

October 24, 2021 E-Newsletter

SOCIAL SECURITY 2100: A SACRED TRUST By Representative John Larson, (D) CT

Social Security Helps Seniors, Veterans and Children Social Security is our most effective anti-poverty program

- ◆ Seniors: For about half of senior beneficiaries Social Security provides a majority of their income.
- ◆ Veterans: Ove 5.3 million veterans receive Social Security benefits.
- ◆ Children: Social Security pays more benefits to children than any other federal program.
- ◆ Millennials: Millennials will rely more on Socail Security

for their retirement security than their parents or grandparents.

Woman and people of color rely on Social Security

- ◆ Social Security lifts 9 million women out of poverty.
- ◆ Without Social Security, 43% of older women would be living in poverty.
- ◆ In 2014, 45% of Blacks, 52% of Latinx, and 41% of Asian Americans seniors relied on Social Security for



John Larson (D) CT

all or nearly all of their income.

Social Security 2100 Act

- ◆ Increases benefits across the board for all Social Security beneficiaries.
- ◆ Improves the cost of Living Adjustment (COLA) so it reflects the inflation actually experienced by seniors.
- ◆ Ensures no one retires into poverty after a full career of work by improving benefits for long-serving, low-wage workers.
- ◆ Improves benefits for

widows and widowers from two-income households.

- ◆ Increases access to benefits for children living with grandparents or other relatives.
- ◆ Repeals the Windfall Elimination Provision (WEP) and Government Pension Offset (GPO) that currently penalize many public servants.
- ◆ Ends the five month waiting period to receive disability benefits.

Analysis Illustrates How Eliminating the Payroll Tax Cap Could Substantially Improve Social Security's Future

The 2021 Social Security Trustees Report states that the Trust Fund can pay full benefits through 2033, and a new Center for Economic and Policy Research (CEPR) analysis lays out several options for ensuring that all beneficiaries receive full benefits beyond that date.

The analysis outlines small changes that would make the Social Security Trust Fund 100% solvent for the next several decades and illustrates the effect of income inequality on its long-term solvency.

In 1983 only 10% of all income earned in the United States was not subject to the payroll tax.

That percentage is expected to grow to 18% over the next decade. In 2022, individuals with incomes above \$147,000 will not be required to pay the Social Security withholding.

"The cap needs to be eliminated for people making more than \$400,000 annually to keep the wealthiest Americans

from paying an even smaller percentage of their income into Social Security over time," said Robert Roach, Jr., President of the Alliance.



Robert Roach, Jr
President, ARA

Social Security Benefits Will Increase by Almost 6 Percent in 2022

Social Security beneficiaries, disabled veterans and federal retirees will see their earned benefits increase by 5.9% in January, marking the largest increase in almost four decades. The cost-of-living adjustment (COLA) will amount to an additional \$92 a month for the average retired worker. "The members of the Alliance are relieved that the nation's nearly 65 million Social Security beneficiaries can expect a significant COLA increase in 2022 after decades of miniscule

increases," said Richard Fiesta, Executive Director of the Alliance

"However, as welcome as this news is, too many older Americans will continue to struggle to make ends meet," he continued. "We are calling on Congress to pass President Biden's Build Back Better Act and include a provision allowing Medicare to negotiate the cost of prescription drugs in the package and lower the amount that beneficiaries are paying at the pharmacy counter."

"The savings from these negotiations should be used to add guaranteed Medicare dental, hearing and vision benefits," Fiesta added.

Congress could also increase benefits by making the wealthiest Americans pay their fair share and remove the artificial earnings cap that is currently \$142,800 per year. The cap will increase to \$147,000 in 2022. This change would strengthen the Social Security Trust Fund while providing all retirees with increased benefits.

In addition, the Alliance is continuing to press Congress to require that COLAs be based on the CPI-E, the Consumer Price Index for the Elderly. The CPI-E reflects health care and housing costs, things that seniors actually spend their money on, and this change will result in fairer COLAs every year, not just every few decades



Rich Fiesta,
Executive Director, ARA

ADD YOUR NAME

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

New Poll Shows Considerable Public Support for Proposed Medicare Changes in the Build Back Better Plan

There is significant public, bipartisan support for the Medicare policy changes lawmakers are considering for inclusion in the Build Back Better budget reconciliation bill.

One **recent poll** finds 84% of Americans—89% of Democrats and 79% of Republicans—favor adding dental, vision, and hearing coverage to Medicare. **Another**, out this week from the Kaiser Family Foundation (KFF), indicates similar levels of support for allowing Medicare to negotiate drug prices—83% were in favor, including 91% of Democrats; 76% of Republicans; and 84% of older adults, who would be most affected by this shift. The support holds steady even after the respondents learn the arguments for and against the policy.

In the budget bill, these popular provisions are linked: the \$450

billion in **projected savings** from the Medicare drug pricing reforms would more than pay for the new Part B benefits. A similar, but more generous expansion was previously **estimated** to cost \$358 billion.

They are also connected in form and function; they would work together to strengthen Medicare coverage and affordability. Half of all people with Medicare live on **\$29,650** or less per year, while one-quarter have less than **\$8,500** in savings. Health care costs take up a **disproportionate share** of Medicare beneficiaries' limited budgets—nearly 30% of Medicare households spend 20% or more of their income on health care, while only 6% of non-Medicare households do so.

A **significant portion** of this



spending is on prescription drugs. People with Medicare take an **average** of four to five prescriptions per month, and over **two-thirds** have multiple chronic conditions. Already, **many** do not fill their prescriptions or take them as directed due to cost and can experience **worse health outcomes** as a result. Although beneficiaries cannot afford to pay more for care, annual drug price hikes **consistently exceed** the rate of inflation, and new drugs are **launching** at ever-higher price points, further eroding access.

Similarly, **high out-of-pocket costs** for vision, hearing, and dental care mean these services are often **out of reach** for people with Medicare. **In 2018**, 43% of beneficiaries who had vision trouble did not have an eye exam

in the past year; 75% who needed a hearing aid did not have one, and 70% who had trouble eating because of their teeth had not visited a dentist in the past year.

Congress must act swiftly to address these affordability and coverage gaps and the resulting unmet needs. The budget reconciliation bill is an historic opportunity to do just that. We urge Congress to rise to the moment by lowering prescription drug prices and improving Part B coverage in the legislation. These popular, commonsense reforms would strengthen Medicare as well as beneficiary health and economic security.

Weigh in today! **Tell Congress** now is the time for transformational improvements and lasting change.

