KHN's 'What the Health?'
Episode Title: Biden Hits the Road to Sell Democrats' Record
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Julie Rovner: Hello and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent at Kaiser Health News. And I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, Oct. 20, 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 Sarah Karlin-Smith of the Pink Sheet.

Sarah Karlin-Smith: Good morning, Julie.

Rovner: Sandhya Raman of CQ Roll Call.

Sandhya Raman: Hi there.

Rovner: And my colleague Mary Agnes Carey.

Mary Agnes Carey: Thanks for having me.

Rovner: So, we're going to get right to the news because there is more than enough of it. Election Day is less than three weeks away, and President [Joe] Biden is out on the campaign trail trying to convince voters that Democrats have delivered in the two years they've been in charge in Washington, despite the economic woes that many people are currently facing. So first on the list is bioterror. The administration has a plan out to prepare for future pandemics and/or bioterror attacks, but it's going to take money that can only come from Congress. Given that lawmakers don't like to spend money for things that haven't happened yet, what is the outlook for the country to actually prepare for the bad things that are, sadly, likely to happen, like another pandemic?

Karlin-Smith: I would say it's not really great right now, just because Congress has not been willing to fund the current public health crises we are still in the midst of, which includes additional funding the Biden administration wants for covid as well as monkeypox. So if you can't get the government to fund money while you're in the midst of a crisis, it's hard to see us going after preparedness more closely. Though I think people were *hoping* that was a lesson we would have learned from covid, it doesn't seem to have stuck with us. And our country tends to be what I think people in the public health world call "boom and bust," or they panic and we go all out, and then we rest for a while, and then we don't do anything until we have to panic again. And unfortunately, despite Biden outlining a pretty reasonable plan, I think, with good targets and goals and so forth, it just doesn't seem like Congress is going to get on board with that anytime soon.

Rovner: I think the phrase is "reactive rather than proactive."

Carey: I mean that's kind of a shame, right? Think about some of the goals of this thing, trying to get federal agencies to work together, to detect early warnings of a biological threat, or prevent an outbreak, or prioritize recruiting and training for a robust public health workforce, working with other countries to strengthen their own capacity, because we know that it's a global issue — covid or, God forbid, other pandemics or bioterror. Working across the world to accomplish these things, it all makes sense. But the point that we've been making here is this whole thing where we can't seem to get ahead of it, even though we know getting ahead of it makes sense.

Raman: I would add another piece is that we have a limited amount of time this year. And two of the folks that have been working on some pandemic preparedness stuff are [Sens.] Patty Murray [D-Wash.] and Richard Burr [R-N.C.] of the HELP [Health, Education, Labor & Pensions] Committee, and Richard Burr is retiring at the end of the year. So a) they would have to restart the process if this is not something they finish this year. And b) she would need another partner on that. And we still don't know who would rise in the ranks and be the top Republican on that committee. *And* if they would be interested in this issue.

Rovner: I think next in line is Rand Paul, who most people think would *not* be interested in pursuing this or might be interested in pursuing it in a way that might not appeal to the rest of the Congress. All right. Well, let's turn to mental health. The White House and the Department of Health and Human Services this week announced more than $300 million in grants to certified community behavioral health clinics. That was a bipartisan program that was created in 2014 and whose funding was beefed up in the gun bill that Congress passed last summer — remember that? — which was really a mental-health-and-a-little-bit-about-guns bill. These clinics, so far only available in 10 states, are to provide emergency care 24/7/365 and outpatient care within 10 days, regardless of patients' ability to pay. And they're to get beefed-up funding from the Medicaid program. Pretty much everybody agrees that there's a mental health crisis in this country, but is doing something about it an actual voting issue? Is this going to win friends and influence people for the president?

Raman: I mean, this program is very bipartisan. It benefits both sides. Sen. [Roy] Blunt [R-Mo.] and Sen. [Debbie] Stabenow [D-Mich.] have been champions for this since the beginning. They both were at the event that HHS Secretary [Xavier] Becerra had this week to talk about this. And I think that this new pot of money from the gun bill starts the process of rolling out nationwide, rather than just the 10 states that were the pilot. So it is a big step, but it's also something that takes a while to roll out and implement, and on the ground you might not see it until it gets ramped up to the level that you might be able to access it in your community. But I think it is definitely a bipartisan issue, which is some of the implementation and the costs of how to fund programs are the things, like everything else, that are divisive. I mean, Biden made mental health and addiction part of his unity agenda in the State of the Union and is emphasizing that a lot. And he has gotten some folks from both sides on that issue. But it's hard to tackle something that big and wide-ranging in Congress, given how many different layers there are to it. And there's no one-size solution for it.

