Mark Masselli (00:04):

At a time of high misinformation and confusion, these journalists are responsible for getting the correct facts to Americans about their healthcare.

Joyce Frieden (00:15):

If I was trying to figure out what people want, I would say the keywords are clarity and transparency and reporters, we need to do a better job too at talking to people about how the science continues to evolve.

Jessica Bartlett (00:32):

Even in Massachusetts, though we have laws protecting abortion access, we would not be immune from federal laws. So, this is a case that is questioning the FDA's approval of mifepristone, which is one of two drugs that are typically used in medical abortions and in early miscarriage management.

Amy Goldstein (00:50):

This is a lawsuit that focuses on one part of the law, but an important part, is the part that, as you said, says that anyone with private health insurance is entitled to certain kinds of preventive health services at no cost to the consumers. This judge said that not all, but many of those preventive services should not be provided for free.

Margaret Flinter (01:18):

Our guests today are Amy Goldstein, the Washington Post national healthcare policy writer, Jessica Bartlett, who covers medical news for the Boston Globe, and Joyce Frieden, the Washington editor for MedPage Today. This is Conversations on Healthcare.

Mark Masselli (01:42):

Welcome all of you to Conversations on Healthcare. It's great to see you. Amy, let's start with you. You recently reported on a federal judge based in Texas who struck down the Affordable Care Act, free preventative health services to everyone with private health insurance. Wonder if you could share with our listeners what are the implications of this ruling and how is the Biden administration pushing back?

Amy Goldstein (02:06):

Well, this was an opinion that came down a week ago from a judge that a few years ago had held that the entire ACA was unconstitutional. That was the most recent case that went up to the Supreme Court, which for the third time said, "No, the law is constitutional." This is a lawsuit that focuses on one part of the law, but an important part. Is the part that, as you said, says that anyone with private health insurance is entitled to certain kinds of preventive health services at no cost to the consumers. This judge said that not all, but many of those preventive services should not be provided for free.

(02:55):

The argument on the part of some conservative Christian plaintiffs who brought this lawsuit has to do with who it is who's defining which preventive services are cost-free. Their argument being that the U.S. Preventive Services Task Force does not consist of presidential appointees and therefore they're arguing and this judge agreed that that's unconstitutional.

(03:25):

The Biden administration, which obviously is a big defender of the ACA, the next day, said that it's going to appeal this ruling. Some people think that the plaintiffs, not to get too nerdy about this, but that the plaintiffs may also appeal trying to broaden the scope of this opinion, which at the moment doesn't apply to every single preventive service. The plaintiffs may want to try to get a little broader. This is going to go next to an appeals court based in New Orleans and perhaps higher than that. We'll see what happens.

Mark Masselli (04:03):

Will they try to get a stay on this first or, the Biden administration?

Amy Goldstein (04:08):

It's almost inevitable that the administration is going to try to get a stay to prevent the opinion from taking effect. In the motion saying that the administration is going to appeal, the Justice Department did not include in there the request for the stay, but it may come as part of the details of the appeal.

Mark Masselli (04:31):

Thank you.

Margaret Flinter (04:32):

Joyce, you've also covered this particular ruling. I have to say out in the field, this one made people sit up and pay attention when this news came out. Because, I think it's been somewhat popular in many areas, popular. But, I understand that it won't affect all preventive services. I think, Amy, that's what you were alluding to. But, why would screenings like mammography or colorectal cancer screening still be covered as requiring full coverage by their insurance, but other screenings would it? What's the distinction there, Joyce?

Joyce Frieden (05:08):

As I understand it, the services that are affected are those that were recommended after the enactment of the Affordable Care Act in March of 2010. Since colonography and mammography came before that, they are not affected by the ruling. But, other things like lung cancer screening and skin cancer screening would be affected. If people have to start paying a copay for something like lung cancer screening, which involves a CT scan, it could get pretty expensive for them.

Margaret Flinter (05:45):

I see. Thank you very much for that.

