

## March 6, 2022 E-Newsletter

### Seniors Praise Nomination of Ketanji Brown Jackson to U.S. Supreme Court

President Biden **selected** D.C. Circuit Court of Appeals Judge Ketanji Brown Jackson on Friday as his nominee to succeed retiring Justice **Stephen Breyer** for the nation's highest court.

"Judge Jackson is exceptionally qualified to serve on the Supreme Court," said Robert Roach, Jr., President of the Alliance. "We have every confidence that she will safeguard the civil rights of all Americans, including protecting older workers from discrimination and defending the right of every worker to join a union. We call on the Senate to confirm her quickly."

Jackson's resume includes an extensive background in criminal defense and public interest law. President Biden elevated her in 2021 from the trial court bench to the appeals court, which is

regarded as second in power only to the Supreme Court. The selection is also historic, since no other Black woman has ever been nominated for the U.S. Supreme Court.

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#### Senators Again Eye "Fixes" to Social Security

If Republicans take one or both chambers of Congress in November, it is possible that attempts to "fix Social Security's finances" will again become an area of bipartisan focus.

Senators Mitt Romney (UT), Bill Cassidy (LA), Richard Durbin (IL), Joe Manchin (WV) and Angus King (ME) are among those currently **discussing the revival of efforts**, similar to previous talks, about "grand bargains" that would reduce deficits and debt. One example of that effort was the Simpson-

Bowles fiscal commission in 2010, which ultimately did not achieve its goals of trimming Social Security benefits while gradually increasing the retirement age.

Last April, Sen. Romney and Rep. Mike Gallagher (WI) **introduced** the "Time to Rescue United States' Trusts" (TRUST) Act as stand alone bills in the U.S. Senate and House (S.1295 and H.R. 2575). That legislation paves the way for cuts to Social Security and Medicare by establishing so-called "Rescue Committees" charged with recommending changes to the Social Security, Medicare and Highway Trust Funds in the name of "long-term solvency."

The Rescue Committees in that legislation are not required to conduct any public hearings; their recommendations could not

be amended by the full House or Senate; and the recommendations must receive an up or down vote on the House and Senate floor. There are no limits to what could be recommended, including benefit cuts, changes to the eligibility age, means testing of benefits, or higher taxes on working Americans "These plans were dangerous when they first arose, and many are still a threat to retirement security," said President Roach. "Seniors can't afford to lose any of their Social Security benefits when they already face high costs for things like prescription drugs, dental work and skilled nursing care. We should be expanding Social Security, not cutting it."



Robert Roach, Jr.  
 President, ARA

### President Biden Addresses Retirees' Needs at State of the Union: Lower Prescription Drug Prices Voting Rights Safer Nursing Homes

*The following statement was issued by Richard Fiesta, Executive Director of the Alliance for Retired Americans, following President Joe Biden's State of the Union address Tuesday:*

"President Biden had seniors' interests at the top of his priorities list last night during his State of the Union address.

"Noting that Americans pay the highest prices in the world for prescription drugs, he continued to push for allowing Medicare to negotiate drug prices, as the Veterans Administration and Medicaid programs do. Capping the cost of insulin at \$35 per month will

also be a welcome and necessary change. Congress should direct Medicare to take the \$450 billion in savings from drug negotiations savings and use it to expand benefits for vision, dental and hearing.

"As of December 2021, legislators in 19 states have enacted 34 laws with provisions that severely restrict voting access. As President Biden said, Congress must pass the Freedom to Vote Act and the John Lewis Voting Rights Advancement Act to ensure that seniors' voices are heard at the ballot box.

"We also fully support President Biden's call for higher standards for nursing homes,

including providing a sufficient number of staff who are adequately trained to provide high-quality care, and withholding taxpayer dollars from poorly performing facilities that offer improper and unsafe care.

"President Biden is all too aware that several measures have stalled in the Senate after House passage. That is why he called for passing the PRO Act, which will allow workers to join a union without facing corporations' unnecessary impediments, and for increasing the minimum wage to \$15 per hour, which would mean higher Social Security benefits for

seniors upon retirement.

"The House has already passed bills that would lower prescription drug prices, protect voting rights, make the PRO Act the law of the land and raise the minimum wage. We call on the U.S. Senate to listen to President Biden and follow suit."



Rich Fiesta,  
 Executive Director, ARA

ADD  
 YOUR  
 NAME

## Get The Message Out: SIGN THE GPO/WEP PETITION!!!!

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## 2022: Congress should scrap the Social security cap

On February 23, millionaires in the US received a late Valentine. They stopped paying into Social Security for the rest of 2022 because they had hit the cap on payroll contributions, even though the vast majority of working Americans pay in to Social Security throughout the year. To bring fairness to Social Security payroll contributions, it's time to scrap the cap.

Social Security is the most successful government program in history, with overwhelming support from Democrats and Republicans alike. A 2017 **Pew Research Center** poll found that 86% of Republicans and 95% of Democrats supported keeping or increasing current spending on Social Security.

In 2022, Americans with **wages over \$147,000** stop contributing into Social Security. (In 2021, the cap was

\$142,800.) Consequently, the small fraction of people earning more than \$147,000 pay a lower tax rate for Social Security than everyone else. Someone earning \$1 million a year pays an effective Social Security tax rate of only 0.8 percent as compared to most Americans who pay a Social Security tax rate of 6.2 percent.

Today, more than nine out of ten Americans (94 percent) contribute all year long into Social Security. They bear a greater burden for contributing to Social Security than millionaires. If the wealthiest Americans contributed to Social Security throughout the year, just as other Americans, the Social Security trust funds would have \$1.4 trillion more.

More than 18 percent of wage



income is projected to not be subject to the Social Security tax over the next ten years. In 1983, 10 percent of wage income was not subject to the tax. As the gap between wealthy and poor has grown in the US, **more income of the wealthy has been shielded from the Social Security tax.**

Social Security is a lifeline for most retirees and their families, providing critical retirement security, **an average annual benefit of \$19,884.** It currently replaces about 40 percent of people's pre-retirement income. Social Security's importance is all the greater today as a retirement crisis looms. But, Social Security benefits have been shrinking relative to earnings. Social Security benefits increase with inflation overall.

But **inflationary adjustments** have not kept up with the rise in health care costs facing retirees and others receiving Social Security benefits. Economist **Dean Baker** has proposed changing the formula for calculating benefits so that it is in line with expenses.

We are the wealthiest nation in the world at the wealthiest moment in our history. We can afford to expand Social Security and increase Social Security benefits for low and moderate workers.

