

May 2, 2021 E-Newsletter

Brown, Collins Reintroduce Bipartisan Bill to Get Public Employees Full Social Security Benefits

April 23, 2021, U.S. Sens. Sherrod Brown (D-OH) and Susan Collins (R-ME) led a bipartisan group of their colleagues in **reintroducing** legislation, **S. 1302**, that would ensure public sector workers and their families can receive full Social Security benefits after two previous statutes reduced them. The Senators' bill, the *Social Security Fairness Act*, would repeal the Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO) from the Social Security Act. Both of the statutes significantly reduce benefits for nearly 2.3 million Americans, including more than 250,000 Ohioans, many of which are teachers, police officers and state, county and local government workers. "These workers have dedicated

their careers to serving our communities, and it's up to us to make sure they can retire with their full Social Security benefits," said Senator Brown. "This small fix will help Ohio teachers, police officers, and other state and local government employees and their families have the peace of mind that their Social Security benefits will be there for them when they retire from a life of dedicated service."



"Public servants from across the country, such as retired teachers and police officers, have dedicated their professional careers to public service, yet many face reduced retirement benefits due to the Government Pension Offset and Windfall Elimination Provision," said Senator Collins. "I held the first Senate oversight hearing on this

issue and have continuously worked to correct it. This important, bipartisan bill would eliminate these unfair provisions that have enormous financial implications for many public service employees. It would also give current public sector employees—many of whom are on the front lines of the COVID-19 crisis—the peace of mind to know that they will be able to receive their full Social Security benefits when they reach retirement age."

The Windfall Elimination Provision (WEP), enacted in 1983, reduces the Social Security benefits of workers who receive pensions from a federal, state, or local government for employment not covered by Social Security. The Government Pension Offset (GPO), enacted in 1977, reduces

Social Security spousal benefits for spouses, widows, and widowers whose spouses receive pensions from a federal, state, or local government. Together, these provisions reduce Social Security benefits for nearly three million Americans – including many teachers and police officers.

The Social Security Fairness Act would repeal both the WEP and GPO statutes, ensuring public sector workers and their families receive their full Social Security benefits.

Here are links to ask your Member of Congress and your Senators to sign onto Senate bill: S. 1302 and the House bill: H.R. 82 (link to house.gov) S. 1302 (link to senate.gov) You can check at the bottom of this Alert to see if your Senator was an original co-signer.

Scrap The Cap (We're Movin' in)

Wage cap allows millionaires to stop contributing to Social Security on February 23, 2021.

Social Security gives retirement, disability, and survivor benefits to almost one-in-five Americans every year, many of whom are children. However, contributions to the program are capped to the first \$142,800 of wage income per

year. This means that someone who earns \$1,000,000 in 2021 stops contributing to the program on February 23.

Most people make less than \$142,800 per year, so they pay the 6.2 percent payroll tax on every paycheck in 2021. But those who make more than \$142,800 don't have to pay into the program once they hit that

cap. That makes their effective tax rate lower than everyone else's; for a millionaire it's not even one percent of their income. The burden of supporting Social Security falls more heavily on those who make less.

Despite the importance of the program, the Social Security Trust Fund is projected to have a shortfall in coming years,

due **largely** to increasing income inequality. In 1983, 10 percent of wage income was above the cap, in 2018 almost 17 percent was.... **Read More**

[Watch the Scrap The Cap \(We're Movin' In\) video](#)



2021 Tell Your WEP/GPO Story Testimonials

The latest Congressional Research Service(RL 32453) shows that women are disproportionately adversely affected. In part, this is because women are more likely to survive their spouse and see a reduced dependent survivor

benefit as a result of the GPO penalty. In addition, thousands of these women may have a lower pension because of having a shorter earning life and the GPO usually eliminates their fully-earned spousal benefit for that



non-earning homemaker period. 83% of the population so affected are women.

If you are one of the retirees or know someone impacted by the WEP/GPO, please go to the **Tell Your WEP/GPO Story** link

below and tell your story.



ADD YOUR NAME

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

Here's the Place to Start Strengthening Social Security Funding and Benefits

Can we strengthen Social Security's financing in such a way that we can also provide a modest boost in benefits? According to the latest Social Security Trust fund baseline from the Congressional Budget Office, Social Security will pay out more than it receives in payroll taxes and other revenues, this year and all years going forward, until the program becomes insolvent in 2034.

How should Congress fix the problem? TSC Senior Surveys have found wide support for raising the amount of earnings subject to the 12.4% payroll tax from the maximum level that is set every year (currently \$142,800 in 2021). Raising the taxable maximum wage base could go a long way towards eliminating the Social Security financing deficit or providing an extra boost to benefits, according to estimates from the Social Security Chief actuary, resolving as much as two thirds

of the long-term deficit. Consider, for example, Tim Cook the CEO of Apple (computers and iPhones). According to the most recent public company documents, Mr. Cook received about \$13,731,000 in compensation in 2020. Mr. Cook and Apple paid a total of \$17,075 in payroll taxes — exactly the same amount as employees making \$137,700. That was the maximum taxable wage amount in 2020. So how much would Tim Cook and Apple have paid if all earnings were taxable? According to our calculations, \$1,702,644.

To put that in context, the average Social Security retirement benefit in 2021 is just \$1,543 a month. If payroll taxes were applied to Cook's full compensation, the \$1,702,644 of payroll taxes would provide full benefits to more than 90 retirees with average benefits for an entire year. Or his payroll taxes



could provide a \$30 per month boost for more than 4,729 retirees for a year.

