

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

**Episode Title:** Looking Ahead to the Lame-Duck Session

**Episode Number:** 267

**Published:** Oct. 6, 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, Oct. 6, 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 Sandhya Raman of CQ Roll Call.

**Sandhya Raman:** Good morning.

**Rovner:** Jessie Hellmann, also of CQ Roll Call.

**Jessie Hellmann:** Hi there.

**Rovner:** And my KHN colleague and substitute podcast host, Mary Agnes Carey.

**Mary Agnes Carey:** Thanks for having me.

**Rovner:** Fun fact — everyone on this week's podcast works or has worked for Congressional Quarterly.

**Carey:** Ta-da!

**Rovner:** This is as nerdy as we're going to get. Later in this episode, we will play my interview with KHN's Sam Whitehead, who wrote the latest KHN-NPR "Bill of the Month," about an urgent care emergency room visit that went a little bit wrong. But first, the news.

So Congress is gone until after the election. And, obviously, what they do when they come back in November and December is very much dependent on which party is going to control Congress come next January. If the Democrats somehow maintain control, I think they might do a little less. If the Republicans take over, Democrats will want to try and get as much done as they can while they still have control. But no matter what, there are things that Congress has to pass, like the spending bills that now expire in December. Then there are things that it would be nice to pass, like the bipartisan pandemic preparedness bill being helmed by retiring North Carolina Republican senator Richard Burr. Then there would be things that would be unpopular not to pass, like extensions of telehealth and other authorities that will expire when the pandemic national emergency is allowed to expire, presumably sometime in early 2023. So let's take them one by one.

First, the spending bills. Do we have reason to expect Congress will really wrap up the fiscal 2023 appropriations process in December? Or will they do what they seem to have done recently and push final decisions to next February or March — or [I] think even April one year?

**Raman:** So I feel like I'm a little bit more optimistic that they will finish earlier this year just because it's a unique situation where the Senate Appropriations chairman and the Senate Appropriations ranking member are both retiring at the end of this year, and not finishing it — it seems like it would be a good way for them to end, as like a legacy thing, for them to wrap this up and go out on a good note.

**Rovner:** It would have been a legacy thing for them to get them done by Oct. 1, when the fiscal year started.

**Raman:** That's true. Yes, but I guess we are not necessarily even as far along as last year in that we have not had the House even vote on their version. We do have versions put up by House and Senate Democrats of Labor [and] Health and Human Services appropriations, but it's still in such the negotiation stages that there's a lot of work that was needed to be done between now and December. But I feel like I'm a little bit more hopeful just because of the unique situation we're in.

**Rovner:** And once upon a time, all of these spending bills would go separately. In fact, I've lost track of whether there are 12 or 13 because they changed it at some point. But only the big ones, Labor [and] HHS and Defense, would be hanging out at the end usually. But now they just put everything together, and it's always one bill. And they always swear, "Next year, we're going to do it regular order." And they haven't done it regular order, I think, since 1999 or 2000. It was the last year of the Clinton administration. Sandhya, are you expecting any attempts to change any of the abortion language in any of these bills?

**Raman:** So I think it's going to play out similar to last year, where there's the push for it. Even if you look at the House, the chairwoman of the House Appropriations Committee, Rosa DeLauro, said a couple of years ago this is the last year that I'm going to include something like the Hyde Amendment in our spending bill. But there's not the votes at this point to get that stripped away from the spending bill. In the House, there is right now. But in the Senate, without 60 votes, it's just not going to happen. And it's not something that even all Democrats are on board with. So without that and larger margins, it's going to be something that they discuss and debate, but it won't necessarily come into fruition for them without more folks on the Democratic side. But it's also interesting to watch, because that is the last major vehicle that I can see for this year. So any other big-ticket or small-ticket health items would probably need to go with that to finish up this year rather than next year.

**Rovner:** What else do we expect to be — you know, obviously, there will be some sort of big bill in December because they have to extend spending in order to keep the government open. What else do we expect lawmakers to try to latch on to that bill?

