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Trump's order to bypass Congress on coronavirus relief faces likely legal challenges

Following the breakdown of talks on Capitol Hill to reach a bipartisan deal, Trump signed four executive orders that he said would extend enhanced federal unemployment benefits, defer some employees' payroll taxes, continue a temporary ban on evictions and reduce the burden of student loans.

His action would reduce the temporary federal unemployment add-on for jobless Americans to $400 from the $600-a-week payments that recently expired. To pay for this, Trump is hoping to use $44 billion in previously approved disaster aid to states.

Trump also said states would be asked to contribute 25% of the cost — or $100 per week — raising the possibility that the supplement would only total $300 if states did not participate.

Trump said Americans earning less than $100,000 would be eligible for a payroll tax holiday through the end of this year, after which they would be required to pay the deferred taxes. But he said that if he is reelected in November, he would "forgive" the deferred taxes and make the cut permanent.

Speaking for the second time this week before a small crowd of supporters who cheered the president at his New Jersey golf club, Trump gave a disjointed speech. He accused top congressional Democrats of blocking desperately needed financial assistance, claimed the economy was "coming back very very strong," and questioned the mental acuity of his Democratic opponent Joe Biden.

The orders Trump signed, he said, would "take care of pretty much this entire situation."

However, it's unclear whether Trump has the legal authority to make such changes on his own, because the power to collect taxes, spend money and write laws rests with Congress. His orders are expected to face legal challenges from Democrats that could blunt their impact.

Asked on Saturday whether his decision to reduce the weekly payments to unemployed workers by $200 would pose a hardship, Trump said it would not. "This gives them a great incentive to go back to work," he said. "There was difficulty with the $600 number because it really was a disincentive."

The president's decision to act on his own is the result of his administration's inability to reach a bipartisan deal with Congress.

Trump may be hoping his orders change the political dynamic around the stalled negotiations. But major areas of disagreement remain after 11 days of negotiations, most crucially over how much to spend overall.

Democrats, who control the House, are asking for $3.4 trillion. Republicans, who control the Senate, want to keep the stimulus under $1 trillion.

House Speaker Nancy Pelosi (D-San Francisco) told reporters that Democrats offered on Thursday to decrease their ask by $1 trillion if Republicans increased theirs by $1 trillion, compromising at roughly $2.4 trillion. She said the cut would come from making some programs expire earlier than planned.

Democrats made the offer again in a roughly one-hour meeting Friday but were turned down, said Senate Minority Leader Charles E. Schumer (D-N.Y.). "We could begin to meet in the middle," he said. "Unfortunately, [Republicans] rejected it. They said they couldn't go much above their existing $1 trillion, and that was disappointing."

"I've told them, 'Come back when you're ready to give us a higher number,'" Pelosi said.

Although both sides have made concessions in some areas, remaining points of disagreement include how much to provide for unemployment insurance, whether to continue delaying student loan payments, whether Congress should impose an eviction moratorium, or help renters make payments, and how much to provide to help schools reopen and to help state and local governments weather the crisis.

In a letter to colleagues Friday, Pelosi laid out the differences that remain, including:

- Democrats want $75 billion for COVID-19 testing and treatment, while the GOP wants $15 billion.
- The GOP has offered $150 billion for states and municipalities; Democrats propose $915 billion.
- She wrote that the sides are "a couple hundred billion dollars apart" on money to help schools reopen. Republicans included $105 billion for schools in their proposed legislation.

Pelosi called for $67 billion for food, water and utility assistance. The GOP has proposed $250,000 for food.

Another major point of contention is the amount at which the federal government should supplement state unemployment insurance.

The $600-a-week extra unemployment benefit that Congress approved in March expired at the end of July. Democrats passed legislation in May that would extend those payments through the end of the year, but Senate Republicans have not acted on it. They have floated multiple counter-proposals, including $400 for 20 weeks or 70% of wage replacement with a $600 cap.

"We have always said that the Republicans and the president do not understand the gravity of the situation, and every time that we have met, it has been reinforced," Pelosi told reporters.

White House Chief of Staff Mark Meadows said Democrats haven't been willing to budge on how much they think the federal government should provide to supplement state unemployment insurance or to state and local governments.

"Both of those are still where they were two weeks ago," Meadows said Friday. He said he was recommending the president issue executive orders for the time being.

"We're going to take executive orders to try to alleviate some of the pain that people are experiencing," Meadows said. "This is not a perfect answer — we'll be the first ones to say that — but it is all that we can do and all the president can do within the confines of his executive power."

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President Trump Can't Stop Talking About His Plans to Cut Social Security

Statement of Richard Fiesta, Executive Director of the Alliance for Retired Americans, on President Trump's Continuing Assault on Social Security and Medicare.

August 8 Remarks Are the Latest in a Long Line

"Donald Trump has spent 2020 telling the American public that he wants to cut Social Security and Medicare.

"It's past time to start taking him literally and seriously -- no matter how many times his advisers go on TV to do damage control and spin their way out of it.

"Maya Angelou famously said, 'When someone tells you who they are, believe them.' Older Americans have heard time and again from President Trump, through his words and his actions, that he will cut Social Security and Medicare. Seniors - and everyone who hopes for a secure retirement - must remember this when they cast their ballots in November."

President Donald Trump, in his own words:

JANUARY 22, 2020
CNBC Interview From Davos, Switzerland

JOE KERNEN (CNBC): Entitlements ever be on your plate?

PRESIDENT TRUMP: At some point they will be. We have tremendous growth. We're going to have tremendous growth. This next year I-- it'll be toward the end of the year. The growth is going to be incredible. And at the right time, we will take a look at that. You know, that's actually the easiest of all things, if you look, cause it's such a--

JOE KERNEN: If you're willing--

PRESIDENT TRUMP: --big percentage.

JOE KERNEN: --to do some of the things that you said you wouldn't do in the past, though, in terms of Medicare--

PRESIDENT TRUMP: Well, we're going-- we're going look.

MARCH 5, 2020
Fox News Town Hall

Martha McCallum (FoxNews): "if you don't cut something in entitlements, you'll never really deal with the debt."

Trump: "Oh, we'll be cutting,"

AUGUST 8, 2020
News Conference
Bedminster NJ

Rich Fiesta, Executive Director, ARA

Trump: "If I'm victorious on November 3rd, I plan to forgive these [payroll] taxes and make permanent cuts to the payroll tax. I'm going to make them all permanent."

Exclusive: Over 900 Health Workers Have Died of COVID-19. And the Toll Is Rising.