Check out this **calculator** from the Center on Economic and Policy Rights to see the last day millionaires are subject to Social Security taxes. **Watch the "Just Scrap The Cap (We're Movin In)" video**

## Senate Working on Bill to Lower Insulin Cost

Senate Majority Leader Chuck Schumer (D-N.Y.) has announced that legislation to lower the cost of insulin will be a priority in that chamber in the next few weeks.

The bill under consideration would cap consumers' out-of-pocket insulin costs at \$35 per month without changing the price drug makers charge for insulin.

This is an effort on the part of the Democratic leadership to get

some kind of drug reduction legislation through Congress this year because their more comprehensive bill that would empower the government to negotiate with drug makers to reduce consumers' prices, limit year-to-year increases in the cost of medicines, and cap out-of-pocket costs is tied up in the Senate.

However, not all Democrats like this idea. Some say the



insulin bill simply isn't enough to lower Americans' drug costs in a meaningful way. The bill would cap consumers' out-of-pocket insulin costs at \$35 per month without changing the price drug makers charge for insulin.

They believe that passing bills to cap copays on an individual basis will simply shift costs and lead to higher premiums and taxes for consumers and that by creating a partial solution it

would take away from the mission to create a complete solution.

The purpose of trying to pass the insulin cost cap alone is meant to test whether it can get bipartisan support in coming weeks. It is expected that no Republicans will support legislation to lower overall drug costs, but Democrats are hoping they can get ten Republican to support the bill to lower insulin costs.

## Social Security Declined By More Than \$31 Billion for the First Time in 40 Years

A worrying trend has begun to take shape in Social Security's cash reserves. For the first time since 1982, Social Security's investments have actually lost more than they have brought Social Security's investments operate much like any traditional balance sheet. Each year, total revenue is determined in the form of the **taxes taken out of our paychecks** every two weeks. Social Security is funded through **payroll tax dollars**, and since 1982, one year before its last major bipartisan overhaul, the program has

consistently brought in more revenue every year than it has paid out. From then until 2020, Social Security's assets have increased from \$25 billion to almost \$3 trillion.

Since the onset of the pandemic, though, things have shifted dramatically. An already -aging baby boomer population and global pandemic were enough of an impetus for a **massive wave of resignations and early retirements** beginning in late 2020. This sudden pressure on distributions was enough to deplete Social Security cash



reserves so much that for the first time in its history, it's in the red. What's more, this rapid depletion is only projected to get worse. The Board of Trustees for the Social Security Board expects Social Security's cash reserves could whittle down just to \$1.35 trillion in the next eight years. This only highlights how critical it is to have your own **retirement plan** in place and adhere to it as you begin to age. For millions of Americans who have already retired, monthly Social Security checks are their **main source of income for basic**

**necessities** like food, shelter and medication. Without certainty that Social Security will be solvent for future generations, it's crucial to have other sources of income — such as a 401k, IRA or individual brokerage account — to draw on once you retire. This will hedge the risk of a shaky Social Security environment, but also toggle your tax obligations overall — not to mention take some of the enormous pressure off sustaining yourself through your later years.

## Medicare out-of-pocket costs

Many if not most Americans breathe a sigh of relief when they are eligible to enroll in Medicare, as they should. Medicare guarantees good affordable coverage that is not available to almost anyone under 65. As good as Medicare is though, it does not offer comprehensive coverage but rather comes with sizable out-of-pocket costs.

A December 20221 **AARP Public Policy Institute paper** provides the latest information on health care out-of-pocket costs for people in traditional Medicare. They include costs for premiums, deductibles, coinsurance, copays as well as the cost for critical health care services that Medicare still does not cover. Medicare does not cover hearing, dental and vision benefits nor does it cover long-term care.

The Public Policy Institute does not address out-of-pocket costs for people in Medicare Advantage plans, explaining that “The analysis excludes people enrolled in Medicare Advantage plans because their personal spending data were not reliable.” Don’t trust Medicare Advantage plan claims about out-of-pocket costs for their enrollees until they make complete and accurate data available for independent analysis.

Based on what little data is available, Kaiser Family Foundation finds higher out-of-pocket costs for many people in poor health in Medicare Advantage than in traditional Medicare with supplemental coverage.

People in traditional Medicare now spend an average of \$6,168



on health care costs that Medicare does not pay for. Nearly half that amount goes towards the cost of supplemental coverage, which picks up Medicare deductibles and coinsurance. About 27 percent of people’s spending goes towards services Medicare does not pay for.

In 2018, 10 percent of people with Medicare had out-of-pocket costs of at least \$10,816. The top quarter of people with Medicare with the greatest spending averaged \$14,123. The bottom 25 percent of people who use the least amount of care spent an average of \$1,606.

People with Medicare spend the most money on long-term care services. People spent an average of \$22,953 out of pocket for a nursing home stay in 2018. Other sources of large out-of-

pocket expenses were skilled nursing facilities, where out-of-pocket costs averaged \$2,216, dental care, for which people spent an average of \$924, and prescription drugs, for which expenses averaged \$703.

These out-of-pocket costs are particularly concerning when understood as a percentage of income. More than half of people with Medicare had annual incomes under \$26,200 in 2018. Out-of-pocket costs represent 16 percent or more of annual income for half of Americans with Medicare.

One in ten people with Medicare spent more than half their income (52 percent) or more on health care.

## Plan to fix Postal Service shifts retirees to Medicare, along with billions in costs

A long-awaited bill to fix the nation’s deteriorating mail service is on the verge of passage in the Senate, but it could come at the expense of an even bigger and more complicated problem: Medicare solvency.

The **Postal Service Reform Act of 2022** would help shore up post office finances by ending the unusual and onerous legal requirement to fund 75 years of retirement health benefits in advance. In return, it would require future Postal Service retirees to enroll in Medicare.

According to **the Congressional Budget Office**, the move could save the postal retirement and health programs about \$5.6 billion through 2031 while adding \$5.5 billion in costs to Medicare during that span,

and probably much more in later years.

Considering the massive size of Medicare — it spent \$926 billion in 2020 — the costs don’t amount to much. That small financial impact, and the ongoing immediate crises with mail delivery, probably account for the strong bipartisan support the postal bill has received in Congress, with 120 Republicans joining Democrats to **pass the bill in the House** on Feb. 8.

But late in the process, some lawmakers are raising alarms over the move, arguing that maybe Congress should look more carefully at the financial impact to Medicare’s trust fund, which is expected to run dry in 2026.



“This bill simply shifts risk to Medicare recipients by adding billions of new costs to Medicare,” Sen. Rick Scott, R-Fla., said Feb. 14 in blocking requests on the Senate floor to expedite passage of the bill. Scott’s objection delayed consideration of the bill until early March, after the Senate returns from its Presidents Day break.