Rovner: And it's hard to, I think, take credit for at least addressing a problem. It just doesn't make the news like fighting with people does. Oh, my God. It's bipartisan. That's no fun. There's nobody yelling at anybody else.

Raman: The thing is also if it's bad news with it, it's more likely to make news — if there are record suicide deaths or a spike in any bad statistic, deaths or overdoses or anything like that. Then that is what catches people's eyes rather than, hey, this has dropped a lot or there are new resources. It's harder to get that across.

Carey: The bipartisan nature of it and the fact that it's Sen. Stabenow and Blunt. These are two heavy hitters. They've been around for a while. They're working together. Could that cooperation mean that at least some of this money comes up? Perhaps if, when they revisit, they do another continuing resolution or some sweeping appropriations bill to fund the government for a period of time. Because to your point, it takes a while for these clinics to get going. So maybe it wouldn't be the entire amount that's requested. But some of it. I mean, I just wonder if that can happen. And, you're right, it's not the top line, not the top takeaway, but they might get enough support to get it going.

Rovner: All right. Well, what clearly *is* a voting issue is abortion. President Biden also spoke out on that, trying to recreate some of last summer's energy around the issue by promising to sign a bill restoring the protections of *Roe v. Wade* by Roe's 50th anniversary, which is Jan. 22, 2023 — if Democrats retain control of the House and Senate, obviously. But even if they do, that's still going to be quite a lift.

Carey: They really have to score.

Raman: Yeah. I mean, they'd have to remove the filibuster and they would need at least 52 Democrats because [Sen. Joe] Manchin [D-W.Va.] and [Sen. Kyrsten] Sinema [R-Ariz.] have already said they're not going to overturn the filibuster. So they need at least that, because neither party is going to hit 60 majority. And they think a) that's a big lift. But also they did not make it clear, the White House, what type of codifying *Roe* bill that they were going to take up. I mean, we have a few different options that might get more or less votes. And I think that would also be a big factor because we have the Women's Health Protection Act that the Senate was not able to pass twice this year, even though the House was last year. And bringing that up again is ... it's kind of a gamble, unless you know that you have the votes to deliver on that message. And then some of the other bills that have been bipartisan, like Sen. [Tim] Kaine [D-Va.] has a

bipartisan bill with [Sens.] Susan Collins [R-Maine], Kyrsten Sinema, and Lisa Murkowski [R-Alaska], but that one doesn't have as much Dem support. So I don't know who they're going to get. And theirs is more straight, just like the *Roe* precedent and then the precedent to ... access to birth control. So I don't know if there's a point in the middle that they can get everyone on board that they would need for this unless they really hit the number of votes.

Rovner: I think what's been hard about this is that Congress has actually been trying to do this since the early 1990s. When you talk about codifying *Roe v. Wade*, anti-abortion forces point out correctly that that would likely wipe off the books a lot of the abortion restrictions that the Supreme Court has allowed since *Roe v. Wade*. That's sort of the origin of the Kaine-Collins bill; it says we're going to codify *Roe v. Wade*, but everything that the Supreme Court says you can have, which includes a lot of parental involvement stuff and waiting periods and ultrasounds, that stuff is still OK. And abortion rights forces really don't like that. But Democrats really don't want to vote for something that says abortion all the time, anytime, you know, there's going to be no government restrictions. And so they end up without anything that everybody agrees on, even though the country seems to be majority pro-choice.

Carey: One of the main themes of this election for Democrats has been abortion. And talking about it based off the Supreme Court ruling, trying to get the base, in particular, perhaps even the more left wing of the party to show up to vote. And it's been their constant theme, you know, that this is a major issue with voters, which could also be up for debate. But I wondered if that was the gist of this, because it's pretty clear from everything we're talking about, you're not going to get 60 votes. You've got opposition to waiving the filibuster. This is an incredibly heavy lift.