KHN and The Guardian unveil an interactive database documenting front-line health care worker deaths. The majority of them are people of color — and nurses face the highest toll.

More than 900 front-line health care workers have died of COVID-19, according to an interactive database unveiled Wednesday by **The Guardian** and **KHN.** Lost on the Frontline is a partnership between the two newsrooms that aims to count, verify and memorialize every U.S. health care worker who dies during the pandemic.

It is the most comprehensive accounting of U.S. health care workers' deaths in the country.

As coronavirus cases surge — and dire shortages of lifesaving protective gear like N95 masks, gowns and gloves persist — the nation's health care workers are again facing life-threatening conditions in Southern and Western states….**Read More**

LINK LOST ON THE FRONT LINES

Analysis Shows Millions More Uninsured Due to COVID-19 Pandemic

There is clear evidence that the COVID-19 pandemic and economic downturn are causing millions of Americans to lose not only their jobs but also their employment-based health insurance. What's less well known is how many of these workers are remaining uninsured, and how many are shifting to other coverage—such as a spouse's plan, Medicaid, or Medicare. Federal data on these changes will not be available until next year. In the interim, a new Families USA **analysis** seeks to partially fill this information gap.

The Families USA report examines the insurance and employment patterns of adults ages 18 to 64 in order to estimate the number of uninsured workers among the newly unemployed in each state. This methodology reveals that of the 21.9 million Americans who lost their jobs or left the labor force between February and May 2020, 5.4 million became uninsured as a result.

This increase in the number of uninsured adults is 39% higher than any annual increase ever recorded. The highest previous jump took place from 2008 to 2009, when 3.9 million adults became uninsured. Notably, because the Families USA estimate does not capture family members, many of whom also lost health insurance, or workers ages 65 and older, the actual number of uninsured Americans is likely even higher.

In a **follow-up report**, Families USA presented newly released U.S. Census Bureau data that confirms significant, ongoing coverage losses among the recently un- or underemployed. Since mid-June, two million adults have become uninsured, all in the 46% of households that have experienced lost wage earnings during the pandemic.

These individuals often find themselves at a confusing crossroads. The coverage options for people facing or anticipating a loss of job-based insurance depend on several factors, including the individual employer, family income, and various state laws. These eligibility and financial considerations are complex, especially for people who are Medicare-eligible. They must also understand how their employment-based or other insurance works with Medicare, as well as the program's timelines and enrollment windows.

As Medicare Rights' Senior Counsel for Education & Federal Policy, Casey Schwarz, explains in this AARP **article**, a mismanaged decision can have serious and lifelong consequences for people with Medicare—such as lengthy coverage gaps, high out-of-pocket costs, and lifetime late enrollment penalties.

These severe consequences underscore the need for the **BENES Act's** clear, timely outreach and education to people who are approaching Medicare eligibility. Medicare Rights also supports the inclusion of strategies to empower beneficiary decision-making as part of any legislative effort to subsidize continuation coverage, such as COBRA, during the pandemic. This protection was included in the House-passed HEROES Act, and **we urge** lawmakers to adopt it alongside any COBRA subsidies that may be included in a final package.

Biden-Sanders Unity Task Force recommends incremental health reforms

The Biden-Sanders Unity Task Force recently released its **recommendations** for health care reform. Unfortunately, the three Sanders' appointees on the health care task force were not able to move the Biden appointees to support reforms that will guarantee health care to all Americans, much less get us meaningfully closer to Medicare for all. Rather, the Task Force's proposed reforms are small and not likely to help most Americans.

Vice-President Joe Biden wants to "build upon our bedrock health care programs, including the Affordable Care Act, Medicare, Medicaid, and the Veterans Affairs system." In his view, building means adding a "**public option**" and **lowering the age of Medicare eligibility to 60**. It's unclear what exactly a public option would mean or how it would help guarantee Americans access to good affordable health care.

Here's what we know: Joe Biden believes that if Americans had the choice of enrolling in a "public health plan"–health insurance provided directly by the federal government–in the state health insurance exchanges, private health insurers would engage in "real competition" and have a financial incentive to deliver quality affordable care. But, the evidence suggests otherwise.

We know that private **Medicare Advantage plans** do not engage in real competition with the public Medicare plan. Rather, they **game the system,** market to healthy people, create barriers to care for their members who need it and drive up costs. There is no reason to believe that private health plans would behave any differently for people under 65 if a public option were available.

What's more, the Unity Task Force has in mind the possibility of more than one public plan choice, but it does not explain why there would need to be more than one choice. It says that at least one choice would not have a deductible and would be administered by traditional Medicare, not a private health insurance company. For reasons that are not explained, the government administrator of the new public plan would engage in its own negotiations with doctors and hospitals over prices rather than piggyback off of Medicare rates.

Anyone with employer coverage or coverage through the ACA would be free to enroll in the public plan. One special feature of this public plan is that people who are not eligible for **Medicaid** but whose incomes are low would automatically be enrolled in the public plan. People living in states that have not expanded Medicaid could also enroll in this public plan. They would not pay a premium for it and could opt out of it if they chose.

In addition to creating a public plan option, the Unity Task Force recommends that, at age 60, anyone could choose to enroll in Medicare. But, it does not recommend an out-of-pocket cap on traditional Medicare or other reforms that would improve Medicare benefits and make it easy to enroll in traditional Medicare.

Of course, with many options available, it will be easy for marketers to confuse people about what health plan is best for them. Inevitably, plenty of health plans will not meet people's needs. For example, they might inappropriately delay and deny care, have narrow networks without high-value health care providers, or high copays. To help people distinguish among plans, the Unity Task Force supports appropriating money to let people know about their options and enroll them. But, assistance is of little help if there are no good options available. And, information that would shed helpful insight into which are better than others–such as which don't have high denial rates–is not available.

The Unity Task Force recommends giving states the right to come up with their own health plans. Many advocates and states want that right. Still, the likelihood of success on the part of states to guarantee residents affordable health care is slim given financial constraints and their lack of resources to take on the private health insurance industry. States have never been able to serve Americans well on the health insurance coverage front and there is no evidence that they will do so in the future.

The Unity Task Force sees its recommendations as meeting the needs of people who are recently unemployed as a result of the pandemic along with people who have been uninsured for a long while. But, it's unclear why. With health care costs continuing to rise and little focus on reining them in, it's hard to imagine the public option–the Task Force's chief way of improving health insurance–will be affordable to most people without substantial federal subsidies.