How many people are earning more than the taxable wage base? According to a report from the Congressional Research Service, about 10.2 million individuals earned more than the taxable earnings base in 2017. Of that group, 7.4 million were men; the rest were women. The Congressional Budget Office points out that the question is not just the number of people that's important, but the overall percentage of earnings that are taxable. Over the past decade, earnings for the highest-paid workers have grown faster than pay for average earners. Thus, receipts from Social Security payroll taxes are falling because the share of earnings above the maximum taxable amount is growing.

And let's consider how well the Social Security cost-of-

living adjustment (COLA) met rising costs in 2021. Not so well, according to those of you who have taken our 2021 Senior Survey. The Social Security COLA that retirees received this year increased benefits by just 1.3%. That boosted an average benefit of \$1,523 per month by just \$20. But when we asked how much your total monthly expenses increased in 2020, only 15% of survey participants said that monthly expenses increased by less than \$20!

Eighty-five percent of participants in our latest Senior Survey confirm that household expenses increased by more than \$20 per month. Even worse, 41% of that group say that expenses rose by \$120 per month or more. The 2021 COLA didn't even come close! These results illustrate why retirees need a boost to their Social Security benefits and a COLA that more fairly keeps up with rising costs.

Social Security's cost-of-living adjustment isn't keeping up with prices retirees pay

This year's Social Security cost-of-living adjustment was 1.3%, yet many of the costs seniors face are rising much more quickly.

In 2021, the estimated average monthly benefit increased by \$20 per month.

Many expenses have dramatically risen in the past year, according to a new analysis of Consumer Price Index data from the Bureau of Labor Statistics done by The Senior Citizens League, a nonpartisan senior group.

From March 2020 to March 2021, the fastest-rising cost was car and truck rentals, which went up by 31.2%. That was followed by laundry equipment, which climbed 24.2%; gasoline, 22.2%; and home heating oil, 20.2%.

Some prices, such as prescription drug and medical costs, stayed constant, although physician services climbed by 5.3%.

Admittedly, all consumers are

grappling with those rising price tags, not just seniors. The Senior Citizens League selected the list based on which costs affect retirees most.

Because older Americans often live on a fixed budget, which typically includes Social Security benefits, having to absorb those higher costs can hit them harder.

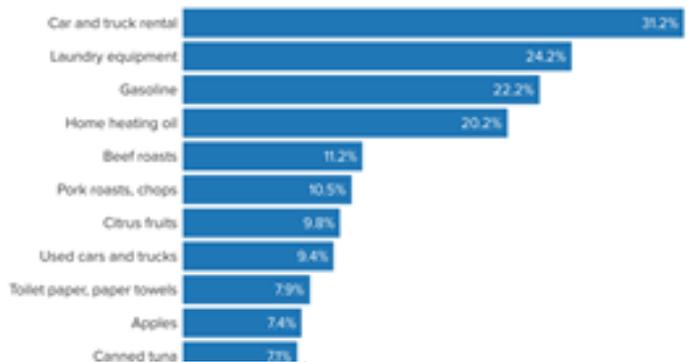
"With inflation rising so fast, what's going on right now is an erosion in buying power," said Mary Johnson, Social Security and Medicare policy analyst at the league.

When measured by the index used to calculate Social Security's annual cost-of-living adjustment — the Consumer Price Index for Urban Wage Earners and Clerical Workers, or CPI-W — inflation has risen since last year.

The CPI-W was more than 3% higher as of the end of March than it was a year ago.

Moreover, inflation grew by 1.4% by in the first quarter of

Fastest growing retiree costs from March 2020 to March 2021



Estimated average monthly benefits

Payable in January 2021

Category	Before 1.3% COLA	After 1.3% COLA
All retired workers	\$1,523	\$1,543
Aged couple, both receiving benefits	\$2,563	\$2,596
Widowed mother and two children	\$2,962	\$3,001
Aged widow(er) alone	\$1,434	\$1,453
Disabled worker, spouse and one or more children	\$2,195	\$2,224
All disabled workers	\$1,261	\$1,277

SOURCE: Social Security Administration

2021, compared with 0% in the first quarter of 2020. The last

time inflation rose that fast was in 2012....[Read More](#)

Prescription Drug Affordability Remains a Top Concern for Many People with Medicare

Though major legislative and regulatory solutions have stalled in recent years, policymakers are once again turning their attention to the important issue of prescription drug affordability. One policy they are likely to debate is the scope of any potential limitations on drug prices.

Previous proposals have differed on this point. For example, some allowed Medicare to negotiate drug prices broadly, while others limited negotiation or reference pricing to certain high-cost prescriptions. While a narrow approach may be more feasible, politically and administratively, it may also

leave savings on the table.

A timely new analysis from the Kaiser Family Foundation (KFF) examines this trade-off. The report finds that a small number of drugs are responsible for a disproportionate share of Medicare prescription drug spending. In 2019, the 10 top-selling Part D drugs with one manufacturer and no generic or biosimilar competition—less than 1% of all covered drugs—accounted for 16% of total Part D spending. Similarly, the 10 top-selling Part B drugs that year comprised 2% of all covered products but 43% of spending.

Given this concentration, KFF



notes that tailoring drug pricing reforms to reduce spending on top-selling, high-cost drugs could be an efficient use of resources. But it would also be an incomplete solution, as it would not directly impact high-cost drugs that are less widely used. As policymakers consider next steps, KFF recommends they weigh whether focusing on all prescription drugs “would achieve sufficient savings to justify the added administrative burden and associated costs.”

Medicare Rights is encouraged by the renewed focus on high and rising drug prices. Earlier today, U.S. House Democrats

reintroduced provisions of the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3), which we enthusiastically supported in the last Congress.

As these conversations continue, so will our pursuit of drug pricing improvements that strengthen Medicare as well as beneficiary health and financial well-being. Needed reforms include better protecting beneficiaries against burdensome costs, filling longstanding gaps in coverage, reducing programmatic barriers, and modernizing appeals processes.

