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RI ARA

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"Fighting for the future of our members."
"NOW, more than ever!!!"

June 20, 2021 E-Newsletter

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RI ARA

From the Rhode Island Alliance
for Retired Americans
Happy Father's Day
To all the great fathers, here and in heaven
that worked hard to make life easier for their family.

Retirees Call On Congress To Pass the Social Security Fairness Act H.R. 82 & S 1302 the Repeal of the WEP/GPO

A petition "**Elimination of the Unfair GPO and WEP Provisions of the Social Security Act"** started by RI ARA President John A. Pernorio, calls on Congress to pass the Social Security Fairness Act.

Why is this important?

To urge all Alliance for Retired Americans members, friends or everyone subject to the GPO/WEP to increase their efforts to make sure the Congress of the United States enacts legislation to repeal the Government Pension Offset and the Windfall Elimination Provision from the Social Security Act.

These two pieces of Legislation in the 117th Congress, the Social Security Fairness Act, (H. R 82) by Representative Rodney Davis. (R) (IL) and S. 1302 by Senator Sherrod Brown (D) (OH) would completely repeal the WEP/GOP.

These two bipartisan Bills ensure that 2.5 million public sector retirees receive the Social Security benefits they earned.

Over 78,000 retirees from across the country signed the petition that was submitted to 36 key senators and members of Congress urging them to pass S. 1302 and H.R. 82, the Social Security Fairness Act.

These provisions reduce Social Security benefits for public sector retirees who receive a public pension or the spouse or survivor of a Social Security beneficiary who worked for a period of time in a job not covered by the Social Security program. The Bills would allow 2.5 million retired public employees, spouses and survivors who have a public pension and are entitled to their spouses' Social Security benefits to receive the full Social Security benefits that they otherwise earned.

"For more than 38 years, millions of federal, state and local workers, and the spouses or survivors who have a public pension and are entitled to their spouses' Social Security, have been denied part of the Social Security wages they have earned, simply because they worked in jobs that offered traditional pensions," said Bette Marafino, a leader of the National WEP and GPO Task Force from West Hartford, Connecticut. "Congress should be working to strengthen retirement security for all, and that includes repealing unfair laws that deny millions the retirement benefits they have earned."

From the Task Force to all the Representatives and Senators that have signed onto the bipartisan legislation and the thousands of petition singers, **THANK YOU**.

To see if your Representative or Senator has signed on as a co-sponsor, go to **https://www.congress.gov/** and search for H. R. 82 and S 1302 and ask them to please sign on to support the repeal of the WEP/GPO.

President Roach Urges House Democrats to Expand Social Security

On June 16th, Alliance President **Robert Roach, Jr.** made the case for expanding Social Security benefits during a meeting of the House of Representatives Democratic Caucus.

President Roach told the representatives that urgent action is needed to strengthen retirement security by increasing Social Security benefits. The number of retirees who are dependent on Social Security for most or all of their income is increasing, in part, due to the decline of traditional pensions.

Earlier in the week, the House Ways and Means Social Security Subcommittee held a hearing on the need to expand Social Security. Five Social Security beneficiaries told the Representatives what Social Security means to them, and how even a small benefit increase of $20 a month would help them purchase enough groceries for their families each month.

Chairman **John Larson** reminded the subcommittee that Congress has not taken action to improve Social Security benefits for 50 years, and current benefits "are inadequate, unfair, and in many cases discriminatory, because of systemic economic inequities."

Robert Roach, Jr
President, ARA

ADD YOUR NAME

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

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Will Congressional Democrats agree on a way to lower drug prices?

The Wall Street Journal reports that Congressional Democrats are trying to find a path to lowering drug prices. But, will they agree on a policy that delivers lower drug prices? Or, will they defer to the pharmaceutical industry and let prices continue to mount, even though such an outcome will be mean the needless death of **tens of thousands of Americans each year**.

President Biden, for his part, has been relatively quiet on this issue. He has said that he supports lower drug prices. But, he did not include it in any of his reform proposals this year. Notwithstanding, many Democrats in Congress recognize that delivering lower drug prices in the US will help to keep the Democrats in power in 2022.

Senator Wyden and his team on the Senate Finance Committee are focused like a laser on this issue. Reports are that the Senator would like to marry the Wyden-Grassley prescription drug bill with Speaker Pelosi's bill in the House. The **House bill** goes a lot farther than the Senate bill; it is not finalized but, in 2019, it called for setting drug prices for 250 drugs at not higher than 120 percent of what other wealthy countries pay.

The Senate bill is also not finalized, but it aims to keep drug prices from rising more than inflation, which rewards all the drugmakers with the most inflated drug prices today. We do not yet know whether it will do anything to reduce the cost of life-saving drugs. In its last iteration, it also reduced out-of-pocket prescription drug costs for people with Medicare, but that's simply squeezing a balloon. Most likely, premiums and other costs would rise.

A recent Government Accountability Office report found that brand drug prices in the US are **three to four times higher** than they are in France and other Western European countries.

Bringing down drug prices in the US for everyone is far more complicated than you might imagine. Congress does not have clear authority over corporate health insurers or over the price retail pharmacies charge for drugs. So, while the House bill will have Medicare negotiate drug prices and allow corporate health insurers to benefit from those prices, it's not entirely clear how. The House bill does not cover the uninsured.

The easiest way to extend regulated drug prices to everyone is for Medicare to negotiate lower prices and for Congress to extend Medicare to everyone free of charge exclusively for the purpose of benefiting from these lower prices at the pharmacy. That is not likely. Alternatively, Congress could make drugs at low prices available to everyone through **Federally Qualified Health Centers**. At the moment, it does not appear that Congress is looking at this option either.

Congress could also lift the ban on prescription drug importation. Corporate health insurers, in turn, could then perhaps be required to cover drugs at those imported prices. The problem, of course, is there are many lifesaving drugs that cannot be imported. And, it can sometimes take months to receive **drugs that are ordered from abroad**.

Republicans now say that they are against Medicare-negotiated drug prices. But, Republican members of the Senate Armed Services Committee just a few years ago supported international reference pricing–pricing drugs at a level comparable to other wealthy countries–by unanimous vote.

Innovation would benefit significantly from negotiated drug prices. Congress could allocate some of the hundreds of billions of dollars saved each year towards research and development of new drug therapies. Right now, Pharma invests little in research and tends to invest primarily in new versions of drugs already available on the market–"me-too" drugs–rather than drugs that are truly breakthrough.

