Rhode Island Alliance for Retired Americans ©

All Rights Reserved
© RI ARA 2020

RI ARA

Affiliated with the Rhode Island AFL-CIO
"Fighting for the future of our members."
"NOW, more than ever!!!"

April 5, 2020 E-Newsletter

Publication 2020 Issue 14
Published in house by the
RI ARA

U.S. stimulus package is biggest ever, but may not be big enough

The Federal Reserve has offered more than $3 trillion in loans and asset purchases in recent weeks to stop the U.S. financial system from seizing up, but it has not yet directly helped large swaths of the real economy: companies, municipalities and other borrowers with less than perfect credit.

That is partly because America's central bank is not allowed to take much credit risk itself, and loans to lower-rated borrowers have a higher chance of losses. The risk is exacerbated by efforts to stop the spread of coronavirus which have brought economic activity to a screeching halt.

To alleviate that constraint, the U.S. Treasury - whose job it is to manage the government's finances and help the Fed keep the economy steady - has taken on some of the risk that Fed loans will not be paid back.

It has contributed about $50 billion from a pool of money called the Exchange Stabilization Fund. That money will be used to absorb losses from Fed loans that go bad. Assuming only a fraction of loans will default, the Treasury contribution has allowed the Fed to lend much more without taking on additional risk.

On Friday, the Treasury got about $450 billion more from Congress as part of a $2.2 trillion U.S. stimulus package, greatly increasing its ability to support the economy. Before the bill passed, the stabilization fund had about $93 billion in assets as of the end of February.

Treasury Secretary Steven Mnuchin told Fox News on Sunday he believed the additional funds could help the Fed and Treasury provide about $4 trillion in loans.

But investors and economists said even this additional money may be insufficient, and Congress will likely need to pony up trillions of dollars more before the Fed and Treasury can make a significant dent in the real economy. If it does not, many U.S. companies and local governments are at risk of defaulting on debt or even going under.

That is because of the sheer size of the world's largest economy, the unprecedented scale of economic disruption caused by attempts to contain the virus and higher credit losses if the government has to step in to support weaker borrowers, according to these experts.

Scott Minerd, chief investment officer of Guggenheim Partners and member of an investor committee that advises the New York Federal Reserve on financial markets, told Reuters he believes the government needs to give the Treasury about $2 trillion to help prop up the economy.

Using expected losses from companies in the lowest tier of investment grade, Minerd estimates that the money approved last week might be only enough to absorb losses on loans of about $900 billion.

BARE MINIMUM

That is just a fraction of the roughly $9.5 trillion in outstanding U.S. corporate debt, much of which is either in the lowest-tier investment grade rating or already rated as junk, with a higher risk of default. Other areas that need support - such as the commercial paper market where borrowers go for short-term funding or the municipal market that local governments use to raise money for roads and schools – total trillions of dollars more.

"I think we'll be back at the table with another program before this is over," Minerd said in an interview.

With the $2 trillion that he recommends, he said, "you're on your way to have something of a big enough scale to get things propped up."...**Read More**

Republican Coronavirus Package Threatens Social Security, While Democrats Fight to Expand Benefits

The following is a statement from **Nancy Altman**, President of **Social Security Works**, on the coronavirus stimulus package currently under negotiation in the Senate:

"Senate Republicans are using the coronavirus crisis as a cynical cover to attack our Social Security system. The proposal they released on Thursday night **would allow** employers to 'defer' their Social Security insurance premiums (FICA contributions) until next January.

In practice, if this becomes law, it is highly unlikely that Congress would ever require the employers to repay the FICA contributions. Even simply restoring them would prove difficult, since Congress would be accused of raising taxes on businesses. Therefore, this should be viewed as a cut to Social Security's dedicated revenue.

The Republican plan would replace Social Security's dedicated revenue with deficit-funded general revenue, but this is a trap. Once the pandemic is done, Republicans will undoubtedly use the general revenue to demand cuts to Social Security in the name of 'reining in entitlements,' something they have **already expressed** their strong desire to do. Since there

are **much better** ways to deliver the same relief to employers, the only reason to deliver it this way is in the hope of undermining Social Security.

In contrast, Senate Democrats are fighting to expand Social Security's modest benefits so that seniors and people with disabilities, who are among the most vulnerable to the coronavirus, have the financial means to weather this crisis.

Senators Elizabeth Warren (D-MA) and Ron Wyden (D-OR), with the support of Democratic Leader Chuck Schumer (D-NY), **are proposing** to send an additional $200 a month to all Social Security beneficiaries, as well as the poorest seniors and people with disabilities receiving SSI, and veterans receiving veterans' pensions.

This will help beneficiaries afford housing, food, medicines, and other vital needs during this challenging time. As a byproduct, it showcases Social Security's efficiency and reach, which are so needed in this moment.

The Senate should adopt the Warren-Wyden plan, which builds on Social Security's strength, and discard the Republican plan, which weakens this vital program.

CMS Releases Coronavirus Guidance for Medicare Advantage and Part D Plans

On March 10, the Centers for Medicare & Medicaid Services (CMS) issued **guidance** around the requirements and flexibilities Medicare Advantage (MA) plans, Part D plans, and certain Medicare-Medicaid plans have to help provide health care coverage to people with Medicare for coronavirus testing, treatments, and prevention. The guidance identifies what plan sponsors must do during a disaster or emergency as declared by their states, and also what the plans are permitted to do. Since the issuance of the guidance, some of the optional flexibilities have become mandatory due to passage of federal legislation.

Medicare Advantage Provisions

Required MA Actions

In addition to **various emergency declarations** from the federal government, **all U.S. states, territories, and the District of Columbia have issued emergency declarations** in response to the coronavirus outbreak. Such declarations trigger special rules for MA plans under 42 CFR 422.100(m)(1).

This includes requiring them to cover Medicare Parts A and B services and supplemental Part C plan benefits furnished at non-contracted facilities if those facilities have participation agreements with Medicare. In addition, the plans must provide the same cost-sharing for the enrollee as if they had gone to a contracted facility.

During the emergency, MA plans must also make access to care easier by waiving requirements for gatekeeper referrals. Any permissible changes that plans make that benefit enrollees (such as reductions in cost-sharing and waiving prior authorizations, as discussed below) must immediately take effect. Normally, such adjustments would be subject to a 30-day notification requirement. Further, these changes must be uniformly applied to similarly situated enrollees who are affected by the emergency.

CMS also flags that all MA plans must have business continuity plans in place to ensure restoration of business operations following disruptions, including emergencies.

