**KHN's 'What the Health?'**

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**Julie Rovner:** Hello, and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent at Kaiser Health News. And I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, Aug. 4, 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 Rachel Cohrs of Stat News.

**Rachel Cohrs:** Hi, everybody.

**Rovner:** Tami Luhby of CNN.

**Tami Luhby:** Good morning.

**Rovner:** And Sandhya Raman of CQ Roll Call.

**Sandhya Raman:** Hello, everyone.

**Rovner:** Later in this episode we'll have my interview with my colleague Bram Sable-Smith about the latest KHN-NPR "Bill of the Month." This month's patient was in a car accident with two of her siblings. But despite lesser injuries, her ambulance bill was much, much larger. We will explain what happened. But first, this week's health news. We're going to start with abortion because, wow, Kansas. In the first test of the abortion issue with voters since the Supreme Court overturned *Roe v. Wade* in June, abortion rights voters in Kansas — yes, *that* Kansas — resoundingly affirmed a right to abortion in the state's constitution. Anti-abortion advocates had purposely put this question on the primary ballot so the vote would be in the summer, where they assumed turnout would be lower, and they worded it so it was difficult to tell whether a yes or a no was to overturn a right to abortion that a court found in the state's constitution in 2019. Had they voted that there is no right to an abortion in the constitution, *then* the legislature could have gone ahead and done a ban or some sort of restrictions. And yet voters refused to overturn the state constitutional right by a nearly 60-40 edge. What exactly happened here, Sandhya? This was not really what we were expecting.

**Raman:** It's really interesting because the limited polling they had done prior to the election had it being pretty close or within the margin of error. Then when we saw the results, the turnout was huge. I think it was close to, like, 909,000 people that voted on this. And if you look back to ...

**Rovner:** It was like a general-election turnout level.

**Raman:** Yeah. So, 2018 was the last gubernatorial primary and it was half that. It was, like, 470,000. And nothing else on the Kansas primary ballot was particularly competitive — people were turning out for *this*, because the candidates for the governor race were pretty settled. And the general election is going to be competitive — that's a tough race this year. But people really showed up for this amendment, and I think that was surprising to a lot of folks. But it's kind of tricky to just paint a picture as that foreshadowing what's going to happen in all of the other states that are taking this up. Because Kansas is Kansas. I mean, every state is a little bit different. Kansas has, you know, a Democratic governor right now, and they do

have some abortion restrictions. There's a little bit of this, a little bit of that. And I think primary turnout versus general-election turnout, there's so many factors there. So I wouldn't draw huge, sweeping conclusions. But I think that you can look to the fact there's a lot of national money poured into this race. There's a lot of people with their eyes focused on it. So it'll be interesting to watch some of the other states in November that are also going to be voting on different abortion initiatives.

**Rovner:** Yeah. This is where I get to point out, as a person who's been covering abortion forever, that I was surprised but not shocked, because in 2006 and 2008, I went to South Dakota, where they had a similar kind of referendum. The South Dakota legislature had passed a ban, so the referendum was on whether or not to overturn the ban. They had decided not to go to court because even then they were worried about what the Supreme Court might do. So they put it to the voters. And South Dakota, with this kind of libertarian streak, voted against it both times. You know, they put it on a second time because they thought the first time it didn't have any exceptions and they thought maybe that had tripped up some voters. So they put it on a second time, two years later, and it lost both times by like 55-45. I actually had to go and look that up. And I think the way the Kansas vote is settling, it's like 59-41. So not that dissimilar from what happened in South Dakota 15 years ago. Where else are we looking later in the general election at some states that are going to have this on the ballot?

**Raman:** So we're going to see four, possibly five, once all the I's are dotted and the T's are crossed. So Kentucky and Montana both have anti-abortion measures. Kentucky's is pretty similar to Kansas', pretty similar language there. Montana has a measure that is similar to stuff that the House was trying to pass a couple of years ago, which would — Republicans want that would protect an infant that was born alive after an attempted abortion or a failed miscarriage, that kind of thing.

**Rovner:** Right. There's a federal law already on that.

**Raman:** Yeah. Yeah. But that has been a big talking point, I think, in sort of the last elections. And then Vermont is finally reaching their years-long process to get a pro-reproductive rights measure voted on that had to vote on two consecutive legislative sessions, and they finally finished that. So that will be up. And then California, more recently, has a similar abortion-rights, right-to-abortion thing that they had gotten together this year, post the *Roe* decision. And Michigan is likely to do theirs as well. They've collected all the signatures on their abortion rights thing. They just have to get those all verified. But from the folks in charge of that, they said they have way more than they need. It just needs to technically be certified to be on the ballot this year, and I think they have until later in September. So we might not see that officially for a little bit.

