

## February 13, 2022 E-Newsletter

### The Alliance and the AFL-CIO Celebrate Black History Month, Lunar New Year

"We may have all come on different ships, but we're in the same boat now," Martin Luther King Jr. famously said.

Since February 1 was both the Lunar New Year — also known as the Chinese New Year — and the first day of Black History Month, the Alliance joins the AFL-CIO in taking this opportunity to note that the Black and Asian American

communities have worked proudly together for working people and for civil rights for many years.

"Corporate power players have historically taken control most easily when allies in the labor and civil rights movements fight amongst ourselves," said Robert Roach, Jr., President of the Alliance. "Do not fall into their trap when our political

opponents attempt to divide us with their misleading rhetoric."

As Team AFL-CIO noted earlier this week, Frederick Douglass spoke against anti-Chinese immigration policies; Grace Lee Boggs fought for civil and worker rights and helped organize Black autoworkers in Detroit for more than 60 years; and Asian organizers created Letters for Black Lives to talk

about anti-Blackness with Asian families in their own language.

"There has never been a more appropriate time than now to remember that our fight for justice will be shared until the day we are all free," President Roach stated.



Robert Roach, Jr.  
 President, ARA

### COVID-19 Widows Struggle to Get Survivors Benefits as Social Security Offices Remain Closed

In addition to causing pain, misery and death to millions of infected Americans, the coronavirus pandemic has forced Social Security offices to close in-person operations, and many children and spouses are experiencing **long delays** in processing their survivor benefit claims. More than 90 percent of those seeking survivor benefits are women.

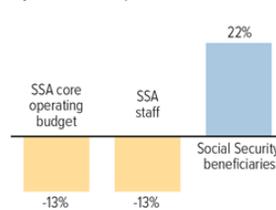
To help alleviate the problem, the Social Security Administration (SSA) is expanding a vital pandemic service to taxpayers that it had

restricted to just one hour a day, **allowing drop boxes at its closed field offices to accept sensitive documents and forms** for more hours as it works toward opening some facilities.

"The combination of SSA's severe underfunding and the pandemic have been enormous hurdles to overcome," said Richard Fiesta,

#### Social Security Administration Faces Increased Workload With Fewer Resources

Percent change from 2010 to 2021 (funding adjusted for inflation)



Note: For beneficiaries, figures reflect the change from Sept. 2010 to April 2021 for staff, between fiscal years 2010 and 2020. These data do not incorporate additional funding from the legislative response to COVID-19.

Source: CBPP analysis based on Social Security Administration and Office of Management and Budget

CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG

Executive Director of the Alliance. "Congress can help SSA address these challenges with sufficient funding that allows a smooth reopening when it is safe to do so. SSA's work force is doing all they can under very difficult circumstances and the additional funding would certainly be put to good use."

According to the Center on Budget and Policy Priorities, the House-passed appropriations bill for the departments of Labor, Education, and Health and Human Services would boost SSA's funding by 9 percent over last year, while the Senate version would provide an 8 percent increase — less than the **10 percent** increase proposed in President Biden's 2022 budget.



Rich Fiesta,  
 Executive Director, ARA

### Biden administration proposes greater accountability from Medicare Advantage

For years, the federal government has paid Medicare Advantage plans and Part D prescription drug plans hundreds of billions of dollars to cover Medicare benefits, demanding little transparency and accountability regarding the amounts they spend on medical care and drugs and the quality coverage they provide. **HealthcareDive** reports that the Biden administration has issued a proposed rule that, if finalized would demand greater transparency and accountability

from Medicare Advantage and Part D plans. But, it's hard to imagine it's enough to ensure these corporate health plans cover the care people need.

If you are enrolled in a Medicare Advantage plan and you develop a serious condition, you might find unwarranted and inappropriate delays and denials of care you need. Please let us know if you do. And, fight back. Appeal the denials. Medicare Advantage plans are obligated to cover all reasonable and



necessary care. The challenge is that Medicare Advantage plans can be engaged in all sorts of behaviors that are harmful to their enrollees and difficult if even possible to detect.

For example, MA and Part D plans sold in the individual market are charging their enrollees (27 million and 24 million respectively) copays based on their negotiated drug prices at pharmacies, even though these plans sometimes pay pharmacies lower rates.

The **proposed rule** would require the Medicare Advantage and Part D plans to disclose those lower prices and pass their savings along to their enrollees through lower copays.

The proposed rule also recognizes the dangers of **deceptive marketing** by Medicare Advantage plans and the third parties they hire to get people to join their health plans. It aims to do a better job of protecting people. Nice to hear, but it's hard to imagine that's possible... **Read More**

ADD YOUR NAME

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

The National WEP/GPO Repeal Task Force requests that all members of various groups supporting the repeal act **NOW**. We have a window during this 117th Congress to actually get this done, but it will take a multitude of voices to get the attention needed to pass either, or both, of the most promising bills: H.R. 82 and H.R. 5723.

**Here is what you need to do:**

1. Highlight and copy the brief message at the bottom of this email
2. Click the link to the staff person of each Representative. Send separate emails to each one.
3. You can now make any additions or alteration, such as adding a sentence or two on how you are impacted.
4. Of course, be sure to add the

Representative's name, at the top and your full name at the end.



5. Before you send the first one, if you have altered it, highlight and copy again so you will not have to alter it for each new email.

**Please copy and paste the message below**

There are Two legislative bills; H.R. 82- Rodney Davis (IL) and H.R. 5723- John Larson (CT), that have been introduced that call for repeal of both the Windfall Elimination Provision (WEP) and Government Pension Offset (GPO).

The WEP and GPO are earned benefits that retirees have paid for. The Windfall Elimination Provision (WEP) penalizes earners who have had two jobs, one where they paid into Social

Security taxes and one in which they paid into a public pension. These pensions were earned separately and differently from Social Security, yet they are used to reduce the amount of Social Security benefits that a worker receives during retirement.

One of the harshest inequities of these two offsets is the Government Pension Offset (GPO) which creates an environment that takes earned benefits, primarily from women, to pay for benefits, not all of which are earned that are primarily for men. The Government Pension Offset (GPO) can eliminate \$24,000 or more fully earned spousal or survivor benefits, paid for by

their spouse causing devastating financial loss.

Now is the time to take action to repeal these two unjust penalties. If you have co-sponsored H.R. 82 and H.R. 5723 we thank you, if you haven't we urge you to co-sponsor H.R. 82 and H.R. 5723 to move this issue to the forefront.