Joyce Frieden (05:46):

Sure.

Mark Masselli (05:47):

Let's turn to Jessica Bartlett with the Boston Globe. Jessica, while you're based in Massachusetts, you and your colleagues are keeping a close eye on an expected ruling from a federal judge in Texas, a different federal judge than the one we were talking with Amy about that could stop medical abortion. Take us through what could happen very soon with that ruling.

Jessica Bartlett (06:12):

Even in Massachusetts though we have laws protecting abortion access, we would not be immune from federal laws. This is a case that is questioning the FDA's approval of mifepristone, which is one of two drugs that are typically used in medical abortions and in early miscarriage management. In Massachusetts, half of all abortions are done via medical abortions. While abortion would still remain legal in Massachusetts, there could be a number of things that happen depending on how the judge rules.

(06:44):

The judge could reverse the FDA's or could reinstate the restrictions that the federal government lifted in 2021 that basically allowed telehealth medical abortions to take place. The judge could completely withdraw the FDA approval of mifepristone, which a number of providers here said would force them to revert to one drug regimen. Now, before mifepristone was approved, one drug was how they took care of medical abortions and early miscarriage management, but it's not as effective. It has more side effects because sometimes the dosage has to be higher. So, more people could opt to do surgical abortions, which could further stress a very stressed healthcare system that kind of doesn't have capacity right now.

(07:30):

There is also some concern that the judge could reference an 1873 law known as the Comstock Act, which forbade the U.S. Postal Service from delivering medication for abortion among other things. While the current case is focused on mifepristone, invoking the Comstock Act could imperil misoprostol, that second drug, in future cases. There's a number of potential outcomes here, and it really will determine on what the judge decides.

Margaret Flinter (07:59):

Amy, as we record this interview, states are really in the process of beginning to cut off about 15 million Americans from the Medicaid roles as the pandemic-related benefits and rules come to an end. You've done some reporting saying there's estimates that nearly 7 million people could lose their Medicaid eligibility by mistake really, even though they're still eligible during this unwinding period. How are Medicaid administrators preparing people in their states, and what are you hearing from the experts about the possible consequences of this?

Amy Goldstein (08:36):

Let me first explain what's going on here because this is like the court opinion we were just talking about. This is a very big deal. Over the time of the pandemic, since early 2020, the number of people on Medicaid in this country has grown a lot. It's grown by about a third to about 85 million people, a lot of people.

(08:58):

It's grown for two reasons. One, because particularly early in the pandemic there were people losing jobs and losing health benefits who are falling onto Medicaid because they were now poor enough in their states. The other reason, which relates to what's going on now, is that for the first time states stopped doing an annual review of who is eligible for Medicaid. They did that because of a first federal COVID relief bill that offered states a little bit of extra money to pay for Medicaid if they promised that they wouldn't knock anybody off Medicaid while they were getting that extra money. You can imagine every state said, "Okay, we'll go along."

(09:46):

So, that promise is ending now. The federal government said that states could begin deciding who was eligible for Medicaid. As you said, under the federal rules that have been established for this, states can start doing these reviews either in April, which five states are doing, May, June, July. It's coming up very soon. States are for the most part, going to spend a year or so going through their rolls to figure out who seems to be eligible. As you said, the federal government has estimated that perhaps 15 million people appear to be ineligible. How many of those ultimately get knocked off the rolls? It's kind of a time-will-tell thing, but that's the federal projection now.

Mark Masselli (10:39):

It's going to be a real disaster, I think. All 50 states in the territories all at once because it's not only the people who are ineligible economically, but for people who don't pick up their email or have all the documentation to go in, it could really unravel.