Democrats do not need a super majority to pass drug price legislation. They can pass it by simple majority through the budget reconciliation process. But, they will need Joe Manchin and Kirsten Sinema and Bob Menendez to vote with them. And, they are not yet guaranteed to do so.

Do You Have to Sign Up for Medicare?

Many people look forward to the day when they finally can sign up for Medicare. But not everyone feels that way.

A Money Talks News reader named Reuben sent me this question:

"Stacy, is every American at age 65 required to sign up for Medicare? Please advise."

This is an important question for anyone approaching 65. And in truth, it breaks down into two smaller questions:

Are you entitled?

Not everybody is automatically entitled to get Medicare. Like Social Security, you have to pay into Medicare in order to be able to use it. (Find out if you're eligible here.) But if you're eligible, this should be your go-to health insurance during your golden years. For most people, it's the least expensive and most comprehensive protection out there.

Also, you've been paying for it all these years; might as well use it.

Are you required?

You won't go to jail for not signing up for Medicare. You're not required to use it.

Medicare has several parts. Part A covers hospitalization. That doesn't have a monthly premium, so there's really no reason to delay signing up for it. (**You can sign up for Part A alone**.)

Part B, which covers doctor visits, has a monthly premium based on your income. Since this cost can be substantial — the standard **minimum monthly premium for 2021 is $148.50** — when people talk about delaying Medicare, they're really talking about delaying Part B.

So, should you sign up? Well, if you're not working and not covered by someone else, such as a spouse, you definitely should. You're crazy not to have health insurance at any age, but especially when you're 65-plus.

You've got a seven-month period — three months before you turn 65, the month you turn 65, and three months after you turn 65 — to sign up for Medicare. If you don't do it during that time and want to sign up later, you'll **typically pay a penalty** in the form of higher monthly premiums for life

The logic here is simple: If you save money by not signing up when you're 65, then sign up later when you need coverage, you effectively gamed the system, so you should be penalized with higher premiums.

Bottom line? As you approach your 65th birthday, sign up for Medicare. Pay attention: Don't miss this window.

Note: When you sign up for Social Security, you're automatically enrolled in Medicare, so you won't have to worry about signing up.

When you might not want to sign up

There are situations when delaying enrollment makes sense and is penalty-free.

For example, if you're working after age 65 and are fully covered by your employer, there is no point paying for Medicare Part B. The same could be true if you're covered by your spouse.

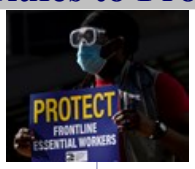
Note, however, that Medicare rules differ depending on how many employees your employer has.….**Read More**.

Labor Department Issues Emergency Rules to Protect Health Care Workers From Covid

Labor Department officials on Thursday announced a temporary emergency **standard** to protect health care workers, saying they face "grave danger" in the workplace from the ongoing coronavirus pandemic.

The new standard would require employers to remove workers who have covid-19 from the workplace, notify workers of covid exposure at work and strengthen requirements for employers to report worker deaths or hospitalizations to the Occupational Safety and Health Administration.

"These are the workers who continue to go into work day in and day out to take care of us, to save our lives," said Jim Frederick, acting assistant secretary of Labor for occupational safety and health. "And we must make sure we do everything in our power to return the favor to protect them."



The new rules are set to take effect immediately after publication in the Federal Register and are expected to affect about 10.3 million health care workers nationwide.

The government's statement of reasons for the new **rules cites** the work of KHN and The Guardian in tallying **more than 3,600** health care worker covid deaths **through April 8**. Journalists documented far more deaths than the limited count by the Centers for Disease Control and Prevention, which through May tallied 1,611 deaths on case-reporting forms that were often incomplete.

The Lost on the Frontline project documented **early calls** for better respiratory protection for health care workers than loose-fitting face masks, noted serious complaints to OSHA from hospital workers that **went unaddressed** and revealed repeated employer **failures to report dozens** of worker deaths. It also found that health care employers were **often remiss** in notifying workers about exposure to the coronavirus on the job.

The new standard would address some of those problems.

The rules require workers to wear N95 or elastomeric respirators when in contact with people with either suspected or confirmed covid. They strengthen employer record-keeping requirements, saying employers must document all worker covid cases (regardless of whether they were deemed work-related) and report work-related deaths even if they occur more than 30 days after exposure.

Until now, employers were required to report a hospitalization only if it came within 24 hours of a workplace exposure. Now all work-related covid hospitalizations must be reported. The rules also mandate notification about exposure to a sick colleague, patient or customer if the worker was not wearing a respirator.

There is a lot to like about the new rule — except for the timing, according to Barbara Rosen, vice president of the Health Professionals and Allied Employees union in New Jersey….**Read More**

Dear Marci: What do my Medicare notices mean?

Dear Marci,
I receive quite a lot of notices from Medicare and what they mean or which ones are important. Can you tell me about some important Medicare notices to look out for?
-Angel (Durham, NC)

Dear Angel,

It is a great idea to look more closely at your Medicare notices. Understanding what they mean can help you avoid and resolve issues with your Medicare coverage! We won't discuss every kind of notice you may receive about your Medicare, but let's start with a few common ones that you'll receive regularly:

First, those with Original Medicare receive a Medicare Summary Notice quarterly. The Medicare Summary Notice (or MSN) is a summary of health care services and items you have received during the previous three months. It contains information about charges billed to Medicare, the amount that Medicare paid, and the amount you are responsible for, although the MSN itself is not a bill (you will receive a bill from providers). Your MSN will also show any non-covered charges. This field shows the portion of charges for services that are denied or **excluded (never covered)** by Medicare. A $0.00 in this field means that there were no denied or excluded services. A charge in this field means you are responsible for paying it. For more information on why you were denied coverage of a service, you can call 1-800-MEDICARE, check **www.medicare.gov**, or read your Medicare & You handbook. If you disagree with a non-covered charge, you should **file an appeal.**

If you have a Medicare Advantage or Part D plan, you will receive an Explanation of Benefits, or EOB. EOBs are usually mailed each month. They similarly show a summary of the services and items you have received and how much you may owe for them (although again, an EOB is not a bill). If your EOB shows that an item or service is not being covered, look for a section that includes notes, comments, footnotes, or remarks to find out the reason why. Contact your plan if you have any questions about your EOB, including to ask for more information about any services not covered. You may decide to **file an appeal**, depending on what your plan tells you.

