

## April 17, 2022 E-Newsletter

### Message from the Alliance *for* Retired Americans Leaders

#### Judge Ketanji Brown Jackson Confirmed as 116th Supreme Court Justice



Robert Roach, Jr.  
President, ARA

Judge Ketanji Brown Jackson was confirmed as the first Black woman to sit on the Supreme Court in a bipartisan, 53-47

Senate vote Thursday. All 50 members of the Democratic caucus were joined by Republican Senators Susan Collins (ME), Lisa Murkowski (AK) and Mitt Romney (UT) in confirming Jackson, who is slated to replace retiring Supreme Court Justice Stephen Breyer

In a recent poll, nearly two-thirds of Americans said they supported her confirmation, making her one of the most popular Supreme Court nominees in recent history. During her Senate hearings, Judge Jackson emphasized the importance of voting rights in a functioning democracy.

A graduate of Harvard Law School, her experience includes working as a public defender and serving as the vice-chair of the United States Sentencing Commission. Most recently she served as a federal judge on the U.S. Court of Appeals for the Washington D.C. Circuit.

"Judge Jackson's record shows that she will be a champion of equal justice and civil rights for all Americans," said Robert Roach, Jr., President of the Alliance. "She is exceptionally qualified. We are confident that she will defend the right of all workers to join a union and

protect older workers from discrimination as a Supreme Court Justice."

#### Medicare Limits Coverage of Aduhelm to Patients in Clinical Trials



Rich Fiesta,  
Executive Director, ARA

Citing data showing the new Alzheimer's drug Aduhelm has serious safety risks and may not help patients, Medicare officials decided Thursday to limit

coverage of the drug to patients in clinical trials. The decision is extremely unusual for Medicare, which traditionally pays for drugs that the Food and Drug Administration has approved, at least for the medical conditions designated on labels

According to The New York Times, some advocacy groups had said that Medicare must pay for a drug approved by the FDA. However, many Alzheimer's doctors and experts cautioned against broadly covering a treatment that scientific evidence shows has uncertain benefit and serious safety risks. Individual patients and families weighed in emotionally from both sides.

Last year, Medicare's actuarial division, acting without knowing what the coverage decision would be, imposed one of the biggest-ever increases in Medicare Part B premiums for 2022. The Centers for Medicare and Medicaid Services (CMS) said that half of the 14.55% increase in the premiums for 2022 was due to the cost of Aduhelm, which was then priced by its manufacturer, Biogen, at

\$56,000 a year.

Since then, Biogen, facing weak sales of the drug after many hospitals and doctors chose not to prescribe it, lowered the price to \$28,800 a year, still much higher than what many analysts have said is defensible.

Xavier Becerra, Secretary of the U.S. Department of Health and Human Services, said previously that he would consider lowering Medicare Part B premiums after the final coverage decision for Aduhelm is made, adding, "We're going to make sure that seniors don't pay more than they have to."

On Thursday, Chiquita Brooks-LaSure, the administrator of CMS, said, "The secretary told us to look at it, and we are going to engage in the process of reviewing the Part B premium."

"Allowing Medicare to negotiate the cost of prescription drugs would go a long way toward diminishing the effect Aduhelm has on Medicare premiums," said Richard Fiesta, Executive Director of the Alliance. "It would make a lot more sense to make decisions based on numbers that include giving Medicare that ability."

#### After Insulin Copay Cap Passes House, Senate Looks for a Broader Bill



Joseph Peters, Jr.  
Secretary  
Treasurer ARA

The chances of passing legislation this year to lower the price of insulin are looking brighter as the Senate undertakes a bipartisan effort to address the issue.

Senate Majority Leader Chuck Schumer (NY) has tapped Senators Collins (R) and Jeanne Shaheen (D-NH) to take the lead in crafting a compromise that members of both parties can accept. The House previously voted on March 31 to pass a more limited bill that caps out-of-pocket insulin costs for many patients with insurance at \$35 a month.

Sen. Collins said in an interview March 30 that she and Sen. Shaheen came up with an outline based on a bill they worked on three years ago. It goes beyond capping what diabetes patients pay and aims to bring down the prices that drug corporations charge.

"The House bill in March was a positive step, and the Senate bill sounds promising, but a broader bill that also brings down the prices of other drugs would clearly be even better," said Executive Director Fiesta. "The 4.4 million members of the Alliance urge the members of the Senate to pass legislation that is similar to what the House passed in November as part of H.R. 5376, the Build Back Better Act. That requires Medicare to negotiate prices for insulin as well as many other prescription drugs. H.R. 5376 also included provisions that capped out-of-pocket prescription drug costs at \$2,000 per year under Medicare Part D."




## WEP/GPO REPEAL TASK FORCE RALLY & DAY OF ACTION IN WASHINGTON, DC

**May 18, 2022. 8 AM - 5 PM.  
Rally from 11:30 AM - 1 PM**

A zoom meeting for registered participants will be held prior to our meeting in D.C.

We will send talking points, detailed schedule when we receive your registration.

**APPOINTMENTS WITH LEGISLATORS:** The focus of this event is a rally on May 18, 2022. Meeting with your elected legislators and/or other targeted legislators to tell your story and those of your friends, colleagues and family is another action we'd appreciate. Please make your appointments prior to coming to D.C.

Instructions for making appointments with legislators will be sent to registrants.

### **COVID SAFETY INSTRUCTIONS**

Individuals are asked to be "up-to-date" on their COVID-19 vaccinations (which means fully vaccinated and having received any boosters for which they are eligible).

It is suggested that you take a Covid at-home swab test prior to traveling, and again once you are in your hotel room.

**MASKS WILL BE REQUIRED** during in-door meetings and when meeting with legislators.

**REGISTRANTS WILL BE RESPONSIBLE for travel, housing, meals on their own.**

**For more information and register by May 9th, [CLICK HERE](#)**

## Congress Begins Two-Week Break

Congress began a two-week break starting today, Monday. While committee work will continue, there will be no votes on the floor of either house until they return. Many of the members will be in their home states or districts so if you call one of their local offices you may be able to schedule a meeting with them. This would be a good opportunity to express your concern about passing legislation to lower prescription drug prices as well as the need for more help for seniors who have suffered so much from the Covid pandemic.

