws, that is the best thing that could happen. But in those states that are passing them, we are engaging with state medical associations, with specialty societies, as we do at the American Medical Association and with individual physicians, and trying to give people the best, most up-to-date information that we can. But these are tough times on that front.

Rovner: Is this going to be the issue that's going to bring “the house of medicine” back together?

Resnick: I'm glad you asked that question, because this is one of those issues where obviously there are individual physicians who bring different individual viewpoints on something like abortion. And our policy recognizes that. But also physicians broadly get it that it is dangerous to have us looking over our shoulders when government tries to get involved and legislate these decisions. So at the AMA we govern our policy by this big thing called the House of Delegates. It's not me. It's not our board that makes all of our policy decisions. I get to go out and execute on policy that is created by this group, that is made up of hundreds of physicians from all across the political spectrum, from every state in the country, every specialty, tiny practices, big practices, rural areas, urban areas. They get together and have science-based, evidence-based debates and make decisions about what our policy is going to be. And that group gathered again and again and has said very clearly that we are extraordinarily troubled by what's happening in the reproductive health arena with government interference right now. So it is quite unifying in a lot of ways.

Rovner: Well, I could go on like this for a while, but I know you have other things to get to. Dr. Jack Resnick, thank you so much for joining us and good luck in your year ahead.

Resnick: Thanks so much for having me. It's been fun to talk.

Rovner: OK, we're back. 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 links on

the podcast page at khn.org and in our show notes on your phone or other mobile device. Shefali, you were the first one to step up this week. What's your extra credit?

Luthra: Love this story. It is from Stat: "Health Care's High Rollers: As the Pandemic Raged, CEOs' Earnings Surged." It is by just a real collection of Rachel's wonderful colleagues, a bunch of all-stars, right? Bob [Herman], Kate [Sheridan], J. Emory Parker, Adam Feuerstein, and Mohana Ravindranath. And they do the story that we all didn't know we need — just showing how it's been a really tough economic period for many people, but if you are the CEO of a health care company, you are doing wonderfully. If you are the CEO of Regeneron, your life is really, really great. And I think this fits into just the excellent body of work that these reporters have done, showing the big business-ification of health care and how this industry that poses such a great financial burden for so many, that is for vast parts of the country just unaffordable is, if you're on the other side, incredibly lucrative. It's a great piece. I recommend it to everyone.

Rovner: Rachel — since Shefali beat you to the Stat piece.

Cohrs: Thanks, Shefali. She did. My pick for this week is Politico's interview with Anthony Fauci headlined "Anthony Fauci Wants to Put Covid's Politicization Behind Him," by Sarah Owermohle. And I mean, this piece was a talker this week. And, you know, I think it spurred a lot of conversation about, is Dr. Fauci retiring? What does that mean? Is he leaving public service? When is he leaving? I love a piece that creates a lot of conversation, but I think there was ...

Rovner: Although that was *not* the most interesting part of this piece.

Cohrs: It wasn't. I thought that it was very interesting that he kind of admitted that, no, he is not going to be able to see a victory over covid through. He said we're just going to have to hire the right people and they're going to have to take this. Because if we stayed, I could see 'til I was 105, you know, and we'd still be talking about covid. And I think that's just such a vastly different perspective than we had at the beginning. And it was just really great to see Sarah's work and early interviews with Dr. Fauci and how his perspective has changed. So yeah, I thought it was very valuable and had a lot in there that, you know, wasn't reflected in the tweets and all of that.

Rovner: Yeah, stuff that we haven't all seen already.

Kenen: It was a really good piece.

Cohrs: Yeah, it was.

Rovner: Joanne.

Kenen: There's a piece in Inside Climate News called "When the Power Goes Out, Who Suffers? Climate Epidemiologists Are Now Trying to Figure That Out," by Laura Baisas. I mean, the whole field of climate epidemiology, basically, that's what this piece is about, is studying that we now need climate epidemiologists. It's not the same thing as a covid epidemiologist, and it goes just beyond forest fires cause asthma. It is the planet is changing. Europe seems to be melting. It's not when or if it's right now. So, looking at planet epidemiology, how is this affecting human health? What patterns are emerging? What do we need to know to survive or to make ourselves more

resilient? And I would also say help poorer countries deal with the human health impact of a warming planet.

Rovner: Environment is becoming more of a health issue every week. And I think ... at least we're starting to accept that. We'll wait to see if the population does, too. Well, my extra credit this week is from my KHN colleagues Lauren Weber and Anna Maria Barry-Jester. And it's called "Conservative Blocs Unleash Litigation to Curb Public Health Powers." And it's about how the backlash against covid restrictions during the current pandemic has undermined the country's ability to be ready for the next pandemic. If I may quote from the story, "Public health experts say it has endangered the fundamental tools that public health workers have utilized for decades to protect community health: mandatory vaccinations for public school children against devastating diseases like measles and polio, local officials' ability to issue health orders in an emergency, basic investigative tactics used to monitor the spread of infectious diseases, and the use of quarantines to stem that spread." As we've discussed here, some of these cases have already reached the Supreme Court. And as Georgetown University public health law expert Lawrence Gostin says in the story, quote, "This will come back to haunt America."

OK. On that somber note, 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 — @kff.org. Or you can tweet me. I'm @jrovner. Joanne?

Kenen: @JoanneKenen

Rovner: Shefali.

Luthra: @Shefalil

Rovner: Rachel.

Cohrs: @rachelcohrs

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