MEDICARE RIGHTS CENTER Getting Medicare right

Blog

Formerly Optional but Now Required MA Actions

When the guidance was issued, MA plans could waive cost-sharing for coronavirus testing and the associated provider visit. Since then, the **Families First Coronavirus Response Act** was signed into law, which waives deductibles and copayments or coinsurance for testing and associated provider visits. It also bars MA plans from using any type of prior authorization or other utilization management tools for the testing products or services.

Optional MA Actions

Other ways to ease beneficiary access are still optional. For example, plans may reduce or waive cost-sharing for additional services, including for telehealth benefits, without running afoul of the federal anti-kickback statute.

MA plans are already allowed to offer telehealth benefits not covered by Original Medicare, including visits for beneficiaries in any geographic area and from a variety of places, including the beneficiary's home. Beyond waiving cost-sharing, CMS guidance clarifies that MA plans may also expand telehealth benefits during times of emergency. Any such changes must apply to all similarly situated enrollees on a uniform basis.

Relatedly, using new authorities provided by the **coronavirus emergency supplemental bill**, CMS is also **lifting the geographic and originating site** telehealth restrictions for people with Original Medicare. Typically, these telehealth benefits are subject to the standard Part B deductible ($198 in 2020) and 20% coinsurance. However, **in complementary guidance**, the U.S. Department of Health & Human Services noted that it is allowing providers to reduce or waive these cost-sharing amounts for telehealth visits during the coronavirus public health emergency.

Medicare Part D Provisions

CMS refers Part D plans to previously issued emergency response guidance and outlines several additional actions sponsors may take during the coronavirus outbreak.

Required Part D Actions

Part D plans must have business continuity plans in place to ensure restoration of business operations following disruptions, including emergencies.

Plans must also ensure beneficiaries have adequate access to covered drugs dispensed at out-of-network pharmacies when needed. Enrollees remain responsible for any cost-sharing under their plan as well as additional out-of-network charge.

Regarding any drug shortages that may result from the coronavirus emergency, CMS notes plans should consult Section 50.13 of **Chapter 5 of the Part D manual** to determine next steps. That guidance notes, in part, that "when a drug shortage occurs, Part D sponsors should begin by considering the type of drug involved, condition (s) being treated by the drug, expected length of the drug shortage, and which enrollees are impacted. Based on this information, Part D sponsors can work with their enrollees and providers to find appropriate therapeutic alternatives."

In addition, CMS notes that if a coronavirus vaccine becomes available, Medicare will cover it. All Part D plans will be required to cover the vaccine if it is a Part D drug.

Optional Part D Actions

Prior CMS memos stated an expectation that Part D plans would relax "refill-too-soon" edits to provide enhanced access to Part D drugs at the point-of-sale and to permit beneficiaries to obtain the maximum extended day supply. The current guidance merely gives plans the option to do either or both. Importantly, both changes are permitted to extend beyond the expiration of disaster declarations and CMS urges plans to work closely with beneficiaries before reactivating such restrictions to ensure continuing access to needed medications.

In situations when a disaster or emergency makes it difficult for enrollees to get to a retail pharmacy, or enrollees are prohibited from going to a retail pharmacy (e.g., in a quarantine situation), plans may relax their policies to permit mail and home delivery.

Plans may also waive prior authorization requirements that would otherwise apply to Part D drugs used to treat or prevent coronavirus, if or when such drugs are identified. Any such waivers must be uniformly provided to similarly situated enrollees.

Medicare Rights will continue to monitor this evolving situation.

We will provide updates and information as available. If you have questions about your Medicare coverage and the coronavirus national emergency, please check our **coronavirus resource page** and call our National Helpline at 800-333-4114.

For the latest on Medicare coverage and services regarding COVID-19, read Medicare Rights' article on **What You Need to Know About Medicare Coverage and the Response to Coronavirus**. We are updating this resource ongoingly, as new information becomes available.

Last week, we weighed in with two coalition letters to Congress that outlined shared priorities for any future legislation:

For more information on the coronavirus, please visit the **Centers for Disease Control website.**

For information and resources specific to CMS, visit the agency's **Current Emergencies** website.

Medicare Rights Outlines Recommendations for Future Action Around Coronavirus

Older adults and people with disabilities are at **high risk** of infection and serious illness from coronavirus. While we appreciate the efforts of policymakers to date to respond to the outbreak, more must be done to anticipate and meet the unique needs of people with Medicare. This week, Medicare Rights sent letters to Congress and the Centers for Medicare & Medicaid Services (CMS), outlining our priorities and recommendations for future action.

Our **letter to Congress** urges lawmakers to prioritize older adults, people with disabilities, and their families in any forthcoming coronavirus relief legislation. We suggest a variety of policy options to improve Medicare enrollment, access and affordability, and prescription drug coverage; as well as to strengthen Medicaid and other programs that support community living.

We expect to refine this non-exhaustive list as the virus spreads, lawmakers respond, and needs change. Our initial set of investments and reforms includes those most clearly needed to promote the health and economic security of people with Medicare during this crisis and beyond. Where Congress can partner with federal agencies to achieve the stated goals quickly and without legislation, we support such approaches coupled with rigorous oversight.

Also this week, **we asked CMS** to take additional steps to address the needs of people with Medicare—specifically by improving the program's enrollment process.

As with our outreach to Congress, we expect to make future requests of CMS as the coronavirus pandemic continues. However, in the near-term, we are most concerned that if older adults and people with disabilities do not have health coverage, they may not be able to obtain medical treatment at a time when they need it most, worsening their own and the public's health outcomes.

Accordingly, our letter focuses on enrollment-related reforms under CMS's purview that are urgently needed to better facilitate access to care. This includes extending Medicare's open enrollment periods, closing months-long gaps in coverage, waiving late enrollment penalties (LEPs) program-wide, easing Medicare application requirements, holding beneficiaries harmless in any processing delays, and extending the availability of equitable relief for Medicare-eligible Marketplace enrollees.

Since the situation is constantly evolving, we urge CMS to put these flexibilities in place immediately and through the end of 2020, at a minimum, and longer if the public health and national emergency declarations extend beyond that date.

We recognize that Congress and CMS may need to work with additional agencies, like the Social Security Administration, to fully implement the policies and safeguards we recommended this week. Medicare Rights urges swift coordination and cooperation where needed. Now more than ever, we must work together to serve those in need and at risk.

For Medicare Rights, that means that as this crisis continues, so will our work. We remain dedicated to protecting and strengthening Medicare and other programs on which older adults, people with disabilities, and their families rely.

Read Medicare Rights' letter to Congress.

Read Medicare Rights' letter to CMS.

How prepared is the US to respond to COVID-19 relative to other countries?

A new analysis and chart collection finds that the U.S. has fewer hospital beds and practicing physicians per capita than many similarly large and wealthy countries with health care systems already strained by the ongoing COVID-19 pandemic.