**Carey:** I mean, all these Medicare extenders, right? All these things to keep funding going, to stop cuts to things like hospitals and physicians. There may be some work on insulin, right? Lowering insulin prices for the rest of us outside of the Medicare space. And the thing about it is, the bigger that bill gets, I think, the easier it is to put these provisions in. And there are also provisions they've done over and over again. You just talked about how they kick the can on the budget appropriations process — and it's the big [continuing resolution] — in the sense of any kind of

required cuts from sequestration that have been out there for a long time and been postponed. "Just do them another year." You know, "just do them for another fiscal year." And you got to remember if you tried to cut physician payment or money to some of these hospitals that are low-volume or really depend on extra Medicare money or ambulance add-on payments, you would get screams and hollers from the folks affected, whether it is the physician community, the hospital community, the beneficiaries themselves. And lawmakers don't like that. So I think a lot of these ... Here come the extenders. It was always one of the last things they do in health care. But it's kind of a must-pass. The price tag usually isn't too high. So if you get a big bill, you squeeze those babies right in there, and they're taken care of.

**Rovner:** So, Jessie, in addition to these extenders that have been going on year by year for a long time, we have what are becoming extenders for the public health emergency, right? The public health emergency won't end before the end of the year because it comes up, I think, next week or the week after, but they didn't give the 60-day notice. So we know that they're going to extend it at least one more time. But at some point, the pandemic public health emergency is going to expire. And all of these things that people have gotten used to doing during the public health emergency will theoretically become impermissible again, like using telehealth for Medicare.

**Hellmann:** Yeah. I know telehealth lobbyists have been pushing really hard for Congress to deal with this issue again in the omnibus. Congress already had telehealth extenders in the last omnibus. As you mentioned, it basically extended Medicare coverage for 151 days after the end of the public health emergency. Very specific, but that's what it is. We still don't know when the public health emergency is going to end. It doesn't seem like it's going to end tomorrow. So I don't think there's a lot of urgency for Congress to extend some of these flexibilities for another year or two, which is what lobbyists are asking for. So I don't know that they're going to deal with that in the omnibus, but it's possible.

**Rovner:** And anything else that you guys are watching for that didn't quite make it before they left to campaign that you expect could make it by the end of the Congress?

**Raman:** There are a few things that either they extend it a little bit with the CR that I have been watching that I think are going to be increasingly important to watch in December. One is just the Medicaid assistance for the territories. Right now, if you look at Puerto Rico, they're going through a lot with the hurricane. And the way the territories have their Medicaid funding is not like the states. They're capped. They get a smaller percentage than states. And the percentage of folks that do use Medicaid is high. And so it's going to be, I think, increasingly important to come to some sort of agreement on funding Medicaid for the territories. But it also has been historically something that has been kind of short term, short term, short term extended rather than with a longer deal.

And then I think a couple of other things are ... At the end of the year, we have to decide, Congress, on classifying fentanyl analogs. And given that we're going through record drug-overdose deaths, that's something that even the administration has said that they've put out a plan and there just hasn't been quite an agreement, even within parties on how to go about extending that. And proponents of classifying the drugs related to fentanyl are like, "this is a huge

driver in drug-related deaths, so we do need some sort of long-term solution.” I think that gets to the broader thing, which is both chambers have been working a lot on bipartisan mental health packages or bills. We have at least five different committees that have been advancing different things or marking up different things. And it's getting close to the end of the year. And even though it is bipartisan, it is something that I think they would like to finish before the end of the year even if one or both chambers flip, given they've been working for the past couple at least years on different things related to this. But it is a short timeline given that we don't even have the full package out yet in any of the committees.

**Rovner:** It's really just a reminder that anything that Congress doesn't do before next Jan. 3 dies and has to start the whole process over again unless they pass it. So they have put a lot of work into mental health.

Well, I want to move on to covid this week. California Gov. Gavin Newsom has signed a first-in-the-nation bill that defines the dissemination of “misinformation or disinformation” about covid by a doctor as part of patient care as unprofessional conduct subject to sanctions by the state's medical board. In a signing statement, the governor said he was signing the bill only because it was narrowly targeted to apply to “only those egregious instances in which a licensee is acting with malicious intent or clearly deviating from the required standard of care while interacting directly with a patient under their care.” So to be clear, it doesn't apply to doctors on social media or elsewhere, but will it open a Pandora's box here? I mean, this has been an ongoing fight in a lot of places about free speech and medical professional autonomy versus doctors peddling what's pretty discredited treatments for covid.

