

Retirees Say Social Security COLA in 2021 Increased Benefit by Less Than \$15

Sixty - five percent of retirees participating in a new survey by **The Senior Citizens League (TSCLE)** report that their monthly household expenses in 2020 rose by more than \$80. That includes 40 percent of survey participants who reported that their monthly household expenses are up by \$120 or more. Yet the same survey also found that 63 percent of participants indicated that their 2021 COLA, which was 1.3 percent, raised their net monthly Social Security benefit by less than \$15 after the deduction for the Part B premium.

Things could get worse for older households. Some economists and policy makers worry that the new economic stimulus will cause consumer prices to spiral. Consumer price

index data through February showed a big jump in some prices and suggests that the next Social Security COLA may in fact be much higher — the highest since 2019 when the COLA was 2.8%. "But right now, those higher prices erode the buying power of Social Security benefits," says Johnson who studies the impact that rising prices have on the purchasing power of Social Security recipients. According to research by Johnson, from January of 2000 to January of 2020, Social Security benefits have already lost 30 percent of buying power.

Johnson cautions, "The current inflationary trend may only be temporary, because prices today are compared with a big sudden



drop in prices a year ago when the impact of COVID-19 first began to hit our economy." "The jump we see now is centered primarily on energy prices, but a number of other spending categories have stayed relatively flat," she says.

There is one trend that of particular concern for all consumers. "There's a relentless march upward in the cost of foods, especially sources of protein, (meats, poultry, seafood), dairy, as well as fruits and vegetables, Johnson says. Some categories of food prices especially for fresh fruits and vegetables have climbed in recent years due to widespread damage from severe weather and wild fires. "COVID-19 simply added another layer of disaster

cost due to loss of restaurant and school lunch markets, labor shortages for growing, harvesting and food processing, and transportation disruptions," Johnson says. "This is the year to plant a vegetable garden," Johnson says.

The \$1,400 stimulus checks will help millions of retirees to cope at a time when Social Security checks don't buy as much due to low COLAs while food and energy costs are climbing. The Senior Citizens League supports boosting Social Security benefits and tying the annual COLA to a consumer price index that more closely reflects the spending patterns of older Americans. To learn more and participate in surveys visit www.SeniorsLeague.org.

Drugmakers prepare for the unusual: A defeat in Washington

Democrats' next big bill could include drug price negotiations and other industry curbs. Pharma may not be able to fight it off this time.

The pharmaceutical industry is preparing to take a hit in Democrats' next major legislative package — and the long-untouchable powerhouse is racing to contain the damage.

Democratic lawmakers are weighing whether to include drug pricing measures that could extract tens of billions of dollars from the industry, or potentially more, to help pay for a massive infrastructure bill they could try to pass along party lines this summer.

A renewed debate over whether to allow the government to negotiate drug prices, which is strongly opposed by pharma and

Republican lawmakers, could become a watershed moment for an industry that's unaccustomed to losing — and survived the Trump era largely unscathed, even as the previous president found rare common ground with Democrats in bashing high drug prices. But those with knowledge of initial discussions told POLITICO that Democratic lawmakers appear intent on using their razor-thin congressional majorities to finally push through a drug pricing overhaul for at least one simple reason: It's one of the few issues under consideration that would save money in a sprawling package expected to cost trillions.

"The huge difference between drug prices and literally everything else out there: Everything else costs money, and



this one saves money," said Alex Lawson, executive director of Social Security Works,

whose group is in close contact with congressional staffers on drug pricing.

The long-running drug pricing debate, propelled by bipartisan voter anger over high medicine costs, had been stalled by the pandemic before it sprang back to life last week with two major developments: House Democrats **began exploring** whether to include negotiations in the forthcoming infrastructure package, and one of the pharmaceutical industry's most vocal critics, Sen. Bernie Sanders (I-Vt.), abruptly scheduled the first hearing on drug prices in the new Congress for Tuesday.

The hearing announcement jolted some pharma lobbyists, who told POLITICO it signaled the industry could become the "piggy bank" for the infrastructure bill. It also underscored the challenge the industry faces in trying to use the pandemic to alter its perception from price-gougers to world-savers.

POLITICO spoke with more than a dozen industry lobbyists, Hill aides and advocates about revived talks over drug prices. Many of them requested anonymity to share sensitive discussions that are still in the early stages.

"Something is coming. We're just not sure when," said one drug industry lobbying source....[Read More](#)

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Landmark Covid Relief Law Pumps More Than \$100 Billion Into Public Health

Acknowledging that chronic underfunding of public health contributed significantly to the nation's fragmented response to the coronavirus pandemic, Democrats included more than \$100 billion in the recently enacted relief package to address urgent needs and enhance future efforts.

"The pandemic has given us possibly the best chance we've ever had of getting on the right track to shore up our public health resources," said Jeffrey Levi, a professor of health management at the George Washington University School of Public Health. "Tens of millions of us have directly experienced what happens when our country is not prepared."

Even so, Levi and other public health advocates worry that momentum will wane once the pandemic abates, as it has after past crises and natural disasters. They also say that more sustained funding will be needed over the next decade and beyond to address **long-festering problems**.

"We heartily support this new law," said Dr. Georges Benjamin, executive director of the American Public Health Association. "But many of its provisions are for one-time and time-limited increases in funding for covid-related needs and financial distress. What we hope is that this will be a down payment on a long-term



commitment to enhancing public health infrastructure and hiring more public health workers at the federal, state and local levels."

He pointed to long-term public health issues that existed before the pandemic, such as high rates of obesity and uncontrolled diabetes, that compounded covid-related hospitalization and deaths in the U.S.

The law steers \$49 billion toward enhancing coronavirus testing, contact tracing and genomic sequencing, to help identify and track virus variants. Even if the number of infections declines, the money assures these efforts continue for the rest of this year and into 2022 if

needed.

Another \$50 billion goes to the Federal Emergency Management Agency to support vaccine distribution and logistical and social support in areas hardest hit by pandemic-related job loss and financial strain. This includes such activities as food distribution.

States and local government agencies are allotted \$350 billion to make up for lost tax revenue amid the pandemic-caused recession. Some of that money is expected to be spent on pandemic response and public health programs, but it comes with a deadline. It must be spent by Dec. 31, 2024... **Read More**

CMS ends policy allowing some Medicare Part D plans to cover fewer drugs

The Biden administration on Tuesday ended a Trump-era policy that would have allowed **Medicare Part D plans** to cover fewer drugs under a new pay model.