Congressional Members Seek SSI Program Changes to Reduce Poverty

Dozens of U.S. Representatives and Senators sent a **letter** late last week urging the Biden administration to support the inclusion of Supplemental Security Income (SSI) program reforms in forthcoming infrastructure proposals. SSI is an income support program for older adults and for adults and children with disabilities who have few resources.

One of the issues the letter flags is the inadequacy of SSI’s income support, which leaves recipients far below the federal poverty level.

The maximum federal benefit is **\$794 a month** for an

individual, nearly \$300 below the poverty level. Similarly, the maximum federal benefit for a couple is \$1,191, nearly \$300 below the poverty line.

People receiving SSI are also limited to \$2,000 in assets, the same as it was in 1984, and they are limited to earning only \$85 per month before there are cuts in their SSI benefits. These rules make it extremely difficult for people receiving SSI support to move into the workplace or establish any income security.

And the punitive rules extend beyond income or assets. Recipients lose SSI benefits if they **receive help from family**



or friends to pay for food, utilities, rent, mortgage, or other needed expenses. Many

recipients may be unable to get married because they cannot afford the loss in income that will result.

The Congressional letter urges changes to eliminate these barriers, including raising the SSI benefit to 100% of the federal poverty level, increasing the asset and income limits, and eliminating the penalties for receiving help from friends and families. As the letter points out, President **Biden campaigned on** protecting and strengthening economic security for people

with disabilities and supported each of these SSI improvements.

At Medicare Rights, we know the SSI program is a vital tool to help older adults and people of all ages with disabilities and few resources gain some security. But the program has been stagnant for too long, and its draconian and confusing rules penalize marriage and family support. We applaud the Congressional letter and urge the Biden administration to push for these important SSI improvements and other changes that will help the economic security and well-being of older adults and people with disabilities.

Be Cautious When Selecting a Medicare Advantage or Supplement Plan

We have all seen the seemingly endless ads on TV by former football players, actors and fake talk show hosts that promote Medicare Advantage and Medicare supplement plans. They all promote the long list of additional benefits that are available at (supposedly) no extra cost.

They also include an 800 number you can call to get more information and talk to an “agent” who can help guide you. Of course, they hide that fact that the “agent” is a licensed insurance agent in the small print that you can barely read.

Now there’s a new study containing an analysis of three large, online broker insurance plan selection tools that found, on average, each included less than half of the available Medicare Advantage products and fewer than two-thirds of the applicable Part D plans.

It turns out that only 43% of available Medicare Advantage products, and 65% of Part D plans, were showcased on broker plan selection tools.

And when researchers searched online for health coverage options, they found that web



results primarily showcased information directly from health plans — not from neutral government, or third-party, sources.

The report, released by the Commonwealth Fund last week, also said that in addition to the need for more transparency, continued support for existing public and not-for-profit outlets that focus on educating consumers about how Medicare works, and helping them navigate the marketplace could be helpful in smoothing seniors’ transition into Medicare.

The current agent model

focuses primarily on helping a patient choose a plan, rather than decide what type of Medicare is right for them. This presents a real problem for those who don’t have access to tools for understanding the differences and trade-offs between plan types.

TACL advises that when searching for a Medicare Advantage plan or Medicare supplement plan, you try to find a local or state government agency that can help you understand what the plans provide and which plan would be best for you.

How a Supreme Court Case About Nonprofit Donations Could Affect America's Elections

Upon first glance, the U.S. Supreme Court case *Americans for Prosperity Foundation v. Rodriguez* might not seem like it could impact elections.

The case, which will be argued before the Supreme Court Monday, examines the constitutionality of a California regulation requiring nonprofits wishing to raise money in the state to disclose their largest donors to the state Attorney General. But the stakes could be much higher for American democracy if the Court rules broadly, so the case has drawn intense interest from leaders and advocacy groups on both sides of the political spectrum, forging

unlikely alliances in the fight over when anonymous donations are protected by the Constitution.

"We are engaged in a quiet battle with dark money forces that seek to exert broad and often secret control within government, and this case could dramatically strengthen their power," Sen. Sheldon Whitehouse, a Democrat from Rhode Island, tells TIME.

The conservative nonprofit Americans for Prosperity Foundation—which has the backing of Republican mega-donor Charles Koch—brought the lawsuit in 2014, arguing that



requiring them to disclose their major donors violates their First Amendment right to freedom of association. (Conservative law firm

Thomas More Law Center filed a similar suit, which was consolidated with this one.) On the other side, California's Attorney General argues that the government needs to collect donor names to prevent fraud, but keeps those names confidential.

Regardless of what happens to California's policy after the Supreme Court rules later this year, the larger effects of the case will hinge in part on what

standard of judicial scrutiny the Court uses to make its evaluation. Financial disclosure laws typically are evaluated under "exacting scrutiny," a roughly mid-level standard. The 9th Circuit sided with California in 2019, ruling that the regulation held up under this standard of review because the state had proven it was substantially related to its interest in preventing fraud. But the plaintiffs argue the policy must be reviewed under a higher standard, and if the justices agree, some advocates worry it could make it easier to strike down other disclosure laws in the future... [Read More](#)

CFPB Offers Tips for Seniors Seeking a Financial Adviser

Recognizing both the importance of financial advisers and the difficulty in identifying a competent and trustworthy one, the Consumer Financial Protection Bureau has published a new guide called [Know your financial adviser](#).

Financial planning for older adults is complicated and should encompass estate planning, income tax laws, savings,

pension and Social Security earnings, and investments. The guide can help seniors ask the right questions and ensure that the adviser they hire has the client's best interest at heart, not their own.