**Contact your elected official's local office**  
<https://www.house.gov>  
**Nancy Pelosi (CA) Speaker of the House**  
[dick.meltzer@mail.house.gov](mailto:dick.meltzer@mail.house.gov)  
**Tom Reed (NY)-Ranking Member Social Security Subcommittee**  
[Luke.wallwork@mail.house.gov](mailto:Luke.wallwork@mail.house.gov)

**How old is too old to file for bankruptcy?**

Filing for bankruptcy protection is a big decision for anyone, but for older people, it also raises some unique concerns. Many older adults have a lot of equity in their homes, something worth protecting, but that could be threatened in certain Chapter 7 bankruptcies.

If you're an older adult, it's important to consider all your options and know what's at risk before filing for bankruptcy.

Is bankruptcy possible?

"When someone comes to me asking about bankruptcy, I would ask 'What's driving you? What's the pressure point? What are your vulnerabilities and what are your goals?'" says bankruptcy attorney Robert Haupt.

This is especially important to ask for seniors, because their situations are usually different than younger adults. If they own their homes, they likely have a lot more equity in their home.



Which means they could have more to lose in the case of a Chapter 7 bankruptcy if their equity isn't protected.

One scenario that would make the value of filing for bankruptcy protection questionable for seniors is if there's simply nothing for a creditor to take. If you're retired and don't have much income, this might apply to you. It could mean you are "judgment-proof." Creditors

generally can't access assets like your Social Security benefits, retirement accounts or things you need to maintain a home like household goods.

"Retirement funds are protected, Social Security benefits are exempt — they can't get them," says Haupt. "Virtually anything IRS recognizes as tax exempt is going to be exempt to a certain level."

....[Read More](#)

**Costs now keep one in three Americans from getting care**

A new **Gallup and West Health** study finds that almost one in three Americans are skipping care because of the cost. That's a huge jump up in the number of Americans skipping care because of cost in the last six months alone. The US has always rationed care based on the ability to pay, and the consequences are dire for more and more people.

Costs are not only a barrier to care for people with average and lower incomes; they are a barrier to care for people with annual incomes of more than \$120,000. One in five households with incomes above \$120,000 a year have skipped getting care—seven times the proportion who skipped

care less than one year ago.

And, it's hard to imagine a time when health care costs will stop increasing. The market does not control health care costs effectively. So, costs keeping going up for health care, including **prescription drugs**. That's why every other wealthy nation regulates health care prices.

The Gallup survey found that more than 12 million people knew someone who skipped care and then died as a result. One in five people knew someone whose condition worsened because the person skipped care.

Nearly one in four Americans



report that the cost of their health care is taking a toll on them financially. And one in three Americans with annual incomes under \$48,000 are facing huge financial burdens because of their need for care. Deductibles, copays and coinsurance are all rising. Two in three **Americans are in debt**, and medical debt is the largest portion of debt. Literally, one in two Americans are now in **medical debt**. **Medical bills** are the biggest reason so many Americans are in debt.

Most people no longer think their health care charges are reasonable. Rather, they don't think they are getting their

money's worth. More than half (52 percent) reported that the health care they got wasn't worth what they had to pay for it. That's up from last April, when 43 percent said their care wasn't worth the cost.

We pay more and more for our health care, yet we continue to fare worse, often significantly worse, than our peers in other wealthy country. Increasingly, however, the health care stakeholders responsible for our exorbitant health care costs control our policymakers, and keep them from regulating prices. We need to vote in more representatives who represent us.

## CMS Says Medicare Will Cover At-Home COVID Tests at No Cost

On February 4th, the Centers for Medicare & Medicaid Services (CMS) **announced** plans to make over-the-counter (OTC) COVID-19 tests available to people with Medicare at no cost by “early spring.”

According to the agency, “[u]nder the new initiative, Medicare beneficiaries will be able to access up to eight over-the-counter COVID-19 tests per month for free. Tests will be available through eligible pharmacies and other participating entities.”

The Medicare Rights Center applauds this development. It appears designed to help correct the imbalance in the administration’s **initial OTC testing policy**, which applied to private insurers but not Medicare.

As the Kaiser Family Foundation subsequently **explained**, there were several reasons why Medicare was excluded. For one, the administration relied on authorities in the **Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act** to

establish private insurance coverage of the OTC tests. But those laws did not include comparable Medicare flexibilities, and the program’s complex rules caused additional setbacks.

Today’s news signals the administration has found a workaround. CMS notes the significance of the moment—and the challenges behind it—saying, “[t]his is the first time that Medicare has covered an over-the-counter test at no cost to beneficiaries. There are a number of issues that have made it difficult to cover and pay for over-the-counter COVID-19 tests. However, given the importance of expanding access to testing, CMS has identified a pathway that will expand access to free over-the-counter testing for Medicare beneficiaries.”

While many specifics have not yet been released, in a related **FAQ** CMS does clarify the tests will be covered under Part B, that the initiative should be operable in the coming weeks, and that more information will be available soon.

“Starting in early spring,



people with Medicare will be able to go to eligible pharmacies and other entities that are participating in this initiative to receive over-the-counter COVID-19 tests for free through their Medicare Part B coverage. More information about eligible pharmacies and other entities that are participating in this initiative will be available in the early spring. Once the initiative is up and running, CMS will encourage beneficiaries to ask their local pharmacy or current health care provider whether they are participating in this initiative.”

Today’s release is a promising step in the right direction. Medicare Rights looks forward to learning more about the initiative, as well as about the agency’s plans for implementation, outreach, and education. As we and other advocates recently **noted**, the Medicare exclusion created an obstacle to care for millions of Americans, many of whom are at increased risk of infection and serious illness from COVID-19. We appreciate the administration’s responsiveness to these concerns. Expanding

access to OTC tests at no cost to people with Medicare will help improve individual and public health.

Until the program is in effect, CMS advises people with Medicare to obtain free tests through the following channels:

- ◆ Request four free OTC tests for home delivery at **[covidtests.gov](https://www.covidtests.gov)**.
- ◆ Access COVID-19 tests through healthcare providers at over 20,000 free testing sites nationwide. A list of community-based testing sites can be found **[here](#)**.
- ◆ Access lab-based PCR tests and antigen tests performed by a laboratory when the test is ordered by a physician, non-physician practitioner, pharmacist, or other authorized health care professional at no cost. In addition to accessing a COVID-19 lab test ordered by a health care professional, people with Medicare can also already access one lab-performed test without an order, also without cost sharing, during the public health emergency.

## Mental Health Therapists Seek Exemption From Part of Law to Ban Surprise Billing

Groups representing a range of mental health therapists say a new law that protects people from surprise medical bills puts providers in an ethical bind and could discourage some patients from care.