When CMS' Center for Medicare and Medicaid Innovation requested Part D Payment Modernization applications for 2022 in January, it said that plans participating in the model wouldn't have to cover all drugs in five of the six protected drug classes: anticonvulsants, immunosuppressants, antidepressants, antipsychotics and antineoplastics. It also allowed Part D plans to only include one drug per class in their formulary instead of two drugs, as currently required, and paused the 10% downside risk requirement for model

participants during the 2022 plan year.

The Trump administration hoped the additional flexibilities would encourage more plans to take part in the model, which aims to lower overall prescription drug spending and beneficiaries' out-of-pocket drug costs. According to actuarial and healthcare consultancy Wakely, the removal of downside risk for 2022 also defended plan sponsors against **the uncertainty surrounding Medicare drug rebates** and their effect on federal reinsurance subsidies.

CMMI said it decided not to move forward with the changes based on stakeholder feedback and other considerations. Patient advocates and many providers opposed the additional flexibilities, warning that they could put beneficiaries' health at risk by denying them access to



some medications. The agency probably reinstated downside risk for the 2022 plan year

because of a court-mandated change in the effective date Medicare drug rebate rule, which removed safe harbor protections for drug manufacturer rebates under **the anti-kickback statute**. The rule is scheduled to take effect Jan. 1, 2023, a year later than HHS originally planned.

Nearly 70 members of Congress asked HHS and CMS to get rid of the new flexibilities in a letter earlier this month.

"When CMS implemented Medicare Part D fifteen years ago, it identified six classes and categories of medicines where patients could face serious risks, complications, and negative health outcomes without access to these medicines. CMS required Part D plans to cover all or

substantially all medications within these six classes, which help treat patients with epilepsy, organ transplants, cancer, HIV and mental health conditions," the letter said.

The **Medicare Payment Advisory Commission** and other experts have recommended several Medicare Part D changes, including additional flexibilities for plan formularies.

"Plan sponsors' inability to exclude products from a plan's formulary limits sponsors from using competitive pressure among alternative drug therapies to negotiate manufacturer rebates. We also recommend that plans be allowed to establish preferred and nonpreferred tiers for specialty-tier drugs to encourage their enrollees to use lower-priced therapies," MedPAC wrote in its June 2020 **report** to Congress.

The Guardian & KHN Lost on the frontline

Our key findings about US healthcare worker deaths to date

The project has counted more than 3,500 healthcare worker deaths, with the majority of people who died under the age of 60

As of 24 March 2021, Lost on the frontline has counted more than 3,500 healthcare worker

deaths. The pandemic is not over, and this project is therefore a work in progress, with new names added weekly.

These are our findings to date.

- ◆ More than half were younger than 60
- ◆ A majority of deceased



healthcare workers identified as people of color

- ◆ Many of the cases involved concerns over inadequate PPE
- ◆ More than a third of the healthcare workers who died were born outside the United

States

- ◆ Nurses and support staff account for most deaths
- ◆ Over 700 worked in New York and New Jersey
- ◆ A huge number of the deaths were early in the pandemic
- ◆ Most people did not work at hospitals... **Read More**

Biden Administration Officially Ends Harmful Public Charge Rule

Last month, the Biden administration **began work to reverse a harmful public charge immigration rule** that disproportionately harmed older adults and people with disabilities. Now, **they have taken the final steps** to reverse the rule which caused members of some communities to avoid health care and other needed services during the pandemic. The administration is “**no longer applying**” the 2019 version of the rule and is reverting to a 1999 iteration, and the Supreme Court **dismissed cases** that

challenged the legality of the rule because it is no longer being used. Over the past several years, the Trump administration attempted to curtail immigration through many means, including by denying immigration to those who may need public services like nutrition services, housing assistance, and even health care. The public charge rule change especially penalized older applicants, applicants with medical conditions or disabilities, and people with lower incomes, and forced



families to choose between the services they needed and were entitled to and the ability to stay in the country.

The rule change was significant, and it was also coupled with widespread misunderstanding and fear about the scope of the change, causing many people, including naturalized citizens, to avoid the use of services they feared could be held against them in the future. This included avoidance of health care like COVID-19 tests, treatment, and vaccines;

health coverage through Medicaid; and help with nutrition and housing.

We applaud the recent decision to abandon this discriminatory and harmful public charge rule. We must encourage the use of appropriate health care, especially during the pandemic. Even more importantly, we must stop all discrimination that impacts older adults, people with disabilities, and their families, and work to ensure everyone has access to the services and supports they need to thrive.

CMS Reverses Proposed Change That Would Have Weakened Part D Protections

The Centers for Medicare & Medicaid Services (CMS), the agency that runs the Medicare program, recently reversed a change to Part D demonstration rules announced by the previous administration that would have allowed participating plans to eliminate important beneficiary protections. The Medicare Rights Center and our partners spoke out strongly against the proposed change and encouraged the Biden administration to

uphold these protections.

The demonstration, known as the Part D Payment Modernization Model, is intended to test Part D changes to see if they will change drug spending. The proposal would have allowed plans that participate in the demonstration to reduce the number of medications they cover, including in the “protected classes.” These are groups of



medications, like antipsychotics, antidepressants, and antiretrovirals, for which the individual and public health consequences of disruption or interruption of care are so significant that plans are required to cover substantially all of the drugs in that group. The proposal would also have halved the number of medications plans are required to cover in all other groups – from

two to one.

While it is clear that drug prices are too high, limiting beneficiaries’ access to needed, life-saving medications cannot be the method used to bring prices down. Medicare Rights commends CMS for responding to stakeholder concerns and deciding not to go forward with these unadvised and dangerous policy changes.

Senate narrowly confirms Becerra as health secretary

Republican Sen. Susan Collins joined all of the Democrats present in the 50-49 vote.

The Senate on Thursday narrowly confirmed Xavier Becerra to lead the Department of Health and Human Services, installing a progressive stalwart in President Joe Biden's Cabinet who's poised to aggressively roll back Trump administration policies and oversee a major expansion of health coverage.

Maine Republican Susan Collins joined all of the Democrats present in the 50-49 vote — the tightest tally for any of Biden's Cabinet picks to date and an unusually narrow margin for an HHS secretary. Becerra, who served in the House for more than two decades before becoming California's Attorney General, will become the first Latino to head the sprawling federal health department.