"The fact is that some financial advisers' titles and credentials require advanced coursework and passing tough exams, but not all," said **Joseph Peters, Jr.**,

Secretary-Treasurer of the Alliance. "The CFPB guide will definitely help seniors make wise choices about their financial future."

When interviewing a financial adviser, the CFPB recommends asking about their level of training, the ethical standards of their training, and whether their financial title is accredited. Seniors should also be able to

file a complaint easily with the organization that issued an advisor's credentials, and that organization should discipline or ban members who don't follow the rules.



Joseph Peters, Jr.

Millions of Americans Have Missed Their Second COVID Vaccine Dose: CDC

More than 5 million Americans have missed the second dose of their COVID-19 vaccine, new government data shows.

The trend seems to be growing. According to the latest data, the number of vaccine recipients who missed their second dose now stands at nearly 8%, more than double the rate seen among people who got inoculated during the first several weeks of the national vaccine campaign, *The New York Times* reported.

Already, millions of people are wary about getting vaccinated at all, and now local health authorities are struggling to make sure that those who get their first shot also get their second.

"I'm very worried, because you need that second dose," Dr. Paul Offit, a professor at the University of Pennsylvania and a member of the U.S. Food and Drug Administration's vaccine

advisory panel, told the *Times*.

Why the missed second shots?

Some said they feared the side effects, which can include flu-like symptoms, while others said they felt they were sufficiently protected with a single shot. But a surprising hurdle has also surfaced: A number of vaccine providers have canceled second-dose appointments because they ran out of supply or didn't have the right brand in stock, the *Times* reported. Walgreens, one of the biggest vaccine providers in the United States, sent some people who got a first shot of the Pfizer or Moderna vaccine to get their second doses at pharmacies that only had the other vaccine on hand, the newspaper said. Several Walgreens customers said they



scrambled to get the correct second dose, but others likely gave up, the newspaper added.

Public health officials had worried from the start that it would be hard to get everyone to come back for their second shot, and now some state officials are scrambling to keep the tally of partly vaccinated people from swelling.

In Arkansas and Illinois, health officials have directed teams to call, text or send letters to people to remind them to get their second shots. In Pennsylvania, officials are trying to ensure that college students can get their second shots after they leave campus for the summer, the *Times* reported. South Carolina has allocated several thousand doses specifically for people who are overdue for their

second shot.

Compared with the two-dose regimen, a single shot triggers a weaker immune response and may leave some people more susceptible to dangerous virus variants, the *Times* said. And though a single dose provides some protection against COVID-19, it's not clear how long that protection will last.

While millions of Americans have missed their second shots, the overall rates of follow-through, with some 92 percent getting fully vaccinated, are strong by historical standards, the *Times* noted. As of Monday, nearly 140 million Americans had received their first shot, while nearly 97.8 million have gotten their second, according to the U.S. Centers for Disease Control and Prevention.... [Read More](#)

Medicare Home Health Coverage: Reality Conflicts with the Law

Medicare home health coverage can be an important resource for Medicare beneficiaries who need health care at home. When properly implemented, the Medicare home health benefit provides coverage for a constellation of skilled and nonskilled services, all of which add to the health, safety, and quality of life of beneficiaries and their families. Under the law, Medicare coverage is available for people with acute and/or chronic conditions, and for services to

improve, or maintain, or slow decline of the individual's condition. Further, coverage is available even if the services are expected to continue over a long period of time.^[1]

Unfortunately, however, people who legally qualify for Medicare coverage frequently have great difficulty obtaining and affording necessary home care. There are legal standards that define who can obtain coverage, and what services are available. However, the criteria



are often narrowly construed and misrepresented by providers and policy-makers, resulting in inappropriate barriers to Medicare coverage for necessary care. This is increasingly true for home health aide services – the very kind of personal care services vulnerable people often need to remain safely at home.

The Law: What Home Care Is Covered Under the Medicare Act?^[2]

Home health access problems have ebbed and flowed over the

years, depending on the reigning payment model, systemic pressures, and misinformation about Medicare home health coverage. Regrettably, these problems are increasing and, if current and proposed policies and practices continue, they will only get worse. Accordingly, it is important to know what Medicare home health coverage should be under the law, especially for people with longer-term, chronic, and debilitating conditions....[Read More](#)

How will living outside of the U.S. affect my Medicare coverage? ?

*Dear Marci,
I plan to move abroad permanently when I retire next year. How will living outside of the U.S. affect my Medicare coverage?*

-Walter (Eugene, OR)

Dear Walter,

If you move outside the United States permanently, you should decide whether to keep Medicare Parts A and B. It is important to remember that you can have Medicare while you live abroad, but it will usually not cover the care you receive.

Since most people pay **no premium for Part A coverage**, it is usually best to keep Part A, even if you are moving abroad, because it is free. If you are enrolled in premium-free Part A, you cannot disenroll without having to pay all benefits you've received back to the **Social Security Administration (SSA)**, including Social Security monthly retirement or disability payments and claims paid by Medicare Part A. If you must

pay a premium for Part A, be aware of the high **monthly cost** for maintaining Part A coverage.

To have Part B coverage, you must pay the monthly Part B premium. You may want to keep Part B if you plan to move back to the U.S. in the future or visit frequently. This is because paying the premium to keep Part B when abroad will ensure that Medicare will cover your care whenever you travel to the U.S., and that you will not face **premium penalties** or gaps in coverage. If you fail to pay for Part B while abroad, when you move back to the U.S. you may go months without health coverage. This is because you may have to wait until the **General Enrollment Period (GEP)**, which runs January 1 through March 31 each year, with coverage starting July 1.