Karlin-Smith: Although I think one thing the Biden administration was criticized for pretty quickly after the *Dobbs* decision was that they were pointing so quickly to the election, saying if you're frustrated with this decision, go out and vote in November. And people were saying you need to do more for us than that. You need to have a strategy in action now. I don't know if that will bring up those frustrations, but I think there was definitely some initial frustration among the community who did not like the *Dobbs* ruling, that the Biden administration was only pointing to elections and didn't seem to have more of a plan for actions they could do more quickly.

Rovner: Yeah, they were caught flat-footed by a decision that everybody knew was coming and that had been *leaked* a month before. That was, I think, also a big frustration. Well, abortion in some fashion is on the ballot in the blue states of California and Vermont, as well as the red states of Kentucky and Montana. But the biggest direct-abortion vote will come in purple Michigan, where voters will decide whether to dump or keep an abortion ban from 1931. The state's Democratic governor, Gretchen Whitmer, is running hard on her support for abortion rights. But her opponent, Republican Tudor Dixon, seems to be shying away from the issue as Republicans are in a lot of races around the country. That has anti-abortion groups furious. They say Republicans would do better to paint Democrats as the extremists on the abortion issue. I am thinking that nobody really knows what's going to happen here. And people who think they know are kidding themselves because we've never actually been in this position. But how much is the election going to really tell us about where the public is in a post-*Roe* world?

Raman: I think it's going to tell us some, but it's not going to tell us everything. So one of my colleagues did a story at Roll Call on Michigan today. And in it, he talked to a lot of voters on the ground. And some of them would say, hey, I support abortion rights or I oppose abortion rights. And it did not necessarily align with their vote either way because of some of the other issues that were important to them. And that's the big purple state that we're talking about. So I don't know that it's necessarily going to be an all-or-nothing based on that, given the other issues that people are considering and just the individual candidates, and so many other things like that. And even with Michigan, we have the governor up, we have the attorney general up, and we have that ballot measure. It doesn't necessarily mean that because someone is voting for one on one side that they're going to vote for all three. So I think it's a little bit more complicated than that. And it's something that we have to wait and see a little closer to then.

Rovner: I'm still ... I see all these political pundits saying, well, in the last few midterm elections, [Donald] Trump won this district and it's been redrawn. So we know that there's this many Republicans and this many Democrats ... and basically basing all their predictions on what's happened before. And I feel like we're in a situation that has never happened before.

Carey: There's also debate, though ... just from some of the more recent polling and so on, about where does abortion rank with voters in the sense of driving their votes. And the inflation numbers, the stock market, the grocery store prices. I mean, it seems — and again, polling can flip, right? We're still about, I think, four weeks out. Less than that.

Rovner: Three weeks.

Carey: Thank you. So when people feel it in their pocketbooks and you talk to a pollster, if you're elevating the gas prices and the grocery prices over abortion because those economic concerns are more dominant right now in your life, I just feel whipsawed. I feel like the polling and a lot of the stuff that we've been talking about is how people were so unified. If you believe in abortion rights, you're going to show up, you're going to vote. And now it seems like the pocketbook stuff is flipping. So it's a space to watch. But I think it's just ... I don't want to say anyone's guess, but I mean, it just seems like things are moving so quickly, which is not unusual.

Rovner: I just feel like there are people who seem pretty certain who maybe shouldn't be, although given the last several elections ...! All right. So I thought it was time for an update from your home state of Indiana, MAC. You may remember the story of the 10-year-old rape victim from Ohio who had to go to Indiana for an abortion because it wasn't allowed in Ohio. And how Indiana's attorney general, Todd Rokita, first said the case didn't exist. And then when the OB-GYN who performed the procedure came forward and said, yes, it did, he accused her of not filing the proper paperwork. The proper forms were promptly produced, and all had been filed as required. But Rokita still launched an investigation into the doctor, Caitlin Bernard of Indiana [University School of Medicine]. Well, now Bernard is preparing to sue the attorney general. This week, her lawyer sent Rokita a cease-and-desist letter demanding that he stop accusing Bernard of having violated the law. And the next step would be filing a defamation lawsuit. Rokita, who's himself is a former U.S. congressman, isn't up for reelection until 2024. Is this something that really appeals to the base, though, going after a doctor, and a woman doctor, for having performed what we now know was a perfectly legal procedure?