Thursday's vote came nearly

four months after Becerra emerged as the nominee following **a turbulent process** to fill the key health post amid a global pandemic. The nomination was then stalled for weeks by a stalemate over how Democrats and Republicans would share power in a 50-50 Senate.

The Senate Finance Committee deadlocked on the nomination earlier this month, requiring the chamber's Democratic leadership to go through the additional step of bringing up the nomination for Thursday's full Senate vote.

Becerra's immediate focus will be on filling out the ranks of HHS' political appointees.

An **unexpectedly bitter fight** over who'll lead the FDA has left an important agency that's part of HHS without a full-time leader, and is posing an early test of how accommodating



the Biden administration will be to the drug industry.

Though Democrats expressed confidence Becerra would be confirmed, his fate remained in limbo until a procedural vote to advance the nomination last week, when centrist Sens. Joe Manchin (D-W. Va.) and Collins, declared their support. Both cited conversations with Becerra about health issues important to their respective states, including opioid addiction and bringing telemedicine to rural areas, despite disagreements with him on abortion, the public health effects of gun violence and other hot button issues.

Becerra had met with more than 40 senators from both parties, following up three or four times with some who had additional questions or concerns, including Collins.

Outside groups also mobilized

on his behalf, including influential Latino advocacy organizations and heavy-hitters from the health care industry, like the American Hospital Association and the Home Care Association of America, who cited Becerra's policy chops as a member of the House Ways and Means Committee. Becerra also got an assist from some unlikely allies — Republican attorneys general with whom he clashed on Obamacare, abortion rights and other issues but who praised his collaboration on the Covid response and combating opioid abuse.

The support helped to blunt an aggressive effort by congressional Republicans and outside conservative groups to tank the nomination, including **ads targeting swing state senators** who are up for reelection in 2022... **Read More**

Traditional Medicare consistently costs less than Medicare Advantage

In a concise online memo, the **Medicare Payment Advisory Committee**, MedPAC, responded to health insurance industry misinformation about **Medicare Advantage**—the private insurance program offering Medicare benefits. MedPAC makes clear that Medicare Advantage has always cost taxpayers more per person than traditional Medicare. The memo should be a wake-up call to Congress and the administration that it is time to do away with Medicare Advantage plans or, at the very least, revise the way they are paid.

According to MedPAC, when compared properly, “Medicare spends more overall for enrollees in Medicare Advantage than the program would have spent for similar

beneficiaries enrolled in traditional FFS Medicare.” MedPAC’s memo says explicitly that AHIP, the trade association representing the insurers offering Medicare Advantage plans, incorrectly represented Medicare Advantage plan costs in a recent blog post. And, AHIP inaccurately described how MedPAC calculates those costs.

Since 2004, MedPAC has been comparing spending levels in Medicare Advantage and traditional Medicare. In so doing, it first ensures it is making an apples-to-apples comparison. It adjusts its calculations based on differences in people’s health status, physical location, and diagnoses, as well as services covered. And, every year, MedPAC finds that Medicare

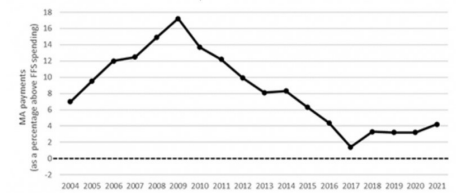
Advantage spending has been higher than traditional Medicare spending.

In some years, Medicare Advantage spending has been significantly higher than traditional Medicare spending. MedPAC goes out of its way to say that its conclusion should not suggest that Medicare Advantage plans are inefficient. (Based on other MedPAC materials, Medicare Advantage plans spend 87 percent of what traditional Medicare spends on Part A and B services, which could argue for its efficiency but also could suggest that it is **inappropriately denying care**.)

MedPAC believes that payments to Medicare Advantage plans should come down and is likely

to recommend a Medicare Advantage spending cut, according to Michael Brady of Modern Healthcare. MedPAC commissioners believe plan rates are too high. In response to any spending cuts, Medicare Advantage plans would likely end or reduce the additional benefits they currently offer. Right now, Medicare Advantage plans allegedly put about 14 percent of their payments towards additional benefits, which all taxpayers pay for. And, that’s a problem.

Figure 1. Medicare has paid more to MA plans than FFS Medicare : been for the same enrollees, 2004–2021



Don't trust Medicare nursing home star ratings

Two and a half years ago, I warned people not to be **misled by Medicare five-star nursing home ratings**. Unfortunately, you still can't trust these nursing home star ratings. If Medicare can't ensure that all nursing homes deliver high quality care, at the very least it needs to rate them appropriately.

The New York Times **reports** that the nursing home gaming of Medicare star ratings continues. The star-

rating system is broken. More than two-thirds of the 3,500 nursing homes with five-star ratings have been cited for problems with infection control and patient abuse.

Five-star nursing home ratings continue to be misleading. Of the 130,000 nursing home residents who have died of COVID-19, those in five-star nursing homes were as likely to die as those in one-star nursing



homes. Five-star nursing homes often fail in-person inspections.

The New York Times **reports** that California is suing Brookdale Senior Living, the nation's largest nursing home chain, for filing false information about its services to Medicare, with the goal of getting a high star-rating. Part of the problem is that Medicare relies mostly on unaudited and self-reported data to determine

the number of stars it gives a nursing home.

Naturally, nursing homes have an incentive to game the system. A five-star rating can lure more people to them and boost profits. Brookdale is alleged to have cooked its payroll books so that CMS would see high staffing levels at its nursing homes, Brookdale also allegedly asked its staff to misrepresent the amount of care their patients receive.

Are you claiming a 2020 stimulus payment on your taxes? The IRS will no longer seize it for unpaid debts — but there are exceptions

The Internal Revenue Service won't take a taxpayer's refund money to pay off any federal debts they owe if that taxpayer claims a 2020 stimulus payment on their tax return, according to a consumer watchdog inside the tax collection agency.

This policy change provides “a needed lifeline to the country's most vulnerable individuals and families,” National Taxpayer Advocate Erin Collins said, announcing the IRS decision this week.

Without the fix, Collins said these people could have seen

their stimulus-check money unfairly eaten up by debts at the time they needed it most.

But there is a catch, Collins noted in a **blog post**. The IRS decision only prevents money being held back to pay federal debts, such as unpaid federal taxes or defaulted student loans. (The Department of Education **already has a moratorium on payments and collections** through the end of September.)

The decision does not apply to state debts, which include back



taxes owed to a state or past-due child support.

