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Ruth Bader Ginsburg's impact on generations of women and girls

The death of Supreme Court Justice Ruth Bader Ginsburg, the second woman to sit on the high court, felt like a personal loss to generations of American women, as well as young girls.

"For women, she was the most important legal advocate in American history. She changed the way the law sees gender," said Abbe Gluck, a Yale Law School professor and former clerk of Justice Ginsburg. "The United States Supreme Court did not even recognize that the constitution prohibits discrimination based on gender until 1971 -- and that's Justice Ginsburg's case."

In the 1970s, the young Ginsburg "convinced the entire nation, through [her arguments at the] Supreme Court, to... adopt the view of gender equality where equal means the same -- not special accommodations for either gender," Gluck told ABC News. "It's astonishing from our modern vantage point to think that Supreme Court recognition for constitutional equality of women is only 50 years old," she said.

Ginsburg, who was appointed to the Supreme Court in 1993, led the court's liberal wing after Justice John Paul Stevens' 2010 retirement, which was "incredibly meaningful" for women to see, Gluck said.

After Sandra Day O'Connor -- the Supreme Court's first female justice -- retired in 2006, and before Justice Sonia Sotomayor joined the court in 2009, Ginsburg was the only woman on the Supreme Court. ...**Read More**

Ginsburg's death crystallizes the choice in November as no other issue can

Justice Ginsburg saw raw racism and sex discrimination long before she joined the court

Coalition to repeal the GPO/WEP Letter Requesting Support

Co-Chairs: Jan Schakowsky, Doris Matsui and Connor Lamb
Vice-Chairs: Debbie Dingell, Aryanna Pressley and Ted Deutch
House Democratic Caucus Task Force on Aging and Families
B245 Longworth House Office Building
Washington, D.C. 20515

Alliance for Retired Americans

Social Security Fairness .org

Dear Representatives Schakowsky, Matsui, Lamb, Dingell, Pressley and Deutch:

The Alliance for Retired Americans, which has over four million members nationwide, and Social Security Fairness have long worked to preserve, strengthen and expand Social Security. This vital program keeps millions of seniors out of poverty and studies indicate that Social Security is the sole or nearly the sole source of income for 33% of retirees.

However, there is another pressing problem affecting many Social Security beneficiaries. In 1983, Congress enacted the Windfall Elimination Provision (WEP), which reduces Social Security benefit payments to beneficiaries whose work histories include both Social Security-covered and non-covered employment when the non-covered employment also provides a defined-benefit pension. In December 2018, nearly 1.9 million beneficiaries were affected by the WEP.

A related provision, the Government Pension Offset (GPO), which affects nearly 700,000 beneficiaries, reduces Social Security benefits paid to spouses or survivors when the spouse or survivor earned a pension from a government job that was not covered by Social Security. The GPO reduction is equal to two-thirds of the amount of the pension payment for non-covered government work. In some cases, the spouse loses the entire spousal benefit, leaving them with nothing. This was the case of nearly half a million women in 2013.

Nearly 2.5 million seniors fall into these two categories and, as a result, lose hundreds of dollars each month. These dollars impact the ability to stay home, pay for food and prescriptions, and live out their lives with dignity. These are also dollars that could go right back into the economy. Statistically, a large number of widows are adversely affected, so it is clearly a women's issue.

In the House, H.R. 141, a bill to repeal the WEP and GPO, currently has 255 sponsors. We are working to secure more sponsors so this bill can be brought to the house floor. We also have a petition on Facebook that endorses H.R. 141 that has garnered nearly 65,000 signatures. We thank you for your support of H.R.141 and we respectfully seek your help to persuade non-signers to add their support. Seniors so negatively impacted would be forever grateful.

Thank you for your commitment to Social Security and all your work on this important task force. If we can be of any help to you on this or other aging issues, please contact us.

Respectfully,
Coalition to repeal the GPO/WEP

ADD YOUR NAME

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

Social Security: Always there for you in a crisis

On this 19th anniversary of the horrific attacks of September 11, 2001, we find ourselves in the midst of several crises, all battering us simultaneously. Nineteen years later, Donald Trump is doing everything he can to divide us and tear down our fundamental institutions. Consequently, it is especially important today to remember how we came together in the aftermath of 9/11 and how essential our institutions were in response to that tragic day.

