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RI ARA

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"NOW, more than ever!!!"

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Resolution for the Elimination of the Unfair GPO and WEP Provisions of the Social Security Act

John A. Pernorio
President,
RI ARA

Resolution for the Elimination of the
Unfair GPO and WEP Provisions of the Social Security Act
Submitted by the Rhode Island Alliance for Retired Americans to the
Rhode Island AFL-CIO Executive Board for Support on June 22, 2020 by RI ARA President, John A. Pernorio

Whereas, The Government Pension Offset (GPO) and Windfall Elimination Provision (WEP) penalize people who have dedicated their lives to public service, including many municipal employees, teachers, firefighters and police officers, by taking away benefits they, or their spouses, have **EARNED**, and

Whereas, The WEP causes hard-working people to lose a significant portion of the benefits they earned themselves, and

Whereas, Nine out of 10 public employees affected by the GPO lose their entire spousal benefit, even though their spouse paid Social Security taxes for many years, and

Whereas, this is a national problem because people move from state to state, especially after retirement, there are affected individuals everywhere, and

Whereas, the loss of a major portion of their earned Social Security benefit forces some people into poverty, and

Whereas, more than 300,000 individuals lose an average of $3,600 a year due to the GPO and the number impacted grows quickly as more people reach retirement age, and

Whereas, this becomes a community problem throughout the country as these unfairly penalized individuals have less money to spend in their local economy, and

Whereas, various forms of the Social Security Fairness Act, which would completely repeal the GPO and the WEP have been introduced, gained bipartisan support and sponsorship, but languished in the halls of Congress for many years, therefore

Be it resolved that on this 22nd day of June, 2020, the Rhode Island AFL-CIO Executive Board supports efforts of the Rhode Island Alliance for Retired Americans (RI ARA) and its members 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, and further requests the President of the United States signs such legislation into law.

Resolution Passed Unanimously

We have passed 50,000 signatures in two weeks! Let's go for 100K! Friends, family and those who might have thought they were going to inherit something from you. Please sign the Petition below. Help us to help you!!!

ADD YOUR NAME

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

Social Security Important Information

On behalf of the Social Security Administration (SSA), we want to let you know that during the current coronavirus pandemic, SSA continues to provide help to you and others in your community.

While their offices are not providing service to walk-in visitors due to COVID-19, SSA remains committed to providing ongoing benefits and vital services. SSA asked me to let you know that they remain ready and able to help you by phone with most Social Security matters. You can speak with a representative by calling your local Social Security office or their National 800 Number. They provide local office phone numbers conveniently online with their **Social Security Office Locator.**

SSA also wants you to know they have many secure and convenient online services to:

- Apply for **Retirement, Disability**, and **Medicare** benefits,
- Check the status of an application or appeal,
- Request a replacement Social Security card (in most areas),
- Print a benefit verification letter, and
- Much more.

Most business with SSA can be done online, but they know that many people still rely on phone or in-person help. That's why they want you to know you can still count on them by phone. And, if you have a critical situation they cannot help you with by phone or online, they may be able to schedule an appointment for you.

If you need help from SSA, please don't wait until they can see you in person. Reach out now and get the help you need.

We ara still available to take your call Monday thru Friday from 9:00 a. m. to 4:00 p. m.

You can also visit **https://www.ssa.gov/** . Many of the services can be completed online.

Please **DO NOT COME INTO** one of our local officers.

Lastly, SSA also understands that getting medical and other documentation can be difficult due to the pandemic. So, they are continuing to extend certain deadlines wherever possible.

Trump on coronavirus: 'If we stop testing right now, we'd have very few cases, if any'

President Trump on Monday downplayed concerns of a rising number of coronavirus cases in states across the country, indicating that the increase was due to more testing.

"If we stop testing right now, we'd have very few cases, if any," Trump said during a White House event highlighting administration actions to help senior citizens.

Trump has frequently made inconsistent comments on testing. At times he has sought to downplay the severity of the coronavirus pandemic by saying the U.S. has tested more people than any other country, and as a result, the number of confirmed cases is higher.

Other times, Trump has complained that the positivity rates and case counts are too high, because the country has been testing so many people.

Trump's dual views on testing were on full display **in a message tweeted** Monday morning.

"Our testing is so much bigger and more advanced than any other country (we have done a great job on this!) that it shows more cases. Without testing, or weak testing, we would be showing almost no cases. Testing is a double edged sword - Makes us look bad, but good to have!!!" Trump tweeted.

Vice President Pence made similar comments on Monday, suggesting the White House has already shifted focus from addressing the health impacts of the virus to holding campaign rallies and reopening states as quickly as possible.

The Trump administration has signaled it has no interest in the nation having a new series of lockdowns given the economic damage shutting down the country has already had.

Administration health officials like White House coronavirus task force coordinator Deborah Birx and **Anthony Fauci** have played considerably less of a public role since the White House ended daily coronavirus briefings in April.

he pandemic has hit the United States during an election year, and Trump's poll numbers have fallen in the midst of the crisis.

Yet even as health experts are warning about surges in states such as Texas, Florida, Arizona, Alabama, Oklahoma and Arkansas, Pence said the country has been making "steady progress" toward putting the coronavirus "farther and farther in the past."

Pence said the spike was likely due to a "dramatic increase in testing."

The number of coronavirus cases has surged in 20 states over the past week, according to data analyzed by The New York Times. Those numbers can be misleading, as some states are also increasing the number of people tested.

However, some states have seen the number of daily tests decline even as the seven-day average of new cases increases. In other states, the rate of new cases is increasing faster than the increase in the average number of tests.

The percentage of positive test results out of total tests has also been on the rise, meaning states do not have the virus under control despite reopening businesses.

Coronavirus: Most Americans believe government should regulate drug prices for COVID care

With the coronavirus pandemic, the dangers of **rationing care based on ability to pay** are all too clear. Financial barriers that deter people from getting COVID-19 care not only endanger their health, but they expose everyone else to heightened risk. A large majority of Americans want Congress to step in and regulate prescription drug prices for COVID-19 care.

A new **West Health Gallup poll** suggests that Americans have little faith that the pandemic will lead Congress to address high health care costs. It finds that almost ninety percent of Americans are either somewhat or very concerned that drugmakers will use the pandemic to justify drug price hikes.