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## CMS Continues Limited Access to Alzheimer's Drug

We have reported in the past about the controversial drug Aduhelm, whose benefits for Alzheimer's sufferers have been widely questioned in the medical community.

In January, the Centers for Medicare and Medicaid Services (CMS) announced an interim policy that Medicare would severely restrict the number of seniors who can access the drug because it planned to only cover the drug for patients participating in rigorous, agency-approved clinical trials.

When Aduhelm came on the market it was announced as the first new Alzheimer's medication in nearly two decades. Initially priced at a whopping \$56,000 a year, it was expected to quickly become a blockbuster drug,

generating billions for the drug company that developed it.

However, from the beginning, it has been controversial. The FDA approved the drug over the opposition of its own advisory panel. In fact, some members of the panel resigned in protest over the approval of the drug.

In addition, doctors have been hesitant to prescribe it, given weak evidence that the drug slows the progression of Alzheimer's and insurers have blocked or restricted coverage over the drug's high price tag and uncertain benefit.

The drug company even cut the price of Aduhelm in half, to \$28,000 per year, apparently with the hope that the lower price would encourage more sales.

Since the interim CMS decision in January there has been a huge lobbying effort in Washington on the part of Alzheimer patient advocates in an attempt to persuade CMS to cover the cost of the drug for all Alzheimer patients. But the uncertainty over the effectiveness of the drug seems to have led to last week's decision.

This final CMS decision means that for Medicare to pay for the drug, patients taking Aduhelm will have to be part of clinical trials to assess the drug's safety and effectiveness in slowing the progression of early-stage dementia.\*\*\*

### Is Cut in Medicare Part B Premiums on the Horizon?

At the beginning of this year, seniors enrolled in Medicare Part



B saw the largest increase in their premiums dollar-wise in the program's

history.

As we previously reported, the large increase came about because of Medicare preparing to pay for the cost of the new drug, Aduhelm, that supposedly helps patients with Alzheimer's disease.

However, the decision announced by CMS last week to continue to only cover Alzheimer's patients enrolled in approved clinical trials means that the number of people receiving the drug will be many fewer than previously estimated.

As a result, Medicare said last week that it is considering a cut in enrollee Part B premiums. Lawmakers have called for a rollback and Health and Human Services Secretary Xavier Becerra already directed Medicare to reassess.

No date was given as to when a final decision might be made nor was there any indication as to how Medicare would go about implementing a lower premium or if the higher premium amount paid so far this year would be rebated in some manner to those enrolled in Part B.

TSCS strongly supports lowering the Part B premium and rebating the higher premiums paid so far this year in some fair and reasonable way.

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### A Word of Caution: Covid-19 is Still With Us

We are all tired of it – tired of even hearing about it - and we

want our lives to go back to normal. But we should remember that Covid-19 is still with us, even though it may be in the form of a new variant.

The rise of Covid cases in some regions of the U.S., just as testing efforts wane, has raised the possibility that the next major wave of the virus may be difficult to detect. In fact, the country could be in the midst of a surge right now and we might not even know it.

Testing and viral sequencing are critical to responding quickly to new outbreaks of Covid. But as the country tries to move on from the pandemic, demand for lab-based testing has declined and federal funding priorities have shifted.

Seniors need to remember that they are the most vulnerable group in the country when it comes to Covid and that we should not let our guard down.

So as a reminder, a second booster dose of the Covid-19 vaccine from both Moderna and Pfizer has been authorized by the Food and Drug Administration for adults 50 and over.

Those who have received a first booster shot at least four months ago can now get another.

Remember, booster doses are becoming an increasingly relied-upon tool in the fight against Covid, especially as states and companies cut back safeguards such as masking and working from home.

## Pandemic Is Leaving U.S. With Shortage of Long-Term Health Care Workers

The pandemic has worsened longstanding staffing shortages at U.S. nursing homes and other long-term care facilities. Now, a [new study](#) shows that high employee turnover rates have yet to improve.

Researchers found that after initial workforce losses in the early phase of the pandemic, U.S. hospitals, outpatient centers and other health care settings were getting back to pre-pandemic turnover rates by late 2021.

That has not been the case, however, in the [long-term care](#) that many elderly and disabled Americans rely on.

There, turnover rates remained higher than pre-pandemic levels through October 2021 -- the last month of the study period.

Experts said the pattern reflects well-known problems in long-term care that worsened during the pandemic.

"Long-term care was in trouble before the pandemic," said researcher Bianca Frogner, a professor at the University of Washington School of Medicine. "These are tough jobs with low pay."

And then came COVID, which first hit [nursing homes](#) and other



long-term facilities -- and hit them hard, Frogner said. Elderly residents were dying at alarming rates, staff lacked personal protective equipment, families were no longer able to visit, and long-term care seemed to be forgotten amid the focus on hospitals.

Not surprisingly, the study found, employee turnover rose in the pandemic's initial months -- as it did in hospitals and outpatient care. But while turnover rates gradually returned to near normal in those other settings, the problem has

persisted in long-term care.

"There's a lot that has to be fixed in long-term care," said Susan Reinhard, senior vice president and director of the AARP Public Policy Institute.

Like Frogner, Reinhard pointed to the fundamental issues that came long before the pandemic. Much of the long-term care workforce is composed of nursing aides and assistants who receive much less education and training, and far less pay, than registered nurses or doctors...[Read More](#)

## Medicare Advantage benefits: Appearances v. reality

The Commonwealth Fund's latest **report** on Medicare Advantage "benefit design" provides what I would call the standard take, highlighting Medicare Advantage's out-of-pocket cap and "additional benefits," as if those are the most important differences. It also assumes that what you see with Medicare Advantage is what you get rather than explaining that appearances belie reality with Medicare Advantage.

The report questions some of the lack of detail available about Medicare Advantage additional benefits. But, the report overlooks the biggest point about Medicare Advantage plan benefits—they tend to be withheld, delayed and denied a lot more than people might imagine.