Try to save your MSNs and/or EOBs. You might need them in the future to prove that certain costs have been covered or paid for. For instance, you may need old MSNs or EOBs if a provider's billing department makes a mistake or if you claimed a medical deduction on your taxes. If you have lost your notice or need a duplicate copy, call 1-800-MEDICARE (for MSNs) or your plan (for EOBs).

Another important notice to look out for is the **Annual Notice of Change, or ANOC.** The ANOC is the notice you receive from your Medicare Advantage or Part D plan in late September. This notice gives a summary of any changes in the plan's cost and coverage that will take effect January 1 of the next year. You should review this notice to see if your plan will continue to meet your health care needs in the following year. If you do not receive an ANOC from your plan, you should contact your plan. **The ANOC is typically mailed with the plan's Evidence of Coverage (EOC)**, which is a more comprehensive list of the plan's cost and benefits for the upcoming year. If you are dissatisfied with changes on your ANOC or EOC, remember that you **can change your Medicare coverage** during **Fall Open Enrollment.**

One last notice we'll discuss here are **notices of creditable coverage**. If you are enrolled in a prescription drug plan through an employer, you should receive a notice from your employer or plan around September of each year, informing you **if your drug coverage is creditable**. Keep these notices. You may need them as proof that you had creditable coverage and should not have a **Part D late enrollment penalty** if you decide to **enroll in a Part D plan** in the future.

As you said, there are often numerous notices you may receive about your Medicare. These are just a few types to look out for, read closely, and keep for your records.

-Marci

CMS Expands Payments for In-Home COVID-19 Vaccine Administration

The Centers for Medicare & Medicaid Services (CMS) took **additional steps** this week to make COVID-19 vaccines available to Medicare beneficiaries who have difficulty leaving their homes or are otherwise hard-to-reach.

Under the new policy, Medicare will pay an additional $35 per dose for in-home vaccine administration, increasing the total payment amount to nearly $75 per dose. For a two-dose vaccine, this results in a total payment that is approximately $70 more than the current rate.

While people with Medicare can get vaccinated at a retail pharmacy, their physician's office, or a mass vaccination site, some beneficiaries who live in the community—including approximately **1.6 million** older adults—may not be able to access these locations on their own or without considerable effort.

The new payment rate is intended to better serve this cohort, by incentivizing providers to meet them where they are. According to the announcement, the update is part of the administration's overall strategy to "make it as easy as possible for all Americans to get vaccinated."

To help providers navigate this shift, the Centers for Disease Control and Prevention (CDC) **issued guidance** on safe and effective in-home vaccination management.

Like all COVID-19 vaccines, those provided in-home to people with Medicare will be free of charge. Regardless of where they receive the vaccine, Medicare beneficiaries pay nothing out-of-pocket; there is no applicable copayment, coinsurance, or deductible.

Looking for a vaccine? Unvaccinated individuals and those assisting friends and family can:

- Visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby.
- Call the National COVID-19 Vaccination Assistance Hotline at 1-800-232-0233 (TTY: 1-888-720-7489) for assistance in English and Spanish.
- Text GETVAX (438829) for English or VACUNA (822862) for Spanish for near-instant access to details on three vaccine sites in the local area.

Record Number of Americans Covered by Affordable Care Act

Based on data from a **new issue brief** by the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Biden administration **announced** a record 31 million Americans now have health care coverage because of Medicaid and the Affordable Care Act (ACA). ASPE advises the HHS Secretary on health care policy development, research, and analysis, and this issue brief explores enrollment trends nationally and by states.

The enrollment numbers include people in ACA marketplace plans, those in expansion Medicaid in participating states, and those who enrolled in non-expansion Medicaid because of greater education and awareness of eligibility through ACA initiatives.

Since it became law, the ACA has driven down uninsured rates, with **20 million** fewer uninsured people nationally. The largest improvements have come in the 37 states and the District of Columbia that have chosen to expand Medicaid. Other coverage gains have come from people having greater access to comprehensive plans through the federal and state-based insurance marketplaces.

Under current policies, these numbers are likely to continue to rise. One of the first big health coverage moves of the Biden administration was to create a special enrollment period (SEP) running from February 15 through August 15 that allows people to enroll in ACA plans if their state is one of the 36 that uses HealthCare.gov. Many states outside of the federal marketplace have followed suit, **creating SEPs in their state-based exchanges**. These SEPs have allowed new enrollees to join ACA plans, and 2021's **American Rescue Plan** has made that coverage more affordable. That bill increased **subsidies that drive down costs for both new and returning ACA plan enrollees**—changes the administration would like to **extend**.

At Medicare Rights, we are encouraged by these enrollment numbers. We strongly support policies that increase the number of people who have affordable, high quality health care coverage. However, significant gaps remain, as many Medicare-eligible individuals are unable to quickly connect with coverage. Ensuring all Americans have access to care is vital, especially during a pandemic.

We **continue** to **urge** Congress and the administration not to leave people with Medicare behind.

For-profit hospitals are causing rising medical debt and personal bankruptcy

Axios reports new findings, in partnership with Johns Hopkins, that medical debt continues to rise. Rising medical debt should come as no surprise as insurers shift more costs onto patients through deductibles, coinsurance and more. People who need hospital care are hit with some of the largest medical bills, at times driving them into medical bankruptcy.

Nearly six in ten people in debt (58 percent) in the US are faced with collection notices because of a medical expense. Hundreds of thousands of people have been forced to file for medical bankruptcy.

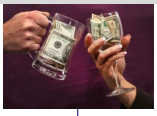
Some hospitals sue patients. Others get liens on their patients' income. The hospitals might claim a portion of a personal-injury settlement.

Ten hospital chains are extremely litigious. Their lawsuits comprise 97 percent of all cases against patients. Two Virginia hospitals are the biggest offenders: VCU Medical Center in Richmond and University Hospital in Charlottesville. They claim to have now stopped suing patients.

As it is, many hospitals charge significantly more than their cost for the services they deliver. More than half (57%) of the top 100 hospitals charge at least five times more than their cost. And, some charge ten times more than cost. Chippenham Hospital in Richmond, Virginia has the highest markup. Even when hospitals don't collect the full amount of their bills, they find that charging higher prices leads to higher revenue.

People generally **cannot and do not price shop for hospital care**. They go to the hospital with which their doctors are affiliated. Moreover, information on the cost of their care is generally not available in advance of a procedure. (Federal law requires hospitals to post their prices, but most are not doing so and people cannot know in advance, let alone control, which ancillary tests and procedures they will receive.)