**Rovner:** I'd say Michigan's another one of those states where the conservatives in Michigan are really conservative and the liberals in Michigan are really liberal. Michigan isn't really a purple state, but it's pretty polarized. So I think that'll be another one to really watch. Well, meanwhile, the Justice Department announced a lawsuit against the state of Idaho for its trigger abortion ban that's supposed to take effect later this month, because the ban doesn't include an exception for health emergencies. The suit charges that EMTALA, the Emergency Medical Treatment & Active Labor Act of 1986, requires doctors in hospitals that accept Medicare or Medicaid to stabilize patients with emergency medical needs, and in some cases, such as an ectopic pregnancy, that could include abortion. This is a pretty risky suit because the Supreme Court could, if it gets that far, could just throw out EMTALA, right? I don't think EMTALA has ever been tested. I don't think anybody has ever sued, you know, over EMTALA before.

**Raman:** It's a tricky issue because all of the different provider groups have said that this is a very important law, that you do need to provide emergency care regardless if someone can pay. That is that the purpose of

this long-standing law. And the ban that would go into effect in Idaho later this month has some vague language where, if you look at it, it's like exceptions for death or a substantial and irreversible impairment of the mother. And it's vague. And the thing that I have heard from so many providers and provider groups is, “What does a lot of that mean? Does that mean someone has to be on death's door, like about to die in 10 minutes? Does that mean that if something isn't done, they'll die fairly soon? Or does it increase the risk of death? And there needs to probably be some more guidance because it's very difficult for, regardless of what state, to know what is they can be litigated for. A provider wants to do what they can to protect their patient, but they don't want to be sued and lose their license and not be able to protect other patients. So I think that is interesting. And even [Attorney General] Merrick Garland yesterday had said that they're going to file another motion for something similar in Texas coming up to protect their right to do emergency abortion care. So, this issue’s not going away.

**Rovner:** Yeah, I mean, we've seen so many, we've now seen all these real-world examples of women with pregnancies that have gone wrong in hospitals and doctors having to go to the hospital’s council, and the council would say, “Oh, my goodness, you've got to wait until the woman is sick.” Or there was that tragic story of a woman who got sent home, and they basically had to wait until she was hemorrhaging. This was theoretical, and it's not theoretical anymore. It's actually happening that doctors are being put in this impossible position of “am I violating my medical ethics by taking care of my patient, which could put my medical license and my personal freedom at risk?” I think that's an outcome that maybe was not predicted. Well, the Justice Department lawsuit is not the Biden administration's only action this week. On Wednesday, President [Joe] Biden signed his second executive order on protecting abortion rights. This one includes some confusing language urging the Department of Health and Human Services to “consider action to advance access to reproductive health care services, including through Medicaid, for patients who travel out of state for reproductive health care services.” Now, there are efforts to get rid of the Hyde Amendment, which currently bans the use of federal Medicaid funds for most abortions. But that Hyde Amendment is not gone yet. Sandhya, do you have any idea how HHS could extend Medicaid waivers while Hyde is still on the books? White House press secretary Karine Jean-Pierre got asked about this at the briefing, and she rather artfully completely dodged the question and said, “Go ask HHS.”

**Raman:** Yeah, I thought that was interesting that she said that we're going to leave this in HHS’ hands. They will figure out how to do this in a way that is legal.

**Rovner:** Good luck to them.

**Raman:** Yes. I think that there are some ways that they could consider. … In the House, we've seen, there's been some legislation piggybacking on what the House passed before that was protecting interstate travel to get an abortion in a state where it's legal. And there's been legislation released, I think, in the last couple weeks that was to fund some grants to do some of that travel. And the Democrats that I've spoken to about that bill and how that could conflict with Hyde have been pointing to Hyde, as they have read it and their legal folks have read it. … It applies just to the actual medical care rather than the other pieces to that puzzle. And that's something that — it's new territory. Whatever happens, I think that there’s probably going to be litigation there. And I don't fully know how HHS can do it, but I think the administration doesn't know either. They are pointing at HHS figuring out what would be possible there. And then even with that news yesterday, there were a bunch of groups that oppose abortion that said, “Hey, this is going to violate Hyde, which is still federal law, unless it is stripped in the next appropriations bill,” which is very unlikely.