People with Medicare (and everyone else) should be able to assume that the health plan they enroll in will cover all the medical treatments that they need. But, each Medicare Advantage plan has different prior authorization and specialty referral requirements, provider networks, and out-of-pocket costs. Each also has different proprietary rules for when they will pay for particular treatments and different rates of

inappropriate delays and denials of care. All of these elements are part of the "benefit" package and can mean the difference between getting needed care and being forced to forgo it. Medicare Advantage plans often rely on proprietary algorithms to determine whether care is covered. They always make their own decisions about medical necessity that lead to their **spending nearly 25 percent less on medical and hospital care** than traditional Medicare. Medicare Advantage plans cover fewer services and fewer costly services than traditional Medicare. The Office of the Inspector General has found that Medicare Advantage plans engage in **widespread inappropriate delays and denials of care and coverage**.

You can't know what you need to know about a Medicare Advantage plan's benefits before you enroll. The consequence: You can't meaningfully distinguish among Medicare Advantage plans and you take a huge risk when you enroll. The Commonwealth Fund's experts warn that people know little about the extra benefits Medicare Advantage plans offer—who gets them, how frequently,



where, and at what cost to them. Putting aside additional benefits, people know little about the standard benefits

Medicare Advantage plans cover—who gets them, when, how frequently, where, and at what cost to them. For example, Medicare Advantage plans must cover physical therapy, but they decide—with no meaningful oversight—when it is warranted, how often an enrollee will get treatment, from whom and the copay.

The Fund highlights that nine in ten Medicare Advantage plans offer dental, vision and/or hearing benefits. But, it does not explain that narrow provider networks and **high out-of-pocket costs keep a large number of people from taking advantage of these benefits**.

Rather, it says that Medicare Advantage "may have more limited provider networks or prior-authorization requirements for some services" as if this is simply a possibility when in fact it is the norm.

On the issue of costs, the report explains that lack of standardization of costs in Medicare Advantage keeps people from knowing what their costs will be in different

Medicare Advantage plans. The majority of people in Medicare Advantage plans are in HMOs, which have no out-of-pocket cap for out-of-network care, an issue which the report omits; and, **out-of-pocket costs are a barrier to care** for many low- and middle-income enrollees.

Also of note and overlooked in the report: The cost of supplemental coverage in traditional Medicare, which has no out-of-pocket cap, tends to be far lower than the out-of-pocket cap for in-network care in Medicare Advantage. Moreover, we do not know typical out-of-pocket costs in Medicare Advantage because no independent reliable data is available.

For sure, costs in Medicare Advantage can be very high for people whose medically necessary care is wrongly denied or not available in-network, potentially keeping people from getting needed care. For example, many Medicare Advantage plans do not have centers of excellence in-network that people may want to use for complex conditions. If enrollees can't afford to pay out of pocket, they can be forced to forgo medically necessary care

## Refurbished Walkers and Wheelchairs Fill Gaps Created by Supply Chain Problems

DENVER — Michele Lujan needed a wheelchair for her 52-year-old husband who had been hospitalized with covid-19. But she had lost her job, and money was tight. Insurance wouldn't cover the cost, and she didn't see the use in buying something to meet a temporary need. So she turned to a loan closet not far from her home in the Denver suburb of Highlands Ranch

At **South Metro Medical Equipment Loan Closet**, crutches hung from the walls, knee scooters lined the floor, and shower seats and toilet risers overflowed from the shelves. She found a wheelchair she could borrow for free.

"I didn't realize all the other medical items they have," Lujan said.

Medical equipment reuse programs like these collect, clean, and lend devices — often at no cost to the borrower. They vary in size from small outposts at community churches to large statewide programs like the **Foundation for Rehabilitation Equipment and Endowment**, or FREE, which provided nearly 5,000 devices to thousands of low-income adults and seniors in Virginia last year.

Such programs save low-income and uninsured patients money, and by refurbishing used medical equipment, they keep it out of landfills. During the pandemic, the programs have also helped soften the impact of supply chain-related shortages and are helping meet increased



demand as delayed elective surgeries resume.

"Once hospitals started elective surgeries again, there was a huge increase in need," said Donna Ralston, who founded the South Metro Medical Equipment Loan Closet six years ago in a 10-foot-by-10-foot shed at her church.

Today, the volunteer-run organization opens its warehouse doors by appointment to anyone who is in need and recovering from surgery, illness, or injury. "Oftentimes, we're loaning equipment to patients who would otherwise have to wait two months to get it from their insurance providers," said the organization's president, Pat Benhmidia. "We fill in these

cracks quite often." Besides insurance delays, hospitals across the U.S. have reported not having enough walkers, crutches, canes, and wheelchairs. Supplies are limited because of shortages of raw materials such as aluminum, said **Alok Baveja**, a professor of supply chain management at Rutgers Business School in New Jersey.

"The availability, not just the cost, has an impact on the durable medical equipment industry," Baveja said.

The crunch may be caused worse by disruptions caused by Russia's invasion of Ukraine, said American Hospital Association spokesperson Colin Milligan.... **Read More**

## Questions for your primary care doctor if you have Medicare

As you might know, the federal government is moving towards a “capitated” payment model for everyone with Medicare, paying insurers, private equity, and other intermediaries a flat fee for each enrollee and handing over to them the power to decide when to cover enrollees’ care and what care to cover. These intermediaries might have your best interests at heart, but they also might be focused on maximizing their profits and not your care needs. Your primary care doctor should be able to help you understand whether you are getting the care you need.

**If you’re in a Medicare Advantage plan**, you signed up for coverage that an insurance company oversees. Some Medicare Advantage plans do a better job than others of ensuring you get the care you need. Others **inappropriately delay and deny care** a lot of the time.

**If you’re in traditional Medicare**, you might not know if an insurance company or private equity intermediary is overseeing your coverage. **Until 2021, that was never the case.** You should find out whether there is an

intermediary, sometimes called a Direct Contracting Entity or DCE. It is possible that this intermediary will inappropriately delay or deny your care.

To help you decide whether your primary care doctor is able to provide you with the care you need or whether you are better off disenrolling from your Medicare Advantage plan or switching primary care doctors and opting out of your DCE, find out the answers to these questions.