The therapists take no issue with the main aim of the legislation, which is to prevent patients from being blindsided by bills, usually for treatment received from out-of-network medical providers who work at in-network facilities. Instead, they are concerned about another part of the law — a price transparency provision — that requires most licensed medical practitioners to give patients detailed upfront cost estimates, including a diagnosis, and information about the length and costs involved in a typical course of treatment. That’s unfitting for mental

health care, they say, because diagnoses can take time and sometimes change over the course of treatment.

Finally, if they blow the estimate by at least \$400, the law says uninsured or self-pay patients can challenge the bills in arbitration.

Arguing that the rule is burdensome and unnecessary, mental health providers wrote a **Jan. 25 letter** to the Department of Health and Human Services, seeking an exemption from the “good faith” estimates for routine mental and behavioral health services. The letter was signed by 11 groups, including the American Psychological Association, the National Association of Social Workers, the American Psychiatric Association, and the



Psychotherapy Action Network.

Some also worry that the law will allow insurance companies to play a larger role in dictating what even non-network mental health therapists can charge, although policy experts say it isn’t clear how that could happen. Although exact figures are not available, it’s estimated that one-third to one-half of psychologists are not in-network with insurers, the psychologists’ association said. And those numbers do not include other practitioners, such as psychiatrists and licensed clinical social workers, who are also out of network.

“We got thrown into this bill, but the intention [of the law] was not mental health but high-cost medical care,” said **Jared Skillings**, chief of professional practice with the American

Psychological Association. “We’re deeply concerned that this [law] inadvertently would allow private insurance companies to set regional rates across the country that, for independent practitioners, would be a race to the bottom.” Therapy costs vary widely around the U.S. and by specialty, but generally range from \$65 an hour to \$250 or more, according to the website **[GoodTherapy](https://www.GoodTherapy.com)**.

The good faith estimates must be given this year to uninsured or self-pay patients for medical or mental health care services. They were included in the No Surprises Act as part of a broader effort to give patients a good idea of cost, both per visit and for a course of treatment, in advance.... **[Read More](#)**

# Kaiser Family Foundation Releases Report on Medicaid in 2022

Last week, the Kaiser Family Foundation **released an issue brief** identifying areas of change and possible concerns in the Medicaid program for 2022. The brief highlights several areas to watch in 2022, including potential Medicaid changes resulting from the ongoing pandemic and Public Health Emergency, the uncertain fate of the Build Back Better Act (BBBA), various state budgets, and Biden administration efforts to further strategic coverage, access, and equity goals through regulatory action.

Notably, they identify enrollment, coverage, long-term care—in institutions and in homes and the community—access to services, and health equity as areas of interest. Noting the continuing trend of increased enrollment in Medicaid and CHIP throughout the pandemic, the report outlines several possible scenarios as some of the federal changes driving that increase expire. The BBBA

would phase out some of these changes more slowly, and some states have taken advantage of increased flexibilities offered under the American Rescue Plan Act (ARPA) or those previously existing to increase eligibility and enrollment in Medicaid. Others, like South Dakota, will have Medicaid eligibility expansion on the ballot in 2022.

The report also summarizes administration actions to review and evaluate previously approved Medicaid waivers that restrict coverage or “undermine” the program, as well as some to “streamline” eligibility and enrollment processes and increase outreach to provide coverage for the approximately 7 million people who are uninsured and eligible for Medicaid.

Medicaid is the nation’s largest payer of long-term care services and, the report shows, staff and residents of long-term



care facilities have been disproportionately affected by the pandemic. Both the direct impact of illness and death, and the impact of the pandemic on the long-term care workforce have highlighted the long-standing unmet need for home- and community-based services and the direct care workforce shortage. The report includes several proposed changes to federal Medicaid spending and Medicaid rules to address this need—the BBBA as currently proposed would include \$150 billion in new federal funds for Medicaid Home and Community based services and update nursing facility staffing requirements to include a requirement to have at least one registered nurse on duty 24 hours a day.

The report also details the need for, and some efforts to address, improved access to care and increased attention to the

social determinants of health and health equity. Post-pandemic telehealth coverage and reimbursement policies are being evaluated in most states. In KFF’s 50 state budget survey, most states reported that the pandemic prompted them to expand Medicaid programs to address social determinants of health, particularly around housing support. Both the administration and the majority of State Medicaid programs are implementing initiatives to address disparities in health care by race/ ethnicity within Medicaid. The report identifies the question of how states will leverage Medicaid to address social determinants of health and racial equity, and how the administration will support these efforts, as “what to watch” in 2022.

**[Read the report.](#)**

## At Nursing Homes, Long Waits for Results Render Covid Tests ‘Useless’

More nursing homes are waiting longer for covid-19 test results for residents and staffers, according to federal data, making the fight against record numbers of omicron cases even harder.

The double whammy of slower turnaround times for lab-based PCR tests and a shortage of rapid antigen tests has strained facilities where quickly identifying infections is crucial for keeping a highly vulnerable population safe.

A KHN analysis of data from the Centers for Medicare & Medicaid Services finds that 25% of nursing homes that sent tests to a lab waited an average of three or more days for results as of Jan. 16. In early December, that number was 12%.

At Lutheran Life Villages in Fort Wayne, Indiana, the long wait for results renders PCR tests “useless,” President Alex Kiefer said. “If we send somebody off to get a PCR test, sometimes it takes two days for them to get an appointment. And then it takes two, three, four days to get a

read.”

So Kiefer’s organization mainly relies on rapid antigen tests. But on Jan. 12, long-term care sites in the state were alerted to shortages of Abbott Laboratories’ rapid BinaxNOW antigen tests, according to the Indiana Department of Health. Lutheran Life Villages was using 125 rapid tests a day, including on vaccinated people. Now as transmission rates remain high, “we are scrounging to try to find enough,” Kiefer said. He called the state shipments sporadic. “The scariest thing is, if we get to a point where we can’t get those, we will have to rely on PCRs, and the timing of that is just really challenging,” Kiefer said.

Federal officials require the country’s 15,000 nursing homes to submit data on covid in their facilities; KHN’s analysis of testing speeds is based on reports of turnaround times in early December and mid-January from about 10,900 homes.



Nursing home residents have high vaccination rates — more than 87% are fully inoculated, and 67% have received boosters. Still, experts warn, delays can pose significant safety risks. For one, in the time it takes to receive results, outbreaks can emerge undetected. And with omicron, breakthrough infections appear to cause more severe symptoms for older people.

This many nursing homes haven’t waited three or more

days for test results since March 2021, CMS data show.