Amy Goldstein (10:59):

That's right. It's going to be two groups of people losing Medicaid. One people who are no longer eligible because they're earning too much money now or other reason they've moved out of state. But also, people who, as you say, didn't respond to notices that every state's sending out saying, "Hey, you've got to pay attention now. You need to let us know a whole lot of things about you so we can decide whether you still deserve Medicaid." Different states are being assertive about that to very different degrees. It's likely that in some states, people are going to be getting a lot more nudging to pay attention and really make sure that they're given an opportunity for their state to figure out whether they still should get Medicaid and other states people are just going to be falling off the rolls.

Mark Masselli (11:52):

Jessica, what does the situation look like in your part of the country as the pandemic-related emergency comes to an end? I'm wondering how Massachusetts is preparing with maybe other governments. I know Massachusetts has the 1115 waiver up there, lots of interesting things going on, but how do you assess the lay of the land across the country?

Jessica Bartlett (12:17):

We're actively involved here in the Medicaid redetermination effort. The state is really ramping up its efforts to make sure that the people who lose Medicaid coverage are because they're no longer eligible, not because they missed some administrative right process. But also, as the federal pandemic winds down, the state too has declared an end to the emergency and has set an end date. Now, as part of that, some of the things will remain, the governor will file legislation to keep certain things, but overall health experts say that this is signaling a shift from a pandemic to an endemic stage. The biggest debate that's happening right now is as part of that unwinding of the emergency, at least in Massachusetts. The mandate that masks remain in healthcare settings will go away. There's a lot of debate about whether healthcare facilities should keep masking requirements, if it should be decided on an ad hoc basis, which health experts weigh in on this, if it's too early. There's a lot of discussion about that as the state tries to shift from an emergency state to more an endemic state of the crisis.

Margaret Flinter (13:33):

Jessica, I think you must have been hanging around the water coolers within our organization today, because that's certainly... Not that there's really water coolers anymore anywhere, but that's certainly a-

Jessica Bartlett (13:43):

The bubblers as we call it in Massachusetts-

Margaret Flinter (13:45):

... a topic of conversation. Individual water bottles, that's what we've gone to. But, there's coverage and then there's care. I think Joyce and Jessica, both of you have reported on the shrinking pool of primary care physicians in particular in this country. Are there initiatives that either or both of you are seeing that you think are successfully addressing the issue?

Joyce Frieden (14:14):

Of course, like so many things, this all comes down to the money. One thing that has happened that may help, the federal government's doing a lot in this area and particularly they provide the training money for primary care physicians and other doctors. At the end of 2021, Congress voted to add about a thousand more training slots, and they're trying to target rural and underserved areas where the primary care shortage is the most acute.

(14:49):

Then, there are more recent things going on. Actually, about two weeks ago, a group of 30 healthcare organizations wrote to the Centers for Medicare and Medicaid Services asking them to boost payments for primary care doctors who participate in a particular kind of Medicare program called the Medicare Shared Savings Program.

(15:12):

Another thing that I thought was interesting in a webinar I covered last week was a woman who was a former Medicare official, she was suggesting splitting the way doctors are paid into two. So, right now, there's one what's called the physician fee schedule. She's saying you should have one fee schedule for mostly primary care services, what they call evaluation and management and then a separate fee schedule for tests and procedures because that kind of gets more of the political blowback. So, it'd be easier to raise the rates on the primary care schedule. I thought that was interesting as well.

Jessica Bartlett (15:54):

Massachusetts, the state has undertaken an effort to at least establish a baseline for primary care doctors and the shortages they're in to identify where action is needed and where investment is needed, but also to track how well their mitigation strategies work. In talking to primary care doctors, a number of them said a good area to focus on is the reimbursements. Given that they are lower often for primary care than for specialists and that impacts the pipeline of people who are even willing to go into the field versus some other more lucrative fields, to pay back that medical debt.

Mark Masselli (16:31):

There's so much going on in terms of ACO reach. As Joyce mentioned, the shared savings, which has no downside, only has upside opportunity for people, so a lot going on. Amy, I'm thinking about the locus because every so often I hear that the Medicare trustees are estimating that the fund is expected to be

insolvent in this case by 2031. I'm wondering if there's time or appetite in Congress to be able to solve this. They can't pass the dead issue. Do you think there's some fix that can come about in this Congress?