### 1. Is your primary care doctor employed or working under contract for an insurance company or a private equity firm?

- ◆ If you are in a Medicare Advantage plan, the answer is always yes.
- ◆ If you are in traditional Medicare, the answer could be yes or no. You should be able to find out the answer by calling 1-800-MEDICARE or by calling your primary care doctor’s office. If the answer is no, you are not in a Direct Contracting Entity and no one



should be interfering with the care you receive. If the answer is yes, the federal government likely involuntarily enrolled you in a Direct Contracting Entity, and you have the right to opt out.

### 2. Is anyone directing your primary care doctor as to how to handle your care? How is it affecting the care your primary care doctor delivers?

- ◆ Is your primary care doctor unable to spend adequate time with you?
  - ◆ Is your primary care doctor being directed to refer you only to lesser quality doctors and hospitals?
  - ◆ Is your primary care doctor ever prevented from getting you the care the doctor thinks you need?
- If the answer to any of these questions is yes, you might want to consider finding a new primary care doctor or opting out of your DCE or Medicare Advantage plan.
- If you are in traditional Medicare and your primary care doctor suggests you either drop

your Medicare supplemental coverage or move to a Medicare Advantage plan, ask why and beware.

- ◆ Dropping your supplemental coverage if you are in traditional Medicare or moving to a Medicare Advantage plan will prevent you from being able to get care wherever you’d like because your out-of-pocket costs could be very high.
- ◆ Moving to a Medicare Advantage plan restricts your choice of health care providers and often limits your ability to get care at centers of excellence and from the best specialists. Your annual out-of-pocket costs could be as much as \$7,550 for in-network medical and hospital care alone.
- ◆ Whether you drop your supplemental coverage and remain in traditional Medicare or switch to Medicare Advantage, you very well may never be able to get supplemental coverage again. Your right to buy supplemental coverage is extremely limited.

## 2022: Health care costs remain a top policy priority

A new **Kaiser Family Foundation** poll finds that Americans continue to see their health care costs as a top policy priority for Congress. Health care prices and unexpected medical bills are a major concern. Slightly more than half of Americans polled say they have delayed or gone without health care in the last 12 months because of the cost.

When it comes to household expenses, one in four Americans are very worried about facing unexpected health care bills. Health care costs are their top household expense worry after gasoline and transportation costs, which 40 percent of Americans are very worried about. Nearly six in ten Americans (58 percent) are very worried or somewhat worried about facing unexpected medical bills.

**What types of health care have people foregone?** More than a third of Americans (35 percent) went without dental care

in the last 12 months because of the cost. One in four went without eye care (25 percent) or a visit to the doctor (24 percent). About one in six (18 percent) went without mental health care and about one in seven (14 percent) went without hospital care.

**How do Americans want Congress to address these issues?** Most of the poll answers focused on people’s out-of-pocket costs and not on health care prices. Americans seem to be more focused on having Congress limit what they pay for their care than on regulating prices. What they might not appreciate is that the money to cover limits on their costs is going to have to come from somewhere. Would they want the money to come from higher taxes, or do they also support price regulation?

The public wants Congress to prioritize a limit on prescription



drug price increases to the rate of inflation (61 percent) over regulation of drug prices (48 percent) for working people. Do Americans understand that a limit on drug price increases does not preclude the introductory price of a drug from being through the roof?

The public overwhelmingly supports drug price negotiation for people with Medicare; 98 percent of Democrats and 84 percent of Republicans see it as a top priority.

The public also supports out-of-pocket drug caps and caps on insulin costs as a top priority for lawmakers. But, at what cost to them? Those caps are likely to drive up overall health insurance premiums considerably if they are not combined with drug price regulation.

The public feels less strongly that policymakers continue to fund COVID-related health care costs. Only about one in four

Americans believe Congressional investments in COVID health care should be a top priority.

Views of the Affordable Care Act are split along party lines. Nearly nine in ten (87 percent) Democrats see the ACA favorably, with more than four in ten of them (43 percent) saying the ACA helped them and their families. In sharp contrast, nearly eight in ten (79 percent) Republicans view the ACA unfavorably, with four in ten saying it hurt them and their families.

Overall, Americans have a negative view of long-term care facilities’ staffing levels, fees and care quality. The 25 percent of Americans with some direct familiarity with long-term care facilities have even stronger negative views of them.

## Report Says Nursing Home Industry Needs an Overhaul

The nursing home industry is awash in ineffective care and staffing shortages, claims a new report that calls for sweeping changes in an industry whose failures have only been exacerbated by the pandemic.

Experts from the National Academies of Sciences, Engineering, and Medicine minced no words in their 605-page **report**, released Wednesday.

"The public is so concerned about the quality of care that most people really fear their family having to be in a nursing home," Betty Ferrell, a nurse who chaired the report committee, told the *Associated Press*. "We're very optimistic that our government officials will respond to what has really been a travesty."

Staffing was one of the major focal points of the study, which advocates have often said is too low in sheer numbers, while also untrained and underpaid.

The report advised additional

study on optimal staffing, while also calling for at least one registered nurse on duty at all times. Nursing home staff should also have an infection prevention and control specialist and a social worker, the report said. President Joe Biden has also **called** for establishing national staffing minimums.

This issue may be a contentious one as industry lobbyists have fought hard against more stringent staffing requirements, the *AP* reported. Federal law requires that nursing homes have sufficient staff to meet residents needs, but exactly what that means in concrete numbers is left open for interpretation by states.

The report's authors also recommend a new national long-term care system that would exist outside of **Medicaid**.

Some of these recommendations would require massive political capital and investment, a challenge in the



current political climate, the *AP* said. "It has been a long time since we as a country have been wanting to dig in and reform how we finance, pay, regulate and delivery nursing home services," David Grabowski, a nursing home expert and Harvard Medical School professor who served on the report committee, told the *AP*.

A forerunner to this report, released in 1986, led to sweeping changes under the **1987 Nursing Home Reform Act**, but some of the recommendations were never addressed.

The new report also addresses some issues that could limit infection and improve quality of life.

Prioritizing private rooms and bathrooms instead of using communal spaces could make nursing homes feel less institutional, the report suggests. These shared spaces may also be fueling infection spread.

Residents in some facilities spend "little, if any, time outdoors," according to the report, which called for more access to the outdoors.

"I think the average nursing home resident has an OK quality of care, but a poor quality of life," Grabowski said.