Democrats are more concerned than Republicans that pharmaceutical companies will raise prices. Half of Republicans are very concerned, while two in three Democrats are very concerned. Most people do not believe that President Trump has done anything to address skyrocketing drug prices.

Most noteworthy, nearly nine in ten Americans want the federal government to regulate drug prices for COVID-19 care. And, Republicans, virtually as much as Democrats, (89 percent v. 91 percent), support government price negotiation of COVID drug treatments. Americans across the political spectrum are justifiably worried about access to affordable care.

Nearly half of Americans recognize that the government's response to the pandemic was either fair or poor. The Trump administration still could step in and assure treatments are affordable to all Americans. But, there is no evidence that it will.

Some states are stepping in to try to control drug prices because Congress has not acted. But, their reforms are limited and they likely will not apply to COVID-19 treatments. For example, some allow their residents to **import drugs** from Canada. Others are limiting people's insulin costs. Others are limiting people's insulin costs. ….**Read More**

Surging US virus cases raise fear that progress is slipping

Alarming surges in coronavirus cases across the U.S. South and West raised fears Monday that the outbreak is spiraling out of control and that hard-won progress against the scourge is slipping away because of resistance among many Americans to wearing masks and keeping their distance from others.

Confirming predictions that the easing of state lockdowns over the past month and a half would lead to a comeback by the virus, cases surpassed 100,000 in Florida, hospitalizations are rising dramatically in Houston and Georgia, and a startling 1 in 5 of those tested in Arizona are proving to be infected.

Over the weekend, the virus seemed to be everywhere at once: Several campaign staff members who helped set up President Donald Trump's rally in Tulsa, Oklahoma, tested positive, as did 23 Clemson University football players in South Carolina. At least 30 members of the Louisiana State University team were isolated after becoming infected or coming into contact with someone who was. Meatpacking plants were also hit with outbreaks.

"It is snowballing. We will most certainly see more people die as a result of this spike," said Dr. Marc Boom, CEO and president of Houston Methodist Hospital, noting that the number of COVID-19 hospital admissions has tripled since Memorial Day to more than 1,400 across eight hospital systems in the Houston metropolitan area.

He warned that hospitals could be overwhelmed in three weeks, and he pleaded with people to cover their faces and practice social distancing.….**Read More**

'Medicaid best price' changes aimed at value-based gene therapy contracts: U.S. agency

(Reuters) - Proposed changes to requirements that state-run Medicaid programs are given the best drug prices would clear the way for commercial health insurers to enter into "value-based" payment schemes, the U.S. Centers for Medicare & Medicaid Services said on Wednesday.

Drug manufacturers by law must give Medicaid their "best price," meaning the lowest price they negotiate with any other buyer. But health plans have expressed concerns that the requirement prevents them from linking drug prices to patient outcomes - a practice known as "value-based" pricing.

"The problem has been that the Medicaid best price regulations are a barrier. ... Today we are announcing that we are updating them to allow for more value-based pricing," CMS Administrator Seema Verma told Reuters in a telephone interview.

The proposed changes are being driven by the increasing availability of very expensive, potentially curative, gene therapy treatments, she said.

Spark Therapeutics Inc, now owned by Roche Holding AG, in 2018 launched its Luxturna treatment for an inherited genetic mutation that causes blindness at a price of $850,000.

Novartis AG last year won U.S. approval for its gene therapy Zolgensma for spinal muscular atrophy, pricing the one-time treatment at a record $2.125 million.

Commercial health insurers have considered linking reimbursement of such drugs to health outcomes, but have been stymied by the Medicaid best price rules, Verma said. "If a drug didn't work in 20% of cases, in those cases the payment might be zero, which could completely alter the Medicaid best price," she explained.

The changes proposed include calculating the best price based not just on one discount, but as a comprehensive blend of prices. They would also allow for price calculations outside of the current three-year window.

CMS said the aim is to provide greater flexibility for payers and manufacturers to enter into value-based agreements while ensuring Medicaid always gets the best deal.

The proposed changes will be open for a 30-day comment period.

Alliance for Retired Americans Sues State of Maine

Today, the Alliance for Retired Americans and two of its members, Don Berry and Doug Born, filed a lawsuit in the Maine Superior Court to protect the rights of older Maine voters during the COVID-19 pandemic. The Alliance was joined in the suit by **Vote.org**.

The lawsuit alleges that the State of Maine's vote by mail requirements are burdensome and will force older voters to choose between protecting their health or casting a ballot they know will be counted.

The plaintiffs noted that the number of people voting absentee by mail has surged as the coronavirus pandemic continues and is expected to reach record levels. The Centers for Disease Control and Prevention have said that Americans should expect a second deadly wave of infections in the fall. It is expected that high-risk people, including older Maine residents, will still be advised to practice self-isolation and social distancing in November and have no choice but to vote by mail.

However, the state's onerous absentee ballot measures make it impossible for older residents of Maine to cast a mail-in ballot and be confident it will count.

The plaintiffs are asking the Maine Superior Court to mandate that Maine:

Allow Maine residents to register to vote online;

- Eliminate the requirement that a voter registration application be accompanied by a photocopy of an identification document;
- Ensure that ballots postmarked by Election Day, but not yet received by a Supervisor of Elections, are counted;
- Permit any third party the voter chooses to submit their sealed ballots in person on their behalf;
- Provide pre-paid postage for all mail ballots; and
- Notify voters and provide an opportunity to cure their ballots if they are rejected due to a technical defect or a signature mis-match

"The right to vote is sacred and older citizens of Maine take their civic responsibility seriously," continued Fiesta. "The court must act now to protect both their personal health and safety and their right to vote. Seniors are most at risk of developing COVID-19. They should not have to stand in long lines at polling sites to make sure their votes are actually counted." "There are more than 235,000 seniors registered to vote in Maine," Mr. Fiesta continued. "The Alliance for Retired Americans is committed to ensuring that all older Americans nationwide can exercise their right to vote, especially during this unprecedented public health crisis." ….**Read More**

Coronavirus and hospital bills: Medicare v. private health insurance

Joseph Goldstein reports for the **New York Times** on a patient with COVID-19 who was hospitalized for 19 days and received bills totaling more than $400,000. Congress provided hospitals with stimulus funds to help ensure that patients were not billed out of pocket for COVID-19 care. But, unless you have traditional Medicare, which requires hospitals and doctors to bill the government directly, you are at risk of receiving bills for services that you should not be paying.