No End in Site for the Stalemate in Congress

For the last month, at least, we've been reporting each week on the fate of attempts by the slim Democratic majorities in Congress to put together legislation that would improve Medicare in one way or another.

It is expected that few, if any, Republicans will support any legislation that would accomplish that, so Democrats have to round up enough votes in their own party to get the job done.

Anyone who's been watching

the national news at all knows by now that the two biggest holdouts among the Democrats are Senators Joe Manchin (W. Va.) and Kyrsten Sinema (Ariz.). They are pitted against the more progressive members in the Senate including Bernie Sanders (Vt.), as well as nearly half of the Democratic members of the House who are members of the Progressive Caucus.

President Biden got personally



involved two weeks ago when he went to Capitol Hill to meet with both sides. However, the stalemate remains.

Last week House Speaker Nancy Pelosi (D-Calif.) announced that she will try to get things moving and get a bill passed by the end of this month, which means there will need to be major progress this week if that goal is to be met. If the legislation gets pushed into

November, things will really start to stack up because they still face the daunting task of passing funding for the federal government for the remainder FY 2022 and raising the debt ceiling, both which must happen by Dec. 3.

No doubt many of the Democrats in Congress are wondering why being in the majority is so hard.

What's causing America's massive supply-chain disruptions?

As the U.S. economy struggles to fully recover from the coronavirus pandemic, supply-chain disruptions across the country are driving up prices and leading to a growing shortage of goods.

The supply-chain bottlenecks -- around the world -- have caused record shortages of many products that American consumers are used to having readily available, from household goods to electronics to automobiles.

Moody's Analytics has warned that problems "will likely get worse before they get better."

"As the global economic recovery continues to gather steam, what is increasingly apparent is how it will be stymied by supply-chain disruptions that are now showing up at every corner," Moody's wrote in a report.

Here is how experts answer some key questions:

What's causing the disruptions?

Analysts say that the lingering effects of COVID-19 mitigation strategies essentially reduced the production of goods and services, and the supply-chain shortages now happening are the result of



struggles to return to pre-pandemic levels.

"The result of that imbalance between supply and demand eliminated all the inventory and eliminated all the grease that allows the wheels of commerce to work smoothly," said Steve Ricchiuto, chief U.S. economist at Mizuho Securities.

Not enough warehouse workers, truck drivers

Economists believe there are several factors contributing to the supply-chain shortages, including a growing number of workers quitting jobs key to keeping

things running smoothly.

A record 4.3 million Americans quit their jobs in August -- the most since the Department of Labor started tracking this data in 2000.

"You have a bunch of sectors that just pay minimum wage and labor is just going to veer over to where it finds the most profit," said Vidya Mani, an associate professor at the University of Virginia's Darden School of Business.

The Labor Department in July reported that the warehouse industry had a record 490,000 job openings.**Read More**

People with Medicare Should Compare Medicare Advantage and Part D Plans Each Year

Medicare Open Enrollment begins tomorrow, October 15, giving people with Medicare the option to shop for new coverage for the coming year. But many beneficiaries do not **compare plans** and may find themselves with coverage that is too expensive or not suited for their needs.

This week, the Kaiser Family Foundation (KFF) released a new report showing that **71% of beneficiaries** did not compare their Medicare Advantage (MA) plan options. The drug plan shares were even worse, with 81% of those in MA drug plans and 72% of those in traditional

Medicare with stand-alone drug plans not reviewing their coverage. Some of this may be because beneficiaries are **overwhelmed** due to the proliferation of plans. According to KFF's report, in 2021, the average person with Medicare has 33 MA plans and 30 stand-alone Part D plans to compare.

Those who are content with their coverage do not have to make a change during Open Enrollment, but everyone with Medicare should at least look over all of their insurance information, including all supplemental coverage such as



Medigaps, to make sure it is the best coverage for their circumstances.

For unbiased, one-on-one help, people can contact their local **State Health Insurance Assistance Program (SHIP)**.

In preparation for Open Enrollment, the Centers for Medicare & Medicaid Services (CMS) **released updated star ratings** to help people shop for and compare MA and Part D plans on the **Medicare Plan Finder**. Both MA and Part D plans can change every year. These changes can include cost-sharing and premiums, pre-authorization rules, covered

drugs or formularies, supplemental benefits, quality as shown in star ratings, and which providers are covered in the networks. Each of these is an important consideration for those who are in or contemplating joining MA or Part D plans.

At Medicare Rights, we continue to urge CMS to make the Plan Finder easier to use but also to reduce the complexity of choices beneficiaries face. We want to see fewer, high-quality plans with standardized benefits and formularies to reduce the burden and the risk of making mistakes during Open Enrollment.

Insurance Focused on Virtual Visits? The Pros and Cons of a New Twist in Health Plans

At the height of the covid-19 pandemic, people often relied on telemedicine for doctor visits. Now, insurers are betting that some patients liked it enough to embrace new types of health coverage that encourages video visits — or outright insists on them.

Priority Health in Michigan, for example, offers coverage requiring online visits first for nonemergency primary care. Harvard Pilgrim Health Care, selling to employers in Connecticut, Maine and New Hampshire, has a similar plan.

"I would describe them as virtual first, a true telehealth primary care physician replacement product," said Carrie Kincaid, vice president of

individual markets at Priority Health, which launched its plans in January as an addition to more traditional Affordable Care Act offerings.

The often lower-premium offerings capitalize on the new familiarity and convenience of online routine care. But skeptics see a downside: the risk of overlooking something important.

"There's a gestalt of seeing a patient and knowing something is not right, such as maybe picking up early on that they have Parkinson's," or listening to their heart and discovering a murmur, said Dr. David Anderson, a cardiologist affiliated with Stanford Health



Care in Oakland, California. He said online medicine is a great tool for follow-up visits with established patients but is not optimal for an initial exam.

When enrolling in one of the new plans, patients are encouraged to select an online doctor, who then serves as the patient's first point of contact for most primary care services and can make referrals for in-person care with an in-network physician, if needed. It's possible patients never meet their online doctor in person.

Many insurers offering virtual-first plans hire outside firms to provide medical staff. The physicians may hold licenses in several states and not be located

nearby. Insurers say participating online doctors can access patients' medical information and test results through the insurers' electronic medical records system or those of the third-party online staffing firm. What might prove tricky, experts warn, is transferring information from physicians, clinics or hospitals outside of an insurer's network. Sharing patient information via EMRs is **challenging** even for doctors operating under traditional insurance plans with in-person visits — especially moving data between **different health systems** or specialty practices... **Read More**

MedPac: High drug prices mean higher Medicare spending

Not only are drug prices rising at the pharmacy for people with Medicare, but drug prices are rising for hospital inpatients as well. MedPac, the agency that oversees Medicare, says rising drug prices are responsible for a huge increase in Medicare Part B drug spending. It wants Congress to rein in these prices.