Broadly, PCR tests are considered the gold standard for accuracy and are more likely to be used for regular surveillance testing because rapid tests can miss asymptomatic cases. The drawback is that labs can take days to return PCR results under normal circumstances, let alone when testing demand and staffing shortages delay processing. ... **[Read More](#)**

### The Longer Wait for Covid PCR Test Results

Slower turnaround times for lab-based PCR tests, coupled with a shortage of rapid antigen tests, have strained efforts to contain omicron in U.S. nursing homes.

Average wait time for nursing homes	Week ending Dec. 5, 2021	Rate	Week ending Jan. 16, 2022	Rate
<1 day	2,955	27%	2,601	24%
1-2 days	6,603	61%	5,638	52%
3-7 days	1,276	12%	2,577	24%
>7 days	18	0%	121	1%

NOTE: Data is from more than 10,800 nursing homes. An additional 4,300 nursing homes either reported sending no covid tests to labs or did not report any data to the Centers for Medicare & Medicaid Services.  
CREDIT: Holly Hacker and Hannah Norman/KHN  
SOURCE: KHN analysis of data from CMS



## Dear Marci: When can I change my coverage in 2022?

**Dear Marci,**  
*I mistakenly enrolled in the wrong Medicare Advantage Plan and did not realize until the plan became effective in 2022. When can I change my coverage now?*  
-Susan (New York, NY)

Dear Susan,  
I'm sorry to hear that! Depending on your circumstances, you may be able to change your coverage. Let's discuss a few possibilities:  
**You can make certain changes during the Medicare Advantage Open Enrollment Period (MA OEP),** which runs from January 1 through March 31. Those enrolled in a Medicare Advantage Plan (like yourself) can switch to a different Medicare Advantage Plan or to Original Medicare with or without a stand-alone Part D plan. Changes made during this period are effective the first of

the month after you make the change.  
You can use Medicare's **Plan Finder** tool to compare plans and call 1-800-MEDICARE to request the change.  
**If you enrolled in a Medicare Advantage Plan or Part D plan by mistake or after receiving misleading information,** you may be able to **disenroll and change plans.** Typically, you have the right to change plans if you:  
◆ **Joined unintentionally:** You may have enrolled believing you were joining a Medigap plan to supplement Original Medicare. Or, you meant to sign up for a stand-alone Part D plan and accidentally joined a Medicare Advantage Plan.  
◆ **Joined based on incorrect or misleading information:** For



Dear Marci:

example, if a plan representative told you that your doctors are in the plan's network but they are not, or you were promised benefits that the plan does not really cover.  
◆ **Through no fault of your own, ended up or were kept in a plan you do not want:** If you tried to switch plans during an enrollment period but were kept in your old plan. You can also make a change if you were enrolled in a plan because of an administrative or computer error.  
Depending on the circumstances, this change may be retroactively effective.  
**You may be eligible for a Special Enrollment Period (SEP) in which to change your coverage.** SEPs allow you to change your health and/or drug coverage outside normal

enrollment periods. For example, if your Medicare Advantage Plan left your area or if you moved out of your plan's service area, you would have an SEP to switch to another MA Plan or to Original Medicare. Those enrolled in certain cost assistance programs, such as **Extra Help** or the **Medicare Savings Program,** are eligible for other SEPs. **Read about other circumstances that might trigger an SEP on Medicare Interactive.**

And of course, you can wait for **Fall Open Enrollment Period** to make changes to your coverage for next year. **Fall Open Enrollment Period** occurs each year from October 15 through December 7, with your new coverage starting January 1.  
I hope this helps you correct your coverage for 2022. Best of luck!

-Marci

## Older adults rise up for a better America

The **New York Times** reports that a burgeoning movement of older adults, including Neil Young and Joni Mitchell, are rising up to fight for a better America. Led by Bill McKibben, Third Act's mission is to organize adults over 60 in ways that can help deliver progressive change. We're talking about 75 million people. Organizing a large cohort of older adults could be difficult because many people tend to lose their progressive

views as they grow older. But, we are at a time when complacency is untenable for many, reinforcing inequities and injustices that must be addressed.

And, many of the baby boomers grew up in the 60's, witnessing horrors and fighting for change. They have time now, as well as skills, resources and a hunger, to pick up the battle. To many, it feels as if the US is



going to hell in a hand-basket. Third Act plans to take on big oil by going after the big banks that support the fossil fuel industry. Watch out Chase, Citi, Bank of America and Wells Fargo. The older generation holds 70 percent of the financial wealth in this country.  
Third Act is also fighting to protect democracy. Older adults represented 44 percent of all voters in the last election. And,

older adults often have time to volunteer and help ensure that people get out and vote.  
We could use Third Act to focus on healthcare in America. Right now many of the big "advocacy" groups are **industry shills.**  
It feels harder than ever to effect change. But, the only way it will happen is if we try and try hard. We're all in this mess together. And, together is the only way out.

## House Republicans and Democrats agree on \$57 billion USPS overhaul

The House on Tuesday advanced a major financial overhaul of the ailing U.S. Postal Service, relieving it of tens of billions of dollars in liabilities that agency leaders said prevented it from modernizing and providing efficient service.

The bill, which passed 342 to 92, marks a major breakthrough for the mail agency and Postmaster General Louis DeJoy, who made the legislation the centerpiece of his 10-year postal restructuring plan.

The Postal Service has implored Congress to help fix its

balance sheet for nearly 15 years, and agency leaders are cautiously optimistic about prospects for the Postal Service Reform Act in the Senate. It has 27 co-sponsors in the upper chamber, including 14 Republicans, sufficient support to defeat a potential filibuster.

Senate Majority Leader Charles E. Schumer (D-N.Y.) said the chamber would vote on the legislation by the end of next week, citing its bipartisan popularity.

Democrats have hailed the legislation as crucial to the preservation of the Postal



Service and its ability to reach nearly every American household six days a week. Republicans say the bill vindicates DeJoy's initiatives and a conservative approach for a smaller mail service.

"We need to take steps to make our post office stronger," Rep. Carolyn B. Maloney, the bill's sponsor and chair of the House Oversight and Reform Committee, told The Washington Post. "This bill helps and it will help in every way. It's a reform bill that will save taxpayers' dollars while at

the same time making the operations of the post office more financially stable and sustainable, and making postal jobs and employee health benefits more secure."

The Postal Service is required to prepay its retirees' health-care costs, a mandate instituted in 2006 when mail volume was steady and the agency was profitable. But decades of falling mail use have turned it into a perpetual financial loser, and the pre-funding requirement has accounted for \$152.8 billion of its \$206.4 billion in liabilities....**Read Moe**

## 4 Social Security Payment Quirks That No One Warns You About

### Social Security Payment Quirks That No One Warns You About

Many people understand the basics of Social Security long before they retire: You pay into the program with your taxes throughout your working years, and then there'll be a nice chunk of change waiting for you afterward.