**Carey:** I mean, in the public arena, people talking about it right now, it's already got legal challenges that this is, “you're violating my free speech — it's overstepping.” But correct me if I'm wrong. As I understand this, it means if doctors who spread false information in this manner could face discipline by California's medical boards. Okay. Medical boards and specialty societies already have the power to do this. So this elevates this to another platform. It gives it more public light, more public attention. And I think that, for example, the doctors that are challenging it will come into the public eye. Cases of misinformation will be elevated, but I don't know if it will really ... a discipline. The medical boards could already do it. Now you have more pressure to do it. But it does kick it up a notch.

**Rovner:** MAC, you and I have both interviewed the new president of the [American Medical Association]. Who?

**Carey:** That's right.

**Rovner:** Who's very, very interested in this topic and in medical boards doing more to try to curb misinformation.

**Carey:** Right. Because in that interview, in talking with him, both of us have discovered, from his description that is, the medical boards and the specialty societies have the jurisdiction, if you will, to investigate and discipline. So I was intrigued by this law, and I think that it will just take it to a

whole other level, especially if — we hope this doesn't happen — new covid variants make things worse this fall and winter for folks, that this will get a lot of attention.

**Rovner:** One of the things that I wondered about ... I mean, we're seeing this in the abortion debate, that doctors are feeling chilled by things: "Well, this might apply to me." Now, MAC, as you point out, this doesn't have state penalties attached to it. So there's that, which I suspect is probably why the governor was willing to sign it. But is there a concern that doctors are going to be afraid to talk about anything now because, for fear of getting thrown up before their medical board?

**Carey:** I don't know if that's the case. And this is a California-specific law, right? And I guess North Dakota has gone to the other end, passing a law allowing doctors to prescribe ivermectin to treat the coronavirus, which could be a whole other podcast.

**Rovner:** And may be at some point.

**Carey:** And it may be. But when you look at abortion, which I know we'll talk about later, you look at that and some of the fear physicians have, even in states that allow exemptions against an abortion ban — rape, incest, save the life of the mother — how scared they are to talk about what they need to do and to actually do it, perhaps to help a woman with an ectopic pregnancy or other difficulties. They're spending ... Not in all cases, and I don't want to spread misinformation myself, but from my understanding of Dr. [Jack] Resneck's interview you've done with them, I've done with them, that doctors are spending a little more time perhaps than they used to talking to the legal departments of a hospital before they do what they think is medically necessary for a pregnant woman in distress.

**Raman:** That is something I was thinking of, too, that in either case, you think of this as a provider in a silo, where there's many layers of hospital administrators and the legal department and all these other people that that might work in whatever medical facility. So that even if you are having whatever conversation with a patient, I think taking into account all of the other people there might make some of these things ... I mean, if this law were taken up or adapted elsewhere, a little bit trickier, given all of the different layers of who is involved in these kinds of decisions and what you can and cannot say to a patient.

**Rovner:** Yeah, I think doctors have painted themselves into a corner here about freedom to practice, a continuing debate that I think is going to continue.

Well, let's turn to abortion. The Biden administration is still trying to do as much as it can with not much to work with, as there's not a whole lot it can actually do without congressional action. But the president did make a speech this week before the commission that he created to address reproductive rights in the wake of *Roe v. Wade*'s repeal, where he mentioned the actions banning birth control or discussion of abortion at the University of Idaho, a topic we talked about on this podcast last week. And he warned that Republicans are indeed coming for your contraception. Is there anything the administration could be doing on the abortion/contraception front that it isn't doing already? I know they tried to make a big fuss about "we're giving out money" because that's one of the things they can do. "We're giving out grants. Yay!"

**Carey:** I think it's important that the administration is trying all these things and they want to do these things, but it's really a ball game in a whole different field.