**Rovner:** Although I do know one of the quirks is that Medicaid can be used to pay for transportation because a lot of people who are on Medicaid don't have cars or don't have any ways to get to the doctor or the hospital for medical treatment. So there actually is provision in the Medicaid statute for it to pay for

transportation. Just obviously, this is not the kind of transportation that Medicaid has ever considered before. It's like, OK, we're going to pay to have women go from states where abortion is banned to states where abortion is not banned.

**Raman:** There's just so many logistical issues, too — even besides Hyde. It would be — what in that realm can be paid for? Is it transportation? Is it child care? Is it lodging? And then just like Medicaid between states, there's not always … reciprocity issues where you can bill here and there, especially if you're going to travel a long distance. There's probably not something in place between Texas and Illinois.

**Rovner:** Right. And Medicaid isn't one program. It's 56 different programs in every state and territory.

**Raman:** Yeah. I don't know how they would do it. I think it would be very complicated if they can get it done. The way that they explained it yesterday, with the limited details, was just that it would be to some states that provide the best proposals. So I don't know how many that would be, what that would take.

**Rovner:** Right. Because it would be Medicaid waivers. All right. Well, this week we also got a bill in Congress that I have personally been expecting, the purported middle ground in a debate that has been completely polarized for as long as I can remember. The bipartisan bill — proposed by Democrats Tim Kaine of Virginia and Kyrsten Sinema of Arizona, along with Republican abortion rights supporters Susan Collins of Maine and Lisa Murkowski of Alaska — seeks to basically freeze in place the state of abortion rights on the day before the *Dobbs* [*v. Jackson Women's Health Organization*] decision was handed down. So states could have some limits on abortion but couldn't ban it before viability, nor after viability without exceptions for the life and health of the pregnant person. This, of course, pleases neither side of the debate. Yet I guess it would poll pretty well with the American people because that's kind of where the public is, which is they don't love abortion but they don't think the government should ban it. Now, before *Dobbs*, I would have said there was never a chance for a bill like this to pass. But now I kind of wonder if the abortion rights side might decide that something is better than nothing. Or if the results in Kansas made them think they can really ride this issue to victory in November.

**Raman:** I think some of the groups that really support abortion rights have already spoken out against it — NARAL and some of those other folks have said, "Yeah, this is not cutting it for us." I do think it's interesting that this bill is very similar to the Collins-Murkowski bill from earlier this year that they had put out when Democrats were pushing forward the Women's Health Protection Act. And if you go through the bill, they're very similar. The main difference is that this new compromise bill also includes those protections for contraception and builds on what was established in *Griswold v. Connecticut* and some of those other cases. Because, again, the *Roe* decision was built on the right to privacy under those. So it's kind of interesting that they have gotten at least two folks on board that when they had no one else on board earlier on this year when they had introduced that other bill.

**Rovner:** Yeah. I'm just curious and I wondered this: "Well, if *Roe* ever went down, would they be willing to take half a loaf?" Basically, [that's] what the decision is here. I mean, both sides are forever accusing the other side of not wanting to solve problems because they want it as a political issue. And this is where we're actually going to see this offered up, although, I mean, could they get 60 votes for this bill? Certainly not now, because the right-to-lifers hate it and the abortion rights groups hate it. I mean, there's only the people who are on it and not very many others. So somebody would have to bend in order for that to happen. All right. Well, let us move on to budget reconciliation, where the script has shifted from waiting for [West Virginia] Sen. Joe Manchin to waiting for Sen. Kyrsten Sinema, who still hasn't said whether she'll support the slimmed-down Inflation Reduction Act because she's waiting for the Senate parliamentarian, Elizabeth MacDonough, to rule on what can and can't be included in this bill, which only needs 50 votes or

51 votes to pass in the Senate. Rachel, where are we with reconciliation? We were expecting to be a little further along by Thursday morning here.

**Cohrs:** Yes, I think that's true. I think there are a lot of questions. I know sometimes Senate leadership and House, too, they send out vote timing just to everybody on the Hill so they know to plan. And when it gets really chaotic, it's just a series of question marks. And that's essentially where we're at right now. So the parliamentarian, as you mentioned, has not completed review of all the sections. They have been talking about the health care and drug-pricing provisions for a little while now. So I think there is a hope that she's going to wrap that up either today or tomorrow. But she's not under a timeline. She can decide when she needs to. And it is a lot for her team to process very quickly. So I think that they are technically waiting on that. I think having a Congressional Budget Office score, too, is something they might like to have. But [New York] Sen. Chuck Schumer, who leads the Democratic caucus, sets the floor schedule, has indicated that they're full steam ahead and they may not wait for all of that if it comes down to it. So I think they're just … There's a sense of desperation right now because Democrats are just crossing their fingers and hoping that nobody gets sick with covid and can't vote. They were supposed to leave today for their summer break, essentially. And everyone's just kind of in limbo right now waiting for any indication of floor timing for this. So it is very much up in the air.