The ongoing novel coronavirus pandemic has already overwhelmed the health systems of several countries and is **projected to overburden** the health system in the United States. A surge in patients with the new coronavirus disease (**COVID-19**) would challenge the ability of the U.S. healthcare system to treat all patients, including those in need of care for other conditions.

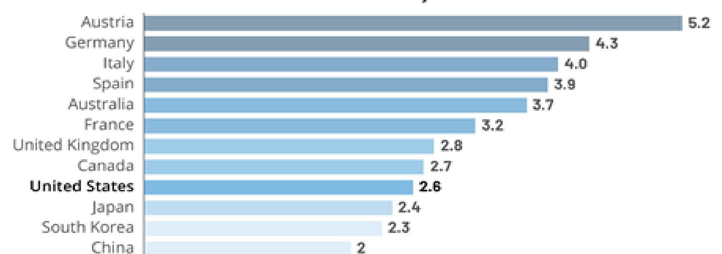
The following charts highlight available cross-national data on the healthcare workforce, hospital resources, and at-risk populations in select countries. Additional charts explore coverage and affordability barriers that may limit access to care or cause serious financial burden for those needing COVID-19 treatment. Where data are available, we compare the U.S. to countries that are similarly large and wealthy (Australia, Austria, Belgium, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, the United Kingdom) as well as other countries that have a large number of patients with COVID -19 (China, Italy, Iran, South Korea, and Spain).

Compared to most similarly large and wealthy countries, the U.S. has fewer practicing physicians per capita but has a similar number of licensed nurses per capita. Looking specifically at the hospital setting, the U.S. has more hospital-based employees per capita than most other comparable countries, but nearly half of these hospital workers are non-clinical staff. Overall, the U.S. has fewer hospitals and hospital beds per capita compared to other similar countries.

The burden of disease due to medical conditions that put people at increased risk of severe complications from COVID-19 is higher in the U.S. than in comparable countries. Additionally, patients in the U.S. are more likely to face higher out-of-pocket costs and to be uninsured than in other comparable countries.

Visit the **Health System Dashboard** to explore additional indicators of health spending, quality of care, access to care, and health outcomes in the U.S. and comparable countries.

In countries where disease burden for high-risk conditions is high, more people may be at risk of severe complications from COVID-19. The long-term effects of COVID-19 are currently unknown, but disease burden may increase in all countries as more people contract and recover from the virus….**Read an View more Charts.**



Wisconsin Alliance Sues State of Wisconsin Over Absentee Ballot Law

Registered Voters and Voting Rights Groups Sue Over Absentee Ballot Signature Mandate During COVID-19 Pandemic

MADISON – Today, the Wisconsin Alliance for Retired Americans, the League of Women Voters of Wisconsin and four registered Wisconsin voters filed a lawsuit in the U.S. District Court for the Western District of Wisconsin seeking to protect the rights of self-quarantining voters who cannot obtain a witness signature on their mail-in ballot during the COVID-19 pandemic.

The lawsuit alleges that due to the severe health threat posed by the COVID-19 pandemic, many Wisconsin voters will be forced to vote by mail-in absentee ballot and, because the state requires each voter to secure a witness signature, it will prevent certain eligible voters who live alone or without an adult U.S. citizen in the household from casting a vote.

The plaintiffs allege that this constitutes an undue burden on the right to vote not justified by any legitimate or important government interest in violation of the First and Fourteenth Amendments to the U.S. Constitution. They are asking the Court to issue an order that would prevent the State of Wisconsin from rejecting and/or refusing to process and count absentee mail-in ballots that lack a witness signature during the COVID-19 pandemic.

"While we appreciate the efforts by the state to expand voting in light of the pandemic, the Wisconsin law requiring a witness signature for every absentee ballot presents an unreasonable barrier to voters that does nothing to increase the safety of casting a ballot," said Debra Cronmiller, executive director of the League of Women Voters of Wisconsin. "Not addressing this particular measure complicates the process for the voters of Wisconsin and would have the impact of depressing turnout or unnecessarily exposing vulnerable voters."

"It is unconscionable –and unconstitutional – to force people to choose between their health and their right to vote," said Jon Sherman, senior counsel at Fair Elections Center. "In the face of a global pandemic and emergency orders mandating self-isolation, a state law requirement to obtain a witness signature on a mail-in ballot simply cannot stand."

"The right to vote is sacred. Older Americans take this civic responsibly very seriously," said Marlene Ott, president of Wisconsin Alliance for Retired Americans. "There are more than 890,000 seniors registered to vote in Wisconsin. This law puts all of us in an impossible position. Either we put our health at risk by violating the public health directive to self-isolate, or we give up our right to vote. We are calling on the courts to act and ensure that older people in Wisconsin are not needlessly disenfranchised."

Along with the organizations, the plaintiffs include Wisconsin voters Sylvia Gear, an 83-year-old retired teacher from Cudahy; Dr. Malekeh K. Hakami, a 73-year-old clinical psychologist from Pewaukee; Patricia Ginter, a 72-year-old realtor from Wauwatosa; and Claire Whelan, a 64-year-old retiree from Appleton. All the individual plaintiffs live alone. They are all self-quarantining in compliance with Wisconsin Gov. Tony Evers' emergency order and because they are at higher risk due to their age and/or underlying medical conditions.

The plaintiffs are represented by Jon Sherman, Michelle Kanter Cohen, and Cecilia Aguilera at Fair Elections Center, and Doug Poland at Rathje Woodward LLC in Madison.

'Red Dawn Breaking Bad': Officials Warned About Safety Gear Shortfall Early On, Emails Show

A high-ranking federal official in late February warned that the United States needed to plan for not having enough personal protective equipment for medical workers as they began to battle the novel coronavirus, according to internal emails obtained by Kaiser Health News.

The messages provide a sharp contrast to President Donald Trump's statements at the time that the threat the coronavirus posed to the American public remained "very low." In fact, concerns were already mounting, the emails show, that medical workers and first responders would not have enough masks, gloves, face shields and other supplies, known as PPE, to protect themselves against infection when treating COVID-19 patients.

The emails, part of a lengthy chain titled "Red Dawn Breaking Bad," includes senior officials across the Department of Veterans Affairs, the State Department, the Department of Homeland Security and the Department of Health and Human Services, as well as outside academics and some state health officials. KHN obtained the correspondence through a public records request in King County, Washington, where officials struggled as the virus set upon a nursing home in the Seattle area, eventually killing 37 people. It was the scene of the first major outbreak in the nation.