Again, Congress passed legislation to keep hospitals from billing patients with private insurance for COVID-19 care. But, there appears **nothing to stop hospitals from doing so** other than good will. Mount Sinai hospital in New York billed one COVID-19 patient, who had insurance through CIGNA, $401,885.57.

Thinking the patient was uninsured because it did not have insurance information for her, it discounted her bill by $326,851.63, a "financial assistance benefit." She was left with $75,000 in costs, even though the hospital had received $63.7 million from the government in COVID-19 stimulus money. Of note, **hospitals can charge the federal government directly for uninsured patients**.

Mount Sinai hospital admits that it erred when it billed the patient. It should have gotten her insurance information and billed CIGNA directly. Now, the patient has been left to try to work the bill out.

The bottom line is that the federal government does not have the ability to keep hospitals and doctors from billing people with private health insurance for services, even when **they are not allowed to**, as with most COVID-19 care. [N.B. If the patient had traditional Medicare or, for that matter, if Medicare for All were enacted, the patient would never receive a hospital bill. The patient would not need to spend precious time getting the insurance company to pay and fending off collection notices.]

Disparities in health stem from inequities

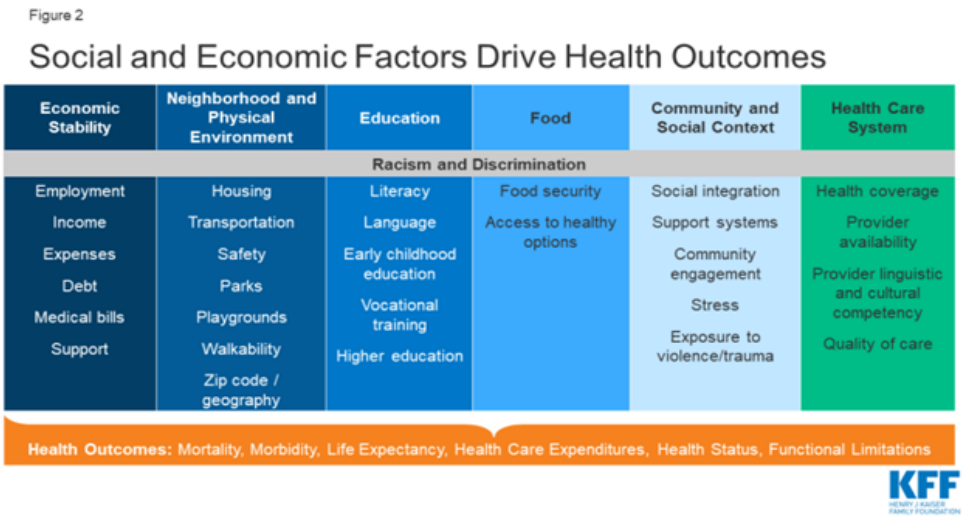
Disparities in health stem from inequities in housing, education, work and racial discrimination

Disparities in health and health care outcomes are a result of inequities in housing, education, work and our justice system as well as **racial discrimination**. These disparities are not new; they are continuing and in some instances worsening, according to a report by the **Kaiser Family Foundation**.

Black Americans, Hispanic Americans and American Indians or Alaska Native (AIAN) individuals experience poorer physical and mental health than White Americans. Their health outcomes have been disproportionately worse during this pandemic than health outcomes for White Americans. And, the pandemic has also disproportionately harmed their **financial wellbeing.** People of color have been more likely to lose their jobs than White Americans. Nearly half of Black and Latinx Americans have struggled to afford food, housing, utilities and health care expenses.

Access to good affordable health care is absolutely critical to the health and wellbeing of everyone. When Medicare was enacted in 1965, it **reduced health disparities for people of color over 65**. But, racial disparities in access to care remain, in part because Medicare has such high out-of-pocket costs and gaps in coverage, such as not offering vision, dental or hearing benefits. Improving Medicare so that it has more benefits and few out-of-pocket costs and expanding it to everyone would help address racial disparities in health and health care. It would be a first step and, perhaps, the first step that could quickly help all people of color.

But, access to good affordable care is not sufficient to combat racial disparities in health and health care. Housing, education, air and water quality, better food quality, and other social determinants of health also need addressing.



More Dispointment from the Republican Senate

Last week TSCL was part of a virtual meeting with Senator John Thune (R- S.D.) who, as the Majority Whip, is the second-ranking Republican in the Senate, after Majority Leader Mitch McConnell (R-Ky.).

During the wide-ranging question and answer session TSCL asked the Senator if legislation to lower prescription drug prices and end surprise medical billing would be passed this year. The Senator's answer was disappointing but also not surprising.

He said it is still possible that legislation regarding those issues could be passed, but not very likely. He said he was afraid they would be caught up in the elections and be used as campaign issues rather than being seriously considered for passage. That means that if any action is taken it will probably not be until later in November or even December, depending on how late in the year Congress works.

According to Senator Thune, there is likely to be another major bill providing more money for businesses and others to keep the economy afloat. However, that may not happen until later in June or sometime in July. Obviously, that will use up time that would otherwise have been spent dealing with the other important issues Congress must address.

Senator Thune also said there are no plans for the Senate to stay in session longer than it normally would to get their work done. That means they will take their usual August break as well as the usual recesses during upcoming holidays.

Meanwhile, the House of Representatives announced they will also be taking the usual August recess – if they get needed legislation passed before then.

Because of the coronavirus pandemic, the Senate is behind in getting its regular work accomplished. We think it's a shame they won't spend more time in session getting the legislation passed that's needed, especially on prescription drug prices, surprise medical billing, shoring up the Social Security and Medicare and Medicaid, and fixing the COLA to reflect the true inflationary costs that seniors face.

Save USPS: Demand Emergency Coronavirus Funding from Congress

If we don't act, the Postal Service as we know it may not exist past September.

Millions of seniors rely on the U.S. Postal Service to deliver important mail and packages, and voters of all ages will need the option of voting absentee in November.

The Trump Administration is singling out the Postal Service -- and refusing to provide any help so it can survive during the coronavirus crisis.

Please sign our petition to demand that Congress approve emergency USPS funding NOW.

To: U.S. Congress
From: [Your Name]

Former U.S. Postmaster General Brennan says the coronavirus pandemic is threatening the postal service's ability to operate. Without support it may be forced to shut down.