**Rovner:** Well, I've been saying that this was supposed to be the week before the August recess, but I think that this is the week before the week before the August recess because it's hard to imagine how this does not bleed into next week. Although my favorite tweet of the day came from Burgess Everett at Politico, who suggested that maybe if we moved the Senate outside, they would get this done faster because it's ridiculously hot and humid here in Washington this week. And that's why they take an August recess, because it's ridiculously hot and humid in Washington. So someone else suggested, well, they could just turn off the air conditioning and that would probably speed things up, too. But we're not going to get anything done here until the parliamentarian has finished scrubbing it. Meanwhile, let's talk again a little bit about what's in this bill. Tami, you've been looking at it. I know that originally that the very, very tiny version of this bill was just the health provisions and now it's expanded. There's some tax provisions and some climate change provisions. And the tax provisions are proving controversial, right?

**Luhby:** Right. And as you mentioned, we're waiting for Kyrsten Sinema, the senator, who has in the past been fairly reluctant to raise taxes on corporations. And in this bill, there's a 15% minimum corporate tax on large companies. And there's also a provision that she really doesn't like, which would narrow the carried-interest loophole, which affects investment managers and provides them with a lower capital gains tax rate.

**Rovner:** It's basically a tax break for hedge fund managers.

**Luhby:** Right. And this would narrow that. And she has opposed this in the past. And she's apparently been speaking to the Chamber of Commerce in Arizona, asking whether this is bad for companies. So we're all still waiting to see what she thinks. The carried-interest provisions are fairly small, but the 15% minimum tax on corporations is a pretty big part of the deficit reduction. So we're waiting to see.

**Rovner:** So if you missed last week's episode, one of the things this bill would do is extend for three more years subsidies for people who buy insurance from the Affordable Care Act marketplaces. Those subsidies help boost the number of people who are on those plans by more than a million. And the Department of Health and Human Services this week is reporting that the percentage of Americans without health insurance has dropped to 8%, which is the lowest on record. We should also mention that this week marks the 25th anniversary of the federal Children's Health Insurance Program, or CHIP — that makes me really

feel old; I did cover that — which has reduced the percentage of uninsured children from about 14% to around 2%. I feel like we've kind of stopped talking about this, but, gee, for decades this was the biggest health issue out there, the uninsured. Tami, now it's just kind of an afterthought, right?

**Luhby:** Well, it won't be if this bill doesn't pass, because you're going to lose the subsidies. And that's been a big part of what has helped drop the uninsured rate so low. So, HHS said that 5.2 million people, including just over 4.1 million adults and 1 million children, gained coverage. And about half of those adults gaining coverage gained it on the ACA marketplace. And they were helped by the enhanced subsidies in the American Rescue Plan. And that's, at this point, expiring at the end of the year. And we already know that rates are going to go up anyway because of inflation pressures, labor expenses, etc. And now people may not have these enhanced subsidies. Plus, once the public health emergency ends, you're going to have a lot of people losing Medicaid coverage — several million people losing Medicaid coverage. If these subsidies continue to exist, it would be much easier for them and more affordable for them to shift over to marketplace coverage. So, we are going to see what happens because a lot of these advances could backslide if the bill doesn't pass.

**Rovner:** Yes. We talk about, “Oh, they've got to do something on climate change, and they got to do something on prescription drugs.” But the bottom line here is this is one of those things that … they wouldn't be adding it, they would be continuing it. But if they don't continue it, then all kinds of things could happen, none of which would be good, frankly, for the Democrats. Which explains why there's no Republicans in favor of this bill.

**Luhby:** Right. Looking not at the policy angle, but at the political angle of it, the marketplace is going to open for open enrollment on Nov. 1, a week ahead of the midterm election. And people are going to see if the subsidies don't exist how much more they're going to actually pay. And that's not going to look good for the Democrats, and they want to avoid that. It's also one reason why initially they were going to extend them for two years. And guess what happens in two years? We have the presidential election.

**Rovner:** There’s another election!

**Luhby:** Exactly. And guess what? That would really look bad for the Democrats during a presidential election. So, they've agreed to do it for three years because who cares what happens in 2025?