Keeping Part B may not be worth the cost if you plan to live abroad permanently and do not take frequent trips to the U.S. To stay enrolled in Part B, you must



Dear Marci

continue to pay monthly Part B premiums even though Medicare will not cover your care. If you plan to move back to the U.S. or travel back frequently, you might still consider dropping Part B only if:

- ◆ You or your spouse currently work outside the U.S. for a company that provides you with health insurance, or you or your spouse work in a country with a national health system. You will qualify for a Special Enrollment Period to enroll in Part B without penalty. This SEP begins at any time while you (or your spouse) are still working and for up to eight months after you lose your health coverage or stop working.
- ◆ You volunteer internationally for at least 12 months for a tax-exempt non-profit organization and have health insurance during that time. You will have a six-month Special Enrollment Period to enroll in Medicare without

gaps or penalties. This SEP begins once your volunteer work stops or your health insurance outside of the U.S. ends, whichever is earlier.

If you have a **Medicare Advantage** or **Medicare Part D plan** before you move abroad, you should **disenroll and stop paying these premiums** when you move because these plans require that you live in their service area in order to be enrolled.

Before you move abroad, make sure to explore your options for health coverage in whichever country you may reside. Once you are a resident of certain foreign countries, you may qualify for national health insurance, or you may be able to buy private health insurance. Get specifics about this coverage to ensure that coverage will be adequate and affordable now and in the future.

Best of luck on your big move!

-Marci

U.S. Aims to Shape New Phase of WHO-Led Probe Into Origin of Covid-19

The U.S. is moving to assert greater influence over a scientific investigation led by the World Health Organization into the origins of Covid-19, with plans to submit recommendations to the agency for a new phase of studies.

Experts from the Department of Health and Human Services, the Department of State, the Agriculture Department and five other federal

agencies are developing recommendations to be submitted to the WHO for its planned second phase of the inquiry into how the new coronavirus started spreading, State Department officials said.

The U.S. is expected to push back on a hypothesis promoted by China that the virus could have spread via frozen-food products, according to people



familiar with the work. Instead, the experts are expected to urge the release of more data as well as more testing of animals and humans for early evidence of the new coronavirus, including in parts of southern China where related viruses were previously found.

The submission of the recommendations will test Washington's clout—both

within the WHO and among the member states that decide its priorities—after President Biden's administration reversed a Trump administration plan to withdraw from the U.N. agency. In a statement issued at the end of March, the U.S. and 13 other member states urged "a timely, transparent evidence-based process for the next phase" of the search....[Read More](#)

Doctor Asked, 'Did You Know You Had a Heart Attack?'

At an annual checkup, Tasha Benjamin's doctor looked over her electrocardiogram readings and asked whether she'd had a heart attack.

Thinking it was a joke, she responded, "Well, I do have a husband and four kids."

"No," the doctor said. "This shows you had a heart attack."

Then 36, Tasha couldn't recall suffering any of the major symptoms of a heart attack – chest pain; shortness of breath; feeling weak, lightheaded or faint; and pain or discomfort in the jaw, neck or back. As for trying to figure out when it might've happened, the tests offered no clues.

The conclusion: Tasha survived a "silent" heart attack, or a heart attack that has no symptoms, minimal symptoms or unrecognized symptoms. It occurs with blood flow to a section of the heart is

temporarily blocked and can cause scarring and damage to the heart muscle.

At her checkup the year before, Tasha was diagnosed with prehypertension. Knowing high blood pressure is more prevalent among Black people – about 58% of non-Hispanic Black adults versus 47% of all U.S. adults, according to American Heart Association statistics – she was inspired to become healthier.

"I decided to do whatever it took to make sure I wasn't on medication for the rest of my life," she said. "I didn't want to become another statistic."

Tasha wasn't overweight but re-evaluated her diet in search of healthier options. She tamed her sweet tooth, drank more water and increased her exercise. She also took her daily blood pressure medication and tracked



her numbers.

Six months later, she'd improved so much that the doctor said she could stop taking medication.

Six months after that came the bewildering discovery of her heart attack.

Further testing indicated her heart muscle was in good shape. Seven years later, all is well.

Another possible factor in Tasha's case is that her husband, LaShaun Benjamin, was an active U.S. Marine. His deployments often left her alone to care for their three daughters and son, in addition to worrying about his safety.

"We were doing what any military family did, but it was a lot of stress," LaShaun said.

LaShaun is now retired from active duty and teaching an ROTC class for high schoolers. Having him back home in Syracuse, New York, and going

for walks as a family are all part of Tasha's routine these days.

She also listens more closely to her body. Whenever she feels anything strange or thinks of any questions, she logs them on her phone so they'll be handy for her next checkup – or sooner, if needed.

"When you're going about your daily life raising children and working, you might have those symptoms, but you're not going to equate it with a heart attack," she said. "I'm definitely contacting my doctor now if something feels off."

She also encourages women to make themselves a priority, especially when it comes to health.

"It's not selfishness," she said. "You have to be there for yourself, so you can be there for others."

Shots and Seniors: Driving Vaccine Compliance Among Older Adults

Plus, the importance of getting all health care workers and essential workers vaccinated.

I appear monthly on the Charlotte version of the "Today Show," and they recently asked me to cover the topic of senior compliance with vaccinations. It surprised me because I assumed that compliance was good. I wasn't quite right.

Since this is a fluid situation, the statistics keep changing. The U.S. Census Bureau, in conjunction with the Centers for Disease Control and Prevention and the National Center for Health Statistics, compiles data every two weeks on the state of vaccinations. Here is where we stood as of late March: **Just over 40% of Americans 65 and older are fully vaccinated**, and close to 70% have had at least one shot.

Senior Helpers, an in-home provider, released findings that showed that more than half of seniors reported they still hadn't received the vaccine.

In terms of data, the real worry to me is **health care workers**

and essential workers, particularly long-term care. Research indicates that 33% of essential workers and 29% of those who work in a health care delivery setting won't get the vaccine.