We learn as we age that things get more complicated than that. Much is written on everything from eligibility requirements for ex-spouses to [how to maximize your Social Security checks](#).

There are also certain things that would've been nice to know ahead of time, but that many folks don't realize until they start receiving benefits. Here's a quick look at some of those.

1. You are paid in arrears Uncle Sam is very particular about your paying him on time, but of course, he isn't quite so considerate in return.

As the Social Security Administration [freely admits](#), you can expect every Social Security check to be "paid in the month following the month for which they are due." In other words, your May check will arrive in June.

But it's not considered a late payment when the federal government does it.

2. You are paid monthly In our working lives, many of us become accustomed to weekly, biweekly or at least twice monthly pay — and we build our budgets around that.



These pay periods describe the vast majority of American paychecks, according to the [federal](#)

### [Bureau of Labor Statistics](#).

Three-quarters of employers pay either weekly or biweekly, while fewer than 5% of employers pay monthly.

Nonetheless, Social Security operates on the unpopular monthly frequency.

3. Your payment date usually depends on your birthday Once upon a time — prior to 1997 — most people received their Social Security checks in the first three days of the month. This didn't work very well. Because everyone expected their checks at the same time, it created a burden on the Social Security Administration, banks,

businesses, the postal service and others.

The SSA found that services were less overwhelmed when checks were spread out throughout the month. This process is called "[payment cycling](#)," and today it works like this:

◆ **If your birthday is on the 1st through the 10th:** Benefits are paid on the second Wednesday of the month.

◆ **If your birthday is on the 11th through the 20th:** Benefits are paid on the third Wednesday.

◆ **If your birthday is on the 21st through the 31st:** Benefits are paid on the fourth Wednesday.

## Harnessing the Herpes Virus to Beat a Deadly Brain Cancer

A genetically modified herpes virus appears to deliver a "one-two punch" to the rare and deadly form of brain cancer that killed U.S. Sen. John McCain, new findings show.

[Glioblastoma](#) brain tumors are a cancer nightmare, with an average survival of 12 to 15 months from initial diagnosis and four to six months after recurrence, researchers say. [McCain](#) died in August 2018, one year after doctors

discovered he had the aggressive cancer.

"Despite 50 to 60 years of research and advances in surgery, chemotherapy and radiation, we haven't pushed the needle much at all in terms of survival," said senior researcher Dr. James Markert, chairman of neurosurgery at the University of Alabama at Birmingham's Heersink School of Medicine. "Only 5% to 10% of patients live



longer than five years. It's almost universally fatal."

But an experimental cancer-fighting herpes simplex virus called G207 has shown promise in fighting [glioblastoma](#), and a paper published Feb. 1 in [Clinical Cancer Research](#) provides a better idea how.

It's been known that G207 directly attacks and kills brain

tumor cells, Markert said.

"There's something different about tumor cells' defense against viruses, so that the changes in the DNA that kept the virus from being infectious in normal human cells weren't present in the tumor cells," he said. "As a result, the virus became selective for infecting and killing tumor cells."...[Read More](#)

## Does social security count as income?

With tax season here, many on social security are wondering if their benefits are taxable. The answer depends on your combined annual income.

Social security benefits are received by millions in the United States and for many it is their only source of income. Once retirees begin to claim benefits, they will not be able to work at the same levels they had as they risk jeopardizing their benefit amount.

### **Do you have to pay taxes if you receive social security?**

During tax season those who receive social security will have to calculate their combined income. This figure income includes the adjusted gross

income (i.e. wages, salary, investments) and social security benefits as well as some types of non-taxable interest. After determining this amount, a beneficiary will know whether they need to pay taxes or not. In most cases, those with a [combined income](#) under \$25,000 (\$32,000 for married couples) a year will not have to pay taxes on their social security benefits. For those with a combined income between \$25,000 and \$34,000 (\$32,000 to \$44,000 for married couples) a year, the Social Security Administration may be able to tax up to fifty percent of your benefits. Finally, with an income over



\$34,000 (\$44,000 for married couples), one can be taxed up to eighty-five percent of their social security benefits.

The Social Security Administration (SSA) will send a benefit statement each year in January to beneficiaries Form SSA-1099. [With this form](#) you will be able to "complete your federal income tax return to find out if your benefits are subject to tax."

Additionally, the SSA also allows beneficiaries to report their incomes quarterly to avoid a surprise at the end of the year. Another option includes having the agency withhold the taxes that would be owed when distributing your monthly

payments. In order for the [taxes on the benefits to be withheld](#) you will need to submit a W-4V Form to the IRS. Private retirement accounts

Many workers in the United States also pay into private retirement accounts like a 401(k) or a Roth IRA. These accounts differ in the way the funds put into them are taxed. Those who wish to pay taxes when they take out the money may choose the 401(k), while those who would rather pay the taxes now can choose the Roth IRA. As one ages, money is impacted by inflation, meaning that the dollars taxed today are worth less than those that could be taxed in the future.

## Biden reignites 'cancer moonshot' effort

President Joe Biden plans to publicize and relaunch his so-called cancer moonshot effort on Wednesday with the goal of stamping out one of the leading causes of death worldwide.

The White House, underscoring that this is a presidential priority, will designate officials to focus on efforts to treat and prevent cancers. But the administration said it will not lay out any new funding announcements for the initiative. A senior administration official told reporters Tuesday night that the cancer moonshot is a bipartisan effort, and he is confident robust future funding will be available.

The effort has three main

goals: cutting the age-adjusted death rate from cancer by 2025, increasing access to cancer screening and improving the experience of people living with cancer and their families.

As vice president in 2016, Biden led the original launch of the cancer moonshot project with the goal of reducing cancer and accelerating treatments. Biden hopes some of the proposed research will be done conducted via his previously proposed agency, the Advanced Research Projects Agency for Health, senior administration officials said. ARPA-H would be housed within the National Institutes of Health and tackle



medical breakthroughs for diseases such as cancer and Alzheimer's disease, though it hasn't yet received congressional funding.

Throughout his 2020 campaign, Biden said he would reignite the cancer moonshot program. The cause is personal for the president — his son Beau died of brain cancer in 2015.

"A lot has changed that has made it possible to set really ambitious goals right now," a senior administration official told reporters, noting that the pandemic has not only put science in the forefront but highlighted health care disparities.

Roughly 9.5 million Americans missed cancer screenings during the COVID-19 pandemic, and the president and first lady Jill Biden will call for more cancer screenings.