During its **October 7 meeting**, MedPac members discussed Medicare Part B drug spending. For years, MedPac has said that Congress needs to rein in drug prices. But, the pharmaceutical industry has consistently

managed to keep Congress from responding appropriately and regulating prices. MedPac members focused on prices for infusible and injectable drugs. Medicare pays for these drugs at the average sales price plus six percent. Members believe that **Aduhelm**, the new FDA-approved drug for people with Alzheimer's disease, could literally wipe Medicare out. Yet, there is little clinical evidence that Aduhelm actually helps people with Alzheimer's or helps them enough to warrant



its **launch price** of \$56,000. Prices are rising on injectable and infusible drugs that have therapeutic alternatives. So, some MedPac members are asking why Medicare should pay the high prices that these drugs command.

And, some MedPac members believe that Congress must change its payment formula for Part B drugs. Medicare's payment rate—average sales price plus six percent—creates an incentive for pharmaceutical companies to keep raising their rates.

Part B drugs have seen nearly 10 percent annual Medicare spending growth over the last 12 years, which MedPac members attribute to higher drug prices. Drugs in the US have higher launch prices than in other countries and higher price increases each year. And, prices keep rising on drugs which have little or no evidence of being effective.

Democrats in Congress are working on legislation in the reconciliation bill that should rein in these prices. Time will tell if they succeed.

Don't judge a Medicare Advantage plan by its stars

When you examine your Medicare plan options during this year's **open enrollment season**, do not judge a Medicare Advantage plan by its stars. The government's star-rating system is deeply flawed. Rather, you should assume that some plans with four and five-star ratings have high denial and mortality rates and low-quality provider networks.

For sure, you should avoid Medicare Advantage plans with one and two-star ratings. They are few and far between. And, if the Centers for Medicare and Medicaid Services is giving them such a low rating, there's a

reason.

But, the higher star-ratings are based on measures that can be extremely misleading. For one, the star ratings are determined on an insurer's group of Medicare Advantage plans, at the Medicare Advantage "contract level." If there's a Medicare Advantage plan that's performing poorly that is assessed with others that are performing better, that poor-performing Medicare Advantage plan will reap the star-rating of its fellow plans. And, people who join that poor-performing plan will have no clue.

MedPac has proposed



changing the star-rating program, which it says is "flawed." It is "inconsistent with the [MedPac] Commission's principles for quality measurement." In addition to giving plans ratings based at the "contract level" and not the individual plan, it does not focus on population-based outcome and patient experience measures. In addition, plans are rated as compared with one another, not relative to objective performance targets. And, plans are not rated by subpopulations served, so there's no way to know if a plan with a high-rating is actually

meeting the needs of its members with special needs and costly conditions.

Another issue with the star-rating system is that it is not budget neutral. The more plans with four- and five-star ratings, the higher their payments. This means that Medicare Advantage plans are not operating on a level playing field with traditional Medicare.

Fierce Healthcare reports that, in 2022, almost seven in ten Medicare Advantage plans have a four-star or five-star rating. That's up from not even five in ten in 2021.

Will Medicare Improvement Make It?

One potential casualty of the negotiations taking place among the Democrats is an expansion of Medicare that would add dental, vision and hearing benefits. The provision is favored by progressives, but at \$350 billion over 10 years, it is one of the costliest pieces of the bill. Worse, the new benefits wouldn't begin until 2028, providing little immediate political benefit.

However, Senator Bernie Sanders and some other liberals have called the Medicare expansion non-negotiable.

The progressives argue Congress still can control costs by authorizing the new Medicare benefits for only a few years, in

the belief that they would prove so popular that future Congresses would have to renew them.

Meanwhile, centrists like Sen. Manchin are insisting that any benefits be means-tested so they're limited to the poorest Americans — a non-starter for many on the left who say it would undermine a basic tenet of social insurance. And depending how low Manchin and others force down the total cost of the bill, the Medicare expansion could be dropped entirely.

Another issue that is in jeopardy is lowering the costs of prescription drugs.

Democrats in the House can



only afford to lose 6 votes from their own members if they are to pass the legislation and already at least 3 members are opposed to the current plans for reducing drug prices.

Rep. Scott Peters (D-Calif.), one of those opposed, said last week he's in talks with Senate Democrats and the White House about how to craft a new drug pricing proposal.

Peters has suggested only subjecting drugs to negotiations in Medicare Part B—those administered in a doctor's office or other medical facility—and removing the tax on companies that won't lower prices.

Peters said he fears the current proposal would harm the pharmaceutical industry's ability to invest in new medicines. It should be noted that some major pharmaceutical companies are located in Peters' Congressional district and there are lots of voters who work for those companies.

Over in the Senate, Senator Sinema has rejected progressives on efforts to lower prescription drug costs and Senator Bob Menendez (D-N.J.), whose state contains the headquarters of more major pharmaceutical companies than any other, has also expressed opposition to current plans.

Surprise-Billing Rule 'Puts a Thumb on the Scale' to Keep Arbitrated Costs in Check

Patients are months away from not having to worry about most surprise medical bills — those extra costs that can amount to hundreds or thousands of dollars when people are unknowingly treated by an out-of-network doctor or hospital.

What's not clear is whether the changes in law made by the No Surprises Act — which takes effect Jan. 1 — will have the unintended consequences of shifting costs and leading to higher insurance premiums.

Probably not, many policy experts told KHN. Some predict it may slightly slow premium growth.

The reason, said Katie Keith, a research faculty member at the

Center on Health Insurance Reforms at Georgetown University, is **that a rule released Sept. 30** by the Biden administration

appears to "put a thumb on the scale" to discourage settlements at amounts higher than most insurers generally pay for in-network care.

That rule drew immediate opposition from hospital and physician groups, with the American Medical Association calling it "an undeserved gift to the insurance industry," while the American College of Radiology said it "does not reflect real-world payment rates" and warned that relying on it so heavily "will cause large imaging cuts and



reduce patient access to care."

Such tough talk echoes comments made while Congress was hammering out the law.

The most recent guidance is the third issued to implement the **law**, which passed in late 2020 after a years-long battle. It was signed by then-President Donald Trump.

The No Surprises Act takes aim at a common practice: large, unexpected "balance bills" being sent to insured patients for services such as emergency treatment at out-of-network hospitals or via air ambulance companies. Some patients get bills even after using in-network

facilities because they receive care from a doctor who has not signed on with an insurer's network.