Congress tried to include funding -- but the Trump Administration blocked it.

That's outrageous. Millions of seniors rely on our postal system for critical services and voters of all ages need to be able to vote by mail during the 2020 election.

The U.S. Postal Service should not be used as a political pawn. Congress must include funding to protect the postal service without delay.

ADD YOUR NAME

What should I do if I am new to Medicare?

Dear Marci,

I will be eligible for Medicare soon and may need to enroll. What steps should I take to make sure that I have coverage that works for me?

-Thelma (Atlanta, GA)

Dear Thelma,

There are several steps you'll want to take when you're new to Medicare:

First, know when to enroll in Medicare Part A (hospital insurance) and Part B (medical insurance).

If you are already receiving retirement benefits from the Social Security Administration or Railroad Retirement Board at the time you become eligible for Medicare, you will be automatically enrolled in Medicare Parts A and B. There are three times you can enroll in Medicare Parts A and B for the first time.

First, during **the Initial Enrollment Period (IEP)**, which is the three months before, the month of, and the three months after your 65th birthday. The effective date of your Medicare coverage will depend on when you enroll. If you want Medicare Parts A and B to begin the month of your 65th birthday, you should enroll in the first three months of your IEP.

Second, if you have a **Part B Special Enrollment Period (SEP)**, it lets you delay enrollment in Part B without penalty if you were covered by insurance based on your, your spouse's, or sometimes a family member's current work when you first became eligible for Medicare. You can enroll in Medicare without penalty while covered by insurance based on current work, or for up to eight months after you lose your group health coverage or you (or your spouse or family member) stops working, whichever comes first. Medicare coverage generally begins the first of the month after you enroll.

Third, you can enroll during a **General Enrollment Period** if you did not enroll in Medicare when you first became eligible for it. The GEP takes place January 1 through March 31 each year, with coverage starting July 1. You may have a Part B late enrollment penalty and face gaps in coverage if you sign up during the GEP.

Second, consider enrolling in Part D prescription drug coverage.

Medicare's prescription drug benefit (Part D) provides outpatient drug coverage. Part D is provided only through private insurance companies that have contracts with the federal government. If you want to get Part D coverage, you have to choose and enroll in a private Medicare prescription drug plan (PDP) or a Medicare Advantage Plan with drug coverage (MAPD). Typically, you should sign up for Part D when you first become eligible to enroll in Medicare. If you have creditable drug coverage from employer or retiree insurance, you can delay Part D enrollment without penalty and you don't need to enroll in a drug plan until you lose this coverage. Contact your employer or drug plan to learn if your drug coverage is creditable. Also note that if you qualify for certain Medicare cost assistance programs, you may be automatically enrolled in a Medicare drug plan.

Third, decide between getting your coverage through Original Medicare or Medicare Advantage.

Unless you choose otherwise, you will have **Original Medicare.** Instead of Original Medicare, you can decide to get your Medicare benefits from a **Medicare Advantage Plan**, also called Part C or Medicare private health plan. Remember, you still have Medicare if you enroll in a Medicare Advantage Plan. This means that you must still pay your monthly Part B premium (and your Part A premium, if you have one). Each Medicare Advantage Plan must provide all Part A and Part B services covered by Original Medicare, but they can do so with different rules, costs, and restrictions that can affect how and when you receive care.

If you get your coverage through Original Medicare, you will also have the option to purchase a **Medicare supplemental plan, also known as a Medigap**. Medigap plans pay secondary to Medicare and cover some or all of the costs of Medicare cost-sharing. You can only enroll in a Medigap plan if you have Original Medicare.

-Marci

Medicare helps reduce racial and ethnic disparities in health care but not nearly enough

Medicare has played and can continue to play in reducing racial disparities. In a separate piece for the **International Journal for Health Services**, Gracie Himmelstein and Kathryn Himmelstein expose the disparities in health care literally rooted in the hospitals Americans use, disparities that Medicare in its current form cannot address. In combination, these pieces reveal the value of expanding and improving Medicare and the value of Medicare for all in addressing racial inequities.

When Medicare was enacted in 1965, it played a major role in addressing racial and ethnic disparities in health care coverage and access to care. Hospitals were required to desegregate in order to benefit from Medicare payments. But, even though virtually everyone over 65 has health care coverage, people with Medicare still experience disparities in access to care and health outcomes.

Black and Hispanic people under 65 are far more likely to be uninsured than White people. Expanding Medicare coverage to everyone, or to people five to 15 years younger than 65, or allowing people to buy-in to Medicare, could all affect health and racial equity to different degrees. Medicare for all would help most in reducing disparities in affordability and access to care. Other options could help, but far less.

Even with the same insurance coverage, both people of color over 65 and people of color with disabilities on Medicare have been **found** to have lower quality of care and worse health outcomes than White people. Out-of-pocket **costs in Medicare** create financial barriers to care. Many people do not know about **Medicare Savings Programs** and other programs that fill gaps in coverage.

And, Medicare does not cover **dental, vision or hearing care.** These benefit gaps need to be addressed to further reduce disparities. So do social determinants of health, such as housing, food and education.

We also need better data. Federally funded health plans are required to collect data on race and ethnicity for their enrollees. **Privately funded health plans are not**. The data collected needs to include quality measures. Then, equity outcomes could be tracked, including inequitable treatment.

On top of guaranteed health care for all with full coverage and improved benefits, we need to address the **inequitable distribution of health care resources** in the US, which the Medicare for All bills in Congress are designed to do. Gracie Himmelstein and Kathryn Himmelstein, MD show in a recent **study** that US hospitals serving people of color have poorer resources, including fewer capital assets, than other hospitals. Fewer resources are likely to mean poorer quality care….**Read More**

President Announces Lower Insulin Costs for some Seniors

President Trump announced last week that there will be a new type of Medicare prescription drug plan that will cap insulin costs at $35 per month for some seniors who have diabetes. While TSCL applauds that as far as it goes, it is woefully short of what is needed.

Unfortunately, it is not as cut-and-dried as "everyone will now pay $35 per month for their insulin." It is much more complicated than that.

To begin with, it will apply only to some seniors, depending on which Medicare supplement program they enroll in, and it is completely voluntary on the part of both the supplement provider and the individual enrolled in Medicare.