Currently, Postal Service employees are covered by plans offered in the Federal Employees Health Benefits program. When they retire they have several choices for health care, including staying in their original plan or switching to Medicare as their primary coverage and having an FEHB plan serve as

supplementary coverage. About 20% of postal retirees do not sign up for Medicare, preferring their current federal plan. Under this legislation, they would have to switch to Medicare, but they would keep a new Postal Service version of the FEHB plan as secondary coverage.

Since the change wouldn’t fully take effect until 2025, and the Congressional Budget Office’s cost estimate doesn’t capture a full decade, Scott wants to know the price tag for the next 10-and 20-year periods, as well as the specific impacts on the various components of Medicare, such as premiums for Medicare’s Part D drug plan and the **Part B program**, which covers a variety of outpatient services....**Read More**

## Covid May be Down, but It’s Still Here

As covid restrictions are being lifted most of us are breathing a sigh of relief with the prospect that we can soon get back to “normal,” whatever that new normal may look like. However, we need to keep in mind that covid is not gone. It is still here and there are still millions of Americans who are at serious risk if they should catch it.

As *Kaiser Health News* reports, “The Centers for Disease Control and Prevention has a strict definition of who is considered **moderately or severely immunocompromised**, such as cancer patients undergoing active treatment and organ transplant recipients. Still, millions of other people are



living with **chronic illnesses or disabilities** that also make them especially susceptible to the disease. Though vulnerability differs based on each person and their health condition — and can depend on circumstances — catching covid is a risk they cannot take.”

In addition to those who are immunocompromised, seniors are the group who have been, and are, most at risk of severe consequences from covid. We still need to be careful and mindful of safe health practices when we are around those still at risk.

## Congress cannot allow Medicare Advantage overpayments to continue

To reduce spending and strengthen the Medicare Trust Fund, Congress cannot allow Medicare Advantage overpayments to continue a non-evidence based piece on payments to Medicare Advantage plans, which cost **substantially more per enrollee than traditional Medicare**, the **Commonwealth Fund** reported on the views of five experts. Some experts suggest that payment cuts might not be warranted. None mentioned the more than **\$100 billion** in Medicare Advantage plan overpayments to date or the **\$600 billion in overpayments** to Medicare Advantage projected over the next eight years.

The experts agree that the payment system creates “inefficiencies” and need to be more equitable and comprehensive. But, the experts did not agree on how to fix this serious issue. One expert believes that across the board cuts to Medicare Advantage should be as little as 2 percent, as Medpac has

suggested. Another expert saw value in a 4 percent reduction. Some experts appear to value Medicare Advantage “efficiency,” irrespective of whether efficiency delivers poor health outcomes. They disregard the data showing that lower spending on medical care in Medicare Advantage plans is in part attributable to inappropriate **delays and denials of care and coverage**. They also disregard the evidence suggesting that Medicare Advantage plans deliver lower-value care to enrollees in **poor health**. In fact, there’s no complete and accurate evidence, according to **MedPac**, that would enable it to assess Medicare Advantage plan quality or innovations.

Experts who do not believe Medicare Advantage across-the-board payment cuts are warranted likely do not agree with the following propositions:

- ◆ Medicare Advantage plans should not be overpaid, even though **overpayments are**



**driving up Medicare spending**, eating into the Medicare Trust Fund and unleveling the playing field between Medicare Advantage plans and traditional Medicare.

- ◆ Medicare Advantage plans are delivering low-value care to significant numbers of people with Medicare with the **greatest health care needs**; the data show that people with significant health care needs are leaving these plans at disproportionately high rates.
- ◆ Medicare Advantage plans should be penalized for failing to release **complete and accurate encounter data** as required by law.
- ◆ Medicare Advantage plans should be penalized for widespread **inappropriate delays and denials of care**, which appear to be harming the health and well-being of enrollees.

The Commonwealth Fund experts were silent on a number

of key issues relevant to Medicare Advantage payment. Their silence suggests they might think it’s appropriate for Medicare Advantage plans to be rewarded with substantial funds for spending less on medical care, without knowing whether they are denying medically necessary care or delivering good health outcomes. Curiously, they only flagged the need to understand how Medicare Advantage plans spend money on additional benefits. How not one expert signaled a need for greater transparency and accountability in Medicare Advantage is curious.

Shockingly, the experts also did not address Medpac’s lack of ability to assess quality in Medicare Advantage plans because of their failure to release complete and accurate encounter data or to distinguish one Medicare Advantage from another. (One of the experts is the chair of Medpac) While this paper focused on payments, payments should be tied to quality.

## Dear Marci: What happens if I enroll in Medicare late?

Dear Marci,  
I just realized I missed my Initial Enrollment Period to enroll in Medicare. What happens if I enroll in Medicare late?  
-Dan (Herman, MN)

Dear Dan,  
If you missed your Initial Enrollment Period (IEP) and need to enroll in Medicare, you will have to enroll during either a **Special Enrollment Period (SEP)** or the **General Enrollment Period (GEP)** to enroll in Part B or Premium Part A unless you have limited income and savings and are eligible for a **Buy In**. If you are eligible for Premium-Free Part A, you can enroll at any time.

- ◆ If you are eligible for the **Part B SEP**, you can enroll in Medicare without penalty at any time while you have job-based insurance and for eight months after you lose your job-based insurance or you (or your spouse) stop working, whichever comes first.

- ◆ If you are under 65, are Medicare-eligible due to disability, and have job-based insurance through a family member’s current work, you may also be entitled to the SEP if there are at least 100 employees at your family member’s place of work.

### General Enrollment Period

- ◆ The GEP takes place January 1 through March 31 of each year. During this period, you can enroll in Medicare Part B or **Part A if you have to pay a premium for it**.
- ◆ Enrolling during the GEP in 2022 means your coverage will start on July 1, 2022. Until that time, you will not be covered by Part B, although your Part A may start sooner if you **qualify for premium-free Part A**.
- ◆ You may have to pay a Part B premium penalty depending on the amount of time between your IEP and your enrollment.



Dear Marci

Let’s talk about the **Part B premium penalty**. For each 12

-month period you delay Medicare Part B enrollment, you will have to pay a 10% Part B premium penalty (unless you are eligible for a SEP through job-based insurance or are eligible for a **Medicare Savings Program**). In most cases, you will have to pay that penalty every month for as long as you have Medicare. If you are enrolled in Medicare because of a disability and currently pay premium penalties, once you turn 65 you will no longer have to pay that premium penalty.