According to a **Washington Post-Kaiser Family Foundation poll**, barely half of front-line health-care workers (52%) said they had received at least their first vaccine dose at the time they were surveyed. More than 1 in 3 said they were not confident vaccines were sufficiently tested for safety and effectiveness.

OnShift, a human capital management software company, reported that employees within senior living and care facilities found a 94% increase in **willingness to take the vaccine** this month, as well as a 41% decrease in plans to decline, compared with an initial survey in December. Sixty two percent of respondents were willing to take the vaccine in the March survey, up from 32% in December. All in all, still a third



are reluctant.

We cannot completely open up our **assisted living and nursing homes** if those who work in them don't get vaccinated. And of course, those who visit – such as family caregivers and vendors – have to be accounted for as well.

Well-Established Anti-Vaccination Reasons

There will always be people who are against vaccinations, but the percentages are few. And yes, you should consult with your physician to make sure you aren't allergic to any of the ingredients. There will always be people with adverse reactions. We've seen it with annual flu shots.

People say the vaccines have developed too fast. Yes and no. Scientists had been working on these ideas pre-SARS, and the ability to collaborate today is exponentially better. There are racial discrepancies, political party discrepancies and even geographical discrepancies. And there are the conspiracy theorists.

Moving the Needle

How can we get those who are hesitant about vaccines to reconsider? Well, let's first look to our seniors as examples and follow their lead. They still outpace the rest of the population in compliance – and to be clear, they were prioritized first, so the numbers reflect that.

Anecdotally, since I'm in this target demographic, we've seen friends adamant about not getting vaccinated totally change their perspective when they thought about their overall health and the peace of mind and freedom that comes with vaccination.

We need targeted strategies and messages. Someone who is opposed because of political views needs a different message than someone who is opposed because of racial inequality.

We can't be dismissive. We have to acknowledge historical reasons for medical distrust among people of color, and work with leaders within their communities....**Read More**

KHN: From Rotten Teeth to Advanced Cancer, Patients Feel the Effects of Treatment Delays

With medical visits picking up again among patients vaccinated against COVID-19, health providers are starting to see the consequences of a year of pandemic-delayed preventive and emergency care as they find more advanced cancer and rotting and damaged teeth, among other ailments.

Dr. Brian Rah, chair of the cardiology department at Montana's Billings Clinic, was

confused in the early days of the covid pandemic. Why the sudden drop in heart attack patients at the Billings Clinic? And why did some who did come arrive hours after first feeling chest pains? Two patients, both of whom suffered greater heart damage by delaying care, provided what came to be typical answers. One said he was afraid of contracting covid by



going to the hospital. The other patient went to the emergency room in the morning, left after finding it too crowded, and then returned that night when he figured there would be fewer patients — and a lower risk of catching covid.

“For a heart attack patient, the first hour is known as the golden hour,” Rah said. After that, the likelihood of death or a lifelong reduction in activities and health

increases, he said.

Dr. JP Valin, executive vice president and chief clinical officer at SCL Health of Colorado and Montana, said he is “kept awake at night” by delays in important medical tests. “People put off routine breast examinations, and there are going to be some cancers hiding that are not going to be identified, potentially delaying intervention,” he said.

How stress causes hair loss

Long-term, or chronic, stress puts people at risk for a variety of health problems. These can include depression and anxiety, as well as problems with digestion and sleep. Chronic stress has also long been linked to hair loss, but the reasons weren't well understood.

Hair growth involves three stages. In growth (anagen), strands of hair push through the skin. In degeneration (catagen), hair ceases to grow, and the follicle at the base of the strand shrinks. In rest (telogen), hair falls out and the process can begin again. Hair is among the few tissues that mammals can regenerate throughout their lifetime.

The hair growth cycle is driven by stem cells that reside in the hair follicle. During growth, stem cells divide to become new cells that regenerate hair. In the resting period, the stem cells are inactive. Until now, researchers

hadn't determined exactly how chronic stress impaired hair follicle stem cells.

A team led by Dr. Ya -Chieh Hsu of Harvard University studied the underlying mechanisms that link stress and hair loss. The study was supported in part by NIH's National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS). Results appeared in *Nature*, on March 4, 2021.

The researchers began by testing the role of the adrenal glands, which produce key stress hormones—corticosterone in rodents and cortisol in humans. Removing the adrenal glands from mice led to rapid cycles of hair regrowth. Hair follicle regeneration didn't slow as these mice grew older, like it did in control mice. Rather, hair follicle stem cells continued to enter the growth phase and regenerate hair



follicles throughout the animals' lifespans. The team was able to restore the normal hair cycle by feeding the mice

corticosterone.

Subjecting mice to mild stress over many weeks increased corticosterone levels and reduced hair growth. Hair follicles remained in an extended resting phase. Together, these findings supported the role of corticosterone in inhibiting hair regrowth.

The scientists next examined how corticosterone affects hair follicle stem cells. They found that the stress hormone was not regulating stem cells directly. By deleting the receptor for corticosterone from different cells, they determined that the hormone acts on a cluster of cells underneath the hair follicle called the dermal papilla.

Further studies revealed that corticosterone prevented the

dermal papilla from secreting GAS6, a molecule they showed can activate hair follicle stem cells. Delivering GAS6 into the skin restored hair growth in mice fed corticosterone or undergoing chronic stress.

Last year, [findings from Hsu's team](#) advanced the understanding of how stress causes gray hair. These results reveal a key pathway involved in hair loss from chronic stress. These findings may also lead to further insights into how stress affects tissue regeneration in other parts of the body.