**Rovner:** Yeah. And, Sandhya, you had [a story](#) about just that this week. Why don't you tell us about it?

**Raman:** Yeah, I did. I was looking at the attorneys general in the state races and the governors races, because that is really the ground to watch, I think, in what's happening with abortion in the country. Regardless of who wins the House and Senate, it's still going to be very difficult to make changes in any direction on the federal level. But on the state level, things are changing day by day. It's hard to tell what's happening even for people that follow this issue very closely. So I think the Democratic gubernatorial candidates and attorneys general candidates are really pushing into this because this can be kind of the last stopgap for them in states like Arizona that just implemented a law that bans all abortions from the 1800s.

**Rovner:** From the 1860s, I think.

**Raman:** Yeah. Yeah. So they currently have a Republican governor and a Republican attorney general who are both term-limited. So it's open. And I think both candidates there are really campaigning on this issue and have said that this is something that is going to motivate voters. And it's definitely more than in previous years that they've really like homed in on this in many different states and in places like Pennsylvania or Michigan, states where it might be a little bit more of a purple situation. They're kind of campaigning on like "we want to keep someone from coming in and changing some of the stopgaps we've had," the veto power to override the legislature or to not implement extremely old laws from the 1800s or early 1900s that might not be as applicable. So it's really a big issue for Democrats. And I think it's interesting because a lot of the Republican candidates have really toned down the messaging on that. I shouldn't say toned down. They have not emphasized it as much on the trail. They're not really doing ads about that since the campaign in the primary and just trying to move in the direction of some of the other issues that are important to them, immigration, inflation, those kinds of things. It's a stark difference in how the ads are playing out there.

**Rovner:** Well, meanwhile, as states pass and implement abortion bans and restrictions we've just been talking about, abortion providers are trying to find creative ways to maintain access. In St. Louis, Planned Parenthood of Missouri is opening a mobile clinic. It will locate across the river, in Illinois. Among other things that should help ease some pressure on Planned Parenthood's nearest Illinois clinic to St. Louis, which has seen a 340% increase in patients in the hundred days since the Supreme Court handed down its decision. Is this the future? Mobile clinics along the borders of states with bans in states without bans.

**Raman:** It is a creative solution. I think of it more as something that has been done in the harm-reduction community or just getting community clinics out for some of the other issues. But it's not necessarily a panacea. I mean, especially with some of the bigger states, getting to a border is still a long distance for folks to travel. If you're going from Texas to New Mexico or something ...

**Rovner:** If you're going from Texas anywhere.

**Raman:** Yeah. Yeah. It's not ... I think it might be something that they can try in some of these states, but it's still difficult. And even with the Illinois/Missouri thing, they're only doing the medication abortion right now. They haven't figured out how to do surgical abortions yet. I think they were trying to aim for next year for that. So it's still a smaller pocket. And if they're doing that only to 11 weeks, if you were having to travel to the border from whatever state or area you are, there's already other difficulties there to make that happen.

**Rovner:** At the same time, one of the “creative” ideas to facilitate abortion access doesn't seem to be getting much traction. [Politico reports](#) that not a single state has taken up the Biden administration's offer to use Medicaid funds to help women travel out of state for abortions. And [a report from Stateline](#) suggests that companies considering offering the benefit, the travel for abortion benefit, aren't seeing much take-up, either. The companies are also worried, with good reason, about being pursued by state authorities if they're in states where abortion is restricted or illegal. And there's some skepticism about whether workers really want to go to their bosses and say, “Hey, I need to take next week off to travel for an abortion.” But might we end up seeing these policies anyway, even if only as virtue signaling from progressive firms that want to keep their employees?