The IRS informed Collins' office, the Taxpayer Advocate Service, of its decision on Monday not to take money for federal debts, but the timeframe on implementation is still being determined.

At this point, anyone who says they are owed their 2020 economic impact payment, also known as a stimulus check, must claim it as a “**Recovery Rebate Credit**” on their income taxes.

The IRS merged people's stimulus money into their tax

refunds and, as a result, the economic impact payment became subject to the same rules that allowed the IRS to seize the refund and pay down the taxpayer's federal and state debts.

That quirk set an unfair playing field for the people seeking their stimulus money now, Collins said. The people getting their economic stimulus payment during the initial distributions did not face the same offset rules, she noted....**Read More**

What's the value of private health insurers?

Many Americans believe that private health insurance has value. And, many wealthy countries with universal health care rely on private health insurers. What is their value?

With private health insurers, the question is who's in control of coverage and costs. So long as private health insurers are in control of coverage and costs, their incentive is to maximize profits through delays and denials of care. But, private health insurers can add value when they act as third-party administrators.

Most people don't appreciate that even traditional Medicare relies on private health insurers to administer claims. Health insurers serve as claims

processors, following the rules set by the government as to what care to pay for, when to pay for it and how much to pay. Many other wealthy countries also rely on private insurers in this capacity.

When the government offering coverage contracts out claims processing to private health insurers, the government bears the risk, as it does in traditional Medicare. The government is responsible for covering the cost of all the claims, not the insurers. So, insurers have no incentive to stint on coverage. They don't profit from denying care.

In a piece for [CounterPunch](#), John Geyman makes the case that we need to get rid of the US health insurance system that

allows profit-driven insurers to benefit from denying care. It has made health care unaffordable for almost everyone in the US, employers and taxpayers included.

We need a non-profit public financing system that covers everyone, as Geyman says. People cannot count on employers for their coverage, as we have seen during the novel coronavirus pandemic. Workers are not guaranteed their jobs.

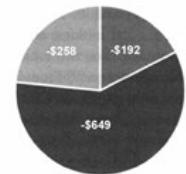
Private health insurance also limits people's choice of doctors and choice of treatments.

Insurers **denied nearly one in five in-network claims** in 2018. And,

private insurance leaves tens of millions of people underinsured, with high out-of-pocket costs.

Furthermore, for reasons that are unclear, the Congressional Budget Office **reports** that the private health insurance industry receives **federal subsidies averaging \$685 billion a year**. The trajectory we are on is unsustainable....[Read More](#)

MEDICARE FOR ALL SAVINGS COMPARED TO CURRENT SYSTEM, 2019



Source: Friedman, E. *The Case for Medicare for All*. Medford, MA, Polity Press, 2020, p. 62.

Drug Pricing Bills Pass Senate - Now House Must Pass

The Senate has passed two measures that, while rather technical in nature, deal the prices of prescription drugs.

One of the bills (S.415) would help lower drug costs by boosting competition and closing loopholes that prevent generics from coming to market. The other bill (S. 164) would direct the Department of Health and Human Services to establish a central website for educational

materials on drugs known as "biosimilars."

However, passage of two measures will have to wait as House leaders struggle over Congress' schedule.

According to [Bloomberg.gov](#), "The House was expected to take up the two measures along with more than a dozen others under suspension of their rules, used largely to wave through minor or non-controversial



legislation, earlier last week, but Republican lawmakers signaled they planned to object"

The House has not scheduled any legislation for passage this week, and is scheduled for a recess the following two weeks.

Senate to Hold Hearings on Drug Prices

Tomorrow, Tuesday, March 23, the Senate Health, Education, Labor, and Pensions

Committee's Primary Health and Retirement Security Subcommittee is scheduled to hold a hearing on drug prices. The hearing is titled, "Why Does the U.S. Pay the Highest Prices in the World for Prescription Drugs?"

We will update you next week if any significant news comes out of that hearing.

Some State Policymakers Pushing Tax Cuts Amid Widespread Hardship

Even as some states take **steps** to help people who are struggling the most due to the pandemic and recession, policymakers in some other states are doing exactly the opposite of what this crisis calls for: proposing extreme tax cuts that would primarily benefit the well-off, weaken the state's ability to help those facing hard times, and worsen racial and economic inequities.

Because of the pandemic, millions of people are **going without enough food, facing eviction, and struggling to pay their utility bills and other household expenses**. Millions of children have effectively **lost** a year of schooling. **Depression, suicidal thoughts, and other mental**

health problems increased sharply after the pandemic hit. All that suffering — which has been concentrated in low-income communities and communities of color — adds to pre-existing hardships, worsening the pandemic's toll and highlighting the need to finally address these inequities. Meanwhile, the stock market has hit record highs and incomes among the well-off have *risen*.

Yet Governor Tate Reeves of Mississippi and Governor Jim Justice of West Virginia, two states with high poverty rates even before the pandemic, have proposed *eliminating* their state income taxes, which account for 31 and 40 percent of state tax



revenues, respectively. They say this wouldn't reduce funding for schools, health care, and other services

because people and businesses would flock to their states. This claim assumes that state taxes are the driving factor in where people and businesses locate, but **studies show they aren't**.

Further, because the income tax is the only major state tax based on ability to pay, eliminating it would ultimately shift who pays for schools, health care, and other services away from the wealthy and toward low-income people, who not only have been hit hardest by the pandemic but **already pay more of their income in state and local taxes** than

wealthy families do. In fact, the Mississippi House recently passed a bill to raise the state sales tax rate to replace part of the lost income tax revenue. Sales taxes fall much harder on families with less income, since they must spend a larger share of their income to buy necessities. (When Mississippi's white supremacist legislature adopted the nation's first general sales tax in 1932, policymakers **considered** this a *feature* of the sales tax because it enabled them to shift state taxes from property owners, most of whom were white, to consumers with little else to tax, many of whom were Black.) Governor Justice's plan in West Virginia also includes a sales tax hike.....[Read More](#)

Surprise! Congress Passes Legislation Banning Surprise Medical Bills

Last year, more than one-fourth of participants in TSCL's Senior Survey reported that they had received a "surprise" medical bill in the past 12 months. While surprise medical bills can refer to any number of situations, including a sudden cost increase for prescriptions, recent legislation passed in December of 2020 addresses a certain type. Specifically, medical bills that a patient unexpectedly receives when treated by an out-of-network provider at an in-network facility.