In our analysis, it appears that this new program adds layers of complexity and apparently will drive up the overall costs of everyone enrolled in the Part D plans that participate in this.

The main point is that this program would be limited in scale, and only available in certain types of plans, which means only in certain areas of the country. The premiums of these plans would be higher for all enrollees due to the capping of the cost of insulin to the patient, but not actually lowering the cost of insulin overall. That means the supplemental insurance plan would still be paying the full cost of insulin that is charged by the drug companies. To pay for that, the insurance companies would likely increase the costs of their Medicare supplement plans to all who are covered, not just those who are diabetic.

We believe that given the complexity of the new program, seniors who need insulin would be wise to enlist the assistance of a trained counselor before switching to such a plan to ensure they aren't giving up better coverage in other ways. This is particularly true if they are now in a Medigap plan and considering moving to a Medicare Advantage plan.

US warns 3 companies over illegal at-home COVID-19 tests

U.S. health regulators are cracking down on three companies for selling at-home blood tests for coronavirus, warning that the products have not been shown to safely and accurately screen for COVID-19.

The Food and Drug Administration sent warning letters to the companies Wednesday, saying their products are illegal because they have not been reviewed by the agency for home use. While the FDA has OK'd a handful of tests that allow patients to collect saliva samples at home, the agency has not cleared any tests for use completely at home.

At-home testing carries risks because consumers could mishandle the sample or misinterpret the results.

The companies targeted by FDA include: Medakit Ltd. of Hong Kong, Antibodiescheck.com of the United Arab Emirates and Sonrisa Family Dental of Chicago.

The letter to the Chicago company flagged online posts promoting "15 minute Covid tests for the whole family!" Among other violations, the company falsely claimed its products were "FDA approved" and appropriated the FDA logo without permission, the agency said.

"Such conduct will not be tolerated by the FDA, and we will continue to monitor tests marketed in the U.S.," Dr. Jeffrey Shuren, FDA's medical device director, said in a statement.

Emails and calls to the companies were not immediately returned.

The warning letters are not legally binding, but the government can take companies to court if they are ignored. The letters give the companies 48 hours to report how they will correct the violations.

Wednesday's action comes as the FDA tries to police dozens of antibody tests that the agency allowed onto the market earlier this year without evidence that they worked. On Tuesday, the FDA revoked authorization from an antibody test it previously cleared after determining it produced too many inaccurate results.

FDA leaders said the original flexible policy was intended to boost testing options and supplies, but critics said the agency created a "Wild West" of unregulated tests. Last month, the FDA said companies must submit testing data to remain on the market.

Antibody tests are different from the nasal swab tests used to diagnose most active infections. The tests instead look for blood proteins called antibodies, which indicate someone had a previous infection. Most of the tests use a finger-prick of blood on a test strip.

Antibody tests were initially thought to have a key role in identifying people who have developed some immunity to the virus. But researchers have not yet determined how to interpret the results in terms of immunity. And even well-performing antibody tests can sometimes produce more false results than accurate ones.

The FDA has granted emergency authorization to 21 antibody tests. Meanwhile, roughly 190 antibody tests launched under the agency's previous policy are awaiting review.

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Ask Your U.S. Senators to Prioritize People with Medicare in Relief Package

The coronavirus public health emergency continues to put older adults and people with disabilities at **significant risk.** Federal policymakers havemade important strides in responding to the outbreak, but more must be done to help people with Medicare. Join Medicare Rights in urging Congress to address the unique and unmet needs of older adults, people with disabilities, families, and caregivers in the next pandemic relief bill.

Right now, lawmakers are making decisions about what to include in the next package.

The U.S. House of Representatives recently passed its vision for a fourth relief package, the **HEROES Act**. That bill contains **several critical improvements** to programs and policies important to people with Medicare. It would strengthen Medicare enrollment and coverage, better protect nursing home residents, and bolster state Medicaid programs. These changes would help more Americans stay safe and healthy in their homes and communities.

Rather than take up the HEROES Act, leaders in the U.S. Senate are drafting their own legislation. That bill is expected to be unveiled in the coming weeks. Congressional negotiators will then work to reconcile any differences between the House and Senate bills. Provisions that are included in both bills will have the best chance of making it into the final package.

Contact your Senators today! Ask them to include key HEROES Act provisions in their forthcoming bill.

For More information:
Read the HEROES Act
Read Medicare Rights' summary of key provisions

As Problems Grow With Abbott's Fast COVID Test, FDA Standards Are Under Fire

In mid-May, the Food and Drug Administration issued a rare public warning about an Abbott Laboratories COVID-19 test that for weeks had received high praise from the White House because of its speed: Test results could be wrong.

The agency at that point had received 15 "adverse event reports" about Abbott's ID NOW rapid COVID test suggesting that infected patients were wrongly told they did not have the coronavirus, which had led to the deaths of tens of thousands of Americans. The warning followed multiple academic studies showing higher "false negative" rates from the Abbott device, including one from New York University researchers who found it missed **close to half** of the positive samples detected by a rival company's test.

But then, in a move that confounded lab officials and other public health experts, a senior FDA official later that month said coronavirus tests provided outside lab settings would be considered useful in fighting the pandemic even if they miss 1 in 5 positive cases — a worrisome failure rate.

The FDA has now received a total of 106 reports of adverse events for the Abbott test, a staggering increase. The agency has not received a single adverse event report for any other point-of-care tests meant to diagnose COVID-19, an agency spokesperson said.

In a statement, Abbott Laboratories said the NYU research was "flawed" and "an outlier," citing studies with higher accuracy rates.

Though the Abbott rapid test is one of over 100 COVID-19 diagnostic tests to receive FDA emergency use authorization during the pandemic, President Donald Trump has featured the product in the White House Rose Garden and the Health and Human Services Department's preparedness and response division has issued more than $205 million worth of contracts to buy the test, according to federal contract records.

"Everybody was raving about it," a former administration official said, speaking on the condition of anonymity to discuss internal deliberations. "It's an amazing test, but it has limitations which are now being better understood."

In its own COVID-19 **testing policy** for labs and commercial manufacturers, the FDA says a diagnostic test should correctly identify at least 95% of positive samples.

But medical professionals are split over the lower 80% threshold for the Abbott and other point-of-care tests' "sensitivity" — a metric showing how often a test correctly generates a positive result. They are debating whether it's sufficient, given the risks that an infected person unwittingly spreads COVID-19 after receiving a negative result.