**Rovner:** Right. That's two Congresses’ problems away. All right. Well, ’tis the season when Congress actually kicks itself into gear and passes stuff, even though we're obviously waiting for reconciliation. Traditionally, the week before the August recess in an election year is one of the busiest of the entire congressional session. This year is no different. We're going to start with the PACT Act, which is legislation to help veterans who were made ill from breathing toxins from burn pits used in the last several wars to dispose of trash, including lots of things that shouldn't have been burned, it turns out. This is the bill that comedian Jon Stewart rather famously lobbied for. It's the follow-up to legislation he helped pass to take care of the health needs of the workers who got sick cleaning up the World Trade Center site after 911. The bill has bipartisan support, but it got caught up in what appeared to be a Republican temper tantrum in the Senate last week after the Democrats sprung their reconciliation agreement. But it finally passed Tuesday night — the PACT Act, not the reconciliation bill — by a resounding vote of 86 to 11. For all the legislative dramatics and back and forth, it's actually an important bill for the veterans. I think it's 3.5 million veterans who are likely going to get health care now, right? I'm seeing people nodding.

**Cohrs:** Yeah, it's also significant spending. And I think that's — the price tag was part of the controversy over that. But it's worth noting the temper tantrum didn't actually change the bill. And I think there has

been some rhetoric about the cost of war and if we're willing to spend on things like fighter jets and equipment that we also need to spend to take care of our veterans and the personal and health costs that they live with. So I think ultimately Republicans weren't willing to stake their ground on that and back down once there was this uproar.

**Rovner:** Yeah, they ended up having a couple of amendments that didn't pass to a bill that hadn't really changed since they passed it the first time. I mean, in the years ahead, when these veterans are actually getting the health care to which they are clearly deserving, we will forget all the pettiness that surrounded actually getting it through. Meanwhile, the House last week approved a bill to continue expanded eligibility for telehealth in Medicare. The expanded eligibility that was made at the beginning of the pandemic. They will extend that through 2024. It basically expands who can provide telehealth services and from where. That had been a big issue, used to actually have to go to a secure location, as it were, to do telehealth. On the one hand, it's been really popular with both providers and with patients. On the other hand, it likely increases use, which puts the government and patients on the hook for more money. Is this a genie that's never going to get put back into the bottle, sort of the Medicare equivalent of the increased Affordable Care Act subsidies? If it were to go away, everybody would freak out.

**Cohrs:** I think so, to some degree. And I think Congress is just trying to buy themselves some more time right now with this two-year extension, because use patterns for telehealth have been so wildly unusual, and we certainly will be in a new reality as time goes on, where usage of telehealth is much higher. But I think there's just a question of how much fraud is going on or how much utilization is saving money and saving time versus creating extra appointments and extra costs.

**Rovner:** Yeah. I would say with telehealth it's not so much fraud, it's just not necessarily necessary care. It's like much easier to have … instead of having one follow-up where the patient has to come in, well, let's have a follow-up once a week for three weeks. So now you have three appointments where you would have had one in person.

**Raman:** I would also point out the audio-only telehealth part that's in there for permanent care. And I think that that has been something that I've just heard so much bipartisan support for throughout the pandemic. And just extending that in particular because of — we're already seeing all of these increased symptoms and diagnoses with a lot of mental health issues. And that, in particular, I have heard from so many folks has been beneficial for them, to be able to use that audio benefit for mental health services.

**Rovner:** Although audio-only is also a double-edged sword because providers used to not charge for phone calls. And so having audio-only telehealth makes that an appointment that you can get reimbursed for.

**Luhby:** Yep. Right. But I think also we're in a mental health crisis in the U.S. right now, and telehealth has really expanded the options for people to get mental health services. It's still not enough. And so if you now take this away, it's going to be an even bigger problem that we have to solve.

**Cohrs:** Right. And just to frame this, the importance of this House bill, the Senate was not on board with this. It's not coordinated. I asked Senate staff what they thought, and they were like, "Oh, I hadn't really been paying any attention to it." So that's kind of the tenor right now. It doesn't mean it couldn't get attached to something. But this conversation isn't over.

**Rovner:** Yeah. It's one of those things that doesn't get huge headlines. It's not abortion. It's not reconciliation. But it's out there, and it's important to an awful lot of people. All right. Well, let us move to covid. It appears that President Biden was prematurely pronounced cured of his covid infection. After testing negative for a couple of days, he began testing positive again over the weekend and as of this

moment I believe is still in isolation, albeit with reportedly very minor symptoms. But while the president's relatively undramatic course of covid last week demonstrated the efficacy of vaccines and therapeutics, this week it seems to be highlighting why covid is still so much with us. How many people even bother to test after their five days of isolation, particularly if they're feeling better, and then may go out and infect other people? So, I mean, has the president sort of been an object lesson for both sides of the covid conundrum, right?