This is a problem that affects retirees enrolled in Medicare Advantage plans much more so than those who have Medigap supplemental coverage which allows enrollees to see any provider that accepts

Medicare. To reduce the costs of care, and to keep premiums low for consumers, Medicare Advantage plans (and health plans covering adults younger than 65) contract with doctors and hospitals to create networks. Cost is a predominant concern and, in the process, plans create networks that exclude higher cost providers.

This creates problems especially in emergency room visits when the patient may require pricey services such as those from an air ambulance, doctor or other provider that does not have a contract with the patient's Medicare Advantage plan. When health plans get such bills, they can reject the claim and patients



wind up on the hook for the "balance bill." While the average emergency room visit is just above \$600, some patients have received surprise bills greater than \$100,000 from out-of-network providers.

Consequently, surprise billing is universally loathed. More than eighty percent of participants in TSCL's 2020 Senior Survey wanted Congress to prohibit surprise medical bills, and the legislation that was signed into law in December prohibits this practice.

It's not perfect — we still have a year to go before implementation starts. However, starting in 2022, consumers will no longer receive surprise or "balance bills" when they are

unknowingly treated by out-of-network providers. Patients will pay only the deductible and copayment amounts they ordinarily would under the in-network terms of their insurance plans. Medical providers will not be allowed to hold patients responsible for difference between the amount they get and the higher fees they would like to charge. Instead providers will have to work that out with insurers.

While that part is good news for consumers, TSCL is closely watching to see how these changes may impact Medicare Advantage premiums and emergency room co-insurance costs. And unfortunately, drug costs are likely to continue to shock us unless Congress takes action to address that next!

Health Provisions in American Rescue Plan Act Improve Access to Health Coverage During COVID Crisis

The American Rescue Plan Act includes several vital provisions that would make comprehensive coverage more affordable and accessible for millions of people. The COVID-19 relief law enhances for two years premium tax credits available through the health insurance marketplaces, boosts financial incentives for additional states to rapidly expand Medicaid, and takes other steps to improve access to health coverage during the health and economic crisis.

Consistent with a proposal President Biden outlined in January, the Act eliminates premiums for many low-income people who are already eligible for plans in the Affordable Care Act (ACA) marketplaces and vastly reduces premiums for others. It extends new help with premiums to people with somewhat higher incomes who face high premium burdens. And it protects marketplace enrollees who experienced income fluctuations last year from large repayments of their premium tax credits to the federal government. Additional provisions will bring down insurance costs for specific

populations, such as those who receive unemployment benefits and those who lose their jobs but want to temporarily maintain their job-based health insurance.

The law also offers a strong incentive for the 14 states that have not yet implemented the ACA's Medicaid expansion to quickly do so by providing increased federal funds to states that newly expand. If the remaining states expanded Medicaid, nearly 4 million uninsured low-income adults, including about 640,000 essential or front-line workers, could gain coverage. Those who could gain coverage also include over 2 million people now in the so-called coverage gap — that is, people whose incomes are below the poverty line, and thus ineligible for premium tax credits for marketplace coverage, but who are ineligible for Medicaid under their state's rules.

Improving premium tax credits and further expanding Medicaid, in particular, will provide much-needed assistance to people who need help obtaining or affording health coverage. Comprehensive health

coverage is important under any circumstances because it improves people's access to care, financial security, and health outcomes when they get sick. But preserving and extending coverage is even more important in the COVID crisis because it shields families from financial hardship and supports public health efforts, easing people's access to testing, treatment, and vaccines.

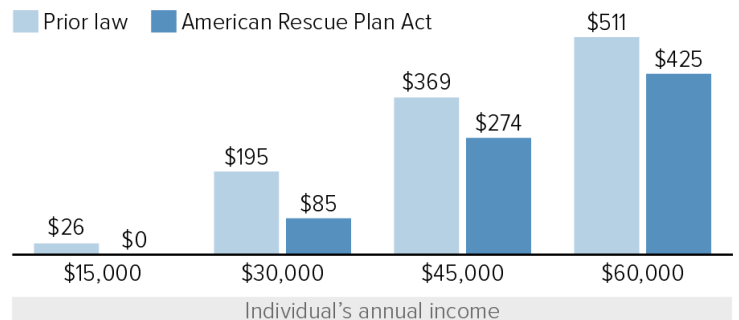
Premium Tax Credit

Improvements Provide Significant Financial Help

The American Rescue Plan Act boosts premium tax credits for 2021 and 2022, eliminating or reducing premiums for millions of current marketplace enrollees to ensure that no marketplace enrollee spends more than 8.5 percent of their income on premiums, irrespective of their income....[Read More](#)

The American Rescue Plan Act Will Make Marketplace Coverage More Affordable

Monthly premium for benchmark marketplace coverage for a 45-year-old, based on national average premium



Note: These premiums are applicable in all states except for those with different poverty level standards than the national standard (Alaska and Hawai'i) and those states that subsidize marketplace premiums beyond the federal subsidy (California, Massachusetts, New York, and Vermont).

Source: CBPP calculations based on American Rescue Plan Act

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Many U.S. Mammography Centers Aren't Following Expert Guidelines: Report

An ongoing debate about when and how often women should undergo screening mammograms is intensifying in medical circles.

A new study and an editorial published online March 15 in *JAMA Internal Medicine* are adding new fuel to the fight.

The research suggests many U.S. screening centers are testing women earlier and more often than necessary, and an accompanying editorial warns that "recommendations from breast cancer centers for frequent screening mammography in younger women may do more harm than good."

That prompted a rapid response from the American College of Radiology (ACR) and Society of Breast Imaging, which called both pieces misleading. The groups added that the writers ignored racial and regional disparities.

So, when should a woman start having mammograms and how often should she go? As the latest debate suggests, it all depends on who you ask.

"We should engage in shared decision making with our patients, to discuss the pros and cons of breast cancer screening," said study author Dr. Jennifer Marti, a breast surgeon at Weill Cornell Medical Center in New York City. "Women should decide if beginning screening at age 45 to 50 or earlier, at age 40, is best for them."

Marti noted that the U.S. Preventive Services Task Force (USPSTF) supports beginning screening mammograms at age 50 and then every two years to 74. The USPSTF says earlier screening should be based on an individual evaluation of risks and benefits. That's in line with most breast cancer screening around the world.

Which age to start?



For the new study, the researchers looked at 487 U.S. centers that provide recommendations on screening mammography.

Of 431 centers that recommended a starting age, 87% advise women to begin screening at age 40; 8% recommended starting at age 45; and nearly 5% at age 50, the study found.