Raman: I'm not sure how it plays to the base, but I do think it's something of a ... messaging and chilling effect. If you are a physician and you see what's happening to Dr. Bernard, you're like, oh, could this happened to me, even if I'm doing something similar that is allowed legally under law or if you're somewhere else in the country, it's that same kind of "It's not my state, but could this happen in my state? Should I be more careful? Should I err on the side of this?" Especially given how a lot of the laws have been changing so quickly in the courts and how there's a lot of nuance where even the doctors in those states have testified to Congress that it's unclear what some of them mean, what an emergency is defined as, that kind of thing. So I think it's a broader issue than just this doctor and this attorney general.

Rovner: Yeah. I mean, he's had plenty of chances to back off and he hasn't, which I just have found a little bit surprising. What is moving him to continue when he's clearly in the wrong and yet he will not admit it and will not back down? You know what purpose is it serving? I guess the chilling effect is probably a good purpose because we know from seeing doctors in other states, particularly in Texas, that doctors are completely freaked out about when they are allowed to intervene to actually save a pregnant woman's life. Do they have to wait until she's, you know, actually on death's door before doing something? It's something that is plaguing the medical profession right now. MAC, you were going to say something.

Carey: I think that Dr. Bernard — what's interesting about this, watching it, is how consistent she has been in challenging accusations she broke the law. No, here's ... I followed this protocol. You know, things keep coming out. She's coming back at it. And that is, to your point, where a lot of doctors, they're very concerned about being attacked if they want to offer abortion services or they're dealing with the hospital legal teams

before they're making decisions about procedures for women that may need them medically. It's just a fascinating thing to watch play out. But I think your messaging point is well taken.

Rovner: Meanwhile, in what I call abortion-adjacent news, the Department of Health and Human Services' Office of Civil Rights is investigating both Walgreens and CVS for failing to fill valid prescriptions, not just for contraceptives but, as we've mentioned before, drugs like methotrexate that are used to treat other conditions but can also be used to end a pregnancy. MAC, you probably remember this, but in the early Aughts, there was a big fight about pharmacists' right to refuse to fill prescriptions that violated their consciences. That was mostly about birth control. But now pharmacists are actually worried about violating state laws and they're caught in this vise between state and federal regulators. Is there some compromise here or is everybody just going to have to cross their fingers and hope the right thing happens?

Karlin-Smith: I mean, some of it seems complicated to me because there are some very clear-cut cases that seem confusing as to why a pharmacist would be concerned. You know, if you have a 10-year-old with juvenile arthritis, the likelihood that this person is capable of getting pregnant and would be using the drug, you know, for an abortion seems increasingly slim. But clearly, I think, as we've seen with the case in Indiana and with cases like this with medication, is that doctors and pharmacists do feel like they have to be on the defensive and very protective of ... to keep their licenses. So I think, again, there is this chilling effect the laws are having on people, even though logically, in many cases, it doesn't make sense to me offhand that pharmacists would feel nervous about filling prescriptions when there's clearly documented medical need and FDA approval for uses of drugs in these other ways.

Rovner: I just happened to be on the CVS website the other day, and the first thing that comes up is this big thing about women's health, and they mention nothing about contraception and certainly nothing about drugs that are useful for some things but can also end pregnancies. And it's like, I'm not sure what you're aiming at, CVS, but it's not really helping here.

Carey: You know, this is just ... this whole debate is one of these unintended consequences of the Supreme Court ruling kicking it to the states. States are taking different approaches. Pharmacists, doctors in these states are reacting differently. I mean, there's just so many ripples and so many ramifications of this that I think we'll be talking about for a long time. I mean, think about the Biden administration that issued EMTALA [Emergency Medical Treatment and Labor Act] guidance to hospitals that if women need a service to protect their life, including abortion, you're supposed to do it. And hospitals in states that have outlawed abortion or have restrictions are afraid to follow the federal guidance, which the Department of Health and Human Services has said dominates over what the state does. I mean, it's just layer after layer after layer. And these stories just keep coming.

Rovner: Yeah, it is. It is quite a mess. All right. Well, we haven't talked about the FDA in a while. And this week we had a very exciting advisory committee meeting about a drug to prevent premature births. Sarah, tell us about Makena and why it's been controversial and what the advisory committee did.