Patients were caught in the middle and liable for the difference between what their insurer paid toward the bill and the often-exorbitant charges they received from the provider.

Once the law takes effect next year, patients will pay only what they would have if their care had been performed in network, leaving any balance to be settled between insurers and the out-of-network medical providers. The law also gives insurers and providers 30 days to sort out discrepancies.....**Read More**

How to Crush Medical Debt: 5 Tips for Using Hospital Charity Care

What if a law passed but no one enforced it? That's essentially what has happened with one small but helpful rule about hospitals and financial assistance for medical bills.

The Affordable Care Act, the health law also known as Obamacare, requires nonprofit hospitals to make financial assistance available to low-income patients and post those policies online. Across the U.S., **more than half of hospitals are nonprofit**— and in some states all or nearly all hospitals are nonprofit. But

many people who qualify for financial assistance — or “charity care,” as it is sometimes known — never apply.

Jared Walker is helping get the word out. He founded **Dollar For**, an organization that directly helps people use hospital financial assistance policies to overcome unaffordable medical bills. Walker earned the public's attention early this year through a viral TikTok he made on a lark, late one night.

In the **60-second video**, Walker outlines the basics of

CHARITY



applying for hospital financial assistance, in response to a prompt that asks TikTokers to share “something you've learned that feels illegal to know.”

“Most hospitals in America are nonprofits, which means they have to have financial assistance or charity care policies,” he says in the video. “This is going to sound weird, but what that means is if you make under a certain amount of money the hospital legally has to forgive your medical bills.”

The video outlines the basics

of applying for hospital charity care, which he says he uses to “crush” medical bills. “**An Arm and a Leg**,” a podcast about the cost of health care, has been covering Walker and his **organization's work** since the video's viral moment, as well as the decades-long fight to establish charity care rules that preceded it.

Here are five strategies Walker endorses and shares during monthly volunteer training sessions:

2022's Social Security Raise Could Come With This Sneaky Surprise



Well, it's official. For months, experts have been talking about seniors on **Social Security** being in line for a massive raise in 2022. And this week, the Social Security Administration announced that beneficiaries will be getting a 5.9% cost-of-living adjustment (COLA), the largest to come down the pike in decades.

In comparison, seniors only saw a 1.3% COLA going into 2021. And so a 5.9% boost gives beneficiaries a lot more buying power.

But while a generous Social Security raise is a good thing in

theory, there's one scenario where it could actually backfire. And seniors need to gear up for that possibility.

Will a giant raise result in taxes on your benefits?

Seniors are often shocked to learn that Social Security income is, in fact, subject to taxes. But whether taxes apply to those benefits depends on how much income seniors have.

Taxes on Social Security hinge on provisional income, which is the sum of non-Social Security income plus 50% of one's annual benefit. For those who are single, a provisional income under \$25,000 means Social Security won't be taxed.



But singles with a provisional income range of \$25,000 to \$34,000 risk taxes on up to 50% of their benefits. And those with a provisional income above \$34,000 risk taxes on up to 85% of their benefits.

These thresholds are slightly higher for married couples collecting Social Security. In that case, couples with a provisional income under \$32,000 get to keep their benefits in full.

But a provisional income of \$32,000 to \$44,000 means that up to 50% of benefits can be taxed. And beyond \$44,000, up to 85% of benefits can be taxed.

Here's how next year's COLA comes into play. Seniors who are

currently on the cusp of being taxed on Social Security could see their benefits rise to the point where their provisional income exceeds the above limits. The result? Being hit with taxes on benefits for the first time.

Avoiding taxes on Social Security

One of the most frustrating things about taxes on Social Security is that the income thresholds above haven't changed in decades, even though the cost of living has increased exponentially. And while current seniors may not be able to do much to lower their provisional income, future beneficiaries can take steps to avoid seeing their Social Security income taxed.... **Read More**

Hospital COVID patients may owe thousands as insurance waivers end

COVID-19 patients hospitalized in 2021 could be on the hook for thousands of dollars in bills for hospital, physician, and paramedic care after insurance companies started charging members for these costs again, an analysis of 2020 US data today in *JAMA Network Open* suggests.

In 2020, most health insurers voluntarily waived copays, deductibles, and other cost sharing for hospitalized COVID-19 patients, but many did away with those waivers in early 2021.

The authors published an earlier version of the study on the medRxiv preprint server on May 30, 2021; since then, a Kaiser Family

Foundation analysis has shown that 72% of the two largest insurers in each state and Washington, DC (102 plans total) ended their waivers by August. Another 10% said they would phase them out by the end of October.

Out-of-pocket costs \$1,500 to \$3,800

A team led by University of Michigan researchers analyzed data on 4,075 COVID-19 hospitalizations of Americans with private or Medicare Advantage insurance from March to September 2020. The study used the IQVIA PharMetrics Plus for Academics Database, which collects claims data from multiple



US insurers.

Among all patients, 33.8% were privately insured, 46.5% required intensive care unit (ICU) stays, and the average length of stay was 7.3 days (9.2 for ICU patients).

The investigators found that the vast majority of COVID-19 patients weren't billed for hospital services such as room and board, suggesting that their insurance companies footed the bill. But patients who were responsible for payment were out thousands of dollars.

That means that COVID-19 patients who have sought emergency or hospital care since that time could face out-of-pocket

costs of roughly \$3,800 (for those with private insurance), while those with Medicare Advantage plans could pay \$1,500, the researchers said. Total out-of-pocket costs were higher than \$4,000 for 2.5% of privately insured patients, compared with 0.2% of Medicare patients.

The out-of-pocket costs are just a small fraction of total hospital charges, however. The authors said that insurers cap hospitalization costs of COVID-19 patients with private insurance at, on average, \$42,200, while the cap is \$21,400 for those using Medicare.... **Read More**

An Adequate Social Security COLA Once Every Four Decades is Not Enough

(Washington, DC) — The following is a statement from **Nancy Altman**, President of **Social Security Works**, in advance of the Social Security Administration's announcement of the 2022 cost-of-living adjustment (COLA), which is expected to be released tomorrow:

"After four decades of inadequate Social Security COLAs, beneficiaries are finally expected to receive one that more

closely matches their rising costs. But large as it may appear on paper, it is not nearly enough for seniors and people with disabilities on fixed incomes to make ends meet.

Social Security beneficiaries face substantial and rising health care costs, forcing too many to cut back on prescribed medication or go without food. While a more adequate COLA in 2022 is welcome, it is far from a



solution to our nation's retirement income crisis. To address that, as well as other challenges facing the nation, including the squeeze on working families and destabilizing income and wealth inequality, we need to expand Social Security. Moreover, we need to change the formula for calculating COLAs so that it accurately measures the rising expenses beneficiaries face every year, not just once every forty

years. We also need to control health care costs, including the outrageous prices of prescription drugs.