**Carey:** I think that's exactly right. I mean, a lot of these companies have been out front saying “we will help our employees obtain these procedures.” But I think your point is so well taken about the employees themselves. If abortion were easily accessible to you, you wouldn't have to spend that many days perhaps traveling to a state, sitting through a waiting period, getting a procedure, and then coming home. But having to go and ask for that specific thing, maybe with your HR department or whatever, there's just an agreement you need a week of medical leave. But it's one of those things where it's understandable that companies would want to support their employees with this and that employees would want to take advantage of it. But it's one of those things about the implementation. You know, devil in the details. It's really tough to make these things happen. Doesn't mean it won't happen. I think they'll still continue with it, that it's sort of this changing landscape that we're talking about that's happening all over the states and how it's playing out and the difficulties that are happening. And this idea of a mobile unit to provide some services, not others. I mean, it's just this continuing story that seems to change daily, weekly, monthly.

**Rovner:** Yeah. Well, speaking of stigma. I feel like one of the things that this debate is doing is prompting more attention to things that used to be more on the fringes of the debate. For example, I have spent years hearing anti-abortion forces talk about how rare things are, like very young teens getting pregnant from rape or incest. Yet this week, we have a report out of Ohio that the 10-year-old rape victim was not an anomaly. The Ohio Department of Health reported this week that of the 538 minors who had abortions in 2021, 57 were younger than 15. Are we at least getting a broader picture now of how integrated into everyday health care pregnancy termination really is? I feel like maybe we're starting to get to see what's really happening out there because so many people have been doing it but not talking about it.

**Carey:** And those are 2021 statistics, too, right?

**Rovner:** Yeah. That was last year.

**Carey:** Yeah, exactly.

**Raman:** I think, I mean ... You can note that that is a very small percentage of the overall number of abortions. I think it was 2.5%. It's still unacceptable given that the age of consent in Ohio is not that age. So these are all considered rape under the state ...

**Rovner:** They're all statutory rape, at the very least.

**Raman:** But I think that it can help raise the issue, given that Ohio is, again, what you said, where the child had to travel to Indiana to seek an abortion after ...

**Rovner:** The 10-year-old child.

**Raman:** Yeah. Yeah. So I think that a statistic like that can help broaden, knowing that this was not just a one-off case, that this is happening more than once a week, if you break it down like that.

It is going to be hard to say because I think there's been more and more of a push in a lot of states where people don't want any exceptions to some of the abortion bans, where I think there was a consensus a lot before around exceptions for rape, incest, and the life of the mother, and that has really been a little bit more fragmented now, where there's people who don't want some of those exceptions. And whatever "life of the mother" means has been dissected a lot as "what does that apply to? It's very broad. How much endangered does the life have to be?" And I think that it's getting difficult to figure out what even some of these laws mean.

**Rovner:** Yeah. But at least we're seeing some of the ramifications that I think had been theoretical before now seem to be a little more concrete. I mean, we're also seeing many more women who are needing late abortions for medical reasons. I mean, these are not women at 30 weeks who decide, "oh, I don't want to be pregnant anymore." These are women with either profound medical problems themselves or carrying fetuses that have things that are incompatible with life. And that's also not as rare as I think they've been made out to be. Five more weeks until the election, but I'm sure this debate is going to carry on well after that.

Well, finally this week, because I am a true health nerd, the Congressional Budget Office is out with a report on proposed ways to reduce payments for hospital and physician care. And as Bob Herman of Stat [points out](#) — which is something I noticed, too — the CBO manages to boil the last half-century of debate over health policy into one single PowerPoint slide. Basically, whether making the market work better via more transparency and competition would be more effective at reducing prices than just having the government set or restrict them. I don't suppose this is going to convince anybody on either side of this debate to change. But with so many incredibly weedy health policies being battled around, many of which we have already talked about this morning, it's refreshing to see the big picture again, isn't it?

**Carey:** Putting it in a chart is really interesting and very clear, but the murky part comes if you again tried to actually implement that kind of cap, that kind of control on spending. Here's another great thing from his story: "Regulating prices, whether it's for hospitals and doctors, drug



companies or some other industry actor, has proven to be a political landmine due to the industry's political lobbying power.”

**Rovner:** Yeah.

**Carey:** That kind of tells a story right there. And in the Inflation Reduction Act, right, as to the ability to negotiate some drugs for Medicare, not all, some, a list of like 10. And there’s all sort of ...