"We should plan assuming we won't have enough PPE — so need to change the battlefield and how we envision or even define the front lines," Dr. Carter Mecher, a physician and senior medical adviser at the Department of Veterans Affairs, wrote on Feb. 25. It would be weeks before front-line health workers would take to social media with the hashtag #GetMePPE and before health systems would appeal to the public to donate protective gear.

In the email, Mecher said confirmed-positive patients should be categorized under two groups with different care models for each: those with mild symptoms should be encouraged to stay home under self-isolation, while more serious patients should go to hospital emergency rooms.

"The demand is rising and there is no guarantee that we can continue with the supply since the supply-chain has been disrupted," Eva Lee, director of the Center for Operations Research in Medicine and HealthCare at Georgia Tech and a former health scientist at the Atlanta VA Medical Center, wrote that same day citing shortages of personal protective equipment and medical supplies. "I do not know if we have enough resources to protect all frontline providers."

Reached on Saturday, Lee said she isn't sure who saw the message trail but "what I want is that we take action because at the end of the day we need to save patients and health care workers."

Mecher, also reached Saturday, said the emails were an "an informal group of us who have known each other for years exchanging information." He said concerns aired at the time on medical protective gear were top of mind for most people in health care. More than 35 people were on the email chain, many of them high-ranking government officials.

The same day Mecher and others raised the concern in the messages, Trump made **remarks** to a business roundtable . "We think we're in very good shape in the United States," he said, noting that the U.S. closed the borders to some areas. "Let's just say we're fortunate so far. And we think it's going to remain that way."...**Read More**

Coronavirus: Medicare Advantage plans doing little to ensure their members get needed care

In the face of the novel coronavirus pandemic, the Centers for Medicare and Medicaid Services (CMS) has mandated that Medicare Advantage plans–corporate health plans that offer Medicare benefits–remove certain restrictions on covered care. Unfortunately, it does not appear that these private plans are letting their members know. Based on the information available on their web sites, they are doing precious little to ensure their members get needed care, endangering the lives of hundreds of thousands of older adults and people with disabilities.

CMS is requiring Medicare Advantage plans to cover coronavirus-related treatment from out-of-network providers in Medicare-participating facilities at the same cost as at in-network facilities. And, people do not need a referral to be covered. Virtually all hospitals in the US are Medicare-participating facilities.

Shockingly, **UnitedHealthcare**, **Humana** and **Aetna** coronavirus web pages do not mention these expanded protections for people in Medicare Advantage plans needing coronavirus treatment. In fact, they are largely silent on coverage for treatment. UnitedHealthcare, Humana and Aetna combined cover **half of all Medicare Advantage enrollees**.

It appears that Medicare Advantage plans are also keeping all cost-sharing and prior authorization requirements in place for people needing coronavirus treatment. **CMS issued guidance** allowing them to waive these requirements, but not mandating that they do so.

Because out-of-pocket costs can be very high for people needing hospital care, **one in four people with corporate health insurance skip treatment**. Of course, deductibles, coinsurance and other barriers to care in Medicare Advantage plans will keep thousands, if not tens of thousands, of older adults and people with disabilities from getting needed treatment. But, they presumably will help Medicare Advantage plans' bottom lines.

A new **Kaiser Family Foundation** paper shows that people in Medicare Advantage plans who are hospitalized for seven or more days will spend more out of pocket for their care than they would had they been in traditional Medicare. Nine in ten people in traditional Medicare will spend nothing or close to nothing because they have supplemental coverage through Medigap, Medicaid or a former employer, which pays for all or virtually all out-of-pocket costs.

The six million people in traditional Medicare who do not have supplemental coverage that picks up the cost of the Part A deductible must pay $1,408 out of pocket if they are hospitalized. After that, they pay nothing for the next 60 days of hospitalization. For most people in Medicare Advantage plans, the average out-of-pocket cost is $1,762 for a seven-day hospital stay and $2,039 for a ten-day stay. Hospitalizations related to treatment for Covid-19, the disease caused by the coronavirus, can be far longer than ten days.

Federal Judge Rules Medicare Patients Can Challenge 'Observation Care' Status

Hundreds of thousands of Medicare beneficiaries who have been denied coverage for nursing home stays because their time in the hospital was changed from "inpatient" to "observation care" can now appeal to Medicare for reimbursement, a federal judge in Hartford, Connecticut, ruled last week.

If the government does not challenge the decision and patients win their appeals, Medicare could pay them millions of dollars for staggeringly high nursing home bills.

To receive coverage for nursing home care, patients must first be admitted to the hospital as inpatients for three consecutive days. Time spent in the hospital for observation doesn't count, even though they may stay overnight and receive some of the same treatment and other services provided to inpatients.

And there's another big difference: While inpatients can file an appeal with Medicare if they question any other coverage denial, observation patients cannot. So, in 2011, seven Medicare beneficiaries and their families sued the Department of Health and Human Services, in what became a nationwide **class action lawsuit**.

On Tuesday, U.S. District Judge Michael Shea ruled that the patients are entitled to appeal if they are admitted as inpatients to the hospital by their doctor but later switched to observation care by their hospital. However, he said patients whose doctors initially place them in observation care under Medicare's "two-midnight" rule cannot appeal because that rule requires doctors to base their decision on medical judgment. If the doctor determines that a patient's stay is unlikely to stretch over two midnights, the patient would most likely receive observation care, though there are exceptions.

Shea's **decision** applies to all traditional Medicare beneficiaries who experienced such a switch since Jan. 1, 2009, spent at least three days in the hospital and were enrolled in Medicare's Part A hospital benefit. If they win their appeal, most hospital expenses and any nursing home bills they paid would be reimbursed under Part A.

Shea estimated that hundreds of thousands of beneficiaries would be able to seek repayment.

Lawyers at the Department of Justice argued that doctors and hospitals make admission decisions so patients can't ask the government to change a decision it didn't make. A DOJ spokeswoman declined to comment on the decision or whether the government would appeal. They have until May 25 to decide.

But the physician's decision is not final because it is "reviewed by the hospital's 'utilization review staff,' a team each hospital participating in the Medicare program must have in place to review whether the physician's decision is correct under mandatory, nationwide standards set by the Centers for Medicare and Medicaid Services," the judge wrote.

Alice Bers, litigation director at the Center for Medicare Advocacy, one of the groups representing the plaintiffs, said the decision recognized that "Medicare coverage is subject to due process protection."

"If I had gone home, I would have died," said Ervin Kanefsky, 94, a plaintiff from suburban Philadelphia. He was admitted to the hospital as an inpatient after fracturing his shoulder in a fall. When he was about to leave after five days to recuperate at a nursing home, a hospital official told him his status had changed to observation. With one arm in a sling, stitches in the other and unable to hold onto his walker, he learned Medicare wouldn't pay for the nursing home.