If you can't afford health insurance as a result of these health care reforms, you might want to get care at community health centers, sometimes known as **Federally Qualified Health Centers**, and rural health centers. The Task Force recommends greater and more predictable funding for these health centers.

To address shortages of health care providers, particularly primary care nurses and dentists and mental health counselors, the Unity Task Force recommends a larger National Health Service Corps.

Donald Trump: If Reelected, I will "Terminate" Social Security

Washington, DC) —
The following is a statement fro m **Nancy Altman**, President of **Social Security Works**, in response to Donald Trump's press conference in which he promised to "terminate" FICA contributions, Social Security's dedicated revenue, if he is reelected:

"Donald Trump **once promised** that he would be 'the only Republican that doesn't want to cut Social Security.' We now know that what he meant is that cutting Social Security doesn't go far enough for him: He wants to destroy Social Security.

Donald Trump's executive order, which seeks to defer Social Security contributions, is bad enough. But his promise to 'terminate' FICA contributions if he is reelected is a full-on declaration of war against current and future Social Security beneficiaries.

Social Security is the foundation of everyone's retirement security. At a time when pensions are vanishing and 401ks have proven inadequate, Trump's plan to eliminate Social Security's revenue stream would destroy the one source of retirement income that people can count on. Moreover, Social Security is often the only disability insurance and life insurance that working families have. If reelected, Trump plans to destroy those benefits as well.

Every member of Congress must speak up now to denounce Donald Trump's unconstitutional raid on Social Security. Voters should treat any Senator or Representative who is silent as complicit in destroying Social Security. Furthermore, every American who cares about Social Security's future must do everything they can to ensure that Trump does not get a second term."

***Social Security Works** is a no n-profit organization working to improve the economic security of disadvantaged and at -risk populations by fighting to expand Social Security, improve Medicare, and lower the outrageous prices of prescription drugs*

Trump's false push on preexisting conditions

President Donald Trump is teasing the possibility of executive action to require health insurance companies to cover preexisting medical conditions, something that he says "has never been done before."

It's been done before.

People with such medical problems have health insurance protections because of President Barack Obama's health care law, which **Trump is trying to dismantle**.

A look at Trump's claim during a **news conference Friday evening** in Bedminster, New Jersey:

TRUMP: "Over the next two weeks, I'll be pursuing a major executive order requiring health insurance companies to cover all preexisting conditions for all customers. That's a big thing. I've always been very strongly in favor. ... This has never been done before."

THE FACTS: No executive order is needed to protect people with preexisting medical conditions because "Obamacare" already does that and it's the law of the land. If Trump persuades the Supreme Court to overturn the Affordable Care Act as unconstitutional, it's unclear what degree of protection an executive order would offer in place of the law.

The Obama health law states that "a group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage."

Other sections of the law act to bar insurers from charging more to people because of past medical problems and from canceling coverage, except in cases of fraud. In the past, there were horror stories of insurers canceling coverage because a patient had a recurrence of cancer.

It's dubious that any president could enact such protections through an executive order, or Obama would never have needed to go to Congress to get his health law passed. Likewise, President Bill Clinton could have simply used a presidential decree to enact his health plan, or major parts of it, after it failed to get through Congress.

"I can't imagine what authority the president could invoke to require insurers to cover preexisting conditions if the Supreme Court does throw the ACA out," said Larry Levitt, executive vice president for health policy at the nonpartisan Kaiser Family Foundation.

"There is no magic wand you can wave to just make it so," he said.

Levitt said to make coverage of preexisting conditions a reality, insurers would need to be barred as they are under Obamacare from placing limits on lifetime and annual benefit payments, and allow for uniform premiums for the sick and healthy. Also, subsidies have to be offered to encourage healthy people to enroll in plans so premiums are kept down….**Read More**

Health insurers spread lies to promote shareholder value

In a Washington Post **op-ed**, Wendell Potter, president of the Center for Health and Democracy and a former Cigna executive, explains that his job at Cigna was to spread lies to Americans about health care in order to promote value for Cigna's shareholders. He spread mistruths about the Canadian health care system. As a result, millions of Americans are uninsured or underinsured and thousands of Americans have died as a result of the novel coronavirus for lack of care when they should not have.

In response to Michael Moore's film, Sicko, in 2007, Potter worked in collaboration with executives at other health insurers to counter its claim that the US health care system was a failure and Canada's worked quite well. They hired a PR firm to develop talking points about the problems with Canada's health care system. They pulled quotes from unreliable sources and spread their falsehoods, misleading Americans to believe that the US health care system was best in class and other public health car systems were not up to snuff.

The US failure to contain the novel coronavirus and Canada's relative success demonstrates the superiority of Canada's system. The US is seeing three times more coronavirus infections per capita and has twice the mortality rate of Canada. The health insurers' trade association, AHIP, continues to spread nonsense about wait times to get care in Canada when Canadians have far **more doctors** and **better access** to medical care than Americans.

People in Canada have access to COVID-19 testing and treatment without having to worry about the cost. They have no out-of-pocket cost–no deductibles, no coinsurance, no copays. And, when they lose their jobs, they still have health insurance. This helps explain why so many fewer Canadians are dying than Americans.

If you look at a variety of metrics, people get better health care in Canada. People in Canada are hospitalized less frequently as a result of a chronic condition. They have longer life expectancies, 82 v. 78.6. And, they spend half the amount we do per person on health care. Moreover, their hospitals rely on a global budget and are protected financially when fewer people seek treatment.

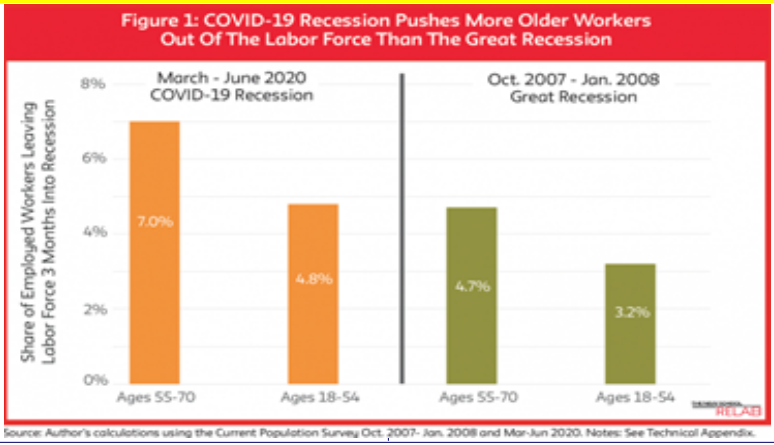
We need a public health insurance system in the US if we care about ensuring Americans receive the care they need. Our **private health insurance system** is designed not to pay for care, to profit from imposing financial and administrative barriers to care.