“In the future, the Gas6 pathway could be exploited for its potential in activating stem cells to promote hair growth,” says first author Dr. Sekyu Choi of Harvard University. However, further study is needed to understand whether the same mechanism is at work in people.

Worry, Depression Can Plague Folks Who Get Implanted Defibrillators

An implanted heart defibrillator is a life changer in more ways than one. More than one in 10 patients who receive the device also developed anxiety or depression, a new study reveals.

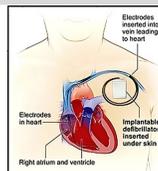
The findings highlight the need for regular screening of patients who receive an implantable cardioverter defibrillator (ICD) in order to identify those who may require additional mental health support, according to the authors of the study.

The research was presented

Saturday at an online meeting of the European Society of Cardiology.

"Most patients adapt well to living with an ICD. For others, it completely changes their life, with worries about shocks from the device, body image, and livelihood as some need to change their job," said study author Susanne Pedersen, of Odense University Hospital in Denmark.

Previous research has shown that anxious or depressed ICD patients have poorer quality of



life and increased risks of heart rhythm disorders and early death.

This study included more than 1,000 patients who completed questionnaires

on their mental health and physical quality of life before and over 24 months after ICD implantation.

Over the follow-up period, nearly 15% of patients reported new-onset anxiety and about 11% reported new-onset depression.

Older age was associated with a lower risk of new-onset

anxiety, while being married, type D personality, and lower self-reported physical functioning were associated with an increased risk. (Type Ds tend to be distressed).

Older age and higher self-reported physical functioning were associated with a lower risk of new-onset depression, while smoking, type D personality and lower self-reported physical functioning were associated with an increased risk, the findings showed.,.,.,[Read More](#)

Loneliness and Social Isolation — Tips for Staying Connected

Click on the links below for the complete tips.

- ◆ [What is the Difference Between Loneliness and Social Isolation?](#)
- ◆ [How Can Feeling Lonely or Being Isolated Affect Older Adults' Health?](#)
- ◆ [How Can You Know Your Risk for Loneliness and Social Isolation?](#)

◆ [How Can You Stay Connected With Friends and Family?](#)

Everyone needs social connections to survive and thrive. But as people age, they often find themselves spending more time alone. Being alone may leave older adults more vulnerable to [loneliness and social isolation](#), which can



affect their health and well-being. Studies show that loneliness and social isolation are associated with higher risks for health problems such as [heart disease, depression, and cognitive decline](#).

If you are in poor health, you may be more likely to be socially isolated or lonely. If you are socially isolated or feeling

lonely, it can put your physical and mental health at risk. Adults who are lonely or socially isolated are less healthy, have longer hospital stays, are readmitted to the hospital more often, and are more likely to die earlier than those with meaningful and supportive social connections.

Frequently Asked Questions About Palliative Care

Planning for care during a serious illness can be challenging. Palliative care is an option that can help patients and their families. To learn more, explore answers to frequently asked questions about palliative care below.

What is Palliative Care?

[Palliative care](#) is specialized medical care for people living with a serious illness. Palliative care can be received at the same time as your treatment for your disease or condition. It focuses on providing relief from the symptoms and stress of serious illness. The palliative care team works to prevent or ease suffering, improve quality of life for both the patient and their family, and help patients and their families make difficult

health care decisions. When a patient decides to forgo treatment for their serious illness or is near the end of life, they may decide to enter [hospice care](#) (see more below).

A serious illness may be defined as a disease or condition with a high risk of death or one that negatively affects a person's quality of life or ability to perform daily tasks. It may cause symptoms or have treatments that affect daily life and lead to caregiver stress. Examples of serious illnesses include dementia, cancer, heart failure, and chronic obstructive lung disease.

Who Provides Palliative Care?

A palliative care team may



include specialist nurses and doctors, social workers, religious or spiritual leaders, therapists, or nutritionists, among other professionals. Your team may vary depending on your needs and level of care.

How Does Palliative Care Differ from The Care I'm Getting Now?

Palliative care can be provided alongside of your current treatment and care. Your palliative care team works with your current doctor and others to provide specific treatments and care plans. Palliative care is meant to enhance your current care by focusing on quality of life for you and your family.

How Do I Know If I Need Palliative Care?

People living with a serious illness such as cancer, heart disease, lung disease, or kidney failure, may experience emotional or physical pain related to their illness. If you're having trouble coping with this pain, palliative care may be right for you. You don't need to wait until your disease is in the advanced stages or you're in the final months of life to start palliative care. [Talk with your doctor](#) if you're considering starting palliative care. To begin the process, your health care provider can refer you to a palliative care specialist. If he or she doesn't suggest it, you can ask your health care provider for a referral....[Read More](#)

Higher Pulse Pressure in Smokers May Signal Cardiovascular Disease Risk

Consistent cigarette smoking has a small but significant effect on pulse pressure, according to research that suggests a possible new link between smoking and cardiovascular disease, especially among Black and white women.

Pulse pressure is the difference between systolic blood pressure, the top number in a reading, and diastolic blood pressure, the lower number. "As that gap widens, it's problematic," said study co-author Kara Whitaker, assistant professor of health and human physiology at the University of Iowa in Iowa City.

It is measured by mmHg, which is a millimeter of mercury. So, for someone with a blood pressure reading of 120/80, the pulse pressure would be the difference between the two

numbers, or 40 mmHg. The normal range is 40 to 60.

"When you exceed 60 is when it's associated with higher cardiovascular disease risk," said study author Rachel Luehrs, assistant professor of exercise science at North Central College in Naperville, Illinois.

In the new study, researchers analyzed 30 years of data from 4,786 participants in the Coronary Artery Risk Development in Young Adults, or CARDIA, study. They examined changes in blood pressure and how that related to race, smoking and a host of other variables. The pulse pressure increase was greatest among both Black and white women who



were consistent smokers – 1.38 mmHg higher for Black women and 1.96 mmHg higher for white women – compared to women of the same race who had never smoked. The results were published Tuesday in the Journal of the American Heart Association.