Of 429 centers that also recommended how often women should get checked, about eight in 10 suggested yearly screening.

The researchers wrote that USPSTF and American Cancer Society recommendations reflect data pointing to the potential harms of earlier screening. Those include false-positive findings, and unnecessary biopsies, surgeries and other therapies for benign or slow-growing tumors.

The study pointed out, however, that best screening practices may differ for high-risk

groups, such as Ashkenazi Jewish and Black women.

"The public advice provided by high-volume breast centers in the U.S. suggests that these centers may prioritize factors not reflected in the data, such as patient and physician preferences, recommendations from specialty societies, concerns about litigation or possible financial considerations," the study authors concluded.

Dr. Anand Habib of the University of California, San Francisco, co-wrote the accompanying editorial.

Over a decade, the editorial noted, false-positive rates for annual screening were 61% compared to 42% for screening every other year. The risk of biopsy from false positives was 7% for annual mammography and 4.8% for the biennial screening....[Read More](#)

COVID Reinfection Is Rare, But Seniors More Vulnerable

Reinfection with COVID-19 in people who've already had the illness is very rare, and most people are protected against reinfection for at least six months, a new report finds. However, immunity appears to drop sharply in those aged 65 and older, researchers found.

Reporting Wednesday in *The Lancet*, a team of Danish scientists looked at reinfection rates among 4 million people during the second surge of COVID-19 -- from September through Dec. 31 -- and compared this to infection rates during the first surge between March and May.

Of the 11,068 people who tested positive during the first surge, only 72 tested positive again during the second.

But age mattered.

The older age group had only about 47% protection against repeat infection, compared to younger people who seemed to have about 80% protection from reinfection, the team discovered.

Less than 1% of those under 65 were reinfected, while 3.6% of people 65 and older suffered a second bout of COVID-19.

The finding does not come as a complete surprise, since people's immune systems weaken as they age.

"Given what is at stake, the results emphasize how important it is that people adhere to measures implemented to keep themselves and others safe, even if they have already had COVID-19," study co-author Dr. Steen Ethelberg, of the Statens Serum Institut in Denmark, said in a journal news release.

"The take away is that the elderly must continue to practice mitigation measures such as wearing masks and social distancing — along with getting vaccinated — even if they have been previously diagnosed with COVID-19," said Dr. Robert Glatter, an emergency physician who's cared for many patients



with the illness "Rapid vaccination is our single best weapon against the continued

spread of COVID-19," said Glatter, who practices at Lenox Hill Hospital in New York City.

Dr. Amesh Adalja is an infectious disease specialist and senior scholar at the Johns Hopkins Center for Health Security in Baltimore. He said that second bouts of COVID-19 might not turn out to be as severe as a first encounter, at least.

"We've known that with other coronaviruses, reinfection is common after a several months-long period of time — which appears to be the case with SARS-CoV-2 as well — and they are generally mild," he said. "It is important to know what severity of clinical symptoms and level of contagiousness these rare re-infections are associated with."

In a commentary that accompanied the study,

immunologists Dr. Rosemary Boyton and Daniel Altmann, of Imperial College London, called the variation in reinfection rates "relatively alarming."

"Only 80% protection from reinfection in general, decreasing to 47% in people aged 65 years and older, are more concerning figures than offered by previous studies," they wrote. "These data are all confirmation, if it were needed, that for SARS-CoV-2 the hope of protective immunity through natural infections might not be within our reach and a global vaccination program with high-efficacy vaccines is the enduring solution."

Edwards noted that, "There's a reason why people over 60 have to get extra vaccines to boost their immunity to various infections, because we know that the immune system starts waning in later life."...[Read More](#)

Another Study Finds COVID Patients Face Higher Risk for Stroke

A new study adds to mounting evidence that COVID patients have an added risk of stroke.

Researchers analyzed data on more than 20,000 U.S. adults hospitalized with COVID-19 between January and November 2020. The analysis found that their risk of stroke was higher than for patients with other types of infections, including flu.

"These findings suggest that COVID-19 may increase the risk for stroke, though the exact mechanism for this is still unknown," said lead author Dr. Saate Shakil, a cardiology fellow at the University of Washington.

The new study found that

1.4% of COVID patients had a stroke confirmed by diagnostic imaging.

Of those, 52.7% had an ischemic stroke (caused by blocked blood flow to the brain); 45.2% had a bleeding or unspecified type of stroke; and 2.5% had a transient ischemic attack (also called a mini-stroke or TIA).

COVID patients who suffered a stroke were more likely to be male (64%) and older (average age: 65) than those who didn't have a stroke (average age: 61).

The study revealed that 44% of ischemic stroke patients had type 2 diabetes, compared with



about one-third of patients who didn't have a stroke. Eight in 10 ischemic stroke patients had high blood pressure, compared to 58% of non-stroke patients.

The heart rhythm disorder atrial fibrillation was found in 18% in ischemic stroke patients and 9% in those without stroke, the study found.

Stroke patients averaged 22 days in the hospital -- 12 days more than patients who didn't have a stroke.

In-hospital deaths were more than twice as high among stroke patients (37%) than in those

without stroke (16%).

Black patients accounted for 27% of COVID patients in the study, and 31% of ischemic stroke cases, according to findings presented Friday at a virtual meeting of the American Stroke Association.

Research presented at meetings is typically considered preliminary until published in a peer-reviewed journal.

"As the pandemic continues, we are finding that coronavirus is not just a respiratory illness, but a vascular disease that can affect many organ systems," Shakil said in a meeting news release.

How Oral Health May Affect Your Heart, Brain and Risk of Death

Dental cavities could significantly increase the risk of a life-threatening stroke from bleeding in the brain, according to new research.

Past studies have shown a link between gum infection and stroke, but few studies have looked into what role dental cavities might play. In the new study, researchers looked specifically at cavities and intracerebral stroke, which occur when an artery in the brain bursts and floods surrounding tissue with blood.

Researchers looked at data from 6,506 people without stroke, and then followed them for 30 years. For the first 15 years, those who developed cavities had a slightly higher risk for stroke from brain bleed, but their risk shot up dramatically in the next 15 years.

In the second half of the study period, people with cavities had 4.5 times higher risk of a stroke from brain bleed than those without cavities, after adjusting for age, gender, race and high blood pressure.