If you have limited income and savings, you may be eligible for additional help. the **Medicare Savings Program (MSP) or Buy-in Program**. MSPs help pay your Medicare Part B premium costs and may also pay Medicare cost sharing and Part A premiums. **Additional benefits of enrolling in an MSP** include:

- ◆ Allowing you to enroll in Medicare Part B outside of

usual enrollment periods (like the GEP)

- ◆ Eliminating your Part B late enrollment penalty if you have one
- ◆ Allowing you to enroll in Premium Part A outside of usual enrollment periods in some circumstance

So, if you have missed your IEP, but have limited income and assets and qualify for an MSP, you will be able to enroll in Part B at any time without incurring a late enrollment penalty. I recommend contacting your **State Health Insurance Assistance Program (SHIP)** to check if you qualify for an MSP in your state.

I hope this helps you learn what to expect as you enroll in Medicare late. Best of luck!

-Marci

## Federal court strikes down part of HHS surprise billing rule

WASHINGTON — A federal court on Wednesday struck down the Biden administration's interpretation of a controversial part of the federal law banning surprise medical bills.

Health care providers have **filed several lawsuits** challenging how the Department of Health and Human Services created a mediation process for hospitals and doctors and insurers to settle disputes over out-of-network medical bills.

A federal court judge in Texas sided with Texas Medical Association, a trade association representing more than 55,000 physicians, and decided that HHS was mistaken in its decision to instruct mediators to give rates insurers and providers contracted with in the past extra weight compared with other factors.

"This decision is an important step towards restoring the fair and balanced process that Congress enacted to resolve surprise billing disputes between health insurers and physicians," said Diana Fite, immediate past president of the Texas Medical Association.

The legal dispute cuts to the heart of an issue that roiled Capitol Hill ahead of the law's passage in December 2020 — what specific factors an arbitrator would be allowed to consider in mediating the disputes, and how much weight each of those factors should get. Lawmakers involved in drafting the bill have split on whether they think the Biden administration interpreted the law correctly. Senate health committee Chair Patty Murray



(D-Wash.) and House Energy & Commerce Chair Frank Pallone (D-N.J.) **said they think the Biden administration's interpretation is correct**, but Ways & Means Chair Richard Neal (D-Mass.), Rep. Kevin Brady (R-Texas), and a **bipartisan group of 152 other lawmakers** who prefer the more doctor- and hospital-friendly approach **argued that lawmakers intended** for all factors to have the same weight. Pallone tweeted Wednesday night that the Texas court decision "ignores the clear letter and intent" of the No Surprises Act, and wrote that the lawsuit will endanger patient protections and raise costs for consumers. The patient protections in the law went into effect in January, but the mediations between

insurers and providers have not yet begun. The patient protections were not struck down by the Texas judge.

The American Hospital Association and American Medical Association filed a separate lawsuit as well, and a decision has not been made in that case.

HHS did not immediately respond to a request for comment.

The decision applies nationwide. If higher courts don't overturn the decision or pause implementation so appeals can play out, mediations will begin without the guidance that was struck down, said Capstone health care analyst Hunter Hammond.

## Rep. Davis Request H. R. 82 The Social Security Fairness Act Be Brought To Floor For Vote

The Honorable Nancy Pelosi  
Speaker  
U.S. House of Representatives  
Washington, D.C. 20515  
February 15, 2022

Dear Speaker Pelosi, Leader McCarthy, Chairman Neal, and Ranking Member Brady:

We write to urge you to discharge H.R. 82, the Social Security Fairness Act, from the Ways and Means Committee and bring it to the House floor for a vote as soon as possible. Passing the Social Security Fairness Act will immediately benefit millions of retired police officers, federal employees, first responders, and other public servants. H.R. 82 has significant bipartisan support – of the more than 7,700 bills introduced this Congress, only 18 have more co-sponsors – and it's time for the House to vote.

The Social Security Fairness Act would remove both the Windfall Elimination Provision (WEP) and the Government

Pension Offset (GPO) from the Social Security Act. The WEP and the GPO have substantially reduced more than 2 million retired public sector employees' Social Security benefits, affecting about 4 percent of all Social Security beneficiaries. In 2020 the WEP reduced benefits for 48,697 Virginians and 99,640 Illinoisians<sup>1</sup> and the GPO reduced benefits for 7,849 Virginians and 48,046 Illinoisians.<sup>2</sup>

When Congress passed the provisions in 1983, it intended to remove a "windfall" for retirees who spent time in jobs not covered by Social Security and also worked in other jobs where they did pay Social Security taxes. In practice, the two provisions dramatically reduce the benefit of low-paid public employees and create an inequity for those public sector employees who also spent time



in jobs covered by Social Security. 1 CRS "Social Security: The Windfall Elimination Provision." Update

November 16, 2021. Available at: <https://sgp.fas.org/crs/misc/98-35.pdf>.

2 CRS, "Social Security: The Government Pension Offset." Updated February 8, 2021. Available at: <https://sgp.fas.org/crs/misc/RL32453.pdf>.

Worse still, the WEP and GPO use arbitrary and regressive formulas to calculate their reductions to a retirees' benefits. The WEP reduces benefits for a retired worker with a public service pension by as much as \$498 per month in 2021. Since the WEP formula applies to the first bracket of the Social Security wage replacement formula, it causes a relatively large reduction in benefits to lower-paid workers. The GPO reduces Social Security benefits

for spouses or survivors who also earned a pension by up to two-thirds of their monthly pension benefits. The decision to reduce spousal benefits by two-thirds was not based on any analysis, but an arbitrary amount decided in conference between the two chambers in 1983.

Bipartisan legislation to repeal the WEP and the GPO has been introduced in every Congress since at least 2001. Nearly 40 years after Congress passed these provisions, the 117th Congress should be the one to finally fix this long-standing inequity and protect the benefits of individuals who made careers out of public service by voting on and passing the Social Security Fairness Act.

Sincerely,  
Abigail D. Spanberger Member of Congress  
Rodney Davis  
Member of Congress

## Interpreting Emojis

Emojis are a crucial part of communication in texts and social media. You might even say they play a role in our social well-being. With thousands of individual characters, our messages to one another can now include hearts, rocket ships,

or cups of coffee. But here's the problem: Do we always understand the meaning of these emojis?

While a thumbs-up or middle finger emoji may be easy to decode, many characters often leave recipients guessing. In



interviewing Americans over the age of 55 in South Florida and conducting a similar online poll, we're able to outline what people do or don't understand about the most popular emojis on the market. Curious to see what's

being interpreted by older adults who live in **55+ communities** or who enjoy other **senior living options**?

**Continue reading to find out.**

## Should Medicare pay for a phone visit with your doctor?

In this age of Covid-19, telehealth and phone visits have been increasing significantly for everyone. Phone visits can last 20 minutes or more. Should Medicare cover a phone visit and, if so, what should it pay?

Today, Medicare pays around \$27 for a 20-minute check-in phone visit and \$14 for a 5-10 minute phone visit. It could be less than what you pay a repairman to fix your refrigerator. But, believe it or not, it's on a par with what Medicare pays for an in-person visit to a primary care doctor.