**Cohrs:** Yeah, I think there were questions that were raised, by especially the White House reporters, about what the guidance actually is and what President Biden was actually doing. I know when I had my bout of covid, I was crossing my fingers at five days and ended up testing positive for several more days after that. And I think that's a pretty common occurrence. So, I think there are questions now that there is a greater availability of tests, what the metric should be — and still questions out there with every new variant of how effective tests are at estimating how contagious someone might be. So I think it absolutely did spark some interesting conversation about that isolation guidance.

**Rovner:** Yes. Well, meanwhile, monkeypox continues to spread even as we're still dealing with covid. The World Health Organization has declared it a public health emergency, as have several states, including California, Illinois, and New York. The federal government has appointed a monkeypox czar, if you will, but has not declared a public health emergency yet. Is that in the offing, or did they not want to have multiple public health emergencies going on at the same time?

**Raman:** I mean, we already do have multiple public health emergencies at the same time. How many? I don't know how many years we've had the opioid epidemic as a health emergency right now. And then, obviously, like the different state ones with natural disasters. I don't think adding one is necessarily going to change that.

**Cohrs:** Yeah, I think there's data potentially collection advantages to a public health emergency. And obviously monkeypox is very serious, is very painful for the people who do have it. But, for the most part, people in the United States are not dying. So, I think there's a cost-benefit for the Biden administration. I think they're just weighing on abortion, too — a public health emergency for that. There's just a lot of conversations going on. They're trying to deal with a lot of things. It's a very large department. But I wouldn't be surprised if that came at some point. But they haven't gotten there yet.

**Rovner:** I think if it wasn't for covid, which is super contagious and deadly in some cases, I think we'd be a lot more freaked out about monkeypox, which, as we point out, is contagious but is not quite as contagious and is serious but not in most cases, not deadly. In some ways, monkeypox is coming at an opportune time for monkeypox because otherwise I think we would be a lot more serious and we would be hearing a lot more about it. All right. Well, that's as much news as we have time for this week. Now we will play my Bill of the Month interview with Bram Sable-Smith. Then we will come back and do our extra credits.

We are pleased to welcome to the podcast my KHN colleague Bram Sable-Smith, who reported and wrote the latest KHN-NPR “Bill of the Month.” Bram, welcome to “What the Health?”

**Bram Sable-Smith:** Thanks for having me. I'm thrilled to be here. Are you looking forward to the texts from the nerds I'm going to get when this runs?

**Rovner:** So we had hoped that after Congress made most surprise bills illegal, we'd have fewer Bills of the Month to deal with. But this month's patient fell into one of the loopholes in that law. Tell us who the patient was and what happened to her.

**Sable-Smith:** So the patient is Peggy Dula. She's a 55-year-old jewelry seller in St. Charles, Illinois, and two of her siblings were coming to visit her. Peggy's daughter trains horses near St. Charles. She invited the siblings to go and see them. So Peggy drove with her brother and sister on this country road she'd never been on before. She got to an intersection. She mistakenly thought it was a four-way stop, so she pulled into it, and her car got slammed by a pickup truck.

**Rovner:** And all three people in the car were somewhat injured and transported to the hospital. And Peggy turned out to be the least injured of the three, but she got the biggest bill from the ambulance company. How big was it and how much bigger was it than the other bills that were sent?

**Sable-Smith:** Yeah, that's right. So Peggy's bill was about $3,600. She was the least injured. She just had some bruising on her sternum. Her sister, Cynthia, was the most injured. She ended up spending five days in the hospital, but her bill was only $1,250. And her brother Jim had cracked ribs and his bill was just $1,400. So Peggy's bill is nearly three times higher than Cynthia's bill, despite her being the least injured of the three of them. And I should say also that the siblings were all billed for the exact same services, something called “Advanced Life Support,” plus a mileage fee for the ambulance.

**Rovner:** So it was just a matter of these three ambulance companies charging dramatically different rates.

**Sable-Smith:** That's exactly right.

**Rovner:** So we've heard a lot this year about the No Surprises Act that Congress passed, but this bill wouldn't even have been covered by this, right?