The report is "a piercing wake-up call," said Katie Smith Sloan, of LeadingAge, which represents nonprofit nursing homes. The industry is "in desperate need of an overhaul," she told the *AP*.

Whether it can lead to remaking the system will depend on how the government addresses funding issues, she said.

"As policymakers consider how to enact the report's recommendations, they must back their actions with sufficient funding to make changes a reality," she said. "Without that, the committee's work will be for naught."

## Harris says White House will seek to ease Americans' medical debt burden

The White House is seeking to help lessen Americans' medical debt burden, Vice President Kamala Harris announced Monday.

In its latest effort to help people deal with increased costs amid **skyrocketing inflation**, the White House laid out a four-point plan to help protect consumers. It builds on President Joe Biden's recent executive order on

increasing **access to affordable health care coverage**.

Plagued by **low approval ratings**, particularly on economic matters, the Biden administration has been rolling out measures aimed at lowering Americans' bills.

Harris began her remarks by noting that some people are contending with the rising cost of



living at the same time as they are still trying to pay off hospital bills that resulted from a burst

appendix or nasty fall years ago. "No one in our nation should have to go bankrupt just to get the health care they need," she said. Officials from several federal agencies spoke of the problems of **medical debt**, which plagues about one-third of American

adults and is the largest source of debt in collections. Black and Hispanic families typically **hold more medical debt** than White ones, while women and younger folks are also more likely to rack up health care bills. Being behind in bills also prompts some people to avoid seeking additional health care and can affect consumers' ability to buy homes or start small businesses....**Read More**

## Dear Marci: How do I file a grievance?

Dear Marci,

I received a favorable decision on an appeal to my Medicare Advantage Plan to cover the cost of a doctor's office visit. I had already paid for the cost of the visit out of pocket, and my plan notified me that I would receive a reimbursement. It has been months and I have still not received one. What should I do? -Shruthi (Los Angeles, CA)

Dear Shruthi,

If you are dissatisfied with your Medicare Advantage or Part D prescription drug plan for any reason, you can choose to file a grievance. A grievance is a formal complaint that you file

with your plan. It is not **an appeal**, which is a request for your plan to cover a service or item it has denied. Times when you may wish to file a grievance include:

- ◆ If your plan has poor customer service
- ◆ You face administrative problems (such as the plan taking too long to file your appeal or failing to deliver a promised refund)
- ◆ You believe the plan's network of providers is inadequate To file a grievance:
- ◆ Send a letter to your plan's Grievance and Appeals department. Check your plan's



Dear Marci

website or contact them by phone for the address.

- ◆ You can also file a grievance with your plan over the phone, but it is best to send your complaints in writing.
- ◆ Be sure to send your grievance to your plan within 60 days of the event that led to the grievance.
- ◆ You may also want to send a copy of the grievance to your regional Medicare office and to your representatives in Congress, if you feel they should know about the problem. Go to [www.medicare.gov](http://www.medicare.gov) or call 1-

800-MEDICARE to find out the address of your regional Medicare office.

- ◆ Keep a copy of any correspondence for your records.
- Your plan must investigate your grievance and get back to you within 30 days. If your request is urgent, your plan must get back to you within 24 hours. If you have not heard back from your plan within this time, you can check the status of your grievance by calling your plan or 1-800-MEDICARE. Best of luck filing your grievance and getting your reimbursement!

-Marci

## Millions could lose health insurance when the public health emergency ends

When the COVID pandemic hit, the Biden administration declared a public health emergency which, among other things, extended Medicaid coverage to millions of people. For the vast majority of them, that coverage is a lifeline. As of now, the public health emergency could end as early as mid July. What happens to people with Medicaid then?

The Biden administration needs to act thoughtfully and deliberately before declaring an end to the public health emergency. Since it was declared, Medicaid enrollment is up 12 percent and 25 percent of Americans now get their coverage through Medicaid. Taking Medicaid away from them because they are no longer eligible will have dire consequences.

With the end of the public health emergency and the federal Medicaid funding that goes with

it, as many as 15 million low and middle-income Americans could end up losing their health insurance. As of now, states are forbidden from kicking people off of Medicaid and have received additional funds to cover Medicaid's cost. But, states will need to ensure all Medicaid enrollees remain eligible once the emergency is over.

Many people who should have Medicaid coverage could lose it. A lot of people with Medicaid who remain eligible for Medicaid might not have the ability to undertake their state's complex renewal application process. Other people with Medicaid might no longer qualify because their income is a little too high, or they might have moved to another state. Many of them likely have no clue that their coverage could end once the public health emergency ends



and will only find out when they are told by their doctor's office, their hospital or their pharmacy.

As it is, the uninsured no longer have access to free Covid-19 testing and treatment. That protection ended last month. There are no funds to pay for it. Free vaccines are also about to end.

It is not unreasonable for the Biden administration to end mask mandates and the like, as Covid's threat to the public health appears to be waning. But, ending Medicaid protections is another story. Covid-19 has not gone away. Without insurance, many Americans will be hard-pressed to afford needed care, be it for Covid or something else.

This year, people who lose Medicaid can still enroll in a state health insurance exchange plan. Because Congressional funding of Affordable Care Act

subsidies for people with low and middle incomes lasts through the end of this year, their insurance premiums will cost very little, if anything. But, in 2023, they will be at risk of being uninsured again.

Our dysfunctional fragmented and costly health care system affords few among us a way to address a public health emergency, let alone a complex disease. Costs are just too high, even with insurance. As a start, the Biden administration should extend Medicaid protections at least through the end of the year, even if it ends other protections that came with the declaration of a public health emergency.

And, if it wants to ensure that Americans are prepared for the next public health emergency or simply to safeguard people's health and well-being, Congress should pass legislation that guarantees health care for all; it should pass Medicare for all.

## Social Security Field Offices Reopen Nationwide

Kilolo Kijakazi, Acting Commissioner of the Social Security Administration (SSA), announced this week that Social Security Field Offices would reopen nationwide on April 7 for the first time since the COVID-19 pandemic forced them to close.

While walk-in visits will be available, Kijakazi urged people to avoid long lines and delays by scheduling appointments in advance. Appointments can be

made online by visiting [www.socialsecurity.gov](http://www.socialsecurity.gov) or over the phone by calling 1-800-772-1213.