Though not usually thought of as one of the nation's first responders, our Social Security system was there in the immediate aftermath of 9/11, protecting and supporting the families of the victims. Social Security was among the first insurers on the scene, working to locate victims' families and assist them in claiming the benefits their loved ones had earned for them.

By Thursday, September 13, just two days after that tragic day, the employees of the Social Security Administration were in overdrive, working 15-hour days, seven days a week. The families of virtually every worker who perished that day were eligible for Social Security survivor benefits. The daunting task facing Social Security was to identify those families, contact them, and help them secure the financial protection their loved ones had earned.

A stay-at-home dad lost his wife in the World Trade Center on September 11. In the midst of his grieving, he could see no way to remain at home with his child or support the child at the level they had been living. Unaware of the valuable Social Security benefits his wife had earned for her family through her work, he reluctantly put the family home on the market after that tragic day. The call from Social Security, from out of the blue, was a godsend. He hung up the phone and called his real estate agent. He could keep his home, after all.

Virtually every child who **lost** a parent on 9/11 received Social Security benefits, as well as surviving spouses. That's over 2,375 children and 850 surviving spouses. And those left with severe disabilities as a result of the attacks, over 640 people, received Social Security benefits, along with 99 of their children and spouses. In addition, over 1,800 family members received one-time payments.

The extraordinary effort on the part of Social Security's civil servants was on top of their regular work, which did not stop. It was on top of dealing with the trauma with which all Americans, including these dedicated first responders, were coping.

They performed that work exceptionally well. Just three weeks after the tragic day, the stay-at-home dad and his child, as well as the other victims' families, were among the 47 million beneficiaries who received those vital Social Security benefits.

As that experience — as well as Social Security's **response to Hurricane Katrina** and other personal and national crises — underscores, this essential institution is there to provide economic stability in times of tragedy and grief.

Right now, we're in the midst of many crises. We're in the middle of a pandemic that has already taken **over 190,000 lives** — with **nursing home residents** and workers accounting for over **40 percent** of the deaths. Our western states are experiencing enormous and deadly wildfires. Gulf states are dealing with the terrible aftermath of Hurricane Laura. We are experiencing the worst economy since the Great Depression and a long overdue reckoning with racial injustice.

In a pandemic where staying home is often the safest option to stay healthy, Social Security allows seniors and people with disabilities — those most threatened by the coronavirus — the modest income they need to be able to pay rent, buy food, and fill life-saving prescriptions. Moreover, Social Security's guaranteed monthly retirement benefits are there for those older Americans who have lost jobs and, unable to return to work, are able to claim their earned benefits.

While Social Security cannot correct our nation's racism, it is **especially important** to people of color, women, the LGBTQ community, and others who have faced discrimination. Moreover, Social Security's disability and survivor benefits, which are **disproportionately earned** by people of color, implicitly compensates a bit for some of the health and longevity inequalities which are a product of that racism.

As important as Social Security is for those who retire after a lifetime of work, it is most accurate to see it as a program that protects the entire family. It is there for those fortunate to live to old age. It is also there when tragedy strikes in the form of death or work-ending illness or injury.

With every paycheck, workers contribute to Social Security's Old Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund. These trust funds, now and in the future, pay benefits to the surviving children and spouses who lost loved ones to COVID-19 and the natural disasters plaguing the Western and Southern states. They pay benefits to those who suffer long-term disabilities as a result of those crises.

Those trust funds to which we all contribute pay benefits to the nation's seniors who have contributed to building our nation, to the nation's veterans and to the nation's workers, when wages are lost in the event of death, disability or old age. The payments to the surviving 9/11 families and first responders came from these same Social Security trust funds.

The unity in the aftermath of 9/11 is a sentiment we should try to restore to our troubled nation. We've never felt more divided, but in the face of so many crises, it's imperative that we come together. To survive, we must recognize that we are the ***United*** States. We are strongest when we join together, recognizing our common humanity, sharing our risks and taking responsibility. Those are the values that underlie our Social Security system.