False negatives increase the risk that patients will not self-isolate or exercise other precautions — such as wearing a mask — and make more people sick than if they had had an accurate diagnosis. Evaluations of the Abbott test have been among the most mixed, with some researchers finding that the test has bigger accuracy problems, but others saying it isn't likely to miss sicker patients.

"There's no way I would be comfortable missing 2 out of 10 patients," said Susan Whittier, director of clinical microbiology at NewYork-Presbyterian/ Columbia University Medical Center. Whittier and co-authors found that the Abbott test correctly identified 74% of positive samples compared with a rival test from Roche, another diagnostics giant. A point-of-care test from Cepheid, a rival company, correctly identified 99% of positives.

An FDA official cited the 80% accuracy minimum for point-of-care tests in late May even after two White House aides tested positive for the virus. The Executive Office of the President has spent roughly $140,000 on Abbott test kits, according to contract records.

In a statement, Abbott said when its test is used as intended it "is delivering reliable results and is helping to reduce the spread of infection in society by detecting more positive results than would otherwise be found." Studies from University Hospitals Cleveland Medical Center and OhioHealth found that its test detected at least 91% of positives. ….**Read More**

People with dementia and their families disproportionally handle costs of care

People with dementia experience significantly higher costs of care compared to those without dementia, and the burden of those higher costs falls disproportionately on people with dementia and their families, according to a recent NIA-funded study. Further, the financial expenditures shouldered by families was higher for people with dementia who lived in the community rather than in a residential facility such as a nursing home, according to the study, which used data from the NIA-funded Health and Retirement Study (HRS), a nationally representative longitudinal study of adults age 50 and older in the U.S. The research was published in the *Journal of the American Geriatrics Society*.

Researchers from Icahn School of Medicine at Mount Sinai, James J. Peters VA Medical Center, the University of California, Los Angeles, the Dartmouth Institute for Health Policy and Clinical Practice at the Geisel School of Medicine at Dartmouth, and Dartmouth College, studied a subset of individuals from the HRS (2,909 decedents aged 72 years or older at death from 2004 to 2015) who had continuous fee-for-service Medicare parts A and B coverage in the seven years before death. Over the study period, the researchers calculated cost of care either covered by insurance (Medicare and Medicaid) or covered by the family (out-of-pocket medical care costs and estimated cost of informal care provided by family members). Costs were compared over time, by dementia status, and by residential status.

Overall costs were roughly equal for people with dementia regardless of where they lived — either in a nursing home or in the community. However, community-dwellers and their families paid, on average, 64% of the total cost, compared to 43% of the costs if the person with dementia lived in a nursing home. Meanwhile, people without dementia incurred a lower cost of care overall, particularly when they lived in the community rather than in a nursing home.

The researchers point out limitations to interpreting the data in this study. For example, they note that the study data did not include direct measures of cost of care for those covered by private insurance and does not capture those covered by Medicare Advantage. Also, the estimates of informal care do not account for the lost wages of caregivers. However, the authors note that the findings demonstrate some of the disparities in care needs that fall to the families of people with dementia compared to those without, and suggest further research to explore financial burden and its impact on families and caregivers as well as the quality of care.

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Trump's Take On COVID Testing Misses Public Health Realities

"If we stopped testing right now, we'd have very few cases, if any."
— President Donald Trump in remarks during a June 15 roundtable discussion

President Donald Trump sought to downplay the numbers associated with COVID-19 in the United States — which have passed 2 million confirmed cases and are nearing 120,000 lives lost — by arguing that the soaring national count was simply the result of superior testing.

"If you don't test, you don't have any cases," Trump **said** at a **June 15 roundtable discussion** at the White House. "If we stopped testing right now, we'd have very few cases, if any."

It's a talking point the administration is emphasizing. Vice President Mike Pence **reiterated it** during a phone call to Republican governors that evening, recommending they use the argument as a strategy to quiet public concern about surging case tallies in some states. It's also a variation on a tweet the president sent earlier in the day.

With that in mind, we wanted to dig deeper. We reached out to the White House for comment or clarification, but we never heard back. Independent researchers told us, though, that the president's remarks are not only misleading — they're also counterproductive in terms of thinking through what's needed to combat the coronavirus pandemic.

The Big Picture

Essentially, the president is arguing that the United States is finding more cases of COVID-19 because we are testing more — and that our increased testing makes it appear the pandemic is worse in the U.S. than in other countries.

"We will show more — more cases when other countries have far more cases than we do; they just don't talk about it," he added.

But that isn't true.

The numbers paint a stark picture. The United States has recorded 2.1 million cases of the novel virus so far, about a quarter of the global total and more than any other country. To Trump's point, the country **is testing more** now than it did at the start of the outbreak — per capita, the U.S. is in the top 20% of countries when it comes to cumulative tests run.

This beefed-up testing still likely reflects an undercount in cases, though. The problem is that the U.S. outbreak is worse than that of many other countries — so we need to be testing a higher percentage of our population than do others.

To best understand this, consider the **number of tests necessary** to identify a positive case. If it's easier to find a positive case, that suggests the virus has spread further and more testing is necessary to track the spread of COVID-19.

For instance, statistics from the United States and the United Kingdom are fairly similar in terms of how many coronavirus tests are done daily per million people. But those tests yield far more positive cases in the United States. That suggests the outbreak here requires more per capita testing than does the U.K.'s.

"We have a much bigger epidemic, so you have to test more proportionately," said Jennifer Kates, a senior vice president at KFF.

Put another way, a larger health crisis means — even after controlling for population size — the United States will have to test more people to find out where and how the virus has spread. (KHN is an editorially independent program of KFF, the Kaiser Family Foundation.)

And while the U.S. has ramped up its testing since March, many parts of the country still don't have sufficient systems in place — from facilities to staff to medical supplies — for diagnosing COVID-19, researchers told us.

What If We Stopped Testing?

And what about the president's assertion that "if we stopped testing right now, we'd have very few cases" or none at all?

On its literal phrasing, it's absurd, experts said.

"The implication that not testing makes the problem go away is completely false. It could not be more false," said Dr. Joshua Sharfstein, vice dean for public health practice and community engagement at the Johns Hopkins Bloomberg School of Public Health in Baltimore. That's because testing doesn't create instances of the virus — it is just a way of showing and tracking them. (The president made a similar point during the same White House roundtable event.)