Retail prices for brand name drugs rise at more than twice rate of inflation



Leigh Purvis and Dr. Stephen W. Schondelmeyer's 2021 **Rx Price Watch report** finds that retail price increases for brand-name drugs have been rising year-over-year at more than twice the rate of inflation since 2006. Of course they have. Pharmaceutical companies generally have the monopoly power to set their prices since Congress does not regulate drug prices, and there is little competition that drives down prices in the brand prescription drug market.

Purvis and Schondelmeyer looked at 260 of the most popular prescription drugs taken by older adults. They found that pharmaceutical companies increased their prices 2.9 percent on average each year. The annual inflation rate averaged 1.3 percent.

Of course, a pharmaceutical company's drug price increase is based on the launch price, which is generally set several times higher than the price of the same drug in other wealthy countries. On average, a brand name drug taken for a chronic condition cost $6,604 in 2020. Five years earlier, it cost around $5,100.

Older adults in the US typically use about $31,000 worth of prescription drugs each year. That figure is based on the fact that, on average, they take 4.7 prescription drugs each month. The $31,000 annual cost is more than 3.5 times higher than the cost in 2005. It is higher than the annual income of most people with Medicare, which is $29,650.

Senators Ron Wyden and Chuck Grassley have proposed limiting price increases on prescription drugs to the rate of inflation. It's hard to know if that will work, as drugmakers might be able to change the formulation of a drug–the way it looks or is administered–and change the price accordingly. With any luck, Congress will regulate drug prices

But, had drug price increases been limited to the rate of inflation since 2006, a drug that cost $2,911 in 2006 would have cost $3,700 in 2020. Instead, it costs $6,604, $2,904 more.

People with prescription drug coverage still bear a lot of the cost of drugs in deductibles and copays. And, Medicare Part D, which covers retail prescription drugs, does not have an out-of-pocket cap on prescription drug costs. Moreover, Medicare premiums rise as prescription drug costs rise.

What's most concerning is that millions of people with Medicare cannot afford the deductibles and copays on their drugs. They **choose not to fill their prescriptions**. As a result, they often die prematurely.

People prefer public insurance over private insurance

A new study published in **JAMA** finds that people with public insurance say they fare better than people with private insurance when it comes to access to care, costs and satisfaction. The study confirms what the polls show, that the public supports a public health insurance option. That said, it does not break down people's preferences as between traditional Medicare and Medicare Advantage. Only traditional Medicare is true public insurance, without a for-profit insurer coming between patients and their doctors.

The study treats both traditional Medicare, government-administered insurance, and Medicare Advantage, private insurance offered by the federal government, as public insurance. Unfortunately, the data is not available for the researchers to distinguish between them as far as people's experiences are concerned. But, traditional Medicare is far more cost-effective according the **MedPAC**. People with traditional Medicare also have **better access to care** than people in Medicare Advantage.

The researchers believe that Congress should be focused on lowering people's out-of-pocket health care costs. However, little research has been undertaken on the different experiences people have with the health care system depending on the type of coverage they have. That said, Medicare and VA coverage tend to be the least costly and the most comprehensive.

Dr. Salomeh Keyhani, one of the researchers explains: "While the conventional wisdom is that private coverage is better, our findings suggest that Americans have better experience with Medicare and VA/military coverage. The findings are especially interesting as private insurance tends to cover individuals that are younger and healthier." Put differently, you might think that people with fewer health care needs would have better experiences with the health care system than people who use it more; that is not the case. Public insurance is preferred.

People with employer coverage tend to have less health security because their jobs can change at any time and with them, their health insurance. ….**Read More**

4 Changes to Social Security You Probably Didn't Know About

Social Security probably won't replace all of your working wages. But for the average American, it could provide 40% of income in retirement, which is significant.

When changes happen that could affect these benefits, knowing as much as possible can help you get the most out of this program. Here's what's changed recently.

The maximum wage base limit has increased

You've probably seen a line item on your pay stub for taxes for Social Security. The amount that you pay as an employee is 6.2% of your income, but only up to a certain amount -- the wage base limit. In 2021, it is $142,800, an increase of $5,100 from $137,700 in 2020. This is the maximum amount of earnings that you will owe Social Security taxes on.

It helps determine how big a monthly check you receive when you retire. If you earn the **maximum wage base** for 35 years, you could qualify for the highest monthly Social Security benefit, which in 2021 is $3,148 at **full retirement age (FRA)** -- up from $3,011 in 2020. And the higher the payment you get, the greater the percentage of your pre-retirement income it could make up.

You got a pay increase

The cost of living adjustment (COLA) is an increase in your monthly benefit to help you **keep pace with inflation**. And in 2021, that was a 1.3% increase. So if your payment in 2020 was $2,000 each month, it would grow to $2,026 in 2021. Every dollar counts, so it could help cover more of your bills. But it will not necessarily equal the inflation rate, which is projected to be 2.26% in 2021. This means that your benefit won't keep pace with the price of the goods and services that you spend your money on -- especially if, as you age, your medical expenses increase faster than inflation. Knowing this, having investments in things like **stocks**, which can grow at a higher rate than inflation, can be crucial in retirement.

You can earn more while working

You can work after you've started taking Social Security. But depending on your age and how much you make, you could see your payments reduced. If you haven't reached your FRA, you will have $1 deducted for every $2 that you earn above $18,960 in 2021. In 2020, that limit was lower, at $18,240. ….**Read More**

How should we pay physicians?

There is not, and there will never be, a perfect system for paying health care providers. Capitated payments, which are upfront, regardless of the number and cost of services physicians deliver, creates an incentive for providers to avoid treating people with costly conditions. Fee-for-service, which pays physicians for services they deliver, creates an incentive for them to deliver more care than necessary. Paying physicians a salary can lead them to be lazy, since they will get paid anyway, or not.

Medicare Advantage, Medicare benefits offered through private health insurers, was an experiment to see whether paying insurers a capitated fee offered any value. To date, it has cost taxpayers and people with Medicare more and there is no evidence that the for-profit health plans deliver as good care as traditional Medicare. In fact, the evidence, to the extent it is available, should elicit grave concern. How can we think a health insurance model like Medicare Advantage for older and disabled Americans, which does not compete to attract members with complex and costly conditions, has any worth?