Coronavirus: Without Congressional action, many more older adults will live in poverty

A **new report** by The New School's Retirement Equity Lab finds that more than half of older workers may be forced to retire involuntarily as a result of the novel coronavirus. In June, the unemployment rate for workers over 55 was 9.7 percent. Unless Congress steps in, the number of older adults living in poverty is projected to increase by millions.

Nearly four million older workers are **likely to lose their jobs** because of the pandemic and not return to work. Since March, nearly 3 million older workers have lost their jobs and left the workforce. Another 1.1 million older workers will be forced to leave their jobs in the coming months, according to projections, and will leave the workforce.

As compared with the 2007 Great Recession, 50 percent more older workers between 55 and 70 have already lost their jobs and permanently left the workforce….**Read More**



Your Favorite Store or Restaurant Is Open. How Do You Know It's OK to Go In?

Just because many businesses are open again doesn't mean the pandemic is over. The coronavirus is still on the loose — actually surging in many locations — which means people have to make serious choices about their health all day, every day.

Nothing in life is without risk, and decisions ultimately hinge on individual calculations. But, according to the public health experts we consulted, there are steps you can take — and signs to look for — to make you feel comfortable and help you decide whether to open the door and walk in. Sometimes, you may want to opt out.

First and foremost, assess your personal situation.

People with certain health conditions — from heart disease to diabetes or obesity, patients undergoing treatments for cancer, or people who are older or who live with older relatives, for example — should limit their outings to a far greater extent than people not in higher-risk categories.

"Some people should not take that risk at all," said Dr. Georges Benjamin, executive director of the American Public Health Association. "It doesn't mean you can't go outside, or go somewhere where you can chill out and relax. But do it away from other people."

The advice you've heard all along still holds: When you go out, wear a mask, keep your distance from others and avoid crowds.

You should also notice the mask-wearing habits at stores and restaurants you might visit. In general, the experts agreed: no mask, no customer. Employees, owners, managers and customers should all have them. If they are not being used, walk away, experts said, especially in regions mandating face coverings. Also, look for signs on the door directing people to wear masks**….Read More**

Commonwealth Fund Analyzes Medicare Flexibilities Granted During the Public Health Emergency

This week, the Commonwealth Fund released a report that summarizes and analyzes the over 200 temporary legislative and regulatory changes that have been made to Medicare in response to the COVID-19 public health emergency. They also looked at the sub-regulatory guidance that the Centers of Medicare & Medicaid Services (CMS) has released to interpret these rules and to provide additional flexibility to providers and Medicare plans.

The article categorizes the changes under several themes and notes that most will expire or end without further action, as they are tied to the public health emergency period. The most prevalent types of changes are to the rules governing providers–altering who can bill Medicare (conditions of participation requirements); how they must bill and report (payment systems and quality programs); and rules about provider staffing (capacity and workforce).

Some of the changes directly impact how people with Medicare experience their health care, while others are "invisible" to Medicare beneficiaries. The report summarizes each change along with anticipated or potential benefits and drawbacks –highlighting that even the most obvious and seemingly necessary changes could have negative effects, "[f]or example, even highly necessary and appropriate changes, like increased COVID-19 testing, come with potential drawbacks for beneficiaries, such as the risk of surprise billing and high cost-sharing amounts." The report also notes that "it may be necessary to let certain temporary waivers expire, possibly even before conclusion of the public health emergency if the continued threat of possible patient harm outweighs the potential benefits of the policy waiver…For example, policymakers may need to significantly limit the duration of the waivers related to on-time preventive maintenance of dialysis machines and scheduled fire inspections."

The authors also call for CMS and others to make use of the "unique opportunity" presented by these temporary and quickly implemented policy changes by closely studying their impact and evaluating continued or further changes considering the lessons learned.

The Medicare Rights Center appreciates that some of the current flexibilities have helped keep people with Medicare, their families, and the health care workforce safe during the pandemic. As policymakers consider which rules may be appropriately continued as-is, we urge a deliberate and thoughtful decision-making process that allows time for proper data collection and evaluation, as well as for public input. Any longer-term or permanent changes must meaningfully center the unique needs of older adults and people with disabilities.

Medicare Rights shares the authors' **caution about some of the changes and urges policy makers to move slowly when it comes to making the changes permanent** once the pandemic is contained.

Coronavirus: Second-quarter profits double for big health insurers

Reed Abelson reports for **The New York Times** that second-quarter profits doubled for big health insurers from the same period in 2019. The Affordable Care Act imposes a limit on the profit that health insurers can keep. But, people with health insurance are not likely to see money back any time soon.

Because few people sought medical care for anything other than COVID-19 between April and June, insurers paid few claims. But, they collected the same premiums they always collect. So, the pandemic has served them very well so far.

The Trump administration has suggested that the health insurers with outsize profits, such as UnitedHealth Group, Anthem and Humana, **speed up rebates**. But, it has no authority to require them to do so. It also suggested that they lower premiums. Again, it has no authority to require them to lower premiums.

According to the Centers for Medicare and Medicaid Services, insurers are not legally allowed to change their premiums during the year. So, it is giving them the right to do so. Big whoopee. Insurers are not going to lower premiums, even if they can, since that would work against the interest of their shareholders. The ACA allows health insurers to keep 15-20 cents on the premium dollar, depending upon the type of insurance policy. They must pay out the rest for medical care. Still, holding on to extra premium money for as long as possible benefits them financially. And, the ACA gives them three years to hold on to the money.

The ACA effectively protects insurers that have made out like bandits on the theory that there could be a swing in health care expenses. For example, if people start going to the hospital and doctor at twice the rate they usually have, insurers would have a cushion. ...**Read More**

Test Sites Quickly Attract Thousands for COVID-19 Vaccine Study

Dr. Eric Coe jumped at the chance to help test a COVID-19 vaccine.

At his urging, so did his girlfriend, his son and his daughter-in-law. All received shots last week at a clinical research site in central Florida.

"My main purpose in doing this was so I could spend more time with my family and grandchildren," Coe said, noting that he's seen them only outside and from a distance since March.

"There's a lot less risk to getting the vaccine than contracting the virus," said Coe, 74, a retired cardiologist. "The worst thing that can happen is if I get the placebo."