Federal agencies, led by the National Cancer Institute, are expected to develop a program to evaluate and study multicancer detection tests, similar to COVID-19 diagnostic tools.

The administration will establish a White House Cancer Moonshot coordinator position in the Executive Office of the President and form a White House Cancer Cabinet, bringing together officials from multiple agencies.

## Macular Degeneration Can Rob You of Sight: Know the Signs

(HealthDay News) -- Early diagnosis and care can often stop the progression of age-related macular degeneration (AMD), which is the leading cause of vision loss in older Americans, the American Society of Retina Specialists (ASRS) says.

As part of AMD Awareness Month in February, the society urges people to pay attention to their vision and learn more about AMD.

Age is the main risk factor for **AMD**, and people with a family history have an increased risk. Other risk factors include:

smoking, obesity, high blood pressure, excessive sun exposure, and a diet low in fruits and vegetables.

It's important to be aware of the symptoms of AMD.

Watch for altered or wavy lines that should be straight. Cover one eye at a time and look at a door frame or a checkerboard. If the lines look wavy or warped, it may be a sign of AMD. Or you can use an Amsler grid, which has black lines on a white piece of paper with a dot in the middle.



Pay attention to blurred central vision that can make it difficult to see a friend or loved one's face clearly.

Look out for colors that appear washed out or dull. You should get your eyes checked if you notice any decrease in the intensity or brightness of color.

"The earlier we see patients experiencing symptoms of AMD or any retinal condition, the sooner we can determine the cause of the symptoms and monitor the issue or use breakthrough treatments to

safeguard sight," ASRS President Dr. Philip Ferrone said in a society news release.

"Advances in imaging technology and newer treatments including **eye injections with anti-VEGF medications** mean, quite often, vision loss and **blindness** can be prevented when patients team with a retina specialist, so seek care at the first sign or symptom," Ferrone said.

### More information

There's more on AMD at the [U.S. National Eye Institute](http://www.nei.nih.gov).

## Deadly Type of Stroke Increasing Among Younger and Middle-Aged Adults

New cases of a debilitating and often deadly type of stroke that causes bleeding in the brain have been increasing in the U.S., growing at an even faster rate among younger to middle-aged adults than older ones, new research shows.

The findings show an 11% increase over the past decade and a half in intracerebral hemorrhage strokes, referred to as ICH strokes. The research, being presented next week at the American Stroke Association's International Stroke Conference, was published Thursday in the American Heart Association

journal Stroke.

"From a public health perspective, these results are troubling and indicate risk factors are not being well managed in young adults in the U.S.," said Dr. Karen Furie, chief of neurology at Rhode Island Hospital and chair of the department of neurology at Brown University's Warren Alpert Medical School in Providence. Furie was not involved in the research.

"Earlier onset of this disease is very alarming and indicates we need to be more aggressive with primary prevention," she said.



ICH strokes occur when blood vessels in the brain rupture and bleed.

They are the second most common type, accounting for 10%-15% of the estimated 795,000 strokes each year in the U.S. Globally in 2020, 18.9 million people had an intracerebral hemorrhage, according to the AHA's most recent heart and stroke statistics report. They are more deadly and more likely to cause long-term disability than other types of stroke.

Smaller previous studies have reached conflicting conclusions

about whether the rate of ICH has been rising or falling in the U.S.

In the new study, lead researcher Abdulaziz Bako, a postdoctoral fellow at Houston Methodist Hospital, and colleagues used aggregated nationwide data from 803,230 ICH hospitalizations. They calculated the rate of ICH over five consecutive three-year periods from 2004 to 2018. People were divided into four age groups: 18-44 years; 45-64 years; 65-74 years; and 75 years and older... [Read More](#)

## A Better Clot-Buster Drug When Strokes Attack?

A newer type of "clot-busting" medication might be safer than the one long used for treating strokes, a preliminary study hints.

Researchers found that among nearly 7,900 stroke sufferers, those treated with the drug -- called tenecteplase -- were less likely to suffer life-threatening brain bleeding as a side effect, compared to those given the standard medication alteplase.

Overall, 3.7% of alteplase patients suffered the complication, known as symptomatic intracranial hemorrhage. That compared with just over 2% of patients given the newer clot-dissolver.

Tenecteplase, sold under the brand-name TNKase, is currently approved in the United States for treating heart attacks. By dissolving the blood clot causing the attack, it can restore normal blood flow to the heart.

Similarly, most **strokes** are caused by a clot in a blood vessel supplying the brain (what doctors call ischemic stroke). Since the 1990s, alteplase, sold as Activase, has been the

standard clot-dissolving drug for treating those strokes.

Tenecteplase is not yet approved by the U.S. Food and Drug Administration for treating stroke. Ongoing clinical trials are looking at how it stacks up against alteplase in terms of effectiveness.

But some medical centers in the United States and elsewhere are already using tenecteplase for stroke. (In the United States, doctors are allowed to prescribe and give FDA-approved medications for conditions other than what's listed on the label.)

Some hospitals have made the switch, because there is already evidence to support using tenecteplase for stroke, said Dr. Steven Warach, lead researcher on the new study.

Past research suggests the drug is at least as good as alteplase in preventing long-term disability after a stroke, said Warach, a professor of neurology at the University of Texas at Austin's Dell Medical School.

There is also evidence that tenecteplase is better at



dissolving large clots, he said.

And practically speaking, tenecteplase is much easier to give, said Dr. Joseph Broderick, a volunteer expert with the American Stroke Association.

Alteplase is given by IV, over the course of an hour, he said, while tenecteplase is injected in one large dose that the body breaks down slowly.

That's especially helpful if a stroke patient needs to be transferred to another hospital for further care, said Broderick, who is also director of the University of Cincinnati's Gardner Neuroscience Institute.

He also noted that, right now, tenecteplase is the less costly treatment.

Broderick cautioned, though, that the new findings do not prove that tenecteplase is the safer drug.

The results do not come from a clinical trial that directly tested the clot-busters, he said. They are instead based on patients treated in the real world.

That means there's a risk of

"bias," Broderick explained.

There may have been differences among the patients, or among the hospitals that used tenecteplase instead of alteplase, that could explain the findings on bleeding risk.

For the study, Warach and his colleagues analyzed data from a registry set up by several hospital systems in the United States, Australia and New Zealand. Some centers have begun using tenecteplase for stroke patients in recent years, while others administer only alteplase...

In all, 6,429 stroke patients received alteplase and 1,462 were given tenecteplase between 2018 and 2021.