Medicare pays a lot more for evaluation and management phone visits, \$55 for 5-10 minutes and \$89 for 11-20 minutes. It's also the same as what Medicare pays for the in-person visit.

In a story for [Kaiser Health News](#), Julie Appleby asks

whether Medicare should pay for these virtual visits. And, if so, should it pay as much for a phone call as for an in-person visit? To be sure, the doctors are taking the same amount of time with the patient on a call as in-person. But, is a phone call the same value to the patient as an in-person visit?

On one hand, if Medicare stops paying for phone check-ups, providers are likely to stop reaching out to patients via phone. On the other hand, if Medicare pays at the same rate as an in-person visit for these phone visits, some experts worry that doctors are likely to spend more time on the phone than needed with patients, driving up health care costs.

Some believe that Medicare should pay for the phone call but not at the same rate as for an in-



person visit. That means that a "virtual check-in" would need a new billing code. And, then the question becomes how to come up with a code that deters doctors from extending the five-minute call to 11 minutes in order to get a higher fee?

Whatever Medicare pays for the visit, patients are expected to pay the 20 percent coinsurance unless they have supplemental coverage to pick up the cost.

Some doctors argue that some patients live in areas without broadband and cannot participate in a video visit. Their only alternative is a long drive to the doctor's office if Medicare won't cover the cost of a phone call.

But, then the question becomes whether Medicare should pay the same amount for a doctor's phone visit as for a phone visit with the physician's

assistant or a nurse practitioner. At the moment, Medicare pays the same rate regardless of which provider is on the call.

To keep doctors from using the phone visit code too often, Medicare won't pay for phone visits within seven days of an in-person or telehealth visit. It also won't pay for calls with patients who need to be seen in person by the doctor.

Medicare's coverage of evaluation and management phone visits is expected to end when the pandemic ends, most likely by next year. But, that could change if Congress or CMS decides it's appropriate to continue paying for these calls when doctors are diagnosing and determining the best treatment for their patients. That said, virtual check-in codes are now permanent.

## Biden to Propose Overhaul of U.S. Nursing Homes

Minimum staffing levels will be a main feature of a major overhaul of U.S. nursing homes that President Joe Biden is expected to announce in his State of the Union speech Tuesday night.

Staffing levels are considered a critical marker for nursing home quality, but the pandemic has left many facilities short of nurses, nursing assistants and other workers who care for patients.

In addition to staffing requirements, Biden's [plan](#) will include 20 separate actions to improve nursing home quality. However, there won't be new sources of federal funding to pay for the changes.

"Overall, these are very positive developments," Harvard health policy professor David Grabowski, who tracks long-

term care, told the *Associated Press*. "If you ask the industry, they'll tell you this will put them out of business. If you ask an advocate, they'll say there's plenty of money in the system. I think the truth is probably somewhere in the middle."

Biden will also announce a \$500 million (nearly 25%) increase in the nursing home inspection budget as part of the plan.

"Despite the tens of billions of federal taxpayer dollars flowing to nursing homes each year, too many continue to provide poor, substandard care that leads to avoidable resident harm," the White House said in announcing its plan.

But nursing homes need more resources, not finger-pointing,



the head of a major industry group said in a [statement](#).

"Additional oversight without corresponding assistance will not improve resident care," said Mark Parkinson, president of the American Health Care Association/National Center for Assisted Living. "To make real improvements, we need policymakers to prioritize investing in this chronically underfunded health care sector and support providers' improvement on the metrics that matter for residents."

"Long-term care was already dealing with a workforce shortage prior to COVID, and the pandemic exacerbated the crisis," Parkinson added. "We would love to hire more nurses and nurse aides to support the

increasing needs of our residents. However, we cannot meet additional staffing requirements when we can't find people to fill the open positions nor when we don't have the resources to compete against other employers."

A representative of nonprofit facilities also expressed concerns.

"[Medicaid](#), the dominant payer of long-term care services, doesn't fully cover nursing homes' cost," Katie Smith Sloan, president of LeadingAge, told the *AP*. "Regulations and enforcement, even with the best intentions, just can't change that math," she said.

## 2022 Minimum Social Security Benefit

Social Security benefits can play an important part in your retirement plan. Understanding how those benefits are calculated can help you to determine when to take Social Security and how much you might receive. The minimum Social Security benefit calculation was developed to

help certain low-income workers boost their benefit amount. This calculation looks at years of coverage in place of someone's earnings to estimate how much they might receive from Social Security. For 2022, the special minimum benefit



starts at \$45.50 for someone with 11 years of coverage and goes to \$950.80 for workers with 30 years of coverage

### How Are Social Security Benefits Calculated?

For most people, [Social Security benefits](#) are calculated

based on lifetime earnings. Earnings are adjusted to account for increases or decreases in average wages since the year your earnings were received....[Read More](#)

# RI ARA HealthLink Wellness News

## Could Common Blood Pressure Meds Help Curb Pancreatic Cancer?

(HealthDay News) -- Pancreatic cancer is notoriously difficult to treat and beat, but new research suggests that commonly prescribed high blood pressure drugs may boost survival in patients.

Known as angiotensin-converting enzyme inhibitors (**ACE inhibitors**) and angiotensin receptor blockers (**ARBs**), those who took them saw slight bumps in survival.

Folks with **pancreatic cancer** who took an ARB had a 20% lower risk of dying during the study period, and those taking ACE inhibitors saw a 13% reduction in their risk of dying when compared to people with the cancer who were not taking these blood pressure medications.

"We don't see results that are a whole lot better with chemotherapy for pancreatic cancer," said study author Scott Keith, an associate professor of biostatistics at Thomas Jefferson

University in Philadelphia. "These are inexpensive medications, have a low side-effect profile, are widely available, and very well could improve survival of people with pancreatic cancer."

Despite this promise, the study authors and other experts caution that it's way too early to suggest that all people with pancreatic cancer start taking these medications in hopes of gaining a survival edge.

The new study wasn't designed to say how, or even if, these drugs improve survival. "In vitro and in vivo studies have suggested that these drugs may improve the way **chemotherapy** works or change the way that tumors are constructed to slow their growth," Keith said.

More research is still needed to understand any potential mechanisms.

Study author Vittorio Maio



added, "We have to have real evidence that something works one way or the another, and we can't prove that

these medications have a really substantial effect yet, so it's not prudent to make recommendations that will create false hope for patients." Maio is the managing director of the Asano-Gonnella Center for Research in Medical Education and Health Care at Thomas Jefferson University.