But even if you take it figuratively — the idea that our expanded testing resources have inflated our sense of the epidemic — it's still misleading.

"We're seeing a lot of cases because we're testing? It just doesn't ring true," Kates said. "The U.S. has made a lot of progress for sure. But that job is not finished."

The president's claim is part of a larger reelection strategy, argued Robert Blendon, a health care pollster at the Harvard T.H. Chan School of Public Health. The idea is to suggest that the health crisis is mostly exaggerated — and that things are getting better, and Americans should feel comfortable going back to work. "If the economy takes off, the president has a chance of reelection," Blendon said. "If it contracts as a result of expansion of cases, and the only way we know how to respond is restriction of economic activity, he's gone."

But the problem, Blendon added, is that COVID-19 counts are still climbing in multiple states. And people are still dying of the virus.

That gets at another point: Diagnostic testing isn't the only data source to reveal the pandemic's existence. Let's not forget about hospitalization rates and death counts. The number of deaths continues to rise, and hospitalizations are higher than they would be in the virus's absence.

Our Ruling

Trump argued that the nation's high count of COVID-19 cases is simply a result of our expanded testing capacity. His point is entirely incorrect.

The most relevant data suggests that the U.S. isn't testing enough to match the severity of the pandemic. Even with our higher testing ratio, we're probably still undercounting compared with other countries.

Testing doesn't create the virus. Even without diagnostics, COVID-19 would still pose a problem. We just would know less about it.

And, in fact, eliminating testing may alter the public's perception of the pandemic but it wouldn't conceal it. If anything, it would likely worsen the crisis, since the public health system wouldn't know how to accurately track and prevent the spread of the coronavirus.

The president's claim has no merit and seriously misrepresents the severity of the public health crisis. We rate it Pants on Fire.

'Body Clock' Might Play Role in Risk for Parkinson's

It often seems the older a person gets, the less they sleep, but new research suggests that inconsistent sleep patterns might predict a future diagnosis of Parkinson's disease.

Researchers who studied 2,930 older men for more than a decade found that those with a particular sleep problem -- called circadian rhythm disruptions -- were three times more likely to develop Parkinson's disease. A central nervous system disorder, Parkinson's affects balance and movement, and often causes tremors.

The study findings "can potentially help with the early detection of Parkinson's in older adults," said study lead author Yue Leng, an assistant professor of psychiatry at the University of California, San Francisco.

Circadian rhythms tell the body when to wake up and when to go to sleep. They rely, in part, on light. When it's light, the body is supposed to be awake, and when it gets dark, it's time to sleep. The normal functioning of this system can be disrupted by lifestyle choices, such as working nights or using a cellphone at bedtime.

Also, sometimes with age, this internal "clock" becomes inconsistent. Older adults often sleep less, and their sleep patterns might change as they become tired in the early evening and wake up early in the morning.

"When we talk about circadian problems … it involves the activity level a person has during the day and during the night, and how regular that pattern is," Leng said.

In 2003, when the study began, participants were asked to wear a device called an actigraph for three days. It detects slight movements in the wrist and makes it possible to figure out when a wearer is resting and when they are active. This cycle of rest and activity is key to understanding if a person's circadian rhythms are normal.

Participants were generally healthy when the study began, and none had Parkinson's disease. Over the next 11 years, however, 78 men were diagnosed with the disease. Those whose actigraph readings revealed abnormal circadian rhythms had triple the odds for Parkinson's, the study found.

That remained true even after researchers accounted for other sleep problems, including apnea, involuntary leg movements and sleep inefficiency (time spent asleep after shutting off the lights).

The findings were published online June 15 in JAMA Neurology.

James Beck is senior vice president and chief scientific officer of the Parkinson's Foundation. He said, "We've known for some time that circadian rhythms are affected in people with Parkinson's, so it was interesting to see that these issues could potentially predict the disease before they're diagnosed. Having a sense in advance that someone may be at risk for Parkinson's disease has a lot of appeal."

Beck called the use of actigraphs exciting, because wearable devices could allow for long-term monitoring of many health conditions.

"The idea of wearables has a lot of appeal for disease in general, and especially with Parkinson's disease," Beck said. "You could imagine a physician, sometime the future, saying to their patients, 'At your age, you have to get your colonoscopy, and you have to wear your actigraph for a week.'"

The question that remains, according to the study authors, is whether disrupted circadian rhythms are an early symptom of Parkinson's, or if they might actually play a role in causing the disease.

"We think the most likely explanation might be that this is an early sign of Parkinson's, but it could also be a mechanism that is leading to Parkinson's," Leng said.

People can take steps to normalize their body clock through light therapy -- exposure to bright lights during daytime hours -- and by taking melatonin. If circadian disruptions are found to be a cause of Parkinson's rather than a symptom, these treatments could potentially be used to help prevent it.

Beck suspects that circadian disruptions are most likely an early symptom of Parkinson's rather than a cause. Still, he said that this research is an important piece of the puzzle that is Parkinson's -- a disease for which there are treatments to alleviate symptoms but no known cure or preventative drug.

Sleep-related problems are among the most common complaints made by Parkinson's patients, and Beck hopes that this study will increase the urgency of studying the role that circadian rhythms play.

"Hopefully, this will spur a conversation with people with Parkinson's and their doctors if they're having trouble with sleep, because there are certainly remedies available to help improve sleep for people with Parkinson's disease," he said.

Parkinson's is the second most common neurodegenerative disorder, after Alzheimer's disease. More than 500,000 people in the United States have been diagnosed with Parkinson's, most after age 60.

More information

There's more about Parkinson's disease at the **Parkinson's Foundation**.

Dr. Fauci gives Congress COVID-19 warning

Dr. Anthony Faici, the administration's top infectious disease doctor, told a House panel on Tuesday that rising U.S. cases of COVID-19 are "disturbing" as new signs emerged of the United States falling further behind other countries in containing the novel coronavirus.

The coronavirus is surging in more than half the country, and states like Florida, Texas and Arizona are setting records of new cases almost daily.

Yet states are continuing to push forward with reopening businesses and lifting restrictions, and Fauci warned that without the ability to fully identify, isolate and trace the contacts of the infected individuals, the situation could worsen.