People of all races, genders, religions, sexual orientations, and political affiliations contribute to Social Security. Whether we are born in the United States or elsewhere, we all contribute, pooling our risks and sharing our responsibilities.

As divided as we are over many issues, we are united in our overwhelming and deep support for Social Security. **Poll after poll** finds that we believe Social Security is more important than ever, that it should not be cut, but rather, should be expanded.

The level and depth of support is unsurprising. Social Security represents the best of American values. It unites us. President Dwight Eisenhower **described** it as "a reflection of the American heritage of sturdy self-reliance which has made our country strong and kept it free." Former Senator Bill Bradley insightfully **explained**, "Social Security is the best expression of community in America."

Our nation is facing a level of crisis and uncertainty unprecedented since the Great Depression. President Franklin D. Roosevelt responded to that crisis by creating our Social Security system. Now, we must come together to build on FDR's foundation by increasing Social Security's modest benefits. An expanded Social Security will provide exactly what's needed in a crisis: Greater stability and peace of mind for all of us.

The upcoming election is a serious test of our values. Donald Trump is a divider. Joe Biden is a uniter. He wants to be president of all of us. Donald Trump **threatens** our Social Security system. Joe Biden **promises** to protect, strengthen, and expand Social Security. Who wins may determine how we survive future times of crisis.

Without Ginsburg, Judicial Threats to the ACA, Reproductive Rights Heighten

On Feb. 27, 2018, I got an email from the Heritage Foundation, alerting me to a news conference that afternoon held by Republican attorneys general of Texas and other states. It was referred to only as a "discussion about the Affordable Care Act lawsuit."

I sent the following note to my editor: "I'm off to the Hill anyway. I could stop by this. You never know what it might morph into."

Few people took that case very seriously — barely a handful of reporters attended the news conference. But it has now "morphed into" the latest existential threat against the Affordable Care Act, scheduled for oral arguments at the Supreme Court a week after the general election in November. And with the death of Justice Ruth Bader Ginsburg on Friday, that case could well morph into the threat that brings down the law in its entirety.

Democrats are raising alarms about the future of the law without Ginsburg. House Speaker Nancy Pelosi, speaking on ABC's "This Week" Sunday morning, said that part of the strategy by President Donald Trump and Senate Republicans to quickly fill her seat was to help undermine the ACA.

"The president is rushing to make some kind of a decision because … Nov. 10 is when the arguments begin on the Affordable Care Act," she said. "He doesn't want to crush the virus. He wants to crush the Affordable Care Act."

Ginsburg's death throws an already chaotic general election campaign during a pandemic into more turmoil. But in the longer term, her absence from the bench could accelerate a trend underway to get cases to the Supreme Court toward invalidating the ACA and rolling back reproductive freedoms for women.

Let's take them one at a time.

The ACA Under Fire — Again

The GOP attorneys general argued in February 2018 that the Republican-sponsored tax cut bill Congress passed two months earlier had rendered the ACA unconstitutional by reducing to zero the ACA's penalty for not having insurance. They based their argument on Chief Justice John Roberts' 2012 **conclusion that the ACA was valid**, interpreting that penalty as a constitutionally appropriate tax.

Most legal scholars, including several who challenged the law before the Supreme Court in 2012 and again in 2015, find the argument that the entire law should fall to be unconvincing. "If courts invalidate an entire law merely because Congress eliminates or revises one part, as happened here, that may well inhibit necessary reform of federal legislation in the future by turning it into an 'all or nothing' proposition," wrote a group of conservative and liberal law professors in a **brief filed in the case.**

Still, in **December 2018**, U.S. District Judge Reed O'Connor in Texas accepted the GOP argument and declared the law unconstitutional. In **December 2019**, a three-judge 5th Circuit appeals court panel in New Orleans agreed that without the penalty the requirement to buy insurance is unconstitutional. But it sent the case back to O'Connor to suggest that perhaps the entire law need not fall.

Not wanting to wait the months or years that reconsideration would take, Democratic attorneys general defending the ACA asked the Supreme Court to hear the case this year. (Democrats are defending the law in court because the **Trump administration** decided to support the GOP attorneys general's case.) The court agreed to take the case but scheduled arguments for the week after the November election.