"I had to pay $2,000 just to get in the door," he said, and his month-long stay in 2016 cost $9,145. He called Medicare numerous times, wrote a letter to the hospital's president and contacted his congressman for help. "I tried every which way," he said, to no avail.

Medicare has temporarily suspended the three-day inpatient admission requirement during the coronavirus emergency.

Congress Should Cap Out-of-Pocket Costs For Medicare Part D Prescription Drugs

Seventy-eight percent of retirees think Congress should cap what Medicare beneficiaries must spend out-of-pocket on prescription drugs, according to new survey by **The Senior Citizens League (TSCL)**. Unlike other types of insurance, Medicare Part D has no annual out-of-pocket maximum. This leaves the sickest retirees spending hundreds, or even thousands, of dollars in pharmacy costs for prescription medications every year.

Capping the Part D out-of-pocket spending requirement is a key provision of the bi-partisan Senate drug bill, **"Prescription Drug Pricing Reduction Act of 2019"** (S.2543). "Several of the provisions of this bill appear to have broad support with Medicare beneficiaries," notes Mary Johnson, a Medicare and Social Security policy analyst for The Senior Citizens League. The new survey found widespread support among survey participants for capping Medicare Part D out-of-pocket requirements at no more than $250 per month ($3,000) per year. About 36 percent of survey participants reported spending up to $250 per month on prescriptions in 2019, and another 21 percent spent more than that.

The bill would limit price increases in drugs covered by Medicare Part D plans to the rate of inflation or drug makers would be forced to pay a penalty in the form of a rebate. "Since Social Security benefits only grow at the rate of inflation, it would help level the playing field if the cost of prescription medications were required to be adjusted in like fashion," Johnson notes. Research on typical retiree costs conducted by Johnson has found that from 2000 to 2019, annual cost – of – living adjustments (COLAs) increased Social Security benefits by 50 percent but spending on prescription drugs grew five times faster — 253 percent — over the same period.

Reducing prescription drug prices is a top issue for older voters. Seventy – two percent of survey participants support a proposal to tie Medicare Part D drugs prices to those paid in other industrialized nations, through the use of an "international drug pricing index" — an approach similar to prescription drug legislation passed by the House (H.R. 3).

The Senior Citizens League encourages older Americans to contact their Senators now to ask for their support in passing this legislation. To learn more, visit **www.SeniorsLeague.org.**

What Takes So Long for COVID 19 Test Results?

After a slow start, testing for COVID-19 has ramped up in recent weeks, with giant commercial labs jumping into the effort, drive-up testing sites established in some places and new types of tests approved under emergency rules set by the Food and Drug Administration.

But even for people who are able to get tested (and there's still a big lag in testing ability in hot spots across the U.S.), there can be a frustratingly long wait for results — not just hours, but often days. Sen. Rand Paul (R-Ky.) didn't get his positive test results for six days and is now being criticized for not self-quarantining during that time.

We asked experts to help explain why the turn-around time for results can vary widely — from hours to days or even a week — and how that might be changing.

It's A Multistep Process

First, a sample is taken from a patient's nose or throat, using a special swab. That swab goes into a tube and is sent to a lab. Some large hospitals have on-site molecular test labs, but most samples are sent to outside labs for processing. More on that later.

That transit time usually runs about 24 hours, but it could be longer, depending on how far the hospital is from the processing lab.

Once at the lab, the specimen is processed, which means lab workers extract the virus's RNA, the molecule that helps regulate genes.

"That step of cleaning, the RNA extraction step, is one limiting factor," said Cathie Klapperich, vice chair of the department of biomedical engineering at Boston University. "Only the very biggest labs have automated ways of extracting RNA from a sample and doing it quickly."

After the RNA is extracted, technicians also must carefully mix special chemicals with each sample and run those combinations in a machine for analysis, a process called polymerase chain reaction (PCR), which can detect whether the sample is positive or negative for COVID.

"Typically, a PCR test takes six hours from start to finish to complete," said Kelly Wroblewski, director of infectious disease programs at the Association of Public Health Laboratories.

Some labs have larger staffs and more machines, so they can process more tests at a time than others. But even for those labs, as demand grows, so does the backlog.

Capacity Is Expanding, But Not Enough

Initially, only a few public health labs and the federal Centers for Disease Control and Prevention processed COVID-19 tests. Problems with the first CDC test kits also led to delays.

Now the CDC has a better kit, and 94 public health labs across the country do COVID-19 testing, said Wroblewski.

But those labs can't possibly do all that's needed. In normal times, their main function is regular public health surveillance — detecting more common threats such as outbreaks of measles or monitoring seasonal influenza — "but not to do diagnostic testing of the magnitude that is required in this response," she said.

Large commercial labs like those run by companies such as Quest Diagnostics and LabCorp were given the go-ahead late last month by the FDA to start testing, too.

The FDA has said it won't stop certain private labs — those that are already certified to perform complex testing — and diagnostic companies from developing their own test kits. Labs at some big-name hospital systems, such as Advent Health, the Cleveland Clinic and the University of Washington, are among those doing this.

In addition, the FDA has approved more than a dozen testing kits by various manufacturers or labs under special emergency **rules** designed to speed the process. Those include tests by Quest Diagnostics, LabCorp, Roche, Quidel Corp. and others. The kits are used in PCR machines, either in hospital labs or large commercial labs.

"A chief medical officer on the East Coast said that, up until two days ago, on average it was taking 72 hours to get results,"

Even so, supply is not keeping up with demand, Roche CEO Severin Schwan told CNBC on March 23. Roche won the first approval from the FDA for a test kit under emergency rules, and it has delivered more than 400,000 kits so far.

"Demand continues to be much higher than supply," Schwan told **CNBC**. "So we are glad that overall capacity is increasing, but the reality is that broad-based testing is not yet possible."

How Many Tests Can Be Done At A Time? ...**Read More**

Why Seniors Don't Report Being the Victim of a Scam

Older adults are often the target of scams. It's an unfortunate reality that causes adult children to worry if an aging parent's financial well-being is at risk. Summer has typically been the busiest season for crimes against seniors. Fake home remodelers, roofers, and driveway repair companies head out in full force when the weather warms up.

There is another time of year, however, that is almost as risky as summer—*tax season*. Experts say identity theft and filing fraudulent tax returns cost seniors billions.

Losses from Scams Are Significant

The Internal Revenue Service (IRS) has detection programs that are helping to decrease losses. As of February 29, 2016, the IRS had successfully prevented 31,578 fraudulent tax returns. Their identity-theft filters helped to prevent $193.8 million in fraudulent tax refunds from being issued.