The federal government also has been testing ways in traditional Medicare to incentivize physicians and hospitals to deliver better care at lower cost and move away from fee-for-service payments. Some of its experiments reward providers financially. To date, there is little evidence that these financial incentives lead to improved quality or lower costs. New research shows that they might be harming some patients. The post below is reprinted from the **Health Justice Monitor.**

Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study, JAMA Health Forum, May 14, 2021, By Dhruv Khullar, Amelia M. Bond, Eloise May O'Donnell, Yuting Qian, David N. Gans, and Lawrence P. Casalino

"Participating in the MIPS program results in substantial financial and time costs for physician practices. We found that, on average, it cost practices $12 811 per physician to participate in MIPS in 2019. We found that physicians themselves spent a considerable amount of time to participate in MIPS. In 2019, physicians spent more than 53 hours per year on MIPS-related activities, which translates to nearly $7000 per physician. If physicians see an average of 4 patients per hour, then these 53 hours could be used to provide care for an additional 212 patients a year—equal to more than a full week's work for a physician."

FAQ: Why inflation is rising and whether you should worry

Inflation is a fancy way of saying rising prices. Nearly every day, prices of food, clothes, airline tickets and more are moving around, as some brands hike prices and others offer discounts. For the past decade, inflation has averaged under 2 percent a year for the typical American. But suddenly, inflation is rising much faster. The latest government data showed prices rose 5 percent from a year earlier, triggering fears that the economy is overheating.

Prices jumped 5 percent in May, continuing inflationary climb. Policymakers say it's temporary.

But what exactly is going on and why are some economists, policymakers and business leaders starting to worry?

How much is inflation going up and why?

Inflation **rose to 5 percent** between May 2020 and May 2021, the Labor Department reported Thursday, which was higher than expected and the biggest jump since 2008. A major reason for the spike is the comparison to prices now versus a year ago, when much of the country was on lockdown. Consider airlines and hotels. Virtually no one was traveling last spring, causing airlines and hotels to massively scale back services, lay off employees and cut prices. Now that the economy is reopening and people are traveling again, hotel prices are up 10 percent versus a year ago and **airfare is up 24 percent.**

Economists expect many of these eye-popping price hikes to be short-lived as the economy adjusts and the comparisons to a year ago get less dramatic.

It's notable that the last time inflation was so high was in 2008 during the Great Recession. Historically, inflation has moved around the most — first moving lower and then spiking — during and just after recessions.

What's driving the biggest changes in inflation right now?

Most of the May inflation spike comes from parts of the economy that are reopening (such as travel) or in areas that saw unusually high demand during the pandemic, which may not persist much longer (like bicycles)…..**Read More**

Social Security Less Damaged by Covid Recession Than Experts Feared

As the Covid crisis took hold in early 2020, budget experts worried that rapidly disappearing jobs and plummeting tax receipts would put a serious dent in Social Security's finances. But according to **The Wall Street Journal's Kate Davidson** Friday, the retirement and disability system is emerging from the recession in better shape than the experts feared.

Before the pandemic struck, the Social Security trustees estimated that the system would exhaust its reserves by 2035. In light of the Covid recession, the trustees updated their estimate last fall and moved that date up by one year, to 2034.

Other projections were more pessimistic. The Bipartisan Policy Center, for example, said the Social Security trust funds could run dry five years early if the recession proved to be as long-lasting and damaging as the one in 2008-2009, resulting in a 25% cut to benefits for retirees and a 13% cut for those on disability.

Now, however, BPC estimates that the cumulative effect of the Covid recession will be more modest, but still result in a loss of one or two years in the lifespan of the trust funds. The Social Security trustees are expected to release a new estimate that incorporates the most recent economic data, as well, but have delayed the update that typically comes in April as they gather more information.

What happened? Jobs have rebounded much faster than the last time around, with two-thirds of the jobs lost in the pandemic already recovered. By comparison, it took about four years to get to that point after 2009. In addition, claims for disability fell in 2020, the opposite of what usually happens in a recession, possibly due to the increased difficulty of traveling to Social Security offices to file claims, as well as the closure of many facilities.

The bottom line: Although there was great risk of serious harm, the Social Security trust funds survived the Covid crisis in better-than-expected shape. Still, the system is facing serious long-term financial challenges, which Congress appears to be in no hurry to address.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

America Is Losing the War Against Diabetes

After years of improvement, Americans with diabetes may be losing some ground in controlling the condition, a new government-funded study shows.

Researchers found that between 1999 and the early 2010s, U.S. adults with diabetes made substantial gains: A growing percentage had their blood sugar, blood pressure and cholesterol down to recommended levels.

Since then, the picture has changed: Progress on cholesterol has stalled, and fewer patients have their blood sugar and blood pressure under control than a decade ago.

The findings are concerning, the researchers said, since the trends could put more Americans at risk of heart disease, stroke and other diabetes complications.

"This is very sobering," said senior researcher Elizabeth Selvin, a professor at Johns Hopkins Bloomberg School of Public Health in Baltimore. "It's not just that rates [of control] are plateauing, they're worsening."

Selvin and her colleagues published the findings in the June 10 issue of the *New England Journal of Medicine*.

As of 2018, over 34 million Americans had diabetes, according to American Diabetes Association. The vast majority had type 2 diabetes, where the body can no longer properly use insulin, a hormone that regulates blood sugar.

As a result, blood sugar levels soar. Over time, uncontrolled blood sugar can damage the blood vessels and nerves, contributing to complications such as heart disease, stroke, kidney failure and eye disease.

On top of that, people with diabetes often have other chronic conditions, like high blood pressure and elevated cholesterol, which can also feed those complications.

So, why would control of those conditions be worsening?

It's not clear from the study, but Selvin pointed to some possibilities. In 2008 and 2009, three clinical trials were published that questioned the value of "intensive" blood sugar control: Diabetes patients assigned to that regimen showed no further reduction in their risk of heart trouble or stroke -- but they did have a greater risk of potentially dangerous drops in blood sugar.

Those trials tested the effects of especially tight control of patients' A1C levels. That's a measure of a person's average blood sugar levels over the past three months.

The trials aimed to get patients' A1C to below 6.5% or 6% -- versus the standard 7%.

After the results were published, some doctors began backing off from tight blood sugar control.

"I think what we're seeing now is something of an overcorrection," Selvin said.

That's because fewer Americans are now achieving even the standard A1C goal of below 7%.

Selvin's team found that between 1999 and the early 2010s, the proportion of diabetes patients meeting that target rose from 44% to 57%. By 2018, that had declined to 50%.

The trends for blood pressure control were similar. Over the earlier time period, the percentage of diabetes patients meeting blood pressure goals improved from 64% to 74%. That figure dipped thereafter, to 70%. (Control was defined as below 140/90 mm Hg.)

The reasons are not clear, but Selvin noted the pattern matches that of the U.S. population as a whole.