**Rovner:** A few. A few drugs.

**Carey:** A few — beg your [pardon]. Thank you. That, you know, will the drug industry sue to block that? They fought against the creation of it, and the implementation will be fraught with all sorts of landmines. I mean, this is just so politically sensitive. It's very, very tough to pull off.

**Hellmann:** One space to watch on this is in the states. There are three states that have public option-style plans that are intended to contain costs or cap payments to health care providers. I don't think that those public options have gone as far as some people would like to see, but ...

**Rovner:** I know one is Washington. What are the other two?

**Hellmann:** Colorado and Nevada. Yeah, I mean, we always say states are where things happen first, but it's hard for me to imagine a public option happening or passing Congress anytime soon, or anything that would really hamper the rates that we pay to providers. I mean, we just started talking earlier in this episode about all the things Congress is probably going to do to stop cuts to Medicare providers. So.

**Rovner:** Yeah, it's the continuing tension of keeping the medical industrial complex working and trying to put the brakes on how much it costs. Speaking of which, that is the news for this week. We will now play my Bill of the Month interview with KHN’s Sam Whitehead. Then we will come back and do our extra credits.

We are pleased to welcome to the podcast my KHN colleague Sam Whitehead, who reported and wrote [the latest KHN-NPR Bill of the Month](#). Sam, welcome to “What the Health?”

**Sam Whitehead:** Thanks for having me, Julie. Great to be with you.

**Rovner:** So this month's patient had a pretty common problem. She was in a car accident, but she wasn't hurt badly enough to need an ambulance. I think that was last month. Tell us more about this month's patient. What happened to her?

**Whitehead:** So Frankie Cook is from Rome, Georgia. It's a small city in the northwest part of the state. And she's a first-year college student now but was a junior in high school when she got in that accident in the spring of last year. She was driving home and lost control of her car on a winding country road. Now, the car rolled a few times and hit a tree, but she and the other passenger were wearing seat belts. The air bags deployed, and both walked away seemingly OK and seemingly pretty lucky. Frankie just reported a bit of a headache when her dad, Russell, came

to get her. But she had a big exam later that week and worried that she might have a concussion. So they decided to go have Frankie checked out by a doctor.

**Rovner:** So her dad logically thinks to take her to urgent care, but they don't get any further than the front door. Why not?

**Whitehead:** So this was logical to them, right? Russell said a family member had recently had a good experience at an urgent care clinic after an accident. They got checked out by a doctor, given a clean bill of health, and all of that for just a few hundred bucks, right? So that's what's in the Cooks' mind when they go into the urgent care. Russell tells the receptionist, "Look, my daughter Frankie, she's been in this car accident. We'd like to have her checked out." And the receptionist says, "We don't take third-party insurance." Now, Russell told me that surprised him, so he asked again and basically got told the same thing by the receptionist: "We don't take third-party insurance. You're going to have to go to the emergency room."

**Rovner:** By "third-party insurance," you don't mean they don't take health insurance.

**Whitehead:** Correct. Not that they don't take health insurance. It seems like the receptionist was referring to car insurance because the Cooks presented as the result of this car accident. That seems to be what they meant by "third-party insurance." So the Cooks took the receptionist's advice. They went to the nearest ER. It was about a mile down the road, actually owned by the same hospital system that owned the urgent care. And while at the ER, Frankie got head and body CT scans, which came back fine, and was told to go home and rest. So, time goes by. And then the Cooks get a letter from the hospital's lawyer, of all people, saying it was \$17,000 for the ER visit, way more than the few hundred they expected to pay at the urgent care.

**Rovner:** Wow. Was the urgent care not required to accept her? Isn't there a federal law that requires patients in emergencies to be treated?

**Whitehead:** So you are thinking about EMTALA. That's the Emergency Medical Treatment and Labor Act. And this requires hospitals to stabilize patients regardless of their ability to pay. But it's not a law that really applies to urgent care centers, even those urgent care clinics like the Cooks went to that are owned by a larger hospital system. So, basically, what that means is an urgent care clinic does have the right to say to you, "No, we can't help." And the reason why can be about money or insurance.

**Rovner:** So they go to the emergency room. They get this huge bill. Did her health insurance not pay it? I mean, how did this bill get sorted out?