The Coes' eagerness to offer up their bodies to science reflects the widespread public interest in participating in the pivotal, late-stage clinical trials of the first two COVID vaccine candidates in the United States.

Those trials began rolling out July 27. During the next two months, vaccine makers hope to recruit 60,000 Americans to roll up their sleeves to test the two vaccines, one made by Pfizer and BioNTech, a German company, and the other by biotech startup Moderna. While small tests earlier this year showed the preventives were safe and led to participants developing antibodies against the virus, the final phase 3 testing is designed to prove whether the vaccine reduces the risk of infection.

Amid a pandemic that in the U.S. has caused roughly 5 million infections and nearly 160,000 deaths while decimating the economy, the vaccine trials have drawn far more interest than is typical for a clinical trial, organizers said. Also, the test sites pay volunteers as much as $2,000 for completing the two-year study.

"We have no shortage of volunteers and we have thousands of people interested in participating," said Dr. Ella Grach, CEO of M3-Wake Research of Raleigh, North Carolina, which is conducting vaccine trials at six sites.

Paul Evans, president of Velocity Clinical Research in Durham, North Carolina, said his company plans to recruit more than 10,000 volunteers in seven states to test COVID vaccines. At least four of Velocity's sites – in Ohio, California and Oregon – have already started injecting volunteers with the Moderna vaccine.

"It's been phenomenal," he said. Patient recruitment is one of the biggest challenges to running trials, but this time patients have been eager to sign up.

"I've been working in this business for 30 years," said Evans. "Outside of a COVID study, you might have to reach out to four or five, up to 10 people to find [one person] who is suitable."

Other vaccine candidates **are being tested abroad** and more tests will be launched in the U.S. later this year.

People 18 and older are eligible to participate in the trials, and Moderna and Pfizer are pushing to include high-risk individuals such as health workers, the elderly and people with chronic conditions such as diabetes and asthma. Organizers are also seeking to enroll Blacks and Hispanics, groups hit hard by the virus….**Read More**

Friday Night Massacre' at US Postal Service

"America is in a dead sprint to authoritarianism. The man is pulling out all the stops to prevent the citizens of this country from holding a legitimate election in which he might face removal from office."

Government watchdogs, Democratic lawmakers, and pro-democracy advocates declared it a "**Friday Night Massacre**" for the U.S. Postal Service after news broke in a classic end-of-the-week dump that Louis DeJoy—a major GOP donor to President Donald Trump and the recently appointed Postmaster General—had issued a sweeping overhaul of the agency, including the ouster of top executives from key posts and the reshuffling of more than two dozen other officials and operational managers.

The shake-up came as congressional Democrats called for an investigation of DeJoy and the cost-cutting measures that have slowed mail delivery and ensnared ballots in recent primary elections.

Twenty-three postal executives were reassigned or displaced, the new organizational chart shows. Analysts say the structure centralizes power around DeJoy, a former logistics executive and major ally of President Trump, and de-emphasizes decades of institutional postal knowledge. All told, 33 staffers included in the old postal hierarchy either kept their jobs or were reassigned in the restructuring, with five more staffers joining the leadership from other roles.

Already under fire for recent policy changes at the USPS that mail carriers from within and outside critics have denounced as a sabotage effort to undermine the Postal Service broadly as well as disrupt efforts to carry out mail-in voting for November's election amid the Covid-19 pandemic, the moves unveiled late Friday were viewed as an overt assault on democracy and a calculated opportunity to boost Republicans' long-held dream of undercutting or privatizing the government-run mail service while also boosting their election prospects in the process.

"Another Friday night massacre by this administration—and this time dealing another devastating blow to our postal service," said Rep. Mary Gay Scanlon (D-Pa.) "The American people deserve answers and we're going to keep fighting for them."

Scanlon was among more than 80 congressional lawmakers who sent a letter to DeJoy earlier in the day expressing "deep concerns" about operational changes he has made for mail carriers that have delayed deliveries and lowered standards.

"It is vital that the U.S. Postal Service not reduce mail delivery times, which could harm rural communities, seniors, small businesses, and millions of Americans who rely on the mail for critical letters and packages," the letter stated. "Eliminating overtime and directing postal workers to leave mail on the floor of postal facilities will erode confidence in the Postal Service and drive customers away, resulting in even worse financial conditions in the future."

Kristen Clarke, president and executive director of the Lawyers' Committee for Civil Rights Under Law, warned what occurred Friday is designed to weak the Postal Service, slow vote-by-mail, and disrupt the 2020 Census.

"We are sounding an alarm regarding personnel changes, policy shifts and service disruptions happening inside the U.S. Postal Service on Louis DeJoy's watch," Clarke said in a statement. "The postal service lies at the heart of our democracy and is critical to the success of an unprecedented vote-by-mail system that is needed for a fair and effective 2020 election season. The postal service helps ensure that our nation's most vulnerable communities are receiving medications and resources during the pandemic. It is also critical to the efforts to achieve a full and accurate 2020 Census."

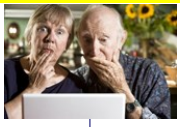
Clarke said the administration's intentions are clear: "DeJoy, a Trump donor, has **donated** more than $2.5 million to the Republican Party, with no experience inside the postal service, has been installed to cause chaos and disruption at a time when the timely delivery of mail could not be more critical."

Many Older Adults Can't Connect With Telehealth: Study

The coronavirus pandemic has fueled big increases in video visits between patients and doctors, but older Americans haven't easily taken to the trend, a new study finds.

More than one-third of those over 65 face difficulties seeing their doctor via telemedicine -- especially older men in remote or rural areas who are poor, have disabilities or are in poor health.

"Telemedicine is not inherently accessible, and mandating its use leaves many older adults without access to their medical care," said lead author Dr. Kenneth Lam, a clinical fellow in geriatrics at the University of California, San Francisco.



"We need further innovation in devices, services and policy to make sure older adults are not left behind during this migration," he added in a university news release.

Video visits are a good way to reach patients at home, but they require patients to be able to get online, use computer equipment and fix technical problems when they arise.

For the study, Lam's team analyzed 2018 data on more than 4,500 Medicare patients. The researchers reported that about 38% weren't ready for video visits, including 72% of those 85 or older, mostly because they were inexperienced with technology or had a physical disability.

Even with outside support, 32% were not ready, and 20% couldn't cope with a phone visit because of dementia or difficulty hearing or communicating, the findings showed.

The most unready Medicare patients were older, male, unmarried, Black or Hispanic, rural, less educated, poor and in poor health, the investigators found.