Dr. Joanna Mitri is an endocrinologist and research associate at Joslin Diabetes Center in Boston. She had no role in the study.

Mitri said that after the trials of intensive glucose (blood sugar) lowering came out, treatment guidelines shifted away from being "glucose-centric" toward a broader focus on controlling other cardiovascular risk factors as well.

For some patients, she said, a relatively higher A1C may be appropriate -- for example, an older adult at risk of low blood sugar episodes. For other patients, keeping A1C below 7% may be the right goal.

The point is, the treatment plan should be individualized, Mitri said. She encouraged diabetes patients to ask their doctor what their A1C goal is, why that's the target, and how best to achieve it.

But don't forget the bigger picture. "We need to improve all three things -- blood glucose, blood pressure and cholesterol -- in addition to weight management, diet and exercise," Mitri said.

According to Selvin, it's possible that lifestyle-related factors, including trends in obesity, contributed to declines in blood sugar and blood pressure control in recent years.

"Complementing medication with lifestyle changes is very important," she said. "Preventing further weight gain is very important."

Selvin also noted that since the 2008/2009 trials, new diabetes medications have become available that can lower blood sugar with less risk of dangerous lows.

Like Mitri, she suggested patients talk to their doctors about their treatment goals and ask whether they are on "optimal" management.

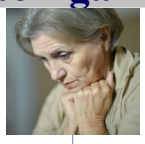
The study was funded by the U.S. National Heart, Lung, and Blood Institute.

'Laughing Gas' Shows Promise Against Tough-to-Treat Depression

When antidepressants fail to rein in hard-to-treat depression, the common anesthetic most know as "laughing gas" might be a safe and effective alternative, new research suggests.

The finding follows work with 28 patients struggling with "treatment-resistant major depression," a severe condition that investigators say affects about one-third of all patients — an estimated 17 million American adults — who develop major depressive disorder.

For such patients, antidepressants often fail to provide relief. But following three one-hour laughing gas inhalation sessions spread across three months, 85% of patients had significant depression relief that endured weeks post-treatment.



"Laughing gas is nitrous oxide, one of the oldest and most commonly used anesthetics," explained study author Peter Nagele, chair of anesthesia and critical care at the University of Chicago.

"And we found that laughing gas, at a much lower concentration than is used, for instance, during dental procedures, can help patients with difficult-to-treat depression," Nagele said.

Between 2016 and 2019, Nagele's team tried out two laughing gas formulations: one at a level of 50% nitrous oxide and one at a level of 25%.

Previous investigations had already demonstrated an antidepressant benefit at the higher level. But those efforts only assessed a post-treatment benefit of 24 hours. And patients exposed to the higher dose commonly experienced side effects, including nausea, sedation and or "mild dissociation," a kind of daydreaming experience.

In the latest study, patients were between the ages of 18 and 75. All were told to continue their usual depression care and maintain their existing antidepressant regimen….**Read More**

There Is No 'Healthy Obesity,' Study Finds

There is no such thing as healthy obesity, a Scottish study reports.

A normal metabolic profile doesn't mean an obese person is actually healthy, because he or she still has an increased risk of diabetes, heart disease, stroke and respiratory illness, University of Glasgow researchers explained.

"The term 'metabolically healthy obesity' should be avoided in clinical medicine as it is misleading, and different strategies for defining risk should be explored," wrote researchers led by Frederick Ho, a research associate at the university's Institute of Health and Wellbeing. The study was published June 10 in the journal *Diabetologia*.

For the study, Ho and his colleagues analyzed data from more than 381,000 people in the United Kingdom who were followed for an average 11.2 years.

They compared metabolically healthy people who weren't obese to those who were obese but deemed metabolically healthy -- meaning they did not have high blood sugar, high blood pressure, insulin resistance and other harmful metabolic changes associated with excess weight.

Compared to healthy folks who weren't obese, those who were metabolically healthy but obese were 4.3 times more likely to have type 2 diabetes; 18% more likely to suffer heart attack or stroke; 76% more likely to develop heart failure; 28% more likely to have respiratory disease; and 19% more likely to have COPD.

Compared to metabolically unhealthy people who weren't obese, those who were metabolically healthy and obese were also 28% more likely to have heart failure.

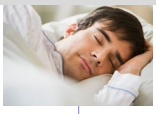
The study also found that among a subset of participants with follow-up data, a third of those with metabolically healthy obesity at the outset became metabolically unhealthy within three to five years.

"People with metabolically healthy obesity are not 'healthy' as they are at higher risk of heart attack and stroke, heart failure, and respiratory diseases compared with people without obesity who have a normal metabolic profile," the researchers said in a journal news release.

They said weight management could be beneficial to all people who are obese regardless of their metabolic profile.

Worldwide, more than 300 million people are obese. If current trends continue, that number is projected to top 1 billion by 2030 -- 20% of the world's adult population.

Poor Sleep After Head Injury Could Point to Dementia Risk



Sleep disorders may increase the odds for dementia in survivors of traumatic brain injury, new research suggests.

The study included nearly 713,000 patients who were free of dementia when they were treated for traumatic brain injury (TBI) between 2003 and 2013. The severity of their brain injuries varied, and nearly six in 10 were men. Their median age was 44, meaning half were older, half younger.

Over a median follow-up of 52 months, about 33,000 of these patients developed dementia. Those diagnosed with a sleep disorder were 25% more likely to develop dementia, the study found. The results were similar for men and women — a sleep disorder was associated with a 26% increase in men's dementia risk and a 23% increase among women.

"Our study's novelty is its confirmation of sleep disorders' association with incident dementia in both male and female patients, independently of other known dementia risks," said lead author Dr. Tatyana Mollayeva, an associate director of the Acquired Brain Injury Research Lab at the University of Toronto, in Canada.

"We are also the first to report on the risks that sleep disorders and other factors pose separately for male and female patients with TBI," she added in an American Academy of Sleep Medicine news release.

Mollayeva said the findings suggest a need for greater awareness of sleep disorder risk in TBI patients.

In the study, the researchers controlled for age, sex, income level, injury severity and other health problems that could affect the results.

A study abstract was recently published in an online supplement of the journal *Sleep*. The findings are also scheduled to be presented Sunday during a virtual meeting of the Associated Professional Sleep Societies.

Old Age No Bar to Successful Heart Transplant, Study Finds

People over 70 are far less likely to be considered for or to receive a new heart -- even though new research suggests their survival rates after transplant are similar to those of younger patients.