Amy Goldstein (17:10):

Before I get to the Medicare solvency question, let me just go back for a split second to the question of not quite enough primary care doctors. This whole question of the mix of primary care versus specialists in this country has been an issue for a very long time. It's not something that's just emerging. The Affordable Care Act, in fact, more than a decade ago now, tried to address that by increasing payments for people going into primary care. There've long been efforts within HHS to try to provide loan forgiveness and other kinds of financial help to doctors in training who are willing to go into primary care, particularly in areas of the country where doctors are scarce. Suffice it to say those efforts haven't all succeeded, which is why we're still talking about this.

(18:10):

As for the Medicare trustees report, this is a report that comes out every year, comes out together with the forecast for Medicare and Social Security, which are obviously two big pillars of this country's social safety net. As you say, the report that came out just a few days ago said that it was going to be 2031 when the Medicare Hospital Trust Fund, this is just the portion of Medicare that covers hospital bills, not going to your doctor or stuff like that. The Hospital Trust Fund was going to not have enough money to fully pay what it should starting in 2031. That's three years later, actually, than last year when it was predicted to be in 2028. But either way, you can see that's pretty close.

(19:04):

You asked about both, "Are there ideas and is there the will?" The question of political will is a very big deal because I've been writing about healthcare nationally since the late nineties, and I was writing about healthcare locally before that for a number of years, and there have been many efforts to try to somehow gin up political consensus to do something about these imminent shortages. Every time there's been a round of either a congressionally mandated task force, a presidential mandated commission. People have said, "Well, we better do something now because we don't do it soon it's going to be even harder later," and later keeps coming along.

(19:53):

At the moment, the Biden administration has recently in its latest budget proposal, put out a plan that would extend the solvency of Medicare for about 25 more years. It would do it in a bunch of ways, but partly by increasing taxes on wealthy people earning more than $400,000 a year. Republicans are against that. The White House is against what Republicans have proposed. It doesn't look like it's going anywhere too fast, at least at the moment.

Margaret Flinter (20:30):

Amy, I will say that we're both veterans of many decades of issues, solutions, issues, solutions. Joyce, I want to ask you about where the American public is from what you see around their assessment, their trust in public health as we've come out of, hopefully, certainly the worst of the COVID pandemic. You wrote about a study that basically said that Americans don't expect their public health leaders to be perfect on this, to make mistakes. They understand that it's not a given that you're going to be able to immediately contain an outbreak of an infectious disease. But overall, what we mostly read is trust in the public health sector is down. What are you seeing as you do your reporting and talk to people?

Joyce Frieden (21:20):

If I was trying to figure out what people want, I would say the keywords are clarity and transparency. And reporters, we need to do a better job too at talking to people about how the science continues to evolve. Instead of getting mad at the CDC for saying, "Oh, masks don't protect you from COVID," one day, and then saying the opposite the other day. The idea, letting them know the idea that as evidence comes in, things change, and the advice is going to change. I think that this is particularly important right now when everything's gotten so politicized, especially with the whole health freedom movement of people saying that they should be free to wear masks or not wear masks or vaccinate or not vaccinate. I think that's what I get the sense that people are looking for.

Mark Masselli (22:21):

Joyce, I'm wondering if you can shine some light on the Biden administration announcement to modernize the organ procurement system, hopefully to give some greater accountability and transparency. I've read that it's going to double the resources available. I don't know if that means it's going to double the number of organ recipients or donors out there, but the current process seems to be very antiquated. I'm wondering if you can opine on whether or not the plan can turn things around.