**Sable-Smith:** Yeah, that's right. So this bill falls into a loophole with the No Surprises Act you've talked about on the show. No Surprises Act is supposed to shield patients from these kinds of surprise medical bills. It limits the patient portion of the bills and makes providers and insurance companies squabble among themselves over the rest of it. But ground ambulances were specifically exempt from that law. So out-of-network ambulances can pretty much charge patients whatever they want to, and most ambulances are out-of-network. So one study that looked at five years of ambulance bills for a large national insurance company found that 71% of ambulance rides were out-of-network for that insurer.

**Rovner:** And we've talked so much on the show about private equity and private companies who are getting into health care and trying to make a profit. But in this case, all three of these ambulance companies were not private, right? They were just sort of your run-of-the-mill, call 911, and the locality sends its ambulance.

**Sable-Smith:** That's right. All three ambulances came from local fire protection districts. So these were all public ambulances. And the researcher who looked at those five years of medical bills from the insurance companies — the five years of ambulance bills — he found that it often is these municipal services that have the highest bills. Maybe it's because they need to charge this much to balance their budget. That's one possibility. But yeah, it's municipal services just as much as it is private companies.

**Rovner:** So what eventually happened with this bill? What did Peggy do?

**Sable-Smith:** Well, her insurance company paid about $900 and then she got balance-billed for the remainder, $2,700. And she might have just paid that because who knows what an ambulance ride costs? Maybe it just costs $2,700. But she had this extra information because she could see her siblings’ bills and she could see that her balance bill was still twice as high as the sticker price that her siblings were being charged. So she was outraged about it. She decided to fight. She sent a letter to the billing company and

asked them to reduce their price down in line with what her sister was being charged. The billing company said, “Oh, we can't do that. You have to talk to the fire department.” She tried to reach out to the fire chief and said she couldn't get through to him. So eventually, as she was battling, battling, battling, she paid $40. It's kind of like a sign of good faith, but eventually she just got sent to collections in June, and that's where it is right now. She's still fighting it, but now she's dealing with the collections agency.

**Rovner:** Wow. So what's the takeaway here? I mean, sometimes you really do need an ambulance and it's not very practical in an emergency to sit up and say, “Are you in my insurance network?”

**Sable-Smith:** Yeah, exactly. And, you know, you don't want to be a hero, especially if you have a head injury. You know, you want to take that stuff really seriously. But if you have minor injuries, it's OK to turn down an ambulance ride. You don't have to take it just because it showed up. There are other ways to get to the hospital. Peggy's daughter, you know, she says in retrospect, she should have accepted a ride from her daughter. Her daughter had offered to come to the crash site and take her to the hospital. And she thought, oh, no, that's OK, I'll just take an ambulance. It's OK to get a ride to the hospital from a friend, a family member; you could call an Uber or Lyft, however you want. There are other ways to get to the hospital when you have minor injuries. And it's also worth figuring out if your own local ambulance is in-network with your insurance or not.

**Rovner:** That's right. I mean, in this case, it was because none of them were local. They were all outside of where they lived.

**Sable-Smith:** That's exactly right. It would have been a different story if Peggy Dula had lived inside the fire district. She wouldn't have had a balance bill at all.

**Rovner:** So beware and drive carefully, I guess, is the take-home message here.

**Sable-Smith:** There it is.

**Rovner:** Bram Sable-Smith, thank you so much.

**Sable-Smith:** Thanks for having me.

**Rovner:** OK, we're back. And it's time for our extra-credit segment, where we each recommend a story we read this week we think you should read, too. Don't worry if you miss it; we will post the links on the podcast page at khn.org and in our show notes on your phone or other mobile device. Rachel, you were the first one to pick an extra credit this week, so you go first.

**Cohrs:** I chose a run of coverage by The Washington Post this week. The flagship first story was headlined “Thousands of Lives Depend on a Transplant Network in Need of ‘Vast Restructuring,’” by Joseph Menn and Lenny Bernstein. And I think this is just an incredible investigation bringing to light the issues in the organ procurement and the transplant process. Because these organizations do have monopolies over their area regions, there's limited accountability by the government, there's limited oversight when things do go wrong. There were several instances of people getting transplants of organs with the wrong blood type and dying, and there just not being a whole lot of consequences for that. So I think, paired with the Senate Finance hearing this week, it is a really interesting issue, one that I think the Trump administration also did try to address in their own way through HHS and some different rulemaking there. This is just such a huge moneymaker as well. Dialysis — there's so many different industry elements here that are really fascinating. And so I think as we move into this lame-duck session, as we move into a potentially more

bipartisan environment moving forward, I think this will be a really interesting issue to watch. And it was great reporting.