Congressional Democrats must include a robust provision in the Build Back Better Act allowing Medicare to negotiate lower prices for prescription drugs. That will ensure seniors and people with disabilities keep more of next year's COLA in their pockets, and out of the pockets of Big Pharma CEOs."

Provision Allowing Medicare To Negotiate Drug Prices Part Of Reconciliation Legislation, But Fate Not Certain

Prescription drug costs are a major concern for retired and disabled households as well as for government spending on Medicare and Medicaid. Pharmaceutical manufacturers are fighting back with a multi-million dollar lobbying campaign to maintain control of their secretive pricing practices, saying that allowing Medicare to negotiate would be Big Government "price setting." But that's not what has been proposed.

While numerous options are under discussion, one of the most widely discussed approach, a key feature of H.R. 3 (the Elijah. E. Cummings Lower Drug Costs Now Act) would not even apply to every drug. According to a

brief by the nonpartisan Kaiser Family foundation, the negotiation process stipulated under H.R. 3 would apply to at least 25 drugs in 2024, lacking generic or biosimilar competitors, selected from a list of 125 drugs with the highest net Medicare Part D spending. The drugs would be selected on the basis of greatest savings to the federal government or individuals who would be eligible for the negotiated price.

A fair price for each selected drug would be determined by the lowest average price in one of the following countries —Australia, Canada, France, Germany, Japan and the United Kingdom) or 80% of the average manufacturer's price if the selected drug has no



international price, (such as a new drug). The proposal would establish an upper limit for the negotiated price of 120% of the Average International Market price. To give Medicare bargaining clout, companies choose to negotiate or, pay penalties. If a manufacturer offers a price that's no more than the target price, the Secretary of HHS would accept this as the maximum fair price for the drug.

The estimated savings from this approach are quite substantial. The Congressional Budget Office (CBO) has estimated \$450 billion over a 10-year time frame. In addition, the CBO estimates that lower drug prices would lead to lower

Medicare beneficiary premiums and out-of-pocket costs for prescription drugs in Part D plans.

The CBO also estimates that the lower revenues from drug sales would lead to a lag in the introduction of new drugs, albeit a small lag. The CBO estimates that there would be 8 fewer drugs coming to market over the next 10 years, of the roughly 300 drugs expected to be approved during this period and 30 fewer in the subsequent decade.

Surveys by TSCL indicate that 85% of survey participants support allowing Medicare to negotiate prescription drug prices and 82% support restricting price increases to the rate of inflation.

'They Treat Me Like I'm Old and Stupid': Seniors Decry Health Providers' Age Bias

Joanne Whitney, 84, a retired associate clinical professor of pharmacy at the University of California-San Francisco, often feels devalued when interacting with health care providers. There was the time several years ago when she told an emergency room doctor that the antibiotic she wanted to prescribe wouldn't counteract the kind of urinary tract infection she had.

He wouldn't listen, even when she mentioned her professional credentials. She asked to see someone else, to no avail. "I was ignored and finally I gave up," said Whitney, who has survived lung cancer and cancer of the urethra and depends on a special catheter to drain urine from her bladder. (An outpatient renal

service later changed the prescription.)

Then, earlier this year, Whitney landed in the same emergency room, screaming in pain, with another urinary tract infection and a severe anal fissure. When she asked for Dilaudid, a powerful narcotic that had helped her before, a young physician told her, "We don't give out opioids to people who seek them. Let's just see what Tylenol does."

Whitney said her pain continued unabated for eight hours.

"I think the fact I was a woman of 84, alone, was important," she told me. "When older people come in like that, they don't get the same level of commitment to



do something to rectify the situation. It's like 'Oh, here's an old person with pain. Well, that happens a lot to older people.'"

Whitney's experiences speak to ageism in health care settings, a long-standing problem that's getting new attention during the covid pandemic, which has killed more than half a million Americans age 65 and older.

Ageism occurs when people face stereotypes, prejudice or discrimination because of their age. The assumption that all older people are frail and helpless is a common, incorrect stereotype. Prejudice can consist of feelings such as "older people are unpleasant and difficult to deal with." Discrimination is evident

when older adults' needs aren't recognized and respected or when they're treated less favorably than younger people.

In health care settings, ageism can be explicit. An example: plans for rationing medical care ("crisis standards of care") that specify treating younger adults before older adults. Embedded in these standards, now being implemented by hospitals in Idaho and parts of Alaska and Montana, is a value judgment: Young peoples' lives are worth more because they presumably have more years left to live.... [Read More](#)

FDA Panel Supports Moderna Booster Shot for Older Adults, People at High Risk

Mirroring a similar recommendation issued last month for the Pfizer COVID-19 vaccine, an expert advisory panel to the U.S. Food and Drug Administration on Thursday recommended a half-dose booster shot of the Moderna vaccine be given to certain recipients six months after their second shot.

Panelists recommended that everyone aged 65 or older who received the two-dose Moderna regimen get a third dose, as well as any younger adult who might be at high risk for COVID-19 due to a medical condition or a job that increases their exposure to SARS-CoV-2, *The New York Times* reported.

The FDA is not obligated to follow its advisory panels' decisions, but it typically does.

The data presented was not particularly decisive, committee members said, but they noted that a precedent had been set in September when the FDA gave emergency authorization to booster shots for the millions of Americans who'd gotten the Pfizer-BioNTech vaccine.

The evidence of a need for booster shots was clearer for the Pfizer vaccine, however. In data presented to the panelists last month, one study from the U.S. Centers for Disease Control and Prevention found that four months after a person's second dose of the Pfizer vaccine, its effectiveness in preventing illness requiring hospitalization fell from 91% to 77%.

But with the Moderna vaccine, the drop-off over time was much



less dramatic, making the justification for any booster shot much weaker.

Acknowledging that, Moderna argued instead that a booster could still be useful in preventing mild or moderate forms of COVID-19.

As part of the data presented, Moderna said its study found that antibody levels to SARS-CoV-2 rose by 1.8 times after people received a booster shot. But the company narrowly missed another threshold set by the advisory panel: The committee hoped to see a fourfold increase in neutralizing antibodies in 88.4% of study participants who got boosters, but the Moderna study observed such a rise in 87.9%, the *Times* reported.

One expert in infectious disease was dubious that boosters for younger, healthier Moderna vaccine recipients are necessary.