For the study, the researchers analyzed data on more than 57,000 adults (aged 18 and older) listed as heart transplant surgery candidates in the United States between January 2000 and August 2018, and they found that only one in 50 was aged 70 or older.

The rate was the same among the more than 37,000 patients who actually had a heart transplant during the study period. However, the researchers did find that the number of older patients receiving a heart transplant each year rose from 30 in 2000 to 132 in 2017.

There was no significant difference between age groups in death rates in the first year after heart transplant, even though older patients were more likely to receive hearts from older donors with chronic diseases, like diabetes and high blood pressure.

The difference in death rates between older and younger patients within five years after heart transplant disappeared when the researchers accounted for factors like patients' body mass index (or BMI, which is an estimate of body fat based on weight and height) and the time patients spent on the transplant waiting list.

Older patients were more likely to have a stroke after a heart transplant, but the risk was still very low (3.5%). Most strokes in older patients occurred in the third year after their transplant, according to study author Dr. Abhishek Jaiswal, of the Hartford Hospital in Connecticut, and colleagues.

The study, published online June 8 in the *Journal of the American Geriatrics Society*, shows that older age alone should not prevent people from being considered for heart transplants, the researchers said.

In addition, people 70 and older with heart failure should consider asking their cardiologist if they could be a candidate for a heart transplant, the study authors suggested in a journal news release.

The researchers noted that most of the older patients in the study who received heart transplants were white, not frail, and didn't have other chronic diseases, and that this group of patients doesn't represent most older adults who have heart failure.

Doctor on Call? Lawmakers Debate How Much to Pay for Phone Appointments

It took covid-19 to give millions of Americans the option of telling their doctor about their aches and pains by phone.

But now that more doctors and patients are returning to in-person appointments, policymakers across the country are divided over how much taxpayer money to keep spending on phone appointments. Although they were a lifeline for Medicaid and Medicare patients who don't have the technology for video visits, critics say they don't provide the same level of patient care and aren't worth the same price.

In California, the Democratic-controlled legislature wants the state's Medicaid program for low-income people — called Medi-Cal — to keep paying for phone calls at the same rate as for video and in-person visits, a policy that began during the pandemic. But Democratic Gov. Gavin Newsom's budget plan directs Medi-Cal to reduce the rate.

Medi-Cal paid for a whopping 2.4 million phone appointments from March 1, 2020, to April 30, 2021, according to the state Department of Health Care Services.

"Prior to the pandemic, audio-only visits weren't a thing," said Chris Perrone, director of the California Health Care Foundation's Improving Access team. "No one considered them telehealth." (California Healthline is an editorially independent publication of the foundation.)

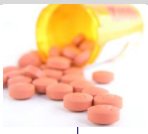
The federal Medicare program — which covers older Americans and people with disabilities — and most state Medicaid programs rarely paid for phone visits before the pandemic. But after doctors shuttered their offices last year and patients stayed home, Medicare and nearly every state Medicaid program began paying for phone visits when it became clear that many patients didn't have access to video. More private insurers began counting phone calls as telemedicine visits, too.

The use of audio and video appointments — generally known as telehealth — has exploded during the pandemic. In California, there were about 10,500 telehealth visits a week per 100,000 Medi-Cal patients in 2020, compared with about 300 in 2019, according to the state Department of Health Care Services.

Medicare saw a similar explosion. Before the pandemic, about 17,000 enrollees used telemedicine each week. That shot up to 1.1 million weekly during the pandemic, according to a Medicare spokesperson.

While most state Medicaid programs began paying for phone visits during the pandemic, they are weighing how to proceed as it wanes. New Hampshire **passed a law** in March 2020 requiring Medicaid and private plans to pay for phone visits at the same rate as video and in-person visits. This March, **Vermont** extended emergency rules to pay for phone visits at the same rate as other types of appointments through 2022, and a state **working group** recommended keeping them permanently. **Connecticut, Delaware, New York, Colorado** and other states passed laws that define phone visits as telehealth, and all are continuing to pay for them to varying degrees….**Read More**

Could a Type of Statin Raise Dementia Risks?



Certain cholesterol-lowering drugs might speed dementia in some older adults whose memories are starting to fail, a small, preliminary study suggests.

The researchers found that of 300 older adults with mildly impaired thinking and memory, those using "lipophilic" statins were more likely to develop dementia over the next eight years.

Lipophilic statins include such widely used medications as simvastatin (Zocor), atorvastatin (Lipitor) and lovastatin (Altoprev).

They're considered lipophilic because they are attracted to fat and can cross into many body tissues, including the brain. That's in contrast to hydrophilic statins — like rosuvastatin (Crestor) and pravastatin (Pravachol) — which act mainly in the liver.

In this study, there was no link between those statins and increased dementia risk. The findings do not prove that lipophilic statins directly raise dementia risk, experts cautioned. But they add to a conflicting body of evidence on statins and brain function.

"This adds another piece to a complicated puzzle," said Dan Berlau, a professor of pharmacy at Regis University in Denver, who was not involved in the new investigation but studies memory and disorders of the brain.

He said that high cholesterol in middle-age is linked to a higher risk of dementia later on. As for whether taking statins might curb that risk, Berlau said, studies have mostly come to either of two conclusions: the drugs show no effect, or a protective one….**Read More**

More Than a Snore? Recognize the Signs of Sleep Apnea

Does your bed partner claim that you snore?

If so, don't just tune him or her out. It may mean you have obstructive sleep apnea (OSA).

Untreated sleep apnea -- which causes repeated breathing interruptions during sleep -- can lead to serious health problems, so the American Academy of Sleep Medicine (AASM) wants you to consider: Is it more than a snore?

"While not everyone who snores has sleep apnea, snoring is a warning sign that should be taken seriously," said AASM President Dr. Kannan Ramar. "If your bed partner snores, or if you've been told that you snore, then it is important to talk to a medical provider about screening or testing for sleep apnea."

Treating obstructive sleep apnea can improve overall health and quality of life, he added.

Nearly 70% of Americans who sleep with a partner say their bed mate snores, according to a 2021 AASM survey. The same survey found that 26% of Americans are unfamiliar with OSA, and 48% don't know its symptoms.

Nearly 30 million U.S. adults have OSA, but AASM estimates that 23.5 million of those cases are undiagnosed.

These are the five warning signs to be aware of: snoring, choking or gasping during sleep; fatigue or daytime sleepiness; obesity; and high blood pressure.

Other indications of apnea include: unrefreshing sleep, insomnia, morning headaches, waking during the night to go to the bathroom, difficulty concentrating, memory loss, decreased sexual desire, irritability, or difficulty staying awake while watching TV or driving.