Karlin-Smith: So Makena is a drug used to prevent preterm birth in women who have previously had preterm births — so, before 37 weeks of pregnancy. Obviously, there are potential health consequences to infants born early and so it would be great to prevent that from happening. The drug was approved in 2011 after years of it being compounded by pharmacists. It's a synthetic hormone and it was approved off of a smaller trial that seemed to show the drug was good at keeping babies in the womb longer and having them reach a longer gestational age. But in FDA's and the medical world, that doesn't necessarily equate with better health outcomes for the infant. So FDA approved it under what's known as the accelerated approval pathway, which allows you to approve drugs on these surrogate endpoints, as they're known, since they aren't directly known to improve health outcomes. And as a requirement of that, the company has to conduct a follow-up study to prove it actually does help the lives of these babies. And what happened was this drug has changed ownership multiple times. It took a really long time for this trial to complete. And then when it did, in 2019, it failed. It was a bigger trial, seen as more robust. It both didn't help babies reach a higher gestational age. And it also didn't improve those health outcomes FDA was really looking for. And so FDA

has moved to withdraw it from the market. At that point, it actually changed ownership again, the drug, and the company that now owns it has been fighting the withdrawal. FDA has ... feels like, under the law, it has to go through a very lengthy process which included this hearing that took place over 2½ days this week. Ultimately, the advisory committee has agreed with FDA, or I should actually say, people say it's the Center [for Drug Evaluation and Research] right now that says it should be withdrawn, and the bigger FDA ... now the advisory committee votes will have to decide whether to make the final decision. I think why this issue has drawn so much attention beyond just this one drug itself is that the entire FDA accelerated-approval program has been under a microscope in terms of whether companies are actually fulfilling the promise that, if FDA speeds it to market, they swiftly conduct the studies, and if they don't pan out, the drugs get pulled. We know companies are often really slow to complete the studies. In this case, if FDA wants to remove them from the market and the company disagrees, it can be a very, very prolonged process. And in the meantime, Makena, for example, between — OIG [the Office of the Inspector General] recently noted that — between 2018 and 2021 cost Medicaid $700 million, which is a lot of money, particularly, again, going back to one of the initial controversies with Makena was, when it was a compounded product before formal FDA approval, it was about $50 per dose, and then they took over and people were paying thousands of dollars for the drug, Congress, as close listeners of this podcast may know, tried to give FDA more authority to deal with some of these problems of the accelerated-approval program in the user fee reauthorization, which recently was signed into law, which helps fund the FDA to a significant extent. What happened was, though, is due to timing issues, disagreements between Republicans and Democrats, Congress essentially passed what's known as a clean user fee reauthorization. They didn't add on any other FDA policy to it. So those accelerated approval reforms got dropped. Now, it'll be interesting to see with year-end bills if this Makena situation or that OIG report I mentioned brings it back to Congress' table and they decide to take more action there.

Rovner: Has the FDA ever withdrawn a drug that was approved under accelerated approval because the subsequent clinical trial showed the drug didn't work?

Karlin-Smith: So they have, this may be the second time it would be withdrawn over the sponsors' objection. Back in 2011, they withdrew a specific breast cancer indication for Genentech's drug Avastin. That was a little bit different because Avastin has multiple uses. It could still remain on the market for those uses, and then if doctors or women felt particularly strongly, there's potential to use it off-label again, assuming you can either pay for it or your insurance company would cover it anyway. This would be the first time the drug would be completely removed. And then there have been other instances where FDA has basically pushed to remove drugs that failed trials and basically gotten the companies to more voluntarily cooperate. A lot of that, though, has taken place in the past couple of years as FDA's cancer drugs head has really kind of gone on a mission to go after companies that have been slow to conduct trials to confirm clinical benefit with these drugs. So FDA has been kind of defensive, saying overall the accelerated-approval program does live up to its promise and they police it appropriately. I think there are people that would argue in many respects FDA has let companies lollygag too long.

Rovner: Just to be clear, this is not something that's partisan. This is something, I mean, where people really disagree about the advantages of early approval of drugs versus the potential dangers.

Karlin-Smith: In covering FDA and drug development for a while, I think the sentiment among politicians on both sides of the aisle is we tend to have a hard time in this country taking away hope from people who are in difficult medical situations and don't have any good options. And when push comes to shove, I think the tendency is to say, well, this may help them, so we should let them keep having this therapeutic. And I think one topic that came up a bit at the advisory committee yesterday among some of the doctors and members of the panel is it's really not helpful to people to give them false hope or let them have something that we have a good inkling isn't effective. Sometimes it's just better to do nothing, as hard as that is for a doctor to say to a patient. But I would say, and people that have chronicled the FDA over the years would say, there is sort of a bit of this libertarian mindset that pervades both Democrats and Republicans when it comes to drug access for patients that are facing these really difficult situations.