"The key question to focus on is whether there is evidence of erosion of protection against hospitalization with COVID," said Dr. Amesh Adalja, a senior scholar at the Johns Hopkins Center for Health Security, in Baltimore. "In those age or risk groups where this has occurred, a booster may be warranted."

However, he said that "it is unclear what benefit those at low risk for hospitalization gain from a booster, as there is not enough data to show that boosters protect for a significant amount of time against mild breakthrough infections."...[Read More](#)

A study of COVID vaccine boosters suggests Moderna or Pfizer works best

If you got the Johnson & Johnson vaccine as your first COVID-19 shot, a booster dose of either the Moderna or Pfizer-BioNTech vaccine apparently could produce a stronger immune response than a second dose of J&J's vaccine. That's the finding of a [highly anticipated study released Wednesday](#), October 13, 2021.

And if you started out with either Pfizer or Moderna, it probably doesn't matter that much, the research suggests, as long as you get one of the two mRNA vaccines as a booster.

The study, which was sponsored by the [National Institutes of Health](#), involved 458 volunteers. They were divided into nine groups with roughly 50 volunteers in each group. Those who initially got the two-dose Moderna or Pfizer vaccines got either a Moderna shot, a Pfizer shot or a Johnson & Johnson shot as a booster four to six months after their primary immunization.

And people who got the one-shot J&J vaccine either got another J&J shot or a Moderna or Pfizer booster.

The researchers then measured

antibody levels in all of those people two weeks and four weeks after the boost. The results were very interesting.

People who got the Moderna vaccine for their original shots and Moderna again for their booster appear to have gotten the best immune response, followed by those who got Pfizer boosted by Moderna and then Moderna boosted by Pfizer — although the increase in immune response with the mRNA vaccines was probably too small to really make a difference in protection in most groups.

The most significant finding suggested that people who initially got the J&J vaccine seem to have gotten the best response if they got Pfizer or Moderna as their booster.

In an email to NPR, Nathaniel Landau, a microbiologist at the New York University Grossman School of Medicine, said the findings show that getting a J&J booster after the initial one-shot immunization is "not as good" as receiving one of the mRNA vaccines as a booster. The antibody levels of people in those groups went up 10 to 20



times higher than in those people who got another J&J shot.

And that antibody increase is probably big enough to make a difference in how much better the protection will be, scientists say. How much better isn't known — this study wasn't large enough to determine how much less likely people who subsequently got infected with the coronavirus were to get sick — or how sick they got. But, based on other research, that kind of difference in antibody response probably is enough to offer greater protection.

"If you get a Moderna or Pfizer first, it really doesn't matter what mRNA vaccine you get next," [Dr. Monica Gandhi](#), an infectious disease specialist at the University of California, San Francisco, [told NPR](#). "But if you have had a Johnson & Johnson, this really shows us that the best vaccine to get next is an mRNA vaccine — either a Moderna or Pfizer."

For its part, J&J said the "study demonstrated that a booster of the Johnson & Johnson COVID-19 vaccine increases immune response

regardless of a person's primary vaccination and confirm previously published data on the strong increase of immune response when the Johnson & Johnson COVID-19 vaccine is administered as a booster shot."

There are some caveats to this study that make it a little hard to know how to interpret the data. First of all, the study wasn't designed to compare one booster to another, rather to see what kind of immune response each generated individually. In addition, the researchers tested full doses of all the vaccines — not the half-dose that Moderna is seeking authorization for in its booster.

Also, researchers measured antibody levels two and four weeks after the booster. So there's a chance antibody levels from a J&J booster could continue to rise with more time. And the scientists are assuming that higher antibody levels translate into more protection. That's probably true, but other factors may also play a role, such as responses by other parts of the immune system....[Read More](#)

Is a Really Bad Flu Season on the Way?

It could be a bad flu season this year — and for a couple of years to come — in places in the United States where COVID-19 restrictions like social distancing and masking have been lifted, researchers warn.

These sorts of measures caused flu cases to decline by more than 60% within the first 10 weeks after COVID-19 lockdowns were implemented in 2020, Columbia University researchers found.

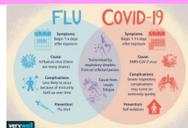
That's because face masks, hand washing and maintaining your distance work as well at preventing influenza infections as they do to stop the spread of COVID-19, said senior researcher Sen Pei. He is an assistant professor of

environmental health sciences at Columbia's Mailman School of Public Health, in New York City.

"We know COVID-19 and influenza share similar transmission routes, so measures to stop the transmission of SARS-CoV-2 will likely reduce the transmission of influenza," Pei said.

Unfortunately, many places across the United States have lifted their COVID-19 measures heading into this flu season, Pei said.

That means the flu likely will be as easily transmitted as in earlier years, but with a difference — people now have less natural immunity against



influenza because the United States essentially didn't have a flu season last year, Pei said.

"For influenza, the virus is mutating all the time," Pei said. "Every two to three or five years, people who were infected by influenza are likely to be susceptible to the virus again. Their immunity will wane over time."

For this study, Pei and his colleagues used a computer model to estimate the impact that travel restrictions, face masks, social distancing and school closures likely had on the spread of influenza in early 2020.

Widespread concern

The new study captures a

"widespread concern" among infectious disease experts heading into this year's flu season, said Dr. William Schaffner, medical director of the Bethesda, Md.-based National Foundation for Infectious Diseases.

The situation might be even more dire than depicted by this research, Schaffner said.

There were around 2,000 cases of influenza reported to the U.S. Centers for Disease Control and Prevention during the 2020-2021 flu season. The season before, the agency received reports of an estimated 35 million cases of flu....[Read More](#)

Model Suggests Earlier Breast Cancer Screenings for U.S. Black Women

Initiating screening 10 years earlier in Black women could reduce Black-White disparities in breast cancer mortality by 57 percent

For Black women in the United States, initiating biennial screening at age 40 years could reduce Black-White disparities in breast cancer mortality, according to a study published online Oct. 19 in the *Annals of Internal Medicine*.

Christina Hunter Chapman, M.D., from the University of Michigan Medical School in

Ann Arbor, and colleagues compared tradeoffs of screening strategies for Black

versus White women under current guidelines. Screening strategies until age 74 years with varying ages of initiation and intervals were examined in a 1980 U.S. birth cohort of Black and White women.

The researchers found that for Black women, biennial screening from ages 45 to 74 years was most efficient, whereas biennial screening from



ages 40 to 74 years was most equitable, with benefit-harm ratios closest to benchmark

values for screening White women biennially from ages 50 to 74 years. In Black versus White women, initiating screening 10 years earlier reduced Black-White mortality disparities by 57 percent; life-years gained per mammogram were similar for both populations. The less effective treatment was for Black women, the more intensively they could

be screened before benefit-harm ratios fell short of those experienced by White women.