"Delaying treatment for sleep apnea can lead to more serious health problems," Ramar said. "Fortunately, many of the damaging effects of sleep apnea can be stopped, and even reversed, through diagnosis and treatment by the sleep team at an accredited sleep center, where patients receive care in safe and comfortable accommodations."

The typical treatment for sleep apnea is continuous positive airway pressure (CPAP) therapy. CPAP keeps the airway open by providing a steady stream of air through a mask that's worn while sleeping.

Using CPAP can improve quality of sleep, boost daytime alertness, concentration and mood and even improve brain and heart health, according to AASM.

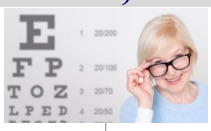
Other treatments include positional therapy, oral appliance therapy and surgery.

Cataracts: Common, and Easy to Treat

Many aging Americans can have their vision dimmed by cataracts, but the good news is that they're easily treated, one expert says.

By age 80, half of Americans either have cataracts or have had surgery to remove them, according to Dr. Waid Blackstone, an ophthalmologist at University of Alabama at Birmingham Callahan Eye Hospital Clinic at Pell City.

"In terms of the typical age-related cataracts, the average age of onset is 40 to 50 years, but most people don't experience vision problems from that until later," he said in a university news release. "The average age for a cataract surgery patient is 73 to 75."



A cataract is a clump of protein that leaves the lens of the eye cloudy or tinted, impairing vision. A cataract can occur in one or both eyes. The cause is unknown.

Often, the early stages of a cataract are accompanied by an increase in nearsightedness, which can be corrected with glasses. As the cataract progresses, night vision may worsen, and colors may appear duller.

"Blurred vision is the primary problem, although that can manifest in a couple of different ways," Blackstone said. "The first thing most people notice is glare. Light hits the cataract, scatters and makes it difficult [to] see. The common complaint is difficulty driving at night because of glare from oncoming headlights. The flip side is that, in dim lighting, cataracts block low levels of light. The next most common complaint is difficulty reading fine print or seeing smaller images."

Early cataract symptoms may be improved with eyeglasses, brighter lighting, anti-glare sunglasses or magnifying lenses. If these measures don't help, surgery is the only effective treatment, according to Blackstone.

Cataract removal is one of the most common operations in the United States, and among the safest and most effective. The surgeon removes the cloudy lens and replaces it with an implant.

Typically, surgeons perform the surgery on one eye, and on the other eye soon after. The most common method takes about 15 minutes. About 95% of people see better after the surgery.

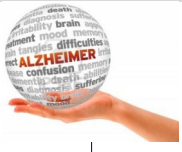
"The decision for any cataract surgery is based entirely on how the patient is functioning," Blackstone said. "We have patients with moderate or even severe cataracts that we elect to leave alone, simply because, based on what that patient's needs are, it may not be a good idea. But we also see patients who can read an eye chart very well but struggle with nighttime glare. It's when they begin having difficulty with daily activities that we start considering cataract surgery."

Good News, Bad News From Alzheimer's Vaccine Trial

An experimental Alzheimer's vaccine appears to safely clear abnormal tau protein from the brain, but it's not yet clear whether the shot will be able to save brain function.

In a Phase 2 clinical trial, the vaccine produced high levels of antibodies to target and attack free-floating tau proteins before they can form "tau tangles" that clog neurons and damage brain function. Tau tangles, along with plaques formed by the protein amyloid-beta, serve as one of the main hallmarks of Alzheimer's.

"While amyloid influences speed of Alzheimer's progression, there is strong evidence that tau pathology relates to the underlying cause of the disease," said lead researcher Dr. Petr Novak, a senior clinical research scientist at AXON Neuroscience, the Slovakian pharmaceutical company developing the vaccine. "Brain atrophy and cognitive loss closely echo the deposition of pathological tau protein, as evidenced by recent tau PET studies."



The vaccine also proved safe during the two-year trial, in which eleven doses were administered to randomly chosen patients with mild dementia. People who received the vaccine, known as AADvac1, experienced about the same numbers of side effects and adverse events as those who were given a placebo.

However, the study did not produce any significant benefits when it came to thinking, reasoning and memory tests performed across the entire patient group -- possibly because there were too few people with clinically diagnosed Alzheimer's participating in the trial.

During analysis of the clinical trial data, the researchers realized that about a third of the participants had low levels of abnormal tau protein, "which makes them not very suitable for evaluating the effects of a treatment halting the progression of tau pathology."

Novak noted that the research team did see some improvement in standard brain function tests given to a smaller group of trial participants who had actually been diagnosed with Alzheimer's.

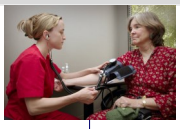
In that group, the vaccine slowed brain decline by around 30% in two different clinical and functional tests, Novak said….**Read More**

U.S. Appears to Lose Ground in Controlling High Blood Pressure

After years of improvement, high blood pressure control in the U.S. dropped regardless of age, race or ethnicity, according to new research.

Previous studies found Americans with high blood pressure were better managing the condition in the early years of the 21st century before rates leveled off from 2009 to 2014.

The new study, published Monday in the American Heart Association journal Hypertension, zoomed in on nationwide health survey data of more than 4,000 adults from 2015 to 2018. Researchers then compared high blood pressure control, awareness, treatment and treatment effectiveness to nearly 6,000 adults surveyed during the prior six years.



They discovered the rate of control – getting blood pressure down to a specific number – had fallen by 7.5%.

"That's a very strong decline," said the study's lead author, Dr. Brent Egan. "We lost about 10 years of progress in four years."

Expecting to find disparities in the fall of blood pressure control by age, race or ethnicity, the researchers found none. "We were surprised by how broad-based the decline (in blood pressure control) was," said Egan, vice president for cardiovascular health at the American Medical Association.

But control rates weren't all that fell. Awareness of having high blood pressure slipped by 3.4%, and being treated for it dropped by 4.6%. Among those being treated, 6% fewer had the condition under control.

The study also found an increase in people being prescribed just one medicine despite a rise in obesity and diabetes, two conditions that require "more intensive (drug therapy) for hypertension control," according to the study.

If health care professionals are reluctant to prescribe multiple medications – and if patients are hesitant to take them – one potential answer is "a combination where you have two or three blood pressure meds in a single pill," Egan said. Falling rates of awareness, treatment and treatment effectiveness occurred even though people had the same access to health care, the findings showed….**Read More**