Overall, tenecteplase patients were about half as likely to suffer an intracranial hemorrhage, and the difference was larger among stroke sufferers who needed a thrombectomy. That's a procedure in which doctors surgically remove the blood clot causing the stroke -- often because it's particularly large.... [Read More](#)

## Pandemic Has Been Devastating to Mental Health of Disabled Americans

Loneliness, isolation and fears about contracting COVID-19 have turned life upside down for people with disabilities, causing high levels of depression and anxiety, a new survey finds.

Even before the pandemic, individuals with disabilities were more likely to experience social isolation than their **peers without disabilities**.

But **this survey of 441** adults conducted between October and December of 2020 found that 61% of respondents who self-reported a disability had signs of a major depressive disorder. About 50% had probable anxiety disorder.

That's significantly higher than in **previous studies** in which people with disabilities had a 22% chance of being diagnosed with depression over a lifetime, the researchers said. In an average year, about 3% of adults in the United States have a generalized anxiety disorder and 7% have a major depressive disorder.

"Sadly, [this] did not surprise me — many of our research team have disabilities ourselves and we're very connected to the disability community, so we knew the stories that people were going through already, but it was important to document," said study co-author Kathleen Bogart, an associate professor of psychology at Oregon State University in Corvallis.

Bogart said the value of this research goes beyond documenting high levels of distress, however.

"We can look at what is associated with those high levels of stress, so that's a way that we can find things to intervene upon," Bogart said.

People who have disabilities often have other health issues that put them at higher risk from **SARS-CoV-2**, according to the study.

Early in the pandemic, stories about people with disabilities not being prioritized when medical



care was being rationed may have added to the isolation, the study author suggested.

Some places had explicit policies to prevent people with disabilities from receiving priority for a ventilator or COVID-19 tests, Bogart noted. The health care system often underestimates the quality of life of a person who has a disability, she said.

When providers stopped "non-essential" care to prevent the spread of COVID-19 or to cope with limited resources, it meant individuals with disabilities could not access physical therapy or surgery, the study authors pointed out.

"Our findings did show that **anxiety and depression** was associated with having experienced disability-related stigma," Bogart said, adding that health care rationing became less common later in the pandemic.

"Even so, there have been many examples many of us have experienced throughout the pandemic where hospitals and health care workers are so strapped dealing with COVID, that people are not able to go in for their regular health care," Bogart said. "And for some people with disabilities, simply being able to go into physical therapy once every few weeks or to get an infusion, say that they may need once a month, to have those disrupted can severely impact their daily function, their pain and all of those things." The findings were recently published online in the journal **Rehabilitation Psychology**.

The study is worth noting, but is also small, said Rhoda Olkin, a professor in the clinical psychology doctoral program at Alliant International University in San Francisco. Olkin was not involved with the study but reviewed the findings.... [Read More](#)

## Shedding Pounds Might Help Stop Pre-Cancerous Colon Polyps

Colon cancer rates are increasing for younger Americans, along with rates of obesity. Could slimming down reduce young people's risk for malignancy?

A new study suggests that even a small amount of weight loss may cut your odds for benign growths in the colon known as adenomas, or polyps. Left unchecked, these growths can lead to [colon cancer](#).

"We have two main public health messages based on our findings. The first is that avoiding weight gain in adulthood may help reduce colorectal adenoma risk. And that may, in turn, reduce the risk of developing colorectal cancer," said study author Kathryn Barry.

"And then the second message is that losing weight in

adulthood, particularly for overweight and obese adults, may help reduce adenoma risk in addition to other potential health benefits," added Barry. She's an assistant professor at the University of Maryland School of Medicine, in Baltimore.

For the study, the researchers used self-reported weight data from the Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial, which enrolled nearly 155,000 men and women aged 55 to 74 from 1993 to 2001.

They chose participants from the screening arm of the trial — a group that received colon screening at baseline and again three or five years later.

The investigators found that [weight loss](#) in adulthood



was associated with a 46% decreased risk of colon polyps.

The amount of weight lost was as small as 1.1 pounds per five years. This reduced risk from weight loss was especially clear in adults who were initially overweight or obese, particularly in men, the study found.

Conversely, adults who gained about six pounds over five years had a 30% increased risk, Barry said.

The American Cancer Society estimates the United States will see [more than 106,000 new cases of colon cancer in 2022](#), along with more than 44,000 cases of rectal cancer. Though the rates are dropping, there has been a rise in rates for folks under the age of 50.

The recommended age

for [colonoscopy](#) and other screening techniques was reduced in 2021 to age 45.

While most studies that have looked at the impact of weight on colon cancer have considered weight gain, there's been little research on the role of weight loss, Barry said.

The findings were published Feb. 1 in *JNCI Cancer Spectrum*.

"I think they had some really, potentially, very important findings and very exciting findings, potentially, if these findings could be replicated," said Lauren Teras, senior scientific director of epidemiology in the department of population science at the American Cancer Society...[Read More](#)

## Round up: Emergency care

As you know, health care costs can be sky high. Regardless of what you pay, your health outcomes depend heavily upon the quality of care you receive. Since emergencies are by definition unexpected, it's important to think about what could be in store for you and to plan ahead for a medical emergency.

**Preparing yourself:**

- ◆ [Five steps to get your affairs in order in case of](#)

- ◆ [emergency Coronavirus: Planning ahead for a medical emergency](#)

- ◆ [Six steps you should take to prepare for a weather emergency](#)

**Making sure Medicare covers your care:**

- ◆ [Two ways to make sure Medicare covers ambulance services](#)



- ◆ [Medicare Advantage costs keep rising, with no clear benefits](#)

**The importance of a good primary care doctor:**

- ◆ [Six reasons you need a primary care doctor in this age of specialization](#)

**Your hospital care:**

- ◆ [Choose your hospital emergency room carefully](#)
- ◆ [Anthem penalizes patients](#)

[who seek emergency room care](#)

**Thinking about costs:**

- ◆ [Two tips for keeping your emergency care costs down](#)

**And, for the broader picture:**

- ◆ [Planning for life's curve balls](#)

## Could a Pap Test Help Detect Breast, Ovarian Cancers, Too?

Pap tests have long been used to detect [cervical cancer](#) early, but preliminary research suggests that cervical cells collected during those tests could also be used to catch other cancers, including deadly ovarian tumors.

Researchers found that by analyzing a particular molecular "signature" in cervical cells, they could accurately identify women with [ovarian cancer](#) up to 71% of the time. Using a similar approach, they were also able to detect a majority of women who had [breast cancer](#) with a poor prognosis.

The findings suggest that the molecular signatures in cervical cells may be picking up a predisposition to other women-

specific cancers, said senior researcher Dr. Martin Widschwendter, a professor of cancer prevention and screening at the University of Innsbruck in Austria.