"Our results suggest that Black women consider initiating biennial screening at age 40 years instead of age 50 years," the authors write. "Given that this screening strategy falls within the 'individual decision making' category for the U.S. Preventive Services Task Force, this represents a practical, evidence-based opportunity to advance equity."

Biden Administration to Invest \$100 Million to Ease Health Worker Shortage

(HealthDay News) -- The National Health Service Corps will receive \$100 million to help tackle the U.S. health care worker shortage, the White House announced Thursday.

That's a five-fold increase in funding from previous years for a program that helps find primary care doctors for communities that struggle to recruit and keep them, according to the U.S. Department of Health and Human Services, *NBC News* reported.

In exchange for a number of years of providing care in areas that lack health care providers, doctors are offered loan repayments and scholarships.

"COVID has basically caused a laser focus on the glaring gaps

and dysfunction across the American health care system," Tener Veenema, a scholar focused on workforce issues at Johns Hopkins University's Center for Health Security, told *NBC News*. "Making investments to redistribute health care providers into rural areas, low-resourced areas, is so important because we know how much they are suffering from a lack of access to good health care."

The latest statistics bear that out: The United States lost 17,500 health care workers in September, and 524,000 since the start of the pandemic, according to the Bureau of Labor Statistics.

"Whether you're in rural



America, or in a low-income part of America, that shouldn't be a reason why you can't access good quality health care," U.S. Health and Human Services Secretary Xavier Becerra told *NBC News*. "And so we want to help states that are going to try to do what they can to keep that public health workforce in those rural communities, those low-income communities, they're where people need them."

States will be able to apply for grants until April and the HHS predicts it will grant up to 50 awards as high as \$1 million per year over the course of four years.

"With these funds, states can

design programs that optimize the selection of disciplines and service locations, and tailor the length of service commitments to address the areas of greatest need in their communities," Diana Espinosa, acting administrator of the Health Resources and Services Administration, which oversees the program, told *NBC News*. "This investment will make a tremendous impact on access to primary care and addressing health disparities at a critical time."

The project doesn't launch until September 2022, so it won't have an immediate effect on the health worker shortage, but will help in the long run, *NBC News* reported.

CDC Reports Record High 12-Month Drug Overdose Death Toll

Drug overdose deaths in the United States hit a new record for the 12-month period ending March 2021, new government data shows.

A record high 96,779 drug overdose deaths occurred between March 2020 and March 2021, representing a 29.6% rise, new statistics from the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics found. The numbers are provisional, and the CDC's estimate for predicted deaths totals more than 99,000 from March 2020 to March 2021, *CNN* reported.

"It is important to remember

that behind these devastating numbers are families, friends, and community members who are grieving the loss of loved ones," Regina

LaBelle, acting director of the Executive Office of the President Office of National Drug Control Policy, said in a statement, *CNN* reported

The state with the largest increase in overdose deaths (85.1%) during that time was Vermont. Opioids accounted for the highest number of overdose deaths, followed by synthetic opioids, excluding methadone, which was linked to the lowest



number of overdose deaths.

Three states saw their number of overdose deaths decline from

March 2020 to March

2021: New Hampshire, New Jersey and South Dakota. South Dakota's reported overdose deaths declined by 16.3%, the highest of any state.

Between March 2020 and March 2021, the COVID-19 pandemic took hold in the United States and disrupted normal daily routines, *CNN* noted.

The CDC data also show a 29.7% increase in drug overdose

deaths between February 2020 and February 2021.

Earlier this year, the CDC said the more than 93,000 drug overdose deaths already reported in 2020 was nearly 30% more than the number observed in 2019, and the largest single-year increase ever in the United States, *CNN* reported.

At the time, National Institute on Drug Abuse Director Dr. Nora Volkow called the figure "chilling" and said the COVID-19 pandemic has "created a devastating collision of health crises in America."

Researchers Find Better Way to Fight Breast Cancer That Has Spread to Brain

Researchers may have found a noninvasive way to temporarily open the brain's borders to allow tumor-fighting medication inside.

By necessity, the brain is shielded by a layer of specialized cells called the blood-brain barrier. Its job is to allow needed substances in -- like oxygen and sugar -- while keeping out substances that could be toxic.

Unfortunately, that means medications often cannot penetrate the brain to any great extent to treat tumors or damaged tissue.

Now scientists are reporting a first: They used an advanced ultrasound technique to noninvasively -- and temporarily

-- open the blood-brain barrier in four patients with breast cancer that had spread to the brain.

That allowed the researchers to deliver the drug trastuzumab (Herceptin) to the patients' brain tumors.

The findings, published Oct. 13 in the journal *Science Translational Medicine*, are preliminary and represent only a "proof-of-concept."

"We're at the first stage, showing this is feasible and safe," said senior researcher Dr. Nir Lipsman, a neurosurgeon and scientist at Sunnybrook Health Sciences Centre, in Toronto.

But there were also signs the



technique increased the amount of drug that reached brain tumors.

And, on average, there was a small reduction in the patients' brain tumor size.

That finding needs to be interpreted cautiously, the researchers stressed, but it lays the groundwork for larger studies.

Ultimately, Lipsman said, the goal is to show whether the technique improves long-term control of brain tumor growth and prolongs patients' survival.

Breast cancer is highly treatable, especially when caught early. Among women diagnosed when the cancer is confined to the breast, 99% are still alive

five years later, according to the American Cancer Society. That survival rate drops to 28% among women with metastatic breast cancer -- meaning tumors have arisen in distant sites of the body, such as the brain.

The new study included four women with HER2-positive breast cancer that had spread to the brain. In HER2-positive breast cancers, tumor cells carry a particular protein (HER2) that helps them grow. Certain drugs, like Herceptin, target that protein.

However, only a relatively small amount of Herceptin can penetrate the brain, according to Lipsman's team. [Read More](#)

Red Cross Announces Urgent Need for Blood Donors

We are giving the information because it could affect many seniors, as well as others, of course.

Recently, the Red Cross announced it faces an emergency blood and platelet shortage. Donor turnout has reached the lowest levels of the year, decreasing by about 10% since August. Those who are eligible to donate are urged to do so now to help overcome this current shortage.