Dr. Kijakazi also offered other guidance for walk-in visitors to avoid lines. "Be aware that our offices tend to be the busiest first thing in the morning, early in the week, and during the early part of the month, so people may want to plan to visit at other times," she explained.



In order to protect the many Social Security beneficiaries with health vulnerabilities, field offices will continue to require masking, physical distancing, and self-health checks for COVID-19 symptoms. Face masks will be provided to visitors and employees as needed

"It is good that the offices have reopened," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "Now if SSA could get

the full funding that it needs from Congress, we'd really be improving things for Social Security beneficiaries."

The omnibus spending bill that Congress passed last month provided SSA with an increase in funding over last year, but it was \$1 billion less than what President Biden had requested.

## Retired seniors' guide to downsizing

There's a lot to consider if you're thinking about downsizing your house, especially in the current market, which strongly favors sellers. You may be able to sell your current place quickly, but many downsizers find themselves moving into an even more competitive market segment, bidding for the same properties as younger buyers looking for starter homes.

While you're likely to be able to make a strong offer for a home, there's still a lot more that goes into this decision, including how the pandemic might have affected your finances. If your savings took a hit or you got laid off and

decided to **retire early**, for example, downsizing might have become a bigger priority for you.

Here are some key considerations for those thinking about downsizing.  
**5 reasons to downsize**

**1. Economic necessity** - It's common for many older adults to be faced with unexpected medical expenses and rising home insurance premiums and utility costs. **Selling your house** and moving into a more affordable space is often the most practical solution.

**2. Health concerns** - Many seniors downsize to a home



where at-home care is more widely available and there are fewer everyday obstacles to contend with, such as stairs or other mobility constraints. The quality of and proximity to hospitals could be motivators, as well, along with access to public transportation, especially if driving has become an issue.

**3. Convenience** - If you're tired of doing all the housework that comes with a larger home, you're not alone. A lot of retirees choose smaller homes where upkeep is less expensive and taxing.

**4. Relocating for retirement** - If

you intend to **retire out of state** or even out of your current city, downsizing in your new location could be part of those plans.

**5. Seller's market** - Even if you're facing hardship right now, you'll likely be able to sell your current home for top dollar. If you've been living there for a while, that means you'll be in a position to walk away with a good chunk of change, enabling you to buy a smaller home and use the remainder to pay off debt or get out of a shaky financial situation... **Read More**

## Could HIV Meds Help Slow Advanced Cancers?

The introduction of **HAART** (highly active anti-retroviral therapy) in the mid-1990s revolutionized the treatment of HIV/AIDS, halting disease progression and dramatically extending lives.

Now, a small new study suggests another potential use for one of the standard HAART medications: It halted disease progression in about a quarter of patients who were battling advanced **colon cancer**.

"What is most surprising is that this is a class of drugs we have used effectively for viruses for many years," said study

author Dr. David Ting. "And now this study opens the opportunity to develop this class of drugs for cancer.

"We are still trying to understand why some patients might benefit more than others," said Ting, who serves as director of the Tumor Cartography Center at Massachusetts General Hospital Cancer Center in Boston.

While acknowledging that more research will be needed, Ting described the findings as "exciting," adding that beyond colon cancer it appears likely



that "this [drug] strategy may be effective across multiple cancer types."

Ting noted that HAART treatment for HIV patients -- which is typically administered as a combination of several medications -- targets specific proteins called "**reverse transcriptases**" (RT).

That's because HIV needs RTs to replicate and spread.

"[But] we and others have previously found that RT proteins in human cells are reactivated in cancer," explained Ting, also an associate professor of medicine with Harvard

Medical School. "Therefore, these RT drugs for HIV [also] have the ability to block these human RTs found in cancer." To underscore that point, Ting highlighted a 2018 research paper that found that patients living with HIV while undergoing a three-drug "cocktail" of HAART therapy do, in fact, tend to have a significantly lower incidence of many types of cancer than the general population. That lower risk, researchers found, includes breast, prostate *and* colon cancer....[Read More](#)

## Experimental Pill May Fight Antibiotic-Resistant UTIs

**Urinary tract infections** are common and usually simple to treat. But for people who become sick enough to land in the hospital with one, an experimental antibiotic may soon offer a new treatment option -- taken by mouth instead of delivered by IV.

In a clinical trial, researchers found that the pill, called tebipenem HBr, worked as well as a standard IV antibiotic in treating patients hospitalized with "complicated" UTIs. That included people infected with bacteria that resist many other

oral antibiotics.

The drug is not yet available, but developer Spero

Therapeutics **announced** earlier this year that the U.S. Food and Drug Administration had granted its new drug application priority review. The company said that, if approved, the oral antibiotic could potentially allow some patients to recover at home, or at least leave the hospital sooner.

If that happens, the medication would "fill a gap" in the treatment of complicated UTIs, said an infectious diseases expert



who was not involved in the trial.

The drug's "real value" would be for patients with UTIs caused by bacterial strains that are highly resistant to common oral antibiotics, said Dr. Neil Clancy, a professor of medicine at the University of Pittsburgh.

"Right now, we have many options for most UTIs, both in and out of the hospital," said Clancy, who is also a spokesperson for the Infectious Diseases Society of America.

But patients in this trial had

UTIs caused by various antibiotic-resistant bacteria, including bugs that produce an enzyme called extended-spectrum beta-lactamases (ESBL). That enzyme breaks down and destroys many common antibiotics, including penicillins and cephalosporins.

ESBL-producing bacteria are a "big issue," Clancy said, noting that the bugs are listed as a **serious threat** by the U.S. Centers for Disease Control and Prevention....[Read More](#)

## Could COVID Infection After Age 50 Leave You Vulnerable to Shingles?

Catching COVID-19 appears to increase an older person's risk of developing a case of shingles.

Researchers found that people 50 and older who had a COVID infection were 15% more likely to develop shingles, compared to people who were never infected. That risk climbed to 21% in people hospitalized with a severe case of COVID.

"It is important that health care professionals and people 50-plus are aware of this potential increased risk so patients can be diagnosed and treated early if they develop shingles following COVID-19," said lead researcher Dr. Amit Bhavsar, director of clinical research and development for the

pharmaceutical company GSK in Brussels.