Joyce Frieden (22:56):

Sure. Obviously, I don't have a crystal ball, but it seems like it's a step in the right direction. I think the biggest thing, in addition to the funding that you mentioned, I think it's going up to 67 million that they're asking for, but the biggest thing that they're doing is opening up who can run the organ procurement network. Because right now, there's only one player, the 800-pound gorilla is UNOS, the United Network for Organ Sharing, and they've been the subject of congressional investigations. Senator Wyden talked about gross mismanagement both in the way organs are allocated and things like organs left to rot in airports. Some of the reports have been pretty scary. Now, they're saying and in fact, Secretary Becerra says he wants to open up the process so that one contractor doesn't think they own the shop. I think that's very important. They're also starting a database with a kind of public dashboard showing how many people are on wait list, how many people have gotten organs, how many donors are out there, so people can see whether progress has been made.

Margaret Flinter (24:17):

That transparency I think people would find very welcome. I think we have time with the amazing opportunity to have the three of you with us to do a go-around for each of you, or what are the big healthcare stories and issues on the horizon that we should be keeping our eye on? Maybe these are the things that you're going to be covering real soon, but that we haven't had a chance to ask you about.

Jessica Bartlett (24:42):

The biggest thing I think in Massachusetts but also nationally is the staffing shortage. This affects every sector of the healthcare economy from physicians' offices to EMS crews, to ED staff, hospital staff, post-acute care staff, the staffing shortages. This is true of the larger economy as well, but they're presenting incredible hurdles and challenges to just providing care and access. Staffing will definitely be one.

(25:14):

Also, as we discussed how we treat the COVID emergency as it shifts from a pandemic to an endemic, do we bring back masking as surges inevitably come, like we see with surges of the flu? Do we have more boosters for a wider range of the population? Then finally, also, how federal fights shape healthcare

policy locally. These decisions in Texas continue to have ramifications, at least for Massachusetts and nationally. So, I'll definitely be paying attention to how those things play out.

Margaret Flinter (25:45):

Great.

Joyce Frieden (25:46):

Speaking of COVID, I'm going to be looking at reauthorization of funding for pandemic preparedness, including looking at the strategic national stockpile, which there were a bunch of issues with last time around. Also, what's continuing to happen with all the issues around drug pricing for COVID vaccines and drug price negotiation and also what's going to happen with telehealth and issues around that.

Margaret Flinter (26:17):

Great.

Amy Goldstein (26:18):

To wrap up, I want to circle back to what's going to happen with Medicaid because we know that the big unwinding project is beginning, but we don't know yet what's going to happen. There are a lot of people's lives are at stake, and that's kind of a subset, even though that was kind of disentangled from the public health emergency, which is ending next month. There are a lot of things that are going to change when the public health emergency goes away. There are many strands to that. A couple of them, my colleagues here have mentioned, what happens with telehealth and some other things. Just watching how the country and the healthcare system are going to react once HHS has formally lifted that state of emergency, big deal.

Mark Masselli (27:07):

There's been so much recently about ChatGPT's and AI influence in healthcare. Do you think over the next, as we get through this transition on Medicaid, that that's going to be something that's going to pique people's interest?

Amy Goldstein (27:27):

I would put it in the time will tell category. It's sort of a hot thing to talk about at the moment, but we don't really know what the real implications are going to turn out to be.

Mark Masselli (27:39):

Thank you.

Margaret Flinter (27:39):

Wonderful.

Mark Masselli (27:40):

Amy Goldstein with the Washington Post, Jessica Bartlett with the Boston Globe, and Joyce Frieden with MedPage Today. We'll look forward to reading all of your reports in the days ahead, and thank you to our audience for joining us as well. There's more online about conversations on healthcare, including a

way to sign up for email updates. Our address is cacradio.com. Again, thank you all for the incredible work that you do and the conversation today.

Joyce Frieden (28:08):
Thank you.

Jessica Bartlett (28:08):
Thank you.

Amy Goldstein (28:09):
Thank you.

Margaret Flinter (28:09):
We will absolutely be following you on all of these issues. Thanks so much.

Mark Masselli (28:14):
Enjoy. Anybody celebrating Passover, happy Passover. Take care.

Amy Goldstein (28:18):
Thank you.