"Throughout the pandemic, we have experienced challenges collecting blood for patients from blood drive cancellations to surging hospital demand. Now

with decreased blood donor turnout, our Red Cross blood supply has dropped to the lowest it has been at this time of year since 2015," said Chris Hrouda, president of Red Cross Biomedical Services. "We recognize that this is a trying time for our country as we balance the new demands of returning to former routines with the ongoing pandemic, but lifesaving blood donations remains *essential* for hospitals patients in need of emergency and medical care that can't wait. The Red Cross is working around the clock to meet the



blood needs of hospitals and patients -- but we can't do it alone."

Those who are eligible are urged to share their good health -- please schedule an

appointment to give blood or platelets as soon as possible by using the Red Cross Blood Donor App, visiting RedCrossBlood.org or calling 1-800-RED CROSS (1-800-733-2767). All blood types are needed.

The Red Cross has had less than a day's supply of certain blood types in recent weeks. The supply of types O positive and O

negative blood, the most needed blood types by hospitals, dropped to less than a half-day supply at times over the last couple of months -- well below the ideal five-day supply. There is also an emergency need for platelets, which is the clotting portion of blood and must be transfused within five days of donation.

All those who come to donate in October will receive a link by email to claim a free Zaxby's Signature Sandwich reward or get a \$5 e-gift card to a merchant of their choice.

Your Next Doctor's Prescription Might Be to Spend Time in Nature

(American Heart Association News) -- Dr. Robert Zarr loves to write prescriptions that you don't have to take to the pharmacy.

Instead, he sends patients outside to soak in the healing powers of nature, combining the benefits of exercise with the therapeutic effects of fresh air and green space.

"Going back millions of years, we've evolved outdoors," said Zarr, a pediatrician who recently relocated to Ottawa, Canada, from Washington, D.C. "Why should we exist indoors? We need to be outdoors. The health benefits of being in nature are obvious."

The idea isn't new. The 16th century Swiss physician Paracelsus declared that "the art of healing comes from nature,

not from the physician." In Japan, public health experts promote shinrin-yoku, or forest bathing, as a key to physical and psychological health.

The premise is backed up with science. A 2018 meta-analysis in the journal *Environmental Research* reviewed more than 140 studies and found exposure to green space was associated with wide-ranging health benefits, including lower blood pressure and cholesterol, and lower rates of diabetes, stroke, asthma, heart disease and overall death.

In a 2020 study in *Frontiers of Psychology*, researchers analyzed 14 studies involving college students and concluded that as little as 10 minutes of sitting or walking in natural



settings reduced stress and improved mental health.

"There's an increasing amount of evidence that time in nature as opposed to time in an indoor environment is beneficial," said Donald Rakow, associate professor at Cornell University's School of Integrative Plant Science in Ithaca, New York, and one of the 2020 study's authors. "Being out in nature is not going to solve every mental or physical condition, but it really can be part of an overall treatment approach."

The Environmental Research analysis called for more studies to establish why nature promotes better health, but suggested several possibilities, including the benefits of sunlight, the idea

that microorganisms in nature can strengthen our immune systems and the mere fact that being outside encourages physical activity.

Zarr didn't need more convincing. What he wanted was a way to get doctors and their patients to take the health benefits of nature more seriously. So in 2017 he founded Park Rx America, a nonprofit that encourages health care professionals to incorporate nature into their treatment plans.

"Prescribing nature is not part of our training," he said. "And then the environment we work in is often so sterile. Doctors don't get much time outdoors during the day, so maybe it's not on our minds."... [Read More](#)

Powell's COVID Death Despite Vaccination Shows Danger to Those With Weakened Immune Systems

Colin Powell, the first Black person to become Secretary of State and a military leader who helped shape U.S. foreign policy for decades, died Monday of complications from COVID-19. He was 84.

"General Colin L. Powell, former U.S. Secretary of State and Chairman of the Joint Chiefs of Staff, passed away this morning due to complications from COVID-19," the Powell family wrote in a Facebook post. "We have lost a remarkable and loving husband, father, grandfather and a great American," they said, noting he was fully vaccinated.

Powell becomes one of the most high-profile American

public figures to die after having a "breakthrough" coronavirus infection, although there were factors that raised his risk of severe COVID-19 infection greatly, experts noted.

"While Powell was fully vaccinated, he also had multiple myeloma, a cancer that suppresses the body's immune response," explained Dr. Gwen Nichols, chief medical officer at the Leukemia & Lymphoma Society. "Multiple myeloma is not curable, so while he may or may not have been on active treatment, his disease, and his age, made him more vulnerable to breakthrough infection, complications and death," she



added. "Whoever transmitted the virus to him may have been asymptomatic, but they gave him a disease he could not fight as well, despite vaccination," Nichols said. "This death does not demonstrate the futility of vaccines, but instead underscores the importance of everyone getting vaccinated to protect society's most vulnerable."

One infectious diseases expert agreed that Powell's death does not mean that coronavirus vaccines aren't working.

"The anti-vaccine movement is probably already trying to use this death to undermine

confidence in the vaccine[s]," said Dr. Amesh Adalja, a senior scholar with Johns Hopkins Center for Health Security, in Baltimore. "It's important to remember that Colin Powell was 84 years old and he had some other medical conditions. This is why we are recommending boosters in this age group."

"We know this isn't the first person who's been fully vaccinated who's died. The fact that he's a celebrity and an icon is garnering all this news, but we know the vaccine, irrespective of these individual cases, is something that decreases the risk of death or severe disease from COVID-19," Adalja said.... [Read More](#)

Watch: Going Beyond the Script of 'Dopesick' and America's Real-Life Opioid Crisis

KHN and policy colleagues at our parent organization KFF teamed up with Hulu for a discussion of America's opioid crisis, following the Oct. 13 premiere of the online streaming service's new series "Dopesick."

The discussion explored how the series' writers worked with journalist Beth Macy, author of the book "Dopesick: Dealers, Doctors, and the Drug Company

That Addicted America," and showrunner Danny Strong to create and fact-check scripts and develop characters. It quickly moved on to a deeper discussion of how the fictionalized version of the opioid epidemic portrayed in the Hulu series dovetailed with the broader reality KFF's journalists and analysts have been documenting in their work

Dopesick for the past few years.

Providing perspective on the role of public health and treatment were KHN correspondent [Aneri Pattani](#), who has reported extensively on opioid policy, substance use and mental health, and KFF senior policy analyst [Nirmita Panchal](#), whose analytical work focuses on mental health and substance

use.

The forum was moderated by [Chaseadaw Giles](#), audience engagement editor and digital strategist at KHN who has written about [hip-hop music's relationship with opioid abuse](#). It was filmed in KFF's Washington, D.C., conference center to an audience of no one (courtesy of covid-19).

[Read More](#)