Dr. Souvik Sen, co-author of the study, said it was one of the first times cavities and intracerebral stroke had been studied in people. While brain bleeds, also called as intracerebral hemorrhages, account for only 10% to 20% of all strokes, they're more deadly than the more common ischemic strokes, which occur when blood flow through an artery is blocked.

While doctors can manage the risk for ischemic stroke in several ways, options are limited for brain bleeds, he said.



"This study throws more light on how we can address and prevent this more devastating form of stroke," said Sen, professor and chair of the department of neurology at University of South Carolina School of Medicine.

South Carolina medical student Elizabeth LaValley presented the research this week at the American Stroke Association's virtual International Stroke Conference. It was one of two studies Sen and his colleagues offered for the conference on the topic of oral disease and stroke. The second study showed gum disease is associated with damage to the brain's tiny blood vessels. Study findings are considered preliminary until published in a peer-reviewed journal.

Sen said gum disease can be caused by 20 to 30 different types of bacteria, but cavities are predominantly caused by one: *Streptococcus mutans*, which has been shown in animal studies to be linked with brain bleeds.

While *Streptococcus mutans* was the most likely "culprit" in the study's results, Sen said, a limitation of the research is that it didn't pinpoint the type of bacteria responsible for the dental cavities. He's currently researching that question in another study, and he'd like to see future work done on whether antibiotics or other treatments for dental cavities that may lower the risk of intracerebral stroke.... [Read More](#)

Lockdowns Are Putting People With Eating Disorders in Crisis

At Eating Recovery Center, which offers treatment and services for people who have eating disorders, intensive outpatient and partial hospitalization programs were switched to virtual when the pandemic began.

But that didn't sit well with people who were working on their recovery.

"Our patients said, 'You can't do this. This is not enough support for us,'" said Ellen Astrachan-Fletcher, a certified

eating disorder specialist and regional clinical director at the Eating Recovery Center in Chicago. "And

within a week, we brought partial hospitalization back on site because we realized that the risk to them not getting treatment on site was worse than the risk to them coming out in public."

Among those who are facing fear, isolation and loss during the pandemic are people who



experience eating disorders, such as anorexia, bulimia and binge eating, according to recent research from Anglia Ruskin University in Cambridge, England.

"It's been well-documented that people with eating disorders control their eating in a negative way, because they feel that they have control over that behavior and there are other areas of their life that they don't have control in," said study author Mike

Trott, a PhD researcher at Anglia Ruskin University.

Researchers from the university reconnected with participants from a 2019 study on body dysmorphia, exercise addiction and eating disorders, to find out how COVID-19 restrictions in 2020 may have impacted their eating disorders. The 319 participants were health club members with an average age of 37... [Read More](#)

Coronavirus: Why isn't every older adult vaccinated?

Eighty percent of people in the US who have died of COVID-19 have been over 65, so the Centers for Disease Control (CDC) rightly prioritized vaccinations for people over 65. In turn, states have done a pretty good job of ensuring that older adults living in long-term care facilities are vaccinated. But, many older adults living in the community are still waiting to get vaccinated; why isn't every older adult vaccinated?

It is unconscionable that in 2021 the US has such a weak public health infrastructure that it has not yet vaccinated millions of older adults. And, our fragmented private health insurance system has been of

little if any help. Instead, in many parts of the country, states have left it to charities and other organizations to ensure people are vaccinated.

Without assistance, older adults will not be vaccinated. A lot of older adults are not able to schedule a vaccine appointment on their own; they might not even know that vaccines are available for them. Many older adults do not have computers. Others have no ability to travel to get the vaccine.

For the most part, the US put the burden on individuals, including frail and vulnerable older adults, to make their own vaccine appointments. Why is the US so backwards? Why



don't we have mobile vaccine clinics? Why aren't hospitals calling the oldest and most medically compromised members of their communities and scheduling appointments for them? Israel and other developed countries actively reach out to residents and schedule appointments for them.

The amount of time all of us are wasting trying to schedule a vaccine appointment could be put to far better use. And, the amount of effort it takes is keeping people from getting vaccine appointments. As a general rule, vaccine sites are not vaccinating people who have not scheduled an appointment.

Consequently, people living alone who are least able to fend for themselves are also the least likely to have gotten vaccinated. It's the healthier older adults who have been vaccinated. In order to enhance your chances of booking a vaccine appointment, you need to be aware of the multiple web sites that offer information on vaccine availability.

The Biden administration is now partnering with health insurers to ensure older adults are all vaccinated. The priority is reaching underserved communities. Time will tell how well that will work.

Coming Soon: Once-a-Week Insulin Injections?

Daily insulin jabs can be the bane of existence for people who live with type 2 diabetes, but an investigational once-weekly insulin shot may be a game changer for these folks.

While the research is still in its early stages, the new drug called basal insulin Fc (BIF) is given once a week and appears to be just as effective at controlling blood sugar (glucose) as insulin degludec,

the gold standard once-a-week shot.

The once-a-week shot is as safe as insulin degludec and may be better at reducing risk for dangerous low blood sugar (hypoglycemia) throughout the day and night, the new study showed.

The major benefit of once-weekly insulin is that more people will be willing to comply with the treatment, said Dr. John



Buse, chief of endocrinology and director of the Diabetes Center at the University of North Carolina at Chapel Hill. Better compliance prevents complications of diabetes, including heart disease, vision loss and kidney problems, he added.

"It is 52 injections a year instead of 365 to 700+," said Buse, who was not involved

with the new study. "On the 100th year anniversary of the discovery of insulin, it is amazing to see continued innovation in insulin therapy."

Both insulin degludec and BIF are forms of basal or background, long-lasting insulin. They control blood sugar levels between meals and are released 24 hours a day....[Read More](#)

So You're Vaccinated Against Covid. Now What?

As you surely know, this country's covid vaccination effort has been plagued by major birth pangs: registration snafus, **poor communication, faulty data** and a scant supply of vaccine — all exacerbated by inequitable allocation, **alleged political favoritism** and **unseemly jockeying** for shots.

Still, as of Friday, over 118 million shots had gone into arms, and about **42 million people, 12.6% of the nation's population**, had been fully vaccinated. Nearly one-quarter of U.S. residents have had at least one dose.

The vaccine rollout is finally ramping up — just as the deadly winter surge has ended, dramatically reducing infection rates, hospitalizations and deaths.

President Joe Biden has promised enough vaccine for **every adult in the country** by the end of May and dangled the hope of a return to semi-normalcy **by July 4**.