**Shingles** is a painful skin rash that occurs in people who've previously had chicken pox.

The virus that causes chicken pox, varicella zoster, hides in people's nerve cells after they've gotten over their initial case of the infectious disease, explained Dr. Carrie Kovarik, a professor of dermatology and medicine with the University of Pennsylvania's Perelman School of Medicine.

In some cases, varicella zoster will reemerge later in life and cause shingles, usually due to a faltering immune system.



"Your T-cells are what keep the chicken pox virus contained,"

Kovarik said. "When your T-cells aren't doing the job -- you'd had an illness or you get stressed or you get old -- the chicken pox virus can come out down the nerve and onto your skin. It can't hold onto it any longer."

Because of this, it makes sense that COVID could prompt shingles, since the virus wreaks such havoc on the immune system, Kovarik said.

"I've definitely seen patients who had one or two episodes of [shingles] in a year who'd never had it before but who had had COVID," Kovarik said. "And I

had multiple patients like this, and it was happening in more of my patients."

Dr. Amesh Adalja, a senior scholar with the Johns Hopkins Center for Health Security, agreed.

"This is not a surprising finding as **SARS-CoV-2** is known to cause immune dysfunction and physiologic stress," Adalja said. "Physiologic stress and dysregulated immune function are known factors" in shingles outbreaks.

Nearly all adults over age 50 have had chicken pox, and therefore are at risk for developing shingles, Bhavsar said....[Read More](#)

## Post-COVID Risk for Blood Clot Lasts at Least 6 Months

COVID-19 increases people's risk of dangerous blood clots and bleeding for months after infection, researchers say.

The new findings suggest that COVID-19 is an independent risk factor for deep vein thrombosis, pulmonary embolism and bleeding.

"Our findings arguably support [treatment] to avoid thrombotic events, especially for high-risk patients, and strengthen the importance of vaccination against COVID-19," the study authors concluded in the report published April 6 in the *BMJ*.

While the added risk of clots and bleeding was known, it was unclear how long it lasted, the researchers noted in a journal news release.

To find out, the investigators compared more than one million people in Sweden who tested positive for COVID-19 between Feb. 1, 2020, and May 25, 2021,

and a control group of more than 4 million people who did not have a positive COVID test.

Compared to the control group, COVID-19 patients had a significantly higher risk of **deep vein thrombosis, or DVT**, (a blood clot in the leg) for up to three months after infection; **pulmonary embolism** (a blood clot in the lung) for up to six months; and a **bleeding event** for up to two months.

After accounting for a number of possibly significant factors, the researchers concluded that those with COVID-19 had a five times' higher risk of DVT; a 33-fold higher risk of pulmonary embolism; and a nearly doubled risk of bleeding in the 30 days after infection.

Deep vein thrombosis occurred in 0.04% of COVID-19 patients and 0.01% of control patients.



Pulmonary embolism occurred in 0.17% of COVID-19 patients and 0.004% of control

patients. And bleeding events occurred in 0.10% of COVID-19 patients and 0.04% of control patients, according to the report.

The risks of blood clots and bleeding were highest in patients whose COVID-19 was more severe, those with other health conditions and those infected during the first wave rather than in the second and third waves. The researchers said that could be explained by improved treatment and vaccine coverage in older patients after the first wave.

Even patients with mild COVID-19 had an increased risk of DVT and pulmonary embolism, the study found. While no increased risk of bleeding was found in those with mild COVID, there was a

noticeable increase in patients with more severe infection.

The study was led by Anne-Marie Fors Connolly of the department of clinical microbiology at Umeå University in Sweden.

Frederick Ho of the Institute of Health and Wellbeing at the University of Glasgow in Scotland and his colleagues **wrote an editorial** that accompanied the findings.

Even though many countries are removing pandemic restrictions and shifting their focus to living with COVID-19, this study "reminds us of the need to remain vigilant to the complications associated with even mild SARS-CoV-2 infection, including thromboembolism," Ho's team wrote.

## Can AI (artificial intelligence) Predict Cardiac Arrest Better Than a Doctor Can?

A new artificial intelligence approach can predict if and when heart patients might die of sudden cardiac arrest far more accurately than a doctor can, and could improve survival rates, according to its developers.

"Sudden cardiac death caused by **arrhythmia** accounts for as many as 20% of all deaths worldwide and we know little about why it's happening or how to tell who's at risk," said study senior author Natalia Trayanova, a professor and co-director of the Alliance for Cardiovascular

Diagnostic and Treatment Innovation at Johns Hopkins University in Baltimore.

As a result, she said patients who may be at low risk of sudden **cardiac death** are getting defibrillators they might not need, while high-risk patients aren't getting treatment that could save their lives.

"What our algorithm can do is determine who is at risk for cardiac death and when it will occur, allowing doctors to decide exactly what needs to be done,"



Trayanova said in a university news release.

The researchers created their deep learning technology using MRI images of damaged hearts from hundreds of patients, along with patient data such as age, weight, race and prescription drug use.

"The images carry critical information that doctors haven't been able to access," said study first author Dan Popescu, who was part of Trayanova's lab during his doctoral studies.

"This scarring can be

distributed in different ways and it says something about a patient's chance for survival," Popescu said in the release. "There is information hidden in it."

The **artificial intelligence** approach provides heart disease patients with an individualized assessment of their risk of sudden cardiac death over 10 years, and when it's most likely to happen...[Read More](#)

## Half of World's People Suffer From Headaches

If you suffer from headaches, you have plenty of company.

Headaches afflict half of the world's population, and women are more likely to get them than men, a new paper says.

"We found that the prevalence of headache disorders remains high worldwide and the burden of different types may impact many. We should endeavor to reduce this burden through prevention and better treatment," said study lead author Lars Jacob Stovner, of the Norwegian University of Science and Technology. The researchers reviewed 357

studies published between 1961 and the end of 2020. They found that 52% of people have a headache within a given year, including 14% with **migraine**, 26% with a **tension-type headache** and about 5% with a headache for 15 or more days a month.

On any given day, almost 16% of people worldwide have a headache and nearly half (7%) have a migraine, according to the findings. The results were published April 12 in the *Journal of Headache and Pain*.