**Rovner:** Yeah, there was a huge blowup about this during the Clinton administration when, ironically, [Sen.] Bill Frist, who was a transplant surgeon, was the head of the public health subcommittee and was basically afraid to say anything about any of it. They did eventually work out a compromise — that was about organ distribution, less than about UNOS [the United Network for Organ Sharing] and what it's doing. ... I highly recommend the investigation. Even though it's really long, it's really interesting. Tami.

**Luhby:** My extra credit is from Kaiser Health News. It's a story by Markian Hawryluk and it's part of KHN's "Patients for Profit" series looking at private equity in health care. It's titled "Hospices Have Become Big Business for Private Equity Firms, Raising Concerns About End-of-Life Care." And I found the stats quite surprising. I really didn't know anything about this. It says that there's been a major shift in hospice care over the past decade and that more than two-thirds of hospices nationwide are now operating as for-profit entities, which was very surprising to me, and that it's attracting, of course, private equity firms. It's a big deal because the U.S. population is aging so rapidly that there is a lot of more need for hospice. And, of course, there's that attractive combo of generous Medicare payments and little oversight. So the profit motive is worrying hospice veterans who say that it could harm both the dying patients as well as their families if the patients don't get adequate care. But private equity firms, as they typically say that they can help smaller hospice businesses grow, give them more access to capital and opportunities, etc. But the story says that for-profit hospices tend to hire fewer employees and expect them to see more patients, which is something we've heard in nursing homes and other places. So hospices are yet another area of health care that private equity firms have seized upon. They're already taking over hospitals, nursing homes, specialty doctor practices, and the KHN story and the series shows how this trend isn't usually in the best interest of the patients.

**Rovner:** Yeah. Or as I like to call the series "This Week in Private Equity in Health Care." Sandhya.

**Raman:** All right. My extra credit is kind of piggybacking on Tami's in that it's also on elder care. It's "Nursing Homes Are Suing the Friends and Family of Residents to Collect Debts." And it's from Noam N. Levey at Kaiser Health News. And I think medical debt has been such a big issue already. And I think that a lot of the focus has been on just researching to prevent it possibly from happening to yourself or your spouse or your dependents. And I think this story was very interesting to me. I've been thinking about it all week, it's just looking at some of the aggressive litigation that can affect you even if the care involves someone else altogether. And Noam digs through some cases in Rochester (N.Y.) where the debt collectors got like $7.6 million over the course of a few years and a lot of these cases are targeting friends and other relatives and accusing them of hiding assets or stealing tens of thousands of dollars from the person that was in the nursing home. And I just thought it was so interesting because he had pointed out that some of the advocates were saying that some of the nursing homes allegedly slip agreements in to make someone else cover the costs and just say, look, you have to sign this. And then some of the examples he used, you know, someone might be estranged from the sick person and gets drawn in or one where a person thinks that their signature was forged from a visitor log and then they were kind of drawn in. And even though a lot of these cases have been dropped, it just was unsettling. And it's a good read.

**Rovner:** Yeah. And just a reminder, we had Noam on the podcast talk about his medical debt project a couple of weeks ago. So if you scroll back in your feed, you will find that. Well, my extra credit this week is also a KHN story from my colleague Brett Kelman. It's called "They Lost Medicaid When Paperwork Was Sent to an Empty Field, Signaling the Mess to Come." And it's about a family that, indeed, discovered when they took their injured son to the emergency room that they had been disenrolled from Medicaid because

a clerk had misaddressed paperwork intended for them. They appealed and were denied again, and they only got their Medicaid for which they had been eligible all along after a public interest law firm called the Tennessee Justice Center got involved. Three years and $100,000 in medical debt later, it turns out that TennCare, which is Tennessee's Medicaid program, had not only been sending renewal packets to horse pastures, but was also sending misleading letters to people who were cut off about their rights to appeal. I confess this story really spoke to me because I did some reporting in Tennessee back in 2006 about how TennCare was failing to serve the people it was supposed to. Apparently, some things don't change.

So 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 this review — that helps other people find us, too. Special thanks, as always, to our producer, Francis Ying, who makes the weekly magic happen. As always, you can email us your comments or questions. We're at whatthehealth — all one word — at kff.org. Or you can tweet me. I'm @jrovner. Sandhya.

**Raman:** I'm @SandhyaWrites

**Rovner:** Rachel.

**Cohrs:** @rachelcohrs

**Rovner:** Tami.

**Luhby:** @Luhby — L-U-H-B-Y

**Rovner:** We will be back in your feed next week with plenty more news, I'm sure. Until then, be healthy.