**Whitehead:** Russell was pretty shocked when he got this notice from a hospital attorney that they could be on the hook for a \$17,000 bill. So Russell started digging. He found a double charge on the bill for a trauma assessment fee, which he got removed after a lengthy appeal. And that knocked about \$5,000 off the bill. He was also trying to find out why Frankie was billed for a Level 4 ER visit — that's the second-highest level of severity — especially when she walked in and out on her own. And he's still trying to figure that out. His insurance company did pay a portion of the bill. Of course, there were adjustments. And so what the Cooks owe as of now is about \$1,000. Russell

still hasn't paid it on the advice from a family friend who's an attorney. Last I heard from Russell, he still is working through another appeal on the bill with his insurance company.

**Rovner:** So what's the takeaway here? I mean, most health plans encourage patients with small emergencies to seek urgent care. That's what this family did. What if they can't be seen?

**Whitehead:** Yeah. I've been thinking a lot about what I would do if I was in the Cooks' situation. I think it's really hard, Julie, as a consumer to often know really how bad an emergency is, how much care you might need, and, honestly, whether or not you can get it at the urgent care around the corner, and especially to try to navigate all of that after an accident. So [with] that in mind, it is important to know that urgent care clinics aren't governed by the same laws as ERs. As we mentioned, they can be selective about who they treat, even for financial reasons. That's something really important to know. Car insurance, as we saw in this case, can really complicate getting medical care at urgent care clinics. This is something we heard from someone with a big urgent care industry group. It's pretty common for these clinics to not want to mess with car insurance. And we've seen from other Bill of the Month stories how car insurance can complicate medical care and payment at other places, too.

**Rovner:** And worker's comp insurance also, right?

**Whitehead:** Correct.

**Rovner:** That's the other big third-party insurance there. So when you go in and they have you fill out the thing ... "Do you have insurance? Was this a result of a car accident? Was this a result of a workplace injury?" They're always going to ask those two questions, right?

**Whitehead:** Correct. And that can really make things more complicated on the back end. And then, finally, while urgent care visits are less expensive, it's good to keep in mind that those clinics generally can't offer the same level of care as an ER. And what could happen, you could show up at an urgent care visit just to get checked out by a doctor who then sends you to an ER for follow-up, which could mean two bills.

**Rovner:** But with head injuries, we should say, neither one of us are doctors. But always good to get those checked out by a medical professional.

**Whitehead:** Yeah. And I will say, after this story [ran], I will say we have gotten comments like that in response to this story. But we did check. There are a few big medical groups that say a CT scan isn't always needed to tell if you have a concussion. This is what the American Board of Internal Medicine says: Not always necessary, though some doctors order them. And the American College of Emergency Physicians says that kind of scan isn't often needed for mild head injuries. So here, yes, the accident was bad, but Frankie was really lucky, right? She was up and moving around and just had a bit of a headache when she reported to the urgent care.

**Rovner:** Well, good. At least that part of this story has a happy ending. Sam Whitehead, thank you very much.

**Whitehead:** Thanks, Julie.

**Rovner:** OK, we are back. And before we get to our extra credits, we have an update on [last month's Bill that Month](#). In case you've forgotten, that was the one where a car accident resulted in three separate ambulances to the same hospital and three very different bills for those ambulances. Conveniently, after our story aired on CBS, patient Peggy Dula [was notified](#) that the \$2,700 ambulance bill she'd been fighting for more than a year has been pulled back from collections and canceled out. It may not be the most effective thing to solve patients' problems one bill at a time, but at least we are getting results.

OK, 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](http://khn.org) and in our show notes on your phone or other mobile device. Sandhya, why don't you go first this week?