"To build an accessible telemedicine system, we need actionable plans and contingencies to overcome the high prevalence of inexperience with technology and disability in the older population," Lam said.

"This includes devices with better designed user interfaces to get connected, digital accommodations for hearing and visual impairments, services to train older adults in the use of devices and, for some clinicians, keeping their offices open during the pandemic," he added.

Here's what Medicare beneficiaries worry about when it comes to costs

The majority of current and soon-to-be Medicare beneficiaries are concerned most about out-of-pocket costs and unexpected medical bills, a recent survey shows.

Medicare comes with a variety of charges, including premiums, deductibles and copays.

At last count, roughly 6 million recipients lacked coverage beyond basic Medicare, according to the Kaiser Family Foundation.

For some Medicare beneficiaries, the pandemic means worrying about more than just their increased health risk from Covid-19. It also raises the specter of large, unexpected medical expenses.

Medicare, the government health insurance program that you generally qualify for at age 65, comes with costs that can surprise beneficiaries. And as the pandemic continues rumbling through U.S. communities, the majority of current and soon-to-be beneficiaries worry most about out-of-pocket costs (66%) and unexpected medical bills (62%), according to a **survey** by Healthinsurance.com.

More than 1,000 Medicare-eligible individuals age 64 or older were recently polled to explore their views on a variety of topics related to Medicare and health care during the pandemic, which in the U.S. has led to **4.66 million cases and 154,860 deaths**.

Some of the results in the survey over costs echo previous findings from the The Senior Citizens League, an advocacy group for older individuals.

"There are high out-of-pocket costs involved with Medicare," said Mary Johnson, a policy analyst for the group. "And they start cascading as you age, because you need additional services or you have new conditions diagnosed.

"And that often takes people by surprise."

About 36% in the Healthcare.com survey have delayed seeing a doctor due to cost at some point — not necessarily amid the pandemic.

The average cost to treat a hospitalized patient with the virus is $30,000, according to an estimate from America's Health Insurance Plans, a trade group for insurers. While that tab would be partially picked up by insurance, exactly how much a Medicare beneficiary pays depends on their specific coverage.

Original, or basic, Medicare consists of Part A (hospital coverage) and Part B (outpatient care and medical equipment). Each of those come with costs.

Most people pay no premium for Part A due to their history of paying into the system through payroll taxes. However, it comes with a $1,408 deductible for each benefit period, as well as potential copays if you remain in the hospital beyond 60 days. Part B has a standard premium of $144.60 for 2020 (higher earners pay more) as well as a $198 deductible and, like Part A, cost-sharing (typically 20% of covered services).

Additionally, basic Medicare comes with no cap on out-of-pocket spending. Nor does Part D, which is prescription drug coverage.

In the Healthcare.com survey, 89% of respondents said prescription drugs are too expensive. Most of them (64%) spend under $50 a month in that category.

If your income is low enough to qualify, you may be able to dually enroll in both Medicare and Medicaid. Others may have retiree or workplace coverage that helps cover some costs.

For many beneficiaries, though, the options to mitigate potential expenses involve turning to private insurers that operate within the Medicare world….**Read More**

"With an Advantage Plan, you may have no premium or a low one, but you could have higher out-of-pocket costs like deductibles and copays. With Medigap, it's the premiums that can be costly."

Medicare Part B premiums 2020

Individual and joint filers

Individual tax filers	Married, file jointly	Adjustment amount	Monthly premium
Up to $87,000	Up to $174,000	$0.00	$144.60
$87,000-$109,000	$174,000-$218,000	$57.80	$202.40
$109,000-$136,000	$218,000-$272,000	$144.60	$289.20
$136,000-$163,000	$272,000-$326,000	$231.40	$376.00
$163,000-$500,000	$326,000-$750,000	$318.10	$462.70
$500,000 or more	$750,000 or more	$347.00	$491.60

SOURCE: Center for Medicare and Medicaid Services

CNBC

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Fauci to David Muir: US in for 'difficult time' if COVID-19, flu outbreaks converge

Dr. Robert Redfield, director of the Centers for Disease Control and Prevention, said in July that the convergence could create "one of the most difficult times that we've experienced in American public health" during a webinar for the Journal of the American Medical Association.

"I totally agree," said Fauci, director of the National Institute of Allergy and Infectious Diseases (NIAID), who has advised six U.S. presidents. He noted that if masks and social distancing is not enforced "in a uniform way" Redfield's prediction may become a reality.

"We'd have a convergence of two respiratory diseases," he said during an interview Monday. "We can have a very difficult time."

"I want to impress upon the American people in a way that's so clear: There are things that we can do that would get the level down," he said. "If we go into the fall and the winter, David, with the same situation… we will have upticks of percent positive, and then you have the inevitable surging of infection."

There is a way the convergence can be avoided, Fauci says, "but it's not by wishful thinking."

Fauci previously named a goal of less than 10,000 cases a day by the fall. The U.S. is still seeing 50,000 to 70,000 cases a day, according to the World Health Organization.

"The way human nature is acting out there, it doesn't seem likely [this goal will be met]. But that doesn't mean it can't be done," Fauci said. "I don't know howmore forcefully I can make that plea to the American people. That we can open the country, we can get back to normality, if we do some simple things."

He said he isn't pessimistic that the country can pull together and bring COVID-19 cases down.

"My message is one of cautious optimism and hope," he said. "But I'm also very realistic to know that if we don't do it, we're going to continue to have this up and down."

Study: Many older Americans get cancer screens they don't need

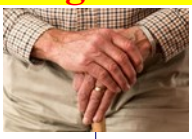
Contrary to recommendations set by the U.S. Preventive Services Task Force, many Americans are getting screened for cancer even when old age or poor health would likely render such screenings risky and pointless, new research finds.

The task force notes that screening always entails some degree of risk, and cancer treatment can be harsh. So the reasoning is that neither the risk nor the ordeal are worth it for those who don't have long to live anyway.

But after reviewing the 2018 screening histories of over 176,000 patients, Penn State investigators determined that many patients were getting "overscreened."

At an average age of 75, roughly 55,000 men and women got tested for colorectal cancer, 83,000 women for cervical cancer and 38,000 women for breast cancer. Overscreening rates were pegged at 60% of men and 56% of women for colorectal cancer tests 46% for cervical cancer and 74% for breast cancer.

According to study author Jennifer Moss, the task force "recommends routine screening for colorectal cancer up to age 75, for cervical cancer up to age 65, and for breast cancer up to age 74."