Rovner: Yeah, I absolutely agree with that, having watched this from afar for 30 years. In another case of something that took a really long time but finally happened, this week marks the availability of over-the-counter hearing aids. Until now, most people who needed hearing help hadn't gotten it because hearing aids cost thousands of dollars and aren't covered by most insurance plans. It seems the first round of over-the-counter devices will still be pretty expensive, as in several hundred dollars, but not several thousand dollars. But one would expect the prices to come down, as they tend to do when you have a competitive market for over-the-counter products. Now, this effort actually predates President Biden becoming president, but his administration is taking credit for unblocking the final regulations from FDA and getting this actually moving. Will he really get credit, though, or is this going to be like so many of the Affordable Care Act benefits that people just come to take for granted and they have no idea how it got that way?

Carey: Probably. I mean, I think that's probably a fair analysis. You know, this idea of lowering the price of hearing aids, putting them over the counter, we should probably talk about [that] it's really for mild to moderate hearing loss, not people with super severe hearing loss. But I think that retailers are going to jump on this. Sony's in the market. Walmart's going to have stuff. Walgreens is talking about it ... that I think once these are in the stores and ... I was unaware of this until I prepped for this podcast that you can get an app to test your hearing. I'm still sort of skeptical, but nonetheless, once they're in the market and people are doing this and buying them, I don't think they'll think, "Thank you, Joe Biden." I mean, I just think they think it's going to be there. My mother paid $2,000 or $8,000 to get one, and I don't have to pay that much. But we also should talk about that there are people that still might want to see an audiologist. This over-the-counter stuff doesn't include the adjustments and seeing an audiologist and getting tests. And one might argue that that was unnecessary. And I'm not saying that it's a must-do, but that there are more options now to deal with hearing loss. And that's so important because people who can't hear have difficulty. They kind of withdraw. You're talking about, you know, especially among the elderly, depression, isolation. And some of our teens are having some hearing problems with all the headphones and loud music. I know I sound like an old fogey, but I've actually seen medical professionals, heard them say this. So this whole thing is definitely a game changer and can change a lot of lives.

Rovner: Yeah. It's a giant potential market.

Raman: Oh, I was going to say it's similar to over-the-counter reading glasses. I mean, it's a little bit of a different market. You know, if you're picking up something standard at the pharmacy for 10 bucks, that's different than going to your eye doctor and getting a prescription and getting the right lenses for you. And I think the government put out some statistics that it was, like, 1 in 4 adults who could benefit from some sort of hearing aid have one. So it's a huge untapped market for those folks that might have some but may not need to go to an audiologist and get all of those steps there. So it kind of broadens who it's available to, not even just in the price point.

Rovner: I wore drugstore reading glasses for like 10 years before I finally succumbed to getting prescription reading glasses — which I expect could happen here too, if, you know, people who have just moderate hearing loss but would like to hear a little bit better can afford this better if it's, you know, at some point going to be $89, then ... You know, my mom got her hearing aids at Costco probably 10, 15 years ago, and they still cost like $3,500. I mean, that was the cheapest you could get them at the time. And it was still a lot of money. This is a big deal that the people who did it may or may not get credit for.

Karlin-Smith: And I was going to say on the politics side of it, I think [Iowa Sen.] Chuck Grassley on the Republican side would be annoyed if it wasn't mentioned that this really was a bipartisan effort over time and that he was, on the Republican side, one of the big people that has been spearheading and pushing this. So it goes back to maybe our earlier conversations of how do some of these bipartisan efforts play out among American voters in terms of who gets credit for it and why or which voters give which party credit.

Rovner: Yes, it was an odd couple of Chuck Grassley and [Sen.] Elizabeth Warren [D-Mass.] who worked on this, that people did not necessarily expect to see backing the same thing. All right. Well, 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 you should read, too. Don't worry if you miss it; we will post the links on the podcast page at khn.org and in our show notes on your phone or other mobile device. Sarah, why don't you go first this week?