For the study, the research team tapped into a database of 3.7 million people in northern Italy that included more than 8,150 people with pancreatic cancer. Close to half of the patients with pancreatic cancer were also taking ACE inhibitors or ARBs to control high blood pressure.

About 86% of the people with pancreatic cancer died within 6.4 months of their diagnosis. Folks taking blood pressure

medications lived longer than those who weren't, the study found. The lower risk associated with ACE inhibitors diminished after three years, while the lower risk associated with ARBs remained.

What's more, the risk reduction seen in people taking ARBs was even greater if they also had surgery for their cancer, the study showed.

Now it's time for a large-scale trial where some people with pancreatic cancer take ACE inhibitors or ARBs and others take a placebo or dummy pill, the researchers suggested.

"We need to get to a point where we have more than just a signal, but can provide a really firm estimate of how long pancreatic cancer patients will survive, on average, versus people who don't take these medications," Maio said... [Read More](#)

## Getting Rid of Meat in Your Diet May Lower Cancer Risk

People who go meat-free, or at least put limits on it, may have lower risks of some of the most common cancers, a new, large study suggests.

British researchers stressed that their findings do not prove definitively that **vegetarian/vegan diets** cut people's cancer risks. In fact, there was evidence that body weight may explain some of the benefits.

But the findings, based on more than 470,000 people, do strengthen the case that no-meat

and low-meat diets are at least associated with lower cancer risks.

They also suggest that the relationship varies depending on the type of cancer, said lead researcher Cody Watling, of the University of Oxford.

One finding reinforced what past research has shown: Less meat was related to a lower risk of **colon cancer**.

People who adhered to a "low-meat" diet (5 or fewer servings



of red meat or poultry per week) had a 9% lower risk of colon cancer, versus people who ate meat more often.

"We know from previous evidence that a high intake of processed meat, and red meat, is associated with a higher risk of colorectal cancer," Watling said.

In fact, groups such as the World Cancer Research Fund and the American Cancer Society already advise people to

limit red and processed meat to curb the risk of colon cancer.

With two other common cancers -- breast and prostate -- the potential effects of diet have been less clear.

Watling's team found that a vegetarian or vegan diet seemed protective against breast cancer, but only among postmenopausal women. Their risk of the disease was 18% lower, versus postmenopausal women who ate meat more than five times per week... [Read More](#)

## Fewer Breast Cancers May Be 'Overdiagnosed' by Mammograms Than Thought

Screening mammograms can lead to overdiagnosis of breast cancer, but a new study finds it happens less often than experts have thought.

Researchers estimated that about 15% of breast cancers caught through routine **mammography screening** are overdiagnoses -- meaning the tumors would never have caused harm if they had not been detected.

The figure suggests those diagnoses are about half as common as some previous, widely reported studies have estimated.

"The good news is, it's less common than we'd thought," said Dr. Katrina Armstrong, of Massachusetts General Hospital in Boston.

She's co-author of an editorial published with the study March 1 in the *Annals of Internal*



*Medicine*.

The problem with overdiagnosed cancers, Armstrong explained, is that they lead to unnecessary treatment, and the side effects and emotional toll that go with it.

Still, the odds of that happening are low for any one woman undergoing breast cancer screening.

According to Armstrong, about 7 in 1,000 women are diagnosed with breast cancer via mammography screening. So based on the new estimate, roughly 1 in 1,000 women who undergo screening will be diagnosed with a cancer that would never have caused problems... [Read More](#)

## Researchers May Be Close to a Cure for Type 1 Diabetes

Science could be well on its way to a cure for **type 1 diabetes**, as researchers hone transplant therapies designed to restore patients' ability to produce their own insulin, experts say.

At least one patient — a 64-year-old Ohio man named **Brian Shelton** — can now automatically control his insulin and blood sugar levels without the need for medication, following a **transplant** of experimental pancreatic stem cells.

Shelton's therapy isn't a perfect cure. He must take a heavy dose of immune-suppressing drugs to keep his body from rejecting the transplant, and those drugs pose their own health hazards.

But the therapy created by **Vertex Pharmaceuticals** could provide immediate relief to thousands

who are lined up for a pancreas transplant because their type 1 diabetes has progressed to the point where it's life-threatening, said Sanjoy Dutta, chief scientific officer for JDRF International.

Some of these folks are suffering hypoglycemic shock and landing in an emergency room multiple times a month, while others have developed resistance to the insulin shots or other diabetes medications that have helped keep them alive.

"Today, there are probably 5,000 to 10,000 people or more cued up for pancreatic or islet transplantation, but they're not going to get it because there's not enough supply," Dutta said.

Researchers next plan to test Shelton's first-generation cure on 17 people, to start gathering short- and long-term data on safety and effectiveness, said Dr.



Yogish Kudva, a type 1 diabetes researcher with the Mayo Clinic in Rochester, Minn.

"The first goal is to do this at multiple centers. They've only reported one patient at this point," he said. "They want to do 17 people and probably have the same approach in all 17."

Vertex and other pharmaceutical companies are also surging forward to the next generation, looking at ways to further improve these stem cell therapies so they would require less immune suppression — or even none at all, Dutta and Kudva said.

Type 1 diabetes occurs when the body's immune system turns against the cells in the pancreas that produce insulin, called beta cells. When enough beta cells have been destroyed, diabetic symptoms appear and can become severe in short order.

Thus, these stem cell transplants have to overcome not only the autoimmune disorder that caused type 1 diabetes, but also the immune response that causes the body to try to reject transplants as foreign invaders.

Two approaches under investigation involve coating the transplanted cells in a capsule that protects them from the immune system, experts said.

These capsules would allow nutrients and oxygen to come in and feed the cells, but prevent larger immune system cells from attacking the transplants, Dutta and Kudva said.

Unfortunately, a clinical trial by the pharmaceutical company ViaCyte involving fully encapsulated cells planted just under the skin did not prove successful, Kudva said....**Read More**

## Allergy Season Is Near: Be Prepared

(HealthDay News) -- Spring allergies are a perennial annoyance, but if you're focusing on the pandemic, they still could catch you by surprise, an expert says.

"People still have COVID on their minds," said Dr. Mark Corbett, president of the American College of Allergy, Asthma and Immunology.

"They might not be thinking about spring allergies, so symptoms could sneak up on them," Corbett said in a college news release.

"One of the most important tools for battling spring allergies

is to get ahead of symptoms," he advised. "Begin taking your allergy medications two to three weeks before your itching and sneezing normally start to occur. And be aware that, thanks to climate change, symptoms may appear even earlier than normal."

Both COVID-19 and spring allergies can cause symptoms such as cough, fatigue and headache. But COVID -- especially the **Omicron variant** -- can cause more nasal congestion, runny nose, sneezing, postnasal drainage and



symptoms of a sinus infection, while allergies rarely cause a fever.