Unfortunately, older adults are still falling victim to fraud and scams. **Experts from the Federal Bureau of Investigations (FBI)** say the trusting nature of adults raised in the 1930s, 1940s, and 1950s is a leading reason they become victims.

When seniors do suffer a loss, many are unlikely to report it. While there are a variety of reasons why an older adult may not report the crime to authorities, here is a list of the most common reasons:

- **Embarrassment:** No one wants to admit they've been conned. It can be embarrassing at any age. Seniors are no different. Many just want to accept their loss and move on before anyone finds out.
- **Fear:** Another reason an older adult may withhold the situation from authorities and their family is out of fear. They may worry an adult child will think they are incapable of making their own decisions or managing their money. This doubt in their abilities may lead to reduced independence.
- **Unaware:** An older adult might not be aware that they are the victim of a crime. Identity theft can go undetected until you apply for a credit card, car loan, or other bank loan. Then it quickly becomes obvious someone else is using your identity.

Preventing Common Scams Targeting Seniors

Prevention is the key when it comes to fraudulent scams. Here are a few tips you can use to protect an older family member:

- **Utilize telephone technology:** Encourage your family member to use Caller ID for every call received, and to not answer when the number isn't recognized. Because many scams targeting seniors begins with a phone call, utilizing Caller ID can help lower that risk. Also, make certain your senior loved one is signed up for the **Do Not Call Registry** on both home and cell phones.
- **Monitor credit report and credit cards:** The law requires that each of the three major credit-reporting companies provide consumers with a free annual credit report. Encourage your aging loved one to take advantage of this service in order to check for irregularities. It can also help to sign up with a credit monitoring service so you are notified of any attempts to file for credit in the senior's name. Finally, talk with your loved one's bank and credit card companies about programs they offer. Many will send a text or email alert if the card number is used without the card being scanned or if spending amounts reach a predetermined limit.
- **Store insurance and Social Security cards:** Another essential step in protecting a senior's identity is by safely storing identifying personal information, such as insurance, Social Security, and Medicare cards. Take them out only on the days they will be required for appointments.

USDA, States Must Act Swiftly to Deliver Food Assistance Allowed by Families First Act

The Families First Coronavirus Response Act[1] provides temporary new authority and broad flexibility for the Agriculture Department (USDA) and states to adapt the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) to address many people's food needs during the current public health emergency and economic shock from the COVID-19 pandemic. USDA and states need to act quickly and aggressively to fully utilize SNAP in order to protect public health and mitigate hardship.

The scope of what USDA will allow and what states will ask for is still unknown in this rapidly changing environment. State and local agencies that run the nutrition programs are working to understand their communities' needs and the changes they can make quickly to address them while keeping their workforce safe. Despite recent advances in online services for participants, SNAP in most states includes much in-person interaction between clients and state eligibility workers, as well as a business model that often has large numbers of state staff working in office buildings. Even as states decide how to operate SNAP in a social distancing environment, they are beginning to see increased demand for SNAP due to losses of jobs and income. On March 20 USDA issued a first round of guidance on some of the key benefit provisions. One hopes that the agency will soon issue additional guidance on the waivers and flexibilities it will quickly approve in order to save already overburdened states the time of developing individual waivers and delaying getting food to needy households.

Benefit increases to boost resources available for food. States can provide short-term benefit increases with approval from USDA under two different provisions.

- The Act allows states to provide emergency supplemental SNAP benefits to many participating SNAP households to address temporary food needs. This would likely be the fastest way to get resources for food into the hands of many SNAP recipients. Unfortunately, USDA is interpreting this provision to leave out SNAP benefit increases for the poorest SNAP households — those who already receive the maximum SNAP monthly benefit.[3]
- For households with children who attend a school that's closed and who would otherwise receive free or reduced-price meals, states may provide meal-replacement benefits through SNAP for households already receiving SNAP, and may make "issuances" to households with school-age children that are not already enrolled in SNAP. This provision can compensate families for the cost of the meals their children are missing out on because their schools are closed.[4] Since more than 90 percent of school -age children who receive SNAP are automatically enrolled for free school meals, USDA should aim to give states a quick way to deliver this benefit as well.[5] Many states may need some time to get the process in place for families with school-age children that do not already receive SNAP.

Nothing in the legislation or USDA's preliminary guidance prohibits a household from benefitting from both provisions. ...**Read More**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Not So Fast Using CPAPs In Place Of Ventilators. They Could Spread The Coronavirus.

The limited supply of ventilators is one of the chief concerns facing hospitals as they prepare for more COVID-19 cases. In Italy, where hospitals have been overwhelmed with patients in respiratory failure, doctors have had to make difficult life-or-death decisions about who gets a ventilator and who does not.

In the U.S., emergency plans developed by states for a shortage of ventilators include using positive airway pressure machines — like those used to treat sleep apnea — to help hospitalized people with less severe breathing issues.

While that measure could stretch the supply of ventilators and save lives, it has a major drawback. Officials and scientists have known for years that when used with a face mask such alternative devices can possibly increase the spread of infectious disease by aerosolizing the virus, whether used in the hospital or at home.

Indeed, that very scenario may have contributed to the spread of COVID-19 within a Washington state nursing home that became ground zero in the United States early on. First responders called to the Life Care Center of Kirkland **starting Feb. 24** initially used continuous positive airway pressure machines, often known as CPAPs, to treat residents before it was known the patients were infected with the COVID-19 virus.

"It's best practice for us for people with respiratory illnesses," said Jim Whitney, medical services administrator for the Redmond Fire Department, whose crews responded to the nursing home's 911 calls. "We had no idea that we potentially had COVID patients there."

It was only later that King County public health officials advised Redmond Fire and other first responders in the region not to use those machines for patients suspected of having COVID-19 illness. Whitney said responders were using the machines with specialized filters, which can reduce the amount of virus released. But county public health authorities recommend that first responders avoid using CPAP altogether. Redmond Fire has now discontinued the use of CPAPs for COVID-19 patients.

….**Read More**

AHA News: Dropping Blood Pressure May Predict Frailty, Falls in Older People

Blood pressure that goes down when you stand up is associated with frailty and falls in older people, according to a new study that advocates more testing.

The research, published Monday in the *Journal of the American Heart Association*, delved into the relationship between geriatric patients and orthostatic hypotension – a type of low blood pressure that occurs when you stand up, sometimes causing you to feel dizzy or lightheaded. The condition occurs in 5% to 30% of people over 65.

Researchers tested 168 men and women, with an average age of 81, who visited a geriatric outpatient clinic for cognitive or mobility problems. Their blood pressure was continuously monitored as they were asked to lie down for five minutes, then stand up and stay standing for three minutes.