The hope, he explained, is to one day have a simple "first-line" screening test for four cancers: cervical, endometrial, breast and ovarian.

Women deemed to be at high risk for any of the diseases could then undergo more intensive screening for them, said Widschwendter. He noted that of all cancers women develop before the age of 65, more than half are breast, ovarian, endometrial or cervical.

Ovarian cancer, in particular,



lacks any good test to use for routine screening. The disease is often deadly, largely because it is typically diagnosed after it has spread.

"Our aim is to identify the vast majority of women who are at risk of developing a woman-specific cancer -- irrespective of genetic or non-genetic factors," Widschwendter said.

However, an ovarian cancer specialist urged caution in interpreting the findings.

They show a "moderate association" between the molecular signature and ovarian cancer, said Dr. Rebecca Stone, director of the Kelly Gynecologic Oncology Service at Johns Hopkins Hospital in

Baltimore.

"They are not showing that it's predictive or diagnostic," Stone stressed.

To see whether the cervical cell signature actually predicts cancer, she said, a study would need to follow a large group of women over a long period.

Widschwendter said such a study is planned. The latest findings were published Feb. 1 in the journal *Nature Communications*.

The research focuses on a process known as DNA methylation -- chemical modifications to DNA that do not cause mutations in genes, but do determine whether a gene is active or dormant at certain times....[Read More](#)

## Almost All Americans Are Now Within 1 Hour of Good Stroke Care

Nine in 10 Americans -- 91% -- live within an hour of lifesaving stroke care, researchers say.

That's up from about 80% a decade ago, due to an increase in hospitals with specialized staff, tools and resources, as well as expanded use of **telestroke** services that use the internet to link small and rural hospitals with stroke specialists in large facilities.

"Investments in improving stroke systems of care have been successful, and we are seeing improved access to stroke expertise and improved health care for patients who are remote from centers of expertise, so it's a message of hope," said study lead author Dr. Kori Zachrisson, an associate professor of emergency medicine at Massachusetts General Hospital and Harvard Medical School in Boston.

The analysis of 2019 and 2020 national data showed that 91% of the U.S. population can reach an acute stroke ready hospital or center within an hour by ambulance. That rises to 96% if telestroke-capable emergency departments are included.

The findings will be presented at a conference of the American Stroke Association, held in New Orleans and virtually, Feb. 8-11.

"There is a narrow window of time for delivering disability-reducing **stroke** treatments," Zachrisson said in a meeting news release.

"Improving post-stroke outcomes for patients depends on a patient's ability to access that care," she said. "With increased implementation of telestroke, optimal stroke care has been made possible for an estimated



96% of the U.S. population, which is remarkable, considering the geographic span of our country."

Still, the percentage of the population without access to either an acute care hospital or telestroke care varied widely by region -- from 1% in the Middle Mountain West, a region that includes Arizona, Colorado, Idaho, New Mexico, Montana, Utah, Nevada and Wyoming.

"Unfortunately, geography plays a role in access to health care -- if you live in rural areas your access to advance stroke care is not as available as if you live in the middle of Boston or New York City, for example," Zachrisson said. "Through telestroke, we have been able to begin to close geographic disparities and improve access to

optimal care by bringing stroke expertise to patients where they are -- this is profound."

Of 5,587 emergency departments nationwide, 46% are in an acute stroke ready hospital or stroke center, the study found. Of these, 55% also have **telestroke** services.

Of the emergency departments that are not in an acute stroke-ready hospital or stroke center, 36% have telestroke services, according to the findings.

Research presented at meetings is typically considered preliminary until published in a peer-reviewed journal.

In May 2020, the American Heart Association's Stroke Council issued new guidance on how to handle suspected stroke cases before they arrive at a hospital during the COVID-19 crisis and future pandemics.

## Red Cross Says Blood Shortage Is Worst in a Decade

(HealthDay News) -- The American Red Cross is pleading for donors as it grapples with its worst blood shortage in more than a decade.

The shortage poses a risk to patient care because doctors are forced to make decisions about which patients receive blood transfusions and which ones must wait until more blood becomes available, the Red Cross said in a **statement**.

The organization supplies 40% of the nation's blood supply, but has had to limit blood product

distributions to hospitals, and some hospitals may not receive 1 in 4 blood products they need.

Blood cannot be manufactured or stockpiled and is only available through volunteer donors. In recent weeks, there's been less than a one-day supply of critical blood types, according to the Red Cross.

The agency cited a number of factors behind the blood shortage crisis.

There's been a 10% decrease in



overall blood donations since March 2020, and a 62% drop in college and high school blood drives due to the **pandemic**. Student donors accounted for about 25% of donors in 2019, but for just 10% during the pandemic.

Not only that, but there are ongoing blood drive cancellations due to illness, weather-related closures and staffing shortages.

Other factors include a surge of COVID-19 cases and an active **flu season**, according to

the organization.

"At a time when many businesses and organizations across the country are experiencing pandemic challenges, the Red Cross is no different. We are all learning how to live in this new environment, how we spend our time, where we work, how we give back, how we make a difference in the lives of others -- donating blood must continue to be part of it," the agency said.

## Brain Changes Appear by Middle Age After Years of High Blood Pressure

Middle-aged folks who had high blood pressure since they were young adults show brain changes that may increase their risk of future mental decline, a new study says.

**Previous research** has found that high blood pressure affects the structure and function of the brain's blood vessels, resulting in damage to regions of the brain that are critical for thinking and memory skills.

"There are studies to suggest changes to the brain may start at a young age," said study lead author Dr. Christina Lineback, a vascular neurology fellow at

Northwestern Memorial Hospital in Chicago. "Our study provides further evidence that high blood pressure during young adulthood may contribute to changes in the brain later in life."

For this study, her team analyzed 30 years of data collected from 142 participants in a long-term U.S. study on coronary artery disease risk. As part of that study, participants had MRI brain imaging at age 30 and again at about age 55.

Those who had high blood pressure from age 25 to 55 had more changes visible on



their **midlife MRI**. The researchers said that may put them at higher risk for problems with thinking and memory problems.

Those high blood pressure-related brain changes were similar across all races and ethnic groups, according to findings scheduled for presentation Wednesday at a meeting of the American Stroke Association in New Orleans and online.

Lineback noted that this study doesn't prove that the brain changes were caused by high blood pressure, as only an association was observed. But

even so, the findings "should encourage health care professionals to aggressively **address high blood pressure** in young adults, as a potential target to narrow disparities in brain health," she said in a meeting news release.

More than 47% of U.S. adults had high blood pressure between 2015 and 2019, according to the American Heart Association. The age-adjusted death rate primarily attributable to high blood pressure was 25.1 per 100,000 in 2019.