If you think you might have COVID-19, get tested as soon as possible. If it's not COVID-19 and your symptoms have been dragging on for a while, get tested for seasonal allergies, Corbett advised.

It's important to know your **allergy triggers** so you can treat them properly.

You may be tempted to open your windows to bring fresh spring air into your home or car, but that's a bad idea if you're allergic to pollen, Corbett said.

Instead, you should use air conditioning in both your home and car to keep pollen out.

See your allergist early in the season. A doctor can offer a number of ways to treat your allergy symptoms. Corbett said one of the best treatments is immunotherapy, which uses injections or pills to target your specific allergy triggers and can greatly reduce the severity of your symptoms.

Allergy shots and pills can also prevent the development of **asthma** in some children with seasonal allergies, according to Corbett.

## Getting Active Can Keep Those 'Senior Moments' at Bay

Want to preserve all those precious memories, including your first kiss and how you felt the first time you got behind the wheel of a car?

If you do, start moving: New research shows that when sedentary older adults started to exercise, they showed improvements in episodic memory, or the ability to vividly recall meaningful moments and events.

These benefits were most pronounced among folks who weren't experiencing

any **memory loss** yet, but everyone saw some benefit when they exercised consistently several times a week.

Episodic memory is the first to show changes in people living with Alzheimer's disease, said Dr. Neelum Aggarwal, a neurologist at Rush Alzheimer's Disease Center in Chicago, who was not involved in the new study.

"As episodic memory is often tested in the physician office and is a complaint that is often cited



by patients ... having a treatment plan that includes exercise is a positive and empowering way for patients to take care of their physical and brain health," she noted.

"**Walking** is the most underrated form of aerobic exercise, yet for many persons, is accessible, free to do and has multiple benefits beyond physical movement, namely reducing stress and enhancing well-being — all of which are important for brain health,"

Aggarwal said.

And you don't have to exercise every day, the study authors noted.

"Exercising for three times a week was enough to see a benefit, and it looks like it takes about four months to reap these benefits in episodic memory," said lead study author Sarah Aghjayan. She is a clinical and biological health psychology PhD student in the Kenneth P. Dietrich School of Arts and Sciences at the University of Pittsburgh....**Read More**

## Sudden Reaction to a Food? It Could Be Adult-Onset Allergy

You bite into an apple and suddenly your mouth starts tingling. Or you eat shrimp for dinner and get hives.

You're not a kid and you've been able to eat these foods your whole life, so what's going on?

A number of conditions could be the cause, but one is adult-onset food allergies. That's becoming allergic -- sometimes seriously so -- after reaching adulthood.

Researchers don't know for sure why some people become allergic to certain foods after adulthood, but there are several theories about triggers as well as possible remedies.

"There's so many food conditions, and it's so important to really understand what you have because you want to know how to manage it, and some of them actually have treatments," said Dr. Ruchi Gupta, director of the Center for Food Allergy and

Asthma, part of Institute for Public Health and Medicine at Northwestern University Feinberg School of Medicine in Chicago.

More than 50 million Americans have food allergies, which happen when a person's immune system overreacts to something in a food, according to the American College of Allergy, Asthma and Immunology (ACAAI).

That includes about 10% of adults, according to Gupta's **own research**. Some allergies carried over from childhood, but nearly half of those began during adulthood. About 38% in the 2019 study of 40,000 people reported having a severe reaction to food that sent them to the emergency room.

While you can be allergic to anything, nine substances cause 90% of food allergies: peanuts, tree nuts, milk, egg, shellfish, fin



fish, soy, wheat and sesame. Among adults, shellfish allergy is the most common, affecting almost 3%, said

Gupta.

### Life changes a trigger

Though allergies tend to run in **families**, among many reasons researchers have identified for new allergies in adulthood is a change in environment. Maybe you've moved and are being exposed to different allergens, which trigger your immune system.

A viral or bacterial infection could also flip that switch.

Hormones can be a catalyst, too, especially in women. It's not uncommon to develop food allergies during puberty, pregnancy or menopause.

"Allergies are a little bit higher in adulthood in women, and we don't quite understand the mechanism yet, but it may have to do with changes in our

hormones," said Dr. Tania Elliott, an ACAAI spokesperson and faculty member at NYU Langone Health in New York City.

Some women may experience worsening allergy systems during different phases of their menstrual cycles, she said.

Another possible cause: Certain medications or alcohol can change gut acidity, so the body stops breaking down certain foods the way it once did, Elliott said.

That triggers what's called an IgE-mediated immune response, which Elliott described as "a fancy term for saying that our body is reacting abnormally to something that naturally occurs in the environment."

That natural reaction triggers the body to release chemicals, including histamine, which can cause itching, redness, swelling and dilation of blood vessels, Elliott said.... **[Read More](#)**

## Early Menopause May Raise a Woman's Odds for Dementia

Women who enter menopause early may be more likely to develop dementia later in life, new research indicates.

During **menopause**, production of the female sex hormone estrogen drops dramatically and a woman's periods come to an end. While women typically enter menopause in their early 50s, many do so earlier — either naturally or due to a medical condition or treatment such as a

hysterectomy (removal of the uterus).

This large study found that women in the U.K. who entered menopause before age 40 were 35% more likely to develop **dementia** later in life than women who started menopause around age 50.

What's more, women who entered menopause before age 45 were 1.3 times more likely to develop dementia before their 65th birthday, the new study



showed.

"Women with early menopause may need a close monitoring of their cognitive decline in clinical practice," said study author Dr. Wenting Hao, a Ph.D. candidate at Shandong University in Jinan, China.

The higher risk for dementia may be due to the sharp **estrogen** drop that takes place during menopause, Hao said.

"Estrogen can activate cellular antioxidants such as glutathione, reduce ApoE4, the most common genetic risk factor in the pathogenesis of dementia, and reduce amyloid plaque deposition in the brain," she explained.

The build-up of amyloid plaques in the brain is one of the hallmarks of Alzheimer's disease, the most common type of dementia.... **[Read More](#)**

## Newly Diagnosed With A-Fib? Here Are Your Options

If you've been told you have the heart rhythm disorder known as **atrial fibrillation** (a-fib), you need to take it seriously, an expert emphasizes.

"While a-fib itself isn't life-threatening, it can lead to a blood clot forming in the heart," said Dr. Christopher Rogers. He is a cardiac electrophysiologist with Penn State Health Medical Group—Berks Cardiology.

"If a blood clot leaves the heart and goes to the brain, it can cause a **stroke**," he explained in a Penn State news release.

Rogers also noted that a-fib "is a progressive disease, and as it advances, it's harder to treat.

That's why we recommend people get diagnosed and treated sooner than later."