One main concern is screening risk, including "discomfort, stress and anxiety, to false positives and unnecessary follow-up procedures, to side effects such as bleeding or pain," she said.

"For more invasive procedures, such as colonoscopy for colorectal cancer screening, side effects can be even more serious, such as complications from anesthesia and perforation of the bowels," noted Moss, who is an assistant professor of family and community medicine and public health sciences with Penn State College of Medicine.

Side effects go up with age, she added. Beyond that, "the tests don't have a proven benefit for improving life expectancy" for those above the task force's upper age limits, Moss explained.

The upshot: ignoring the task force's advice "translate[s] into many, many unnecessary tests, costs and potential harms," she noted.

Her team found that women (but not men) living in or near cities were more prone to get overscreened.

As to why, investigators theorized that women outside of urban centers may have more trusting relationships with doctors, that screening may also be less accessible in rural areas, and that urban dwellers might be getting more automated screening reminders.

More broadly, Moss said that patients may be unfamiliar with the task force's advice, while doctors may be uncomfortable touching on issues related to life expectancy. But she added that insurance companies pose a particular problem.

To reduce overscreening, "the strategy that would have the biggest impact would likely be if insurance companies stopped reimbursing providers for these screening tests that go against national guidelines," she said.

Still, Moss stressed that doctors can also help by talking to elderly patients "about 'graduating' from screening so they come to expect that cancer screening ends at some point."

But the situation may be less black and white, suggested Robert Smith, senior vice president of cancer screening with the American Cancer Society.

Smith acknowledged that both patients and some doctors need to be better informed about the protocols, and that doctors need to step up and have hard conversations when warranted.

"But there's also a flip side," he added. "Yes, it may not make sense to send a patient to get a mammogram if they have really severe COPD and just one year life expectancy."

"But what does a physician do when an elderly person walks in in stunningly good health? Say a perfectly healthy 75-year-old. Her life expectancy is about 18 years. And at that point in her life, breast cancer incidence is very high, and patients may benefit from getting an early diagnosis," Smith explained.

"That may not necessarily be overscreening," he said.

Smith added that it's worth considering whether in some cases the task force guidelines are too conservative, "because the larger question is that we want to prevent premature deaths among healthy people as long as they can be avoided, and as long as the person has a significant number of years of life to benefit from that intervention."

States Where Alzheimer's Is Soaring

Alzheimer's disease is a degenerative brain disorder that causes memory loss and impairs speech, behavior, and cognitive functions. The most common risk factor for the disease is age. The vast majority of Americans with Alzheimer's disease are at least 65 years old.

The Alzheimer's Association estimates that 5.8 million Americans 65 and older are living with the disease, as of 2020. As more and more of the baby boomer generation reaches that age, the number of Americans with the disease will increase to a projected 7.1 million people by 2025, an increase of nearly 22%. Yet this growth will not be uniform everywhere. In some states, the number of older people Alzheimer's disease is projected to grow by less than 10%, while in others it is projected to grow by more than 30%.

To determine the states where Alzheimer's is soaring, 24/7 Tempo reviewed the projected increase in the number of Americans 65 and older with Alzheimer's disease between 2020 and 2025 in every state from the Alzheimer's Association's Alzheimer's disease **Facts and Figures report**.

The projected increase in Alzheimer's disease by state is based on the projected population growth of residents aged 65 and older. Some Americans in this age bracket opt to relocate, moving from colder areas to warmer ones, typically in the southern and western parts of the nation. Many cities in these parts of the country have experienced significant population growth over the past decade, due largely to retirees moving in. **These are the cities Americans are flocking to**.

You Could Have COVID for This Many Days and Not Know It, Study Says

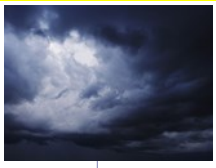
While just 10 percent of the infected study subjects remained asymptomatic for a full 14 days, the researchers found that the median incubation period was 7.75 days, three to four days later than most previous estimates.

Of course, understanding COVID's incubation period can make a tremendous difference in whether we successfully contain the virus. "By providing health authorities with a **potentially more accurate figure** for the incubation period, the results could inform **guidelines for containment efforts** such as quarantines and studies investigating the disease's transmission," the researchers shared in a press release.

The new study is likely more accurate than previous studies on the subject of incubation because it used the largest patient sample in **any such analysis** to date. As the researchers pointed out, "The few existing estimates of four to five days were based on small sample sizes, limited data, and self-reports that could be biased by the memory or judgement of the patient or interviewer." This study instead relied on public databases that logged the dates of infection as they occurred, to try to eliminate recall bias.

Finally, the researchers came to one more startling conclusion: that it is possible we've underestimated the total 14-day incubation period. The team determined that there is between a five and 10 percent chance that this is the case—meaning sick individuals may be putting others at risk by ending their quarantines too soon. That's why, as the particulars of the virus continue to unfold, it's wise to err on the side of caution: if you suspect having been exposed, **don't wait for symptoms to confirm**. When or whether they come doesn't affect your ability to spread coronavirus. And for more on asymptomatic cases, find out why **80 Percent of People in This Age Group Are Asymptomatic**.

As Climate Change Intensifies Storms, Seniors' Health Could Suffer: Study



Global warming may ultimately rain on everyone's parade, but new research suggests that major thunderstorms are already wreaking some havoc on the respiratory health of seniors.

That's because atmospheric changes that precede storms increase the risk that older people with asthma or chronic obstructive pulmonary disease (COPD) could develop breathing problems serious enough to send them to the hospital.

The conclusion follows a 14-year-long investigation -- described as the largest of its kind -- that tracked stormy weather and emergency room visits among more than 46 million Medicare recipients.

"Changes in the atmosphere that lead up to thunderstorms, which includes increased temperatures and levels of particulate matter, coincided with increased emergency visits for breathing problems among seniors," said study author Dr. Christopher Worsham. He's a research fellow in the pulmonary and critical care unit at Massachusetts General Hospital in Boston.

Particulate matter is very small particles in the air caused by fires, auto or industrial emissions, as well as dust and dirt.

These small particles can make their way deep into the lungs and irritate airways, aggravating asthma or COPD, Worsham noted.

His team pored over nationwide data collected between 1999 and 2012, looking for weather events defined by the presence of lightning, increased precipitation and above-average wind speed.

The researchers also examined Medicare records for nearly 46.6 million patients (average age: 77) over the same time period. Just over 10% had asthma, and 26.5% had COPD. Nearly 7% had both.

Over a decade and a half, roughly 822,000 major storms struck the United States. During that time, there were more than 22 million ER visits for breathing problems.