The study found dropping systolic blood pressure rates had the strongest association with how frail the person was and the number of falls they had in the past year. Systolic is the top number in a blood pressure reading, and diastolic is the bottom number. Frailty was measured by four factors: mobility, incontinence, cognitive function and activities of daily life.

The magnitude of diastolic blood pressure drop had the strongest association with a different set of frailty markers: unintentional weight loss, exhaustion, physical inactivity, walking speed and handgrip strength.

While low blood pressure isn't necessarily a problem for healthy people, testing a geriatric person's blood pressure drop rate could be a meaningful way to predict who is likely to become frail and fall, said Dr. Andrea Maier, the study's lead author.

"Frailty is a major problem because it means you're likely not able to continue to live independently and you're likely to die in the coming years. Knowing why frailty and falls occur is very important," said Maier, a geriatrician and professor at the University of Melbourne and Vrije University in Amsterdam.

Low blood pressure in geriatric patients can be a sign of inadequate blood flow to other vital organs, including the heart and brain, she said.

"If you're blood isn't flowing and it's hard to stand up, it's a bit like the electricity has been shut off to the body," Maier said. "As medical professionals, we sometimes think about treating one organ and we forget that organs interact together, like a network."

Dr. Jeff Williamson, who was not involved in the study, said the findings serve as a reminder that doctors need to keep a close eye on the subset of geriatric patients with orthostatic hypotension.

"You also need to be careful that blood pressure medicine is not contributing to this, although in the vast majority of people, that's not the case, and it's safe to treat their blood pressure to guideline level," said Williamson, a professor of gerontology and geriatric medicine at Wake Forest University in Winston-Salem, North Carolina. He also is chief of geriatric medicine at Wake Forest Baptist Health. Williamson was part of the writing committee for the most recent blood pressure guidelines issued in 2017 by the American College of Cardiology and American Heart Association.

He said the new study was limited by its design. "This is an association study that doesn't say low blood pressure causes frailty. It just says frailty and low blood pressure walk hand-in-hand."

Williamson called for future studies on which types of blood pressure medication – and what dosage – works best for frail geriatric patients with low blood pressure. He'd also like to see research on whether moderate exercise and a better diet could help older people with orthostatic hypotension.

Maier said she's conducting research on oxygenation levels of blood in the brain to better understand how it is impacted by orthostatic hypotension. "We're trying to individualize our diagnostics so we can have personalized care for blood pressure regulation."

In the meantime, she asked clinicians to be more aggressive in testing geriatric patients for orthostatic hypotension with the same measurement used in the study: Lie down for five minutes, then stand up and stay standing for three minutes, all with continuous blood pressure monitoring.

"It takes eight minutes, which is a long time for a doctor, and that's why it's been a bit neglected in clinical practice," Maier said. She advises older people to talk to their doctors "if you don't feel well when you stand up, or you've had a fall in the past, or you just think 'I'm declining physically.' Given all the knowledge we have, the test should be routinely done."

Preventing Repeat Heart Attack, Stroke More Important Than Ever: AHA

With the new coronavirus severely straining the U.S. health care system, experts are calling on heart attack and stroke survivors to take extra steps to reduce their risk of a repeat event.

The American Heart Association (AHA) said current information suggests that elderly people with heart disease or high blood pressure are more likely to be infected with the coronavirus and to develop more severe symptoms. And stroke survivors may be at increased risk for complications if they're infected and get sick.

Up to 25% of people who survive a heart attack or stroke will have another one. Lifestyle changes and working closely with your doctor to manage your health can help minimize that risk, the AHA explained in a news release.

"What many people don't realize is the hidden risks that led to your first event may be managed and, by doing this, you may reduce your risk of having another one," said Dr. Nieca Goldberg, medical director of the NYU Women's Heart Program in New York City. She is also an AHA volunteer.

Up to 80% of heart attacks and strokes are preventable. Goldberg suggests talking to your doctor about a secondary prevention plan, and following these AHA guidelines:

- **Take your medications as prescribed.** Make sure you have enough of your medicines to last for an extended time. If necessary, ask your doctor and pharmacist if a larger amount can be prescribed.
- **Get meds by mail, if possible.** To avoid possible exposure to the coronavirus, getting medications by mail-order may be an option. Check the U.S. Centers for Disease Control and Prevention on recommendations for getting medications.
- **Ask your doctor about aspirin.** Taking aspirin as recommended by a doctor is one way to help prevent another attack. Never start, stop or modify an aspirin regimen without consulting your doctor first.
- **Follow doctor's orders.** Manage your risk factors -- such as high blood pressure, high cholesterol and diabetes -- by taking medications as prescribed, not smoking, eating healthy and being active.
- **Keep follow-up medical appointments.** This helps your doctors keep track of your condition and recovery. Ask if a virtual visit is possible.
- **Try online rehab.** Take part in virtual cardiac rehabilitation, a medically supervised program designed to help you recover after a heart attack. Ask if there are exercises you can do at home.

Finally, lean on loved ones and other heart attack or stroke survivors for moral support. They can help you cope when you are scared, confused or overwhelmed. With many local support group meetings canceled due to the coronavirus pandemic, the AHA's free online support network can help you get connected.

Coronavirus: Coping Tips & Resources for Seniors and the Elderly

Coronavirus (COVID-19 and SARS-CoV-2) is impacting everyone around the world, and particularly seniors and the elderly, who are thought to be most at risk of catching the virus. *The Doctors* share important tips and resources for those most vulnerable.

1. Make sure you or your older loved ones (and those with chronic medical conditions like heart disease, diabetes, and lung disease are prepared with adequate supplies, practicing proper social distancing, and avoiding crowds and travel. The CDC stresses if there is a coronavirus outbreak in your community to stay in your home as much as possible. Get more tips on how to prepare your home and family,
2. Always practice coronavirus prevention, including frequent hand-washing, avoiding high-touch surfaces in public, not touching your face, mouth or nose, and cleaning and disinfecting tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks, and phones regularly. *The Doctors* share more coronavirus prevention tips, along with cleaning tips to prevent viruses.
3. If the current situation is causing financial issues with your utility, phone, internet or car payment, there are programs in place to help strapped consumers. Many companies are providing relief for customers experiencing financial hardships including Comcast, PG&E, AT&T, Verizon Hyundai, Ford, Duke Energy, and many more companies.
4. Are you or an older loved one having trouble with resources like food? Programs like Meals on Wheels and Feeding America can help.
5. Feeling stressed out and not sure what to do? *The Doctors* share these tips, tricks and food ideas that may help to alleviate your anxiety and stress. Plus, check out these 5 exercise suggestions for seniors (that can be done while still practicing good social distancing) and also consider downloading a meditation app, both of which have been shown to help people during times of stress or anxiety.
6. Feeling antsy about being stuck at home? Consider going on a virtual museum tour at places like New York's Museum of Modern Art and Amsterdam's Van Gogh Museum. Also, virtually enjoy national parks like Yellowstone and Yose mite. Get even more great ideas about places to visit virtually from the safety of your home.
7. The toll of social distancing (feeling blue or lonely) might be eased with something new to watch, read or do. Help your older loved ones set up a new streaming platform and help them download new content on their devices. Our friends at CNET have a list of places for free TV, movies, video games, magazines, ebooks, and audiobooks.