Medications are often the first line of treatment and typically involve blood thinners to help prevent blood clots from forming, as well as medications to control heart rhythm.

But medications alone may not be enough to manage a-fib in some people, so minimally invasive electrophysiology procedures may be needed. Rogers outlined three of the most common ones:

**Cardioversion**. It uses electric current delivered through paddles on the chest and



sometimes the back to "shock" the heart into a normal rhythm.

**Ablation**. It's a procedure where the heart tissue that causes a-fib is disabled. A catheter is inserted through the groin and threaded up to the left atrium, the chamber of the heart where a-fib typically originates. It typically takes three months to determine if ablation has been effective. "Initial procedures carry a success rate of about 80%," Rogers said, but some patients may need more than one ablation for successful treatment.

**Watchman**. Another option is a small quarter-sized implant that's

inserted into the left atrial appendage of the heart, where blood clots most often form. "People with Watchman can eventually discontinue blood thinners and still have the same level of protection from clotting," Rogers said.

Procedures to treat a-fib are elective, so patients considering them should talk with their health care provider and weigh the benefits and risks, he advised.

People with weaker hearts, chronic and persistent a-fib or enlarged hearts may have less chance of a successful outcome, Rogers noted.

## Leg Cramps, Pain? It Could Be PAD

(HealthDay News) -- Pain or cramping in your legs during physical activity may be an early sign of a condition called peripheral artery disease (**PAD**) - and you should get checked out by your doctor, an expert says.

PAD occurs when plaque develops in the arteries of the extremities and restricts blood flow to the legs, and sometimes the arms. The condition is more common in older people, and affects up to 10% of those in their 60s and 70s.

In the most severe cases, PAD can lead to **amputation**, according to Dr. Matthew Cindric, a vascular surgeon with

Penn State Health.

PAD causes no symptoms in its earliest stages. The first and most common symptom people notice is repeated pain, cramping or heaviness in one or both legs during walking or exercise. These symptoms occur because muscles can't get enough oxygen and nutrients.

As PAD advances, symptoms typically become more severe, and can include wounds or ulcers on the feet that won't heal, or continuous pain or numbness. Either of these may be precursors to onset of gangrene.

"Vascular problems tend to



escalate rapidly without prompt diagnosis and intervention, particularly in patients who have wounds on the feet that won't heal,"

Cindric said in a Penn State Health news release. "The earlier you notice the signs and get evaluated, the sooner we can get you on a path toward healing."

If you notice any signs of PAD, talk with your doctor, Cindric said. Treatments can include diet changes, exercise, medications or procedures to open blocked arteries.

Genetics play a role in PAD, but the other 4 of the 5 top risk factors are controllable: smoking,

high blood pressure, high blood cholesterol, and high blood sugar or diabetes.

"Smoking is far and away the leader," Cindric said. "PAD is far more prevalent in **smokers** than nonsmokers."

He offered the following advice for people with PAD.

"Start with smoking cessation, get into a structured exercise habit, and work with your [doctor] to manage these risk factors," Cindric said. "Even if you ultimately require a surgical intervention, long-term results are strongly dependent on how well these other factors are managed."

## Newly Diagnosed Diabetes in COVID Patients Often Temporary: Study

Newly diagnosed diabetes in many COVID-19 patients may be a temporary type triggered by COVID, according to a new study.

Blood sugar levels returned to normal in about half of the newly diagnosed diabetes patients after they left the hospital, and only 8% required insulin after one year, according to the report published online recently in the ***Journal of Diabetes and its Complications***.

"We believe that the inflammatory stress caused by COVID-19 may be a leading contributor to 'new-onset' or newly diagnosed diabetes," said lead author Dr. Sara Cromer, an investigator at Massachusetts General Hospital (MGH) in

Boston.

"Instead of directly causing diabetes, COVID-19 may push patients with pre-existing but undiagnosed diabetes to see a physician for the first time, where their blood sugar disorder can be clinically diagnosed," she added in a hospital news release. "**Our study** showed these individuals had higher inflammatory markers and more frequently required admission to hospital ICUs than COVID-19 patients with pre-existing diabetes."

For the study, Cromer's team looked at 594 COVID-19 **patients who had signs of diabetes** when they were admitted to MGH at the height of



the pandemic in the spring of 2020.

Of those, 78 had no previous diabetes diagnosis. Many had less severe blood sugar levels but more severe COVID-19 than those with a previous diabetes diagnosis, the study found.

However, blood sugar did revert to normal in about half of these COVID-linked cases.

"This suggests to us that newly diagnosed diabetes may be a transitory condition related to the acute stress of COVID-19 infection," Cromer said.

Acute insulin resistance appears to be the key mechanism underlying newly diagnosed diabetes in most COVID-19 patients, and if it occurs, it is

generally not permanent, she explained.

"These patients may only need insulin or other medications for a short time, and it's therefore critical that physicians closely follow them to see if and when their conditions improve," Cromer added.

COVID-19 patients who were newly diagnosed with diabetes were more likely to be younger, non-white, and uninsured or on Medicaid than those with previously diagnosed diabetes, the study found.

The researchers said that finding suggests that many of the new cases were pre-existing but undiagnosed diabetes in people with limited access to health care services.

## Had Hernia Surgery? You May Need Another

(HealthDay News) -- If you've had hernia repair surgery and you think you've solved your medical issue for good, you might be wrong.

A hernia occurs when an internal organ pushes through a weak region of muscle or tissue, often creating a noticeable bulge. Hernias typically do not improve without surgery. Left untreated, a hernia can cause severe complications, including cutting off blood flow to surrounding tissue.

A new study found that about 1 in 6 (15%) of older Americans who'd had **hernia repair**

**surgery** required repeat surgery less than 10 years later, which is just a slight improvement from the 1990s, when the rate was about 1 in 5.

"After a patient has had surgery to fix their hernia, it can be devastating for that hernia to come back, especially if it means more surgery," said study first author Dr. Ryan Howard, a general surgery resident at Michigan Medicine-University of Michigan.

"We conducted this study to understand how often this was happening," Howard said in a



university news release.

The research involved more than 175,000 patients on Medicare who had hernia repair surgery between 2007 and 2018. Those who had minimally invasive procedures were more likely to need follow-up operations than those who had open surgeries, the researchers found.

The study also showed that patients who had surgery for **umbilical hernias** -- which are small and located near the belly button -- were less likely to require a second operation than those who had surgery

for **ventral or incisional hernias**, which tend to be larger, can occur anywhere on the abdomen and often involve more complex repairs.

Since not all patients whose hernia returns after surgery undergo a second operation, hernias likely recur even more frequently than the study showed, according to the authors.

The study was published March 1 in the *Journal of the American Medical Association*.