Stacking the data side by side, researchers found that respiratory -related ER visits rose in the days before and after storms.

The biggest surge occurred the day *before* a storm actually hit, the study found. That observation aligned with the way storms tend to play out: Temperatures and particulate levels rise the day before a deluge, then taper off during the storm itself and the days to follow.

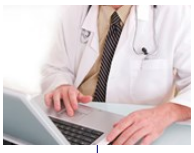
Based on population data, Worsham and his colleagues estimated that thunderstorms triggered an extra 52,000 ER visits for respiratory distress.

Because the study focused on seniors, it's not clear whether thunderstorms might have a similar effect on younger patients with a history of chronic asthma and other breathing difficulties. It's also unclear how weather patterns may evolve over time.

But scientists expect thunderstorms to increase in intensity as global temperatures rise. And that, Worsham said, suggests that the study's most important observation is clear: "Environment impacts our health."

That thought was seconded by Dr. Meredith McCormack, medical director of the pulmonary function lab at Johns Hopkins University in Baltimore, and a volunteer spokeswoman for the American Lung Association. She reviewed the study and said the findings break ground….**Read More**

Telemedicine Is Here: Experts Offer Tips for Seniors



MONDAY, Aug. 10, 2020 (HealthDay News) -- Virtual medical visits have been invaluable for many during the COVID-19 pandemic, but older adults may still need help managing them -- especially if they are hard of hearing.

That's according to doctors at Johns Hopkins University, in Baltimore. Writing in the Aug. 11 *Annals of Internal Medicine*, they offer some practical advice on navigating "telemedicine."

First and foremost, they say, it should be assumed that any older adult will have some difficulty hearing during a virtual visit.

Hearing loss is very common: About half of Americans older than 75 have some difficulty with hearing, according to the U.S. National Institutes of Health.

Yet those hearing issues have not necessarily been diagnosed.

"Many people don't even realize they have hearing loss," said Dr. Carrie Nieman, of the Cochlear Center for Hearing and Public Health at Johns Hopkins.

But the issue may come to the fore, she said, when older patients have a telemedicine visit. The volume or quality of the sound -- whether over the phone or Zoom -- can present a problem, as can the lack of in-person visual cues.

One way to manage, Nieman said, is for both doctors and patients to use headphones or a headset -- which amplify sound and drown out background noise. "You can get fairly inexpensive ones," she noted.

A video visit is preferable to a phone call, Nieman said, since it allows doctors and patients to see each others' expressions and gestures. And that visual information can give doctors an idea of whether a patient is understanding what's being said.

But the reality is, not all older adults have the devices or internet access needed for videoconferences. Other times, there are privacy concerns: "Some patients don't want you to see their home," Nieman said.

All of those issues are more likely to be barriers for low-income seniors. Doctors need to be aware of that, Nieman said, and -- even though video is ideal -- ask patients what type of telemedicine visit they prefer.

It's true that many telemedicine visits during the pandemic have been by phone call, according to Dr. Ateev Mehrotra, an associate professor of health care policy at Harvard Medical School, in Boston.

Many patients are used to phone calls being a courtesy, he pointed out. So one issue that has come up is money: Patients are often surprised, and unhappy, to get a bill for a telemedicine visit done by phone.

However, telemedicine -- which has been around for decades -- is here to stay. It grew to a "staggering" degree during the pandemic, Mehrotra said, and "we can't go back."

Old-fashioned medical visits will never be replaced, he stressed, and as doctors' offices have reopened in recent months, telemedicine visits have declined. But Mehrotra expects that going forward, around 8% of doctor visits will be of the remote variety….**Read More**

Are Baby Boomers Less Sharp Than Previous Generations?

Aging baby boomers may not be as mentally sharp as their parents were, a new study suggests -- raising questions about what the pattern could mean for future dementia rates.

Looking at two decades' worth of data on U.S. adults, the study found generational differences in tests of cognitive function. That refers to essential mental abilities such as remembering, reasoning and problem-solving.

On average, Americans born in the early- to mid-boomer generation -- between 1948 and 1959 -- fared a bit worse on those tests than previous generations. The pattern reversed what had been an improving outlook: Americans born between 1942 and 1947 had generally outperformed those born between 1890 and 1923.

On one hand, the findings are surprising, according to study author Hui Zheng, an associate professor of sociology at Ohio State University.

Boomers would have certain things going for them -- including higher education levels, less smoking and access to treatments for heart disease risk factors such as high blood pressure and high cholesterol. All have been linked to lower risks of mental decline.

In addition, studies have found that older adults today seem to have a lower risk of dementia than their parents and grandparents did. However, Zheng said, there's some evidence that decline is stabilizing.

And while boomers have some positives in their corner, they are worse off than previous generations in some respects -- including higher rates of obesity and physical inactivity.

In fact, Zheng found that those two patterns seemed to offer a partial explanation for boomers' lower scores on cognitive tests.

But, he said, there was an even stronger factor: rising rates of depression and loneliness.

It's not clear why, but some studies have found a link between depression and dementia risk, Zheng said.

Whether depression is actually a risk factor for dementia remains unknown, according to Heather Snyder, vice president of medical and scientific operations for the Alzheimer's Association. The dementia process is a long one, and it's possible that those underlying brain changes cause the depression symptoms, explained Snyder, who wasn't involved with the study.

"It's a really important area of research," she said.

To Snyder, the takeaway from this new study is that people should address modifiable factors that are believed to contribute to dementia. In general, good cardiovascular health supports brain health, so it's important to eat a healthy diet, exercise and control blood pressure, cholesterol and blood sugar, she said.

The study, recently published online in *Journals of Gerontology: Social Sciences*, pulled data from a long-running health study of Americans older than 50.

Zheng focused on more than 30,000 people who took part in the study between 1996 and 2014. All took the same battery of cognitive tests. On average, test scores peaked among "war babies" born between 1942 and 1947 -- then dipped among boomers.

The pattern held true for Americans of all income and education levels, according to Zheng.

And the findings were not explained by deaths among older generations leaving the healthier and hardier behind. Zheng said the cognitive differences between war babies and boomers were apparent before age 55.

"This study suggests cognitive health has started to decline in the U.S.," Zheng said, adding it's not clear what the patterns will be for generations younger than the boomers.

Zheng echoed Snyder in stressing the ways that people can protect their brain health.

"Physical health and cognitive health aren't separate -- they're related," he said. "Try to spend more time being physically active, and pay attention to your cardiovascular risk factors."