Stay informed on the **latest information on the coronavirus from the Centers for Disease Control and Prevention and the World Health Organization and learn about prevention methods and what to do if you are infected.*

Other Links

- **The Dos and Don'ts of 'Social Distancing'**
- **How Far Does a Cough or a Sneeze Travel? Asking for a Friend.**
- **Is Your State Doing Enough to Combat the Coronavirus?**
- **20 Unhealthiest Home Habits During This Virus**
- **How to prepare for coronavirus quarantine if you or a loved one has Covid -19**
- **You can still go outside while social distancing, but you'll need to take some precautions**
- **Can you contract coronavirus from delivery packages?**
- **'Social Distancing' Is Not Just A New Buzz Word. It's The Most Important Thing You Can Do.**

Odds of Hospitalization, Death With COVID-19 Rise Steadily With Age: Study

Once infected with the new coronavirus, a 20-something has about a 1% chance of illness so severe it requires hospitalization, and that risk rises to more than 8% for people in their 50s and to nearly 19% for people over 80, a comprehensive new analysis finds.

On the other hand, the death rate from COVID-19 is significantly lower than that seen in prior estimates, the new report found. Among diagnosed cases, just under 1.4% of patients will die, according to a team led by Neil Ferguson, of the Imperial College London.

And when undiagnosed cases -- typically individuals with mild or no symptoms -- are added into the mix, the overall death rate from coronavirus infections drops further to 0.66%, the British researchers found.

That's still much higher than the 0.02% death rate observed during the H1N1 flu season of 2009, the investigators noted.

A person's odds for death after infection with the new coronavirus also rose with age. An estimated 0.031% of people in their 20s will die, the new analysis found, compared to 7.8% of people over 80.

The new report, based on data from almost 44,700 cases occurring in mainland China, was published March 30 in *The Lancet Infectious Diseases* medical journal.

"Our estimates can be applied to any country to inform decisions around the best containment policies for COVID-19," said study co-author Azra Ghani, also from Imperial College London.

While the tragic deaths of young people from COVID-19 may get a lot of media play, she said, older patients are still in the most danger.

"Our analysis very clearly shows that at age 50 and over, hospitalization is much more likely than in those under 50, and a greater proportion of cases are likely to be fatal," Ghani said in a journal news release.

Early on in the pandemic, the World Health Organization issued a COVID-19 death rate of 3.4% -- a relatively high death toll. But as the London researchers pointed out, that number was based on a tally that only included cases severe enough to have been brought to medical attention and diagnosed.

It's thought that many more cases are either mild or asymptomatic, or the person infected simply can't access a coronavirus infection test kit.

The new analysis of Chinese cases attempted to account for that discrepancy. Ferguson's group used data from situations such as outbreaks on cruise ships or people repatriated from Wuhan, where widespread testing was done. They then extrapolated those findings to the wider population, and also looked at death statistics from nearly 44,700 confirmed cases within China.

A subset of 3,665 Chinese cases was also used to calculate the percentage of infected patients who might go on to require hospital care.

One piece of very good news: Babies and young children are extremely unlikely to become critically ill or die in the pandemic. Out of more than 70,000 cases studied, there were no deaths to children under 10 and the hospitalization rate for children aged 10 to 19 was 0.04%, the analysis found.

There was another statistical anomaly -- people in their 50s made up the biggest age demographic among hospitalized patients, with 222 out of 790 hospitalized cases being aged 50 to 59.

But that doesn't mean that people in their 50s are necessarily at the highest risk.

As the researchers explained, there's thought to be a very wide pool of infected-but-well people in their 50s in the general population. So, when Ferguson's group adjusted for those hidden cases, the rate of hospitalization for people in their 50s was still much lower than for people in their 80s -- 8.2% versus 18.4%, respectively.

By decade, the risk of hospitalization from infection with the new coronavirus is: Zero for kids under 10; 0.1% for kids 10 to 19; 1% for people aged 20 to 29; 3.4% for people aged 30 to 39; 4.3% for people in their 40s; 8.2% for those in their 50s; 11.8% for people aged 60 to 69; 16.6% for those in their 70s; and 18.4% for those in their 80s or above.

As for the death rate, the risk was near zero for people under 40, crept up to 0.2% for people 40 to 49, to 0.6% for 50-somethings, just under 2% for people in their 60s, 4.3% for those in their 70s, and 7.8% for those in their 80s, the findings showed.

Between 50% to 80% of people around the globe could be infected before the pandemic is over, the London researchers noted.

That's why countries must work now to prepare health systems for the onslaught, Dr. Shigui Ruan, of the University of Miami, said in a commentary that accompanied the study.

"Estimates of case fatality ratios might vary slightly from country to country because of differences in prevention, control, and mitigation policies implemented, and because the case fatality ratio is substantially affected by the preparedness and availability of health care," Ruan wrote.

Access to prompt testing will be crucial, he added.

"Early studies have shown that delaying the detection of infected cases not only increases the probability of spreading the virus to others (most likely family members, colleagues, and friends) but also makes the infection worse in some cases, thereby increasing the case fatality ratio," Ruan added.

According to *The New York Times*, over 156,000 cases of COVID-19 had been confirmed across the United States by Monday afternoon, including nearly 2,900 deaths.

More information

The U.S. Centers for Disease Control and Prevention has more on the **new coronavirus**.

What to know about myopia

Myopia, or nearsightedness, is a common eye condition that makes focusing on objects in the distance difficult. However, items that are close will likely appear perfectly clear.

People can treat myopia by wearing corrective lenses, such as glasses or contacts, or opting for laser surgery.

This article will take a closer look at myopia, including its causes, symptoms, and treatment options.

What is it?

Myopia is a refractive error, meaning that the eye is unable to bend, or refract, light correctly. The eye does not focus the light that enters it properly, so images in the distance appear blurry and unclear.

Myopia is very common. The American Optometric Association estimate that it affects nearly 30% of people in the United States.

There are several types of myopia. The sections below will discuss these in more detail.

Read More on…...

- **Causes and risk factors**
- **Symptoms**
- **Progression**
- **Diagnosis**
- **Treatment**
- **Orthokeratology**
- **Surgery**
- **Prevention**
- **Outlook**