**Raman:** So my extra credit this week is [“As WV Officials Tout Small Reductions in Drug Overdose Deaths, Epidemic Remains at Crisis Levels,”](#) and it's from Allen Siegler at Mountain State Spotlight. So I found this story really interesting, not only just because I'm from West Virginia, but the story takes a closer look at specifically how the state has been a leader nationally in per capita drug overdose deaths during the drug crisis and the last month the state health department announced a 4% drop in deaths. That's still an extremely high number. I mean, even comparing 2016 to this year, nearly twice as many people died from overdoses. And so he talks to some different health care workers and groups on different methods they found that are proven to reduce deaths, and some of the state policies in West Virginia that have been limiting access to that, laws that have blocked building new methadone clinics, and a new law from last year that restricts dispensing sterile needles to just syringe exchanges and things like that. And just how this could make the epidemic worse in a state that has already faced a huge number of deaths.

**Rovner:** And just like covid, the fact that the opioid epidemic is no longer top of mind does not mean that it is over. Jessie.

**Hellmann:** So my extra credit is [a story from Jay Hancock](#), who used to work for Kaiser Health News and is appearing in Kaiser Health News again to talk about a cheaper solution he found to sleep apnea problems. I don't know if I should spoil what that solution is — I think you should read the story. But I think it's just a really interesting look at how conflicts of interests can shape the health care choices that we make and the ones that are being put forward by our doctors and increase health care spending.

**Rovner:** Jay was my cubicle-mate. And this is very Jay, that when he goes and gets a medical diagnosis and [is] asked to do something expensive, he looks to see why it is being prescribed. And it's a wonderful story. And he's happily retired, and I miss him very much in the office. MAC.

**Carey:** So mine's from The Washington Post, [“Seniors Are Stuck Home Alone as Health Aides Flee for Higher-Paying Jobs.”](#) It's written by Christopher Rowland. It's just a look at some of the difficulties. They profile a particular couple in the story. They're both in their 80s. The wife was the ... has been the caretaker for the husband, and she had a medical emergency. And all the things that happened that surrounded that. I mean, this is a problem that happened before covid,

but covid really exacerbated it. And as we age, OK, more people want to stay at home. They don't want to go to nursing homes. And nursing home enrollment, in fact, has dropped. So the demand for home health aides is really high, but the pay hasn't caught up with it. And some folks that have been in the home health aide space have gone to other jobs that are not as taxing and pay more money. And some aren't even going into the home health industry. And the story has a lot of heartbreaking examples of families in desperate, desperate need that have not been able to get a home health aide. They can't even get on a waiting list. And we also have to remember that this is also impacted folks under 65 who are disabled and are at home and need aides. So this is a growing workforce problem that will affect millions of people.

**Rovner:** [We can't] ever have too many stories about the health care workforce and the problems they're in. You're going to have a wonderful health care system, but if you have nobody to actually provide the care, you don't have a wonderful health care system.

Well, my story this week is from NPR by Wynne Davis. And it's called "[The Ice Bucket Challenge Wasn't Just for Social Media. It Helped Fund a New ALS Drug.](#)" And if you remember way back to 2014, you might recall a whole lot of people in your social media feeds getting a huge bucket of ice water dumped over their heads or even dumping the bucket on themselves. I never did this, actually, but the so-called Ice Bucket Challenge was a fundraising gimmick for the ALS Association, which works on behalf of those with amyotrophic lateral sclerosis, also known as Lou Gehrig's disease. It's a fatal neurodegenerative ailment for which there is still no cure and very few treatments. But it turns out that the ALS Association invested \$2.2 million of the funds that it raised with the Ice Bucket Challenge into the development and trial of a drug called AMX0035. And last week, the FDA actually approved that drug, although it will be another two years before the end of its large-scale clinical trial. At this point, the drug has shown to be safe and possibly effective. But at least it's some good news for the more than 6,000 people diagnosed with ALS every year.

OK, that's our show for this week. As always, if you enjoyed the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review; that helps other people find us, too. Special thanks, as always, to our producer Francis Ying, who makes the weekly magic happen. As always, you can email us your comments or questions. We're at [whatthehealth](#) — all one word — [@kff.org](#). Or you can tweet me. I'm [@jrovner](#). MAC.

**Carey:** [@MaryAgnesCarey](#)

**Rovner:** Jessie.

**Hellmann:** [@jessiehellmann](#)

**Rovner:** Sandhya.

**Raman:** [@SandhyaWrites](#)

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