Governors in states that were the most aggressive in reopening have finally acknowledged the potentially dire nature of the rising virus cases in recent days but have not indicated they will reimpose any restrictions, or even pause the reopening push.

Fauci said time is running out to address the spikes in cases. "Right now, the next couple of weeks are going to be critical in our ability to address those surgings that we're seeing in Florida, in Texas, in Arizona and in other states," Fauci told the House Energy and Commerce Committee Tuesday.

The hearing marked a rare opportunity for House Democrats to grill administration officials about their response to the coronavirus pandemic. It was the first time members of the White House coronavirus task force appeared before Congress in over a month. The White House has also ended public briefings by officials from the group.

Oversight efforts by Congress have separately been stymied by the White House's policy that senior officials are not allowed to testify without permission from chief of staff Mark Meadows….**Read More**

More Young Americans Developing Unhealthy Predictors of Heart Disease

A new study finds that 1 in 5 people under age 40 now have metabolic syndrome, a group of risk factors that together increase the odds for many serious conditions, including diabetes, heart disease and stroke.

The rate of metabolic syndrome is rising in all age groups -- as many as half of adults over 60 have it. But among 20- to 39-year-olds, the rate rose 5 percentage points over five years, the study reported.

Metabolic syndrome is a group of heart disease risk factors that occur together. They include:

- A large waistline,
- High blood pressure,
- Higher-than-normal blood sugar levels,

High triglyceride levels (triglycerides are a type of blood fat),

Low levels of good (HDL) cholesterol.

"The trends for metabolic syndrome are very alarming. A huge proportion of the adult population is affected -- overall, 37% of adults in the United States. In young adults, the prevalence was remarkably higher than in our previous study through 2012," said study co-author Dr. Robert Wong, from the Veterans Affairs Palo Alto Health Care System in California.

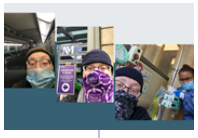
Wong said the specific effects of metabolic syndrome in younger people haven't been well studied yet, but it's concerning to see because the impact is cumulative. "Young adults have so many years for damage and impact from metabolic syndrome," he said.

While many effects of metabolic syndrome take years to develop, a more immediate concern is COVID-19. People with metabolic syndrome, including younger people, have greater odds for developing severe complications if infected with the new coronavirus, according to Wong. **...Read More**

Fearing The Deadly Combo Of COVID-19 And Cancer

Three Tuesdays each month, Katherine O'Brien straps on her face mask and journeys about half an hour by Metra rail to Northwestern University's Lurie Cancer Center.

What were once packed train cars rolling into Chicago are now eerily empty, as those usually commuting to towering skyscrapers weather the pandemic from home. But for O'Brien, the excursion is mandatory. She's one of millions of Americans battling cancer and depends on chemotherapy to treat the breast cancer that has spread to her bones and liver.



"I was nervous at first about having to go downtown for my treatment," said O'Brien, who lives in a suburb, La Grange, and worries about contracting the coronavirus. "Family and friends have offered to drive me, but I want to minimize everyone's exposure."

While her treatment hasn't changed since the novel coronavirus spread across the United States, the 54-year-old is at high risk of severe complications should she become infected. Those risks haven't declined significantly for her despite the Illinois governor's loosening of COVID-related restrictions.

She's not alone in fearing the deadly combination of COVID-19 and cancer. **One study**, which reviewed records of more than 1,000 adult cancer patients who had tested positive for COVID-19, found that 13% had died. That's compared with the overall U.S. mortality rate of 5.9%, according to **Johns Hopkins.**

Beyond the concern of cancer patients — with their already depleted immune systems — catching the virus, many doctors worry about people delaying their scans and checkups and missing time-sensitive diagnoses….**Read More**

Can Covid-19 Harm Your Brain?

At the beginning of the pandemic there was a short list of **Covid-19 symptoms**: Fever, cough, and shortness of breath. Today, that list has grown. Now it seems there is an entire suite of neurological effects that may even pop up as the **earliest symptoms**—even before that telltale terrible cough.

A review of world literature, published in June in the *Annals of Neurology*, looked at the **neurologic symptoms** that can be caused by a Covid-19 infection. These are wide-ranging and include **headaches, dizziness**, alteration of consciousness, a decrease in smell and taste, muscle weakness, muscle pain, **strokes**, and **seizures**, says study co-author **Igor Koralnik**, MD, chief of neuro-infectious disease and global neurology in the department of neurology at Northwestern Feinberg School of Medicine in Chicago.

"Based on data coming mainly from China and Europe, neurologic manifestations occur in about half of hospitalized Covid-19 patients," Dr. Koralnik says.

What's happening in your brain?

So how does the infection make its mark on the brain? There are many possibilities. Don't forget that if you're coughing and struggling to breathe, the other organs in your body are deprived of oxygen, too. This lack of oxygen, as well as a spike in **inflammation,** can affect the nervous system and brain, leading to problems like confusion, explains Dr. Koralnik.

The SARS-CoV-2 virus can also invade the brain and its protective membranes, causing viral meningitis. An autoimmune reaction (when the body essentially attacks itself) can flare, attacking the brain.

Finally, there's also the chance that the infection could contribute to a clotting disorder, and directly lead to a stroke, he says. **Stroke** has been found to be more common in patients with severe infections compared with those with milder illness, according to a study that looked at patients in Wuhan, China, and was published in the *Journal of Neurology,*

How long will the symptoms last?

Covid-19 is no doubt deadly. More than 105,000 people in the United States have **died from Covid-19** as of June 19, according to the Centers for Disease Control and Prevention (CDC). However, the majority of people recover from the infection. When it comes to neurological symptoms, there's no guarantee that these problems disappear when the illness does.

"Since the pandemic started only six months ago, there's no knowledge beyond this [time period]," says Dr. Koralnik. Milder problems, like headaches and dizziness, may diminish, but if damage led to a stroke or seizures, the effects may be long-lasting or permanent.

What's most important, says Dr. Koralnik, is the knowledge that cognitive problems like dizziness or loss of smell may be among the first symptoms to appear when someone becomes ill with Covid-19. That means you shouldn't discount weird or "off" changes in your health or assume you can't have Covid-19 if you feel confused or are delirious but aren't coughing.

Talk to your doctor, consider getting tested or isolating and do your part to prevent spreading a possible infection to friends, family, and members of your community.