We'll see if that happens. Unfortunately, ill-advised behavior, or a mutant strain of the covid virus — or both — could still ignite another surge. And we're not entirely certain to what extent vaccination prevents you from infecting unvaccinated people, or for how long it protects against covid.

Bottom line: Optimism is warranted, but all of us — even the vaccinated — still need to be careful.

In case you missed it, the Centers for Disease Control and Prevention issued new **public**



health guidelines March 8 that offered a small glimpse of what the not-so-distant future might

hold if enough people are vaccinated. The most striking point was that it's OK for vaccinated individuals to meet indoors with *unvaccinated* members of another household, without masks, as long as nobody in that household is at risk for severe covid.

That's big news if you've not seen your children or grandchildren in person for a while. If you are fully vaccinated, it's now likely safe to visit with them indoors without masks, regardless of their vaccination status. You can even hug them.

As long as they don't live too

far away, that is: The CDC **still frowns** on long-distance travel.

If everybody in your group is vaccinated, so much the better. In that case, hosting a maskless dinner party inside your home, for example, is "likely a low risk," according to the new guidance.

But Dr. George Rutherford, a professor of epidemiology at the University of California-San Francisco, warns not to interpret this new freedom too liberally: "People say, 'Oh, we can have a wedding reception for 50 people at a hotel as long as they are all vaccinated.' I say, 'What about the people serving you — are they all vaccinated? And the band?'"...[Read More](#)

Some Folks Do Age Slower Than Others

People really do vary in how fast they age, and the divergence starts in young adulthood, a new study suggests.

The researchers found that by the tender age of 45, people with a faster pace of "biological aging" were more likely to feel, function and look far older than they actually were. And that relative sprint toward old age began in their 20s.

The findings, the study authors said, suggest we need to take a different view of aging.

"Aging is a lifelong process. It doesn't suddenly begin at the age of 60," said lead investigator Maxwell Elliott, a doctoral student at Duke University in Durham, N.C.

Anyone who has ever known a spry, sharp-as-a-tack 80-year-old -- or a 50-year-old burdened with health problems and disabilities -- knows that chronological age does not tell the whole story.

The concept of biological aging -- or the speed at which body systems decline over time -- acknowledges that.

But it's not clear exactly when people begin to diverge in their rate of biological aging, Elliott said.

The new findings suggest that split happens fairly early in life.

For the study, Elliott and his colleagues used data on more than 1,000 New Zealanders who have been followed since birth,



in the 1970s, to age 45.

The pace of their biological aging was tracked starting at age 26, based on measures like body fat, heart fitness, lung capacity, markers of inflammation in the blood, and even cavities.

It turned out that, indeed, people varied widely in biological aging: The slowest ager gained only 0.4 "biological years" for each chronological year in age; in contrast, the fastest-aging participant gained nearly 2.5 biological years for every chronological year.

And by age 45, rapid biological agers were already showing some health indicators normally associated with old age. Compared with their peers,

they moved more slowly, had weaker grip strength, and more problems with balance, vision and hearing.

Differences in mental sharpness were clear, too, the researchers found.

On average, rapid agers scored lower on tests of memory performance, and they generally reported more forgetfulness in daily life. Meanwhile, MRI scans showed they typically had more signs of brain-tissue thinning.

The findings were published online March 15 in the journal *Nature Aging*.

Elliott said he was surprised by the extent of the aging differences at the relatively young age of 45...[Read More](#)

Nearly 95 percent of older adults take prescriptions that increase their risk of falling

A new study conducted by researchers from the University of Buffalo explored how prescription drugs may pose a health risk to **older consumers**.

Their work revealed that nearly 95 percent of older adults are taking prescription drugs that increase their risk of **falling**. This is concerning because falls for **older consumers** can lead to more serious health complications and increase the risk of death.

"Our study indicates two trends increasing concurrently at a population level that should be examined at the individual level," [said](#) researcher Amy Shaver. "Our hope is that it will start more conversations on health care teams about the pros

and cons of medications prescribed for vulnerable populations."

Prescriptions linked to higher risk of falling among seniors

The researchers analyzed responses to two national surveys -- the Medical Expenditure Panel Survey and the National Vital Statistics System -- that included datasets from 1999 through 2017. They were able to hone in on consumers over the age of 65 and see what kinds of prescription drugs they were taking, how often falls occurred, and the subsequent consequences associated with falling.

The study revealed that an alarming number of seniors are



prescribed drugs that increase their risk of falling. When the study began in 1999, less than

60 percent of seniors were taking drugs that affected their likelihood of falling; by 2017, that figure surged to nearly 95 percent of seniors.

High blood pressure medication was identified as the most common drug that increased the risk of seniors falling, but several other types of drugs were also linked to these outcomes. In particular, the team noted that antidepressant use was up significantly between 1999 and 2017 and led to a higher risk of falls among older consumers.

"The rise in the use of antidepressant medications seen

in this study is likely related to the use of these agents as safer alternatives to older medications for conditions such as depression and anxiety," said Shaver.

"However, it is important to note that these medications are still associated with increased risks of falls and fractures among older adults."

These findings are important because they highlight how a rise in prescribed medications can increase the risk of serious injuries and even death among seniors. Because many of these commonly used medications pose a threat to consumers' health, the researchers hope that health care providers take time to reconsider their treatment plans with older patients.

Breakfast Timing Could Affect Your Odds for Diabetes

Could the time you eat your breakfast determine your health?

Yes, suggests new research that finds eating your morning meal before 8:30 a.m. may reduce your risk for developing type 2 diabetes.

People in the study who ate breakfast early had lower blood sugar levels and less insulin resistance than folks who ate a later breakfast. Insulin resistance occurs when your body becomes

resistant to the effects of the hormone insulin, causing blood sugar levels to rise.

The new findings held regardless of whether people restricted their eating to less than 10 hours a day or spread it out over windows of more than 13 hours.

Such time-restricted feeding is a form of intermittent fasting, which is all the rage these days



due to a laundry list of potential health benefits ranging from weight loss and lower risk for disease

to longevity. People who practice time-restricted eating typically eat during an eight to 12-hour daytime window and fast during the remaining 12 to 16 hours.

However, the new study suggests it is not the duration of the window, but the timing of

the meals that may matter most when it comes to diabetes risk.

"Timing is what's important, and earlier seems to be better," said study author Kristen Knutson, an associate professor at the Center for Sleep and Circadian Medicine at Northwestern University's Feinberg School of Medicine in Chicago. "Our ability to process the food we eat works better in the morning..."[Read More](#)