All types of headache are more common in women than men, especially migraines (17% in females vs. about 9% in males) and headaches on 15 or more days a month (6% in females vs. less than 3% in males).

"Compared to our previous report and global estimates, the data does suggest that headaches and migraines rates may be increasing. However, given that we could explain only 30% or less of the variation in headache estimates with the measures we looked at, it would

be premature to conclude headaches are definitively increasing," Stovner said in a journal news release.

"What is clear is that overall, headache disorders are highly prevalent worldwide and can be a high burden. It may also be of interest in future to analyze the different causes of headaches that varied across groups to target prevention and treatment more effectively," he added.

Most of the studies in the analysis included adults ages 20-65, but some also included adults older than 65 and children as young as age 5.

## New Insights Into Why Alzheimer's Can Bring Drowsiness

**Alzheimer's** patients are often drowsy during the day, but it might not be because of poor sleep at night.

Instead, a clinical trial that monitored patients' sleep and then studied their brains after death discovered an entirely different reason for such sleepiness -- they suffer a loss of neurons that help keep a person awake.

"You can think of this system as a switch with wake-promoting neurons and sleep-promoting neurons, each tied to neurons controlling circadian rhythms," said study co-lead author Joseph Oh, a medical student at the University of California, San Francisco.

"Finally, with this post-mortem tissue, we've been able to confirm that this switch, which is known to exist in model animals, also exists in humans

and governs our sleep and awake cycles," Oh said in university news release.

The researchers studied both Alzheimer's patients and those with a neurodegenerative condition known as **progressive supranuclear palsy (PSP)** who have trouble sleeping.

The study included 33 patients with Alzheimer's, 20 with PSP, and 32 volunteers who had healthy brains through the end of life.

The individuals were patients at the UC San Francisco Memory and Aging Center who had their sleep monitored with an **electroencephalogram** and donated their brains after they died. The study having access to patients both during their lives and after their deaths helped provide some long-unknown



answers. "We were able to prove what our previous research had been pointing to --

that in Alzheimer's patients who need to nap all the time, the disease has damaged the neurons that keep them awake," said Dr. Lea Grinberg, a neuropathologist who, along with psychiatrist Dr. Thomas Neylan, is a senior author on the study.

"It's not that these patients are tired during the day because they didn't sleep at night," Grinberg noted in the release. "It's that the system in their brain that would keep them awake is gone."

In the PSP patients, neurons that make them feel tired are damaged, so they are unable to sleep.

The research team measured the two proteins associated with the neurodegenerative

process, **beta amyloid** and tau, during the study. Though most past research has suggested beta amyloid accumulation is responsible, this team found the opposite. The PSP patients did not have a large amount of accumulated beta amyloid protein in their brains.

"But it turns out that they have none," Neylan said. "These findings confirm with direct evidence that **tau** is a critical driver of sleep disturbances."

"We see that these patients can't sleep because there is nothing telling the "awake" neurons to shut down," Grinberg said. "Now, rather than trying to induce these people to sleep, the idea is to shut down the system that's keeping them awake..."[Read More](#)

## Heart Disease & Sleepless Nights Often Go Together

(HealthDay News) -- Insomnia is widespread in heart disease patients and significantly boosts the risk of heart attack, stroke or other major heart event, a new study says.

The findings show the need to check for and treat sleep problems in heart disease patients, according to researchers.

"Our study indicates that insomnia is common in heart disease patients and is linked with subsequent cardiovascular problems regardless of risk factors, coexisting health

conditions and symptoms of mental health," said lead author Lars Frojd, a medical student at the University of Oslo in Norway.

The new study included more than 1,000 heart disease patients (average age: 62). They participated for an average 16 months after a heart attack and/or a procedure to open blocked arteries -- either bypass surgery or stent implantation.

At the start, 45% said they had **insomnia** and 24% said had used sleep medication in the



previous week. During an average 4.2-year follow-up, 225 patients had 364 major heart events. They included hospitalization for heart attack, restoring blocked blood flow, stroke, heart failure and cardiovascular death.

**Insomnia** accounted for 16% of repeat heart events, ranking it third in importance after smoking (27%) and inactivity (21%), according to findings presented Thursday at a virtual meeting of the European Society of Cardiology. The study was

also published in the journal *Sleep Advances*.

"This means that 16% of recurrent major adverse cardiovascular events might have been avoided if none of the participants had insomnia," Frojd said in a meeting news release.

He noted more research is needed to learn whether **insomnia treatments** such as cognitive behavioral therapy and digital applications would help heart patient

## U.S. Life Expectancy Drops for 2nd Year in a Row

Researchers report that life expectancy in the United States dropped in 2021, continuing a troubling trend that began in the first year of the pandemic.

Specifically, average U.S. life expectancy tumbled from 78.86 years in 2019 to 76.99 in **2020**. It then fell by a smaller amount in 2021, to 76.60 years, the new report found.

One thing was different about the latest longevity numbers: Losses in life expectancy among white Americans were largely responsible for that continuing trajectory, the new **study** found.

In 2020, Black and Hispanic Americans were disproportionately impacted by the pandemic amid chronic health disparities.

The research team speculated that the reason for the changing dynamics in 2021 could be vaccine hesitancy among some white Americans and a resistance to pandemic restrictions, including in states with disproportionately white populations.

"We already knew that the U.S. experienced historic **losses in life expectancy in 2020** due to the COVID-19 pandemic.



What wasn't clear is what happened in 2021. To our knowledge this is the first study to report data for 2021, and the news isn't good," corresponding study author Dr. Steven Woolf, director emeritus of the Center on Society and Health at Virginia Commonwealth University, said in a university news release.

"Early in 2021, knowing an excellent vaccine was being distributed, I was hopeful that the U.S. could recover some of its historic losses," said Woolf.

"But I began to worry more when I saw what happened as the year unfolded. Even so, as a scientist, until I saw the data it remained an open question how U.S. life expectancy for that year would be affected. It was shocking to see that U.S. life expectancy, rather than having rebounded, had dropped even further."

The emergence of the faster-spreading Delta and Omicron COVID-19 variants played a big role, the experts said....[Read More](#)