Karlin-Smith: Sure. I took a look at a piece in Scientific American by Daniel Leonard called "Some People Really Are Mosquito Magnets, and They're Stuck That Way." And I was motivated to pick it because I wanted to read the piece because I think I'm a mosquito magnet, as Julie, I think, mentioned, she might be. It's an interesting study where they basically seem to believe that there are compounds that everybody's bodies produce that are a bit unique. And this study seemed to show that if your skin produces high levels of carboxylic acid — I think I'm pronouncing that right — you are more likely to attract mosquitoes. And unfortunately, this seems to be a steady-state thing over the course of your life. There's not much you could do at this point to change it. It is not related to poor grooming practices or some scent you may be putting on your body. It seems like something you are born with, unfortunately. At the same time, the researchers do think that their findings might help people figure out how to develop better bug-protective sprays or so forth for people that are more attractive to mosquitoes. And another thing I think to point out is that they didn't torture people like Julie and I, who are prone to getting a lot of mosquito bites, for this. What they did was they put stockings on their bodies, let the cloth pick up the smell, and then, you know, tested the cloth in a controlled environment to see which people, by proxy, would be more driving the mosquitoes to them.

Rovner: I used to joke that mosquitoes think I taste good, and it turns out from this study that that's probably about it. Mosquitoes think some of us taste better than others of us. Sandhya, why don't you go next?

Raman: So my extra credit this week is actually a study called "Use of Straighteners and Other Hair Products and Incident Uterine Cancer" It's from the NIH [National Institutes of Health]. And the lead author is Alexandra White. And I was interested in this because I think that there's a lot of news in the wellness and health space that is just ... connects things that are incorrect, especially about beauty. And so I thought it was interesting that they got into something that is proven. So the study looked at women who used chemical hair-straightening products and found that they were at higher risk for uterine cancer compared to women who didn't. And while anyone can get their hair chemically straightened, it's generally used far more often and at an earlier age among Black women. And so, NIH says, accordingly, they're going to be more likely to be effective. And so that creates some of these disparities among Black women. And even though uterine cancer is, like, a small percentage of all new cancer cases, it has been rising and especially among Black women. So I think it's kind of an important thing to note. And the researchers did say that this is the first study examining the relationship between chemical hair-straightener use and uterine cancer. But they'd previously done some other studies about permanent hair dye and these straighteners that can increase breast and ovarian cancer risk. So there's more to it than just that.

Rovner: So yeah, a lot of these cosmetic procedures can be more dangerous than seems to appear. MAC.

Carey: So my extra credit is written by our KHN colleague Darius Tahir, and it appeared in USA Today. And the headline on the story, like a great headline always does, tells the story: "Blind to Problems: How VA's Electronic Record System Shuts Out Visually Impaired Patients." And so while the VA [Department of Veterans Affairs] has this new medical record system, millions of patients and employees who are blind or low-vision say that it's hard to use. There's more than a million VA patients that are blind or have low vision. They rely on this software to access their prescriptions or if they want to email their doctors. But either the screens don't allow users to zoom in on the text or screen-reader software that translates the text to speech isn't compatible. And this is quite a big deal, right? Because folks will withdraw if they're trying to use technology to deal with the VA health system. And if they can't, they're going to withdraw. They're going to have to ask for help. It's going to increase dependence, that kind of thing. The developers of the system say that they can fix these things in short order, but the question is knowing the VA patient base, and even some of the employees: Why didn't you anticipate this and take care of it before?

Rovner: So glad that that got pointed out. All right. My story is also from KHN; it's from the KHN-NPR project on medical debt. It's by NPR's Yuki Noguchi and it is called "Kids' Mental Health Care Leaves

Parents in Debt and in the Shadows.” And you can read it or listen to it or both. It's about how the medical debt problem for physical health is even worse for mental health, particularly for children, where there's a shortage of practitioners and an even more severe shortage of practitioners who accept health insurance. Mental health care is expensive. That's why we have health insurance. But despite laws and regulations that are supposed to make insurers cover mental and physical health that quote-unquote “parity,” it often doesn't happen still. And mental health care goes uncovered and bankrupts entire families. So still more evidence of our broken health care system, just broken in another way.

OK, that is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review — that helps other people find us, too. 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. MAC?

Carey: @maryagnescarey

Rovner: Sandhya.

Raman: @SandhyaWrites

Rovner: Sarah.

Karlin-Smith: @SarahKarlin

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