Although smoking and high blood pressure are each well-established risk factors for cardiovascular disease, the link between smoking and blood pressure is less clear. Smokers experience a brief rise in blood pressure after they smoke a cigarette, but evidence is mixed on the long-term effects. Some studies have even shown long-term smokers experience a slight decrease in blood pressure.

"That's what was interesting to us and why we wanted to do this study," said Luehrs, who has a doctorate in health and human physiology. "It just didn't make sense: Why would chronic cigarette smoking, which is known to be associated with a high cardiovascular disease risk, be associated with lower blood pressure?"

Previous studies of smoking and blood pressure could have had mixed findings because the researchers did not adequately consider the influence of race, the new study's authors said. The effects of racial discrimination are associated with both nicotine dependence and may increase blood pressure....[Read More](#).

Promoting Health for Older Adults

CDC works to help older adults remain healthy, active, and independent as long as possible.

The increase in the number of older adults in the United States is unprecedented. In 2016, 49 million US adults were 65 or older, representing 15% of the population. That number is expected to reach 71 million by 2030 and 98 million by 2060—when older adults will make up nearly 25% of the population.

Age brings a higher risk of chronic diseases such as dementias, heart disease, type 2 diabetes, arthritis, and cancer. These are the nation's leading

drivers of illness, disability, deaths, and health care costs.

Alzheimer's disease and other dementias are most common in adults 60 and older, and the risk increases with age. In 2019, health care and long-term care costs associated with Alzheimer's and other dementias were \$290 billion, making them some of the costliest conditions to society.

CDC's **National Center for Chronic Disease Prevention and Health Promotion** funds partners to improve the health of older adults by:

- ◆ Helping those with dementia



remain active, independent, and involved in their community as long as possible.

- ◆ Providing resources to help caregivers stay healthy and deliver quality care to their care recipients.
- ◆ Increasing early assessment and diagnosis, risk reduction, and prevention and management of chronic diseases for people with or at risk for Alzheimer's disease and other dementias.
- ◆ Increasing the use of other clinical preventive services

like blood pressure checks, cancer screenings, and blood sugar testing.

- ◆ Increasing the number of people who speak to a health care provider about their worsening memory.
- ◆ Providing CDC-recognized lifestyle change programs to Medicare beneficiaries through the National Diabetes Prevention Program (National DPP) to reduce the risk of type 2 diabetes.
- ◆ Promoting physical activity programs to reduce the risk of dementia, arthritis pain, and falls.

Providing Resources to Help Caregivers

In the United States, people are living longer, and dementia and other disabling chronic conditions are becoming more common. The need for caregivers, both informal (family and friends) and formal (paid professionals), will likely increase significantly as the population ages. Although caregiving may be rewarding, caregivers are at risk of increased stress, depression, unhealthy behaviors, and poor

attention to their own health. Caregivers of people with dementia are at even higher risk, and they may delay dealing with their own health needs.

Informal or unpaid caregivers provide most of the long-term care in people's homes. According to 2015–2018 BRFSS data, about 20% of US adults aged 18 or older reported providing care or assistance to a



person with a long-term illness or disability in the past 30 days. Four in five of these caregivers manage household tasks, such as finances or cleaning, and more than half help with personal care, such as bathing. In 2019, the value of this unpaid caregiving was an estimated \$244 billion.

CDC worked with partners to develop an **action guide** for using REACH OUT, an

evidence-based intervention designed to promote health and well-being among people who care for someone with Alzheimer's disease or dementia. CDC also created a guide for program developers, planners, and evaluators called **Assuring Healthy Caregivers. A Public Health Approach to Translating Research into Practice: The RE- AIM Framework pdf icon [PDF – 7 MB]**.

Fact Sheets and At A Glances



Our fact sheets describe the most common

preventable diseases in America,

the key risk factors that cause them, and CDC's health promotion activities for all age groups and in multiple settings.

- ◆ **Chronic Disease Risk**

Factorscross the

- ◆ **Chronic Diseases**
- ◆ **NCCDPHP Programs**
- ◆ **Activities Supported by Multiple Divisions**

- ◆ **Health Across the Life Span**

Read more on these fact sheets from the CDC

Promoting Programs to Reduce Arthritis Pain and Prevent Falls

In the United States, 23% of all adults, or more than 54 million people, have arthritis. It is a leading cause of work disability, with annual costs for medical care and lost earnings of \$303.5 billion. CDC recommends several proven ways to help people manage arthritis symptoms:

Join a self-management education program, such as the **Chronic Disease Self-Management Program**, that teaches the skills and confidence to live well with arthritis every

day.

- ◆ **Be active.** Physical activity, such as walking, bicycling, and swimming, decreases arthritis pain and improves function, mood, and quality of life. Better physical function reduces the risk of falls and fall-related injuries and helps older adults stay independent. Adults with arthritis should move more and sit less throughout the day. Getting at least 150 minutes of



moderate-intensity physical activity each week is recommended. However, any physical activity is better than none. **CDC-recognized physical activity programs** can help improve the health of participants with arthritis.

- ◆ **Maintain a healthy weight and protect your joints.** People can reduce their risk of knee osteoarthritis by controlling their weight. They can help prevent osteoarthritis by

avoiding activities that are more likely to cause joint injuries.

- ◆ **Talk with a doctor.** Recommendations from health care providers can motivate people to be physically active and join a self-management education program. People with inflammatory arthritis (like rheumatoid arthritis) have a better quality of life if they are diagnosed early, receive treatment, and learn how to manage their condition.