While the fate of the ACA was and is a live political issue, few legal observers were terribly worried about the legal outcome of the case now known as *Texas v. California*, if only because the case seemed much weaker than the 2012 and 2015 cases in which Roberts joined the court's four liberals. In the 2015 case, which challenged the validity of federal tax subsidies helping millions of Americans buy health insurance on the ACA's marketplaces, both Roberts and now-retired Justice Anthony Kennedy voted to uphold the law.

But without Ginsburg, the case could wind up in a 4-4 tie, even if Roberts supports the law's constitutionality. That could let the lower-court ruling stand, although it would not be binding on other courts outside of the 5th Circuit….**Read More**

President Trump's executive order won't lower drug prices

President Trump finally issued his fourth prescription drug **executive order**, related to pricing drugs at the average of what other wealthy countries pay. Much like his **first three executive orders**, it does precious little. While it appears to take on high drug costs, the executive order language is so weak that it is not likely to lower drug prices.

First, President Trump's executive order only applies to the 20 percent of the population with Medicare. It does not apply to working people or children. Even for people with Medicare, the executive order includes language that allows for extreme delay in implementation, if in fact it will ever come to pass.

While the executive order applies to drugs administered in a physician's office as well as those purchased at a pharmacy, it targets a small number of drugs. It only applies to "some high-cost drugs and biological products." Moreover, the executive order is only to "test" the value of pricing these drugs at a price similar to other wealthy countries.

The executive order does not try to regulate the price of drugs developed with federal research or funding. In short, President Trump has not acted to lower or even freeze prescription drug prices, although he has **promised to do so**. And, he has said nothing about pharmaceutical company drug price hikes, which are happening.

For example, Noam Levy reports for the **LA times** that AstraZeneca has exercised its monopoly pricing power to hike up its prices dramatically this year. AstraZeneca's drug prices have risen far faster than inflation, up as much as six percent when inflation is at about one percent. At the same time, it has benefited from $1.2 billion in taxpayer dollars to develop a COVID-19 vaccine.

AstraZeneca is not alone. Many other pharmaceutical companies have raised the prices of some of their best-selling drugs far more than inflation. AbbVie raised the price of Humira by 7.4 percent, along with the price of other drugs. GlaxoSmithKline also raised some drug prices significantly.

The leaders of other wealthy nations ensure medicines are affordable for everyone by negotiating prescription drug prices. President Trump has not even required the pharmaceutical companies that received hundreds of millions of taxpayer dollar to develop a COVID-19 vaccine to commit to charging a fair price for their vaccine. How many millions of Americans will end up without a vaccine and remain at high risk for getting COVID-19 because of the vaccine's cost?

Uninsured Rate Increased in 2019, Even as Incomes Rose and Poverty Declined

Census data released last week show that the number of uninsured Americans has been on the rise in recent years. The share of those who were uninsured at the time of the survey grew for the third year in a row, even as the economy was growing. In 2018, 8.9% of Americans (28.6 million people) reported being uninsured. In 2019, that number rose to 9.2%, or 29.6 million people. Some populations were particularly affected—there was a 0.7 percentage point decline in insurance coverage among Hispanic individuals, and a 1.4 percentage point drop in the share of Hispanic individuals with public insurance. Drops among those with public health insurance, when not accompanied by increases in private insurance, are particularly worrisome indicators of the effects of Trump administration and state policies that make it more burdensome to apply for, access, and retain public health insurance for low-income individuals.

As concerning as these numbers are, they are almost certainly optimistic compared to the current situation. The health coverage data comes from the U.S. Census Bureau's American Community Survey, which was conducted and completed before the COVID-19 pandemic hit. In contrast, the income and poverty data that was released at the same time comes from the Current Population Survey (CPS), which was compromised by the pandemic's impact on the data collection – stopping in-person interviews, for example. The Census Bureau concluded that the increased non-response to the CPS, particularly among lower-income households, artificially boosted income figures and lowered the poverty rate for 2019 and has therefore issued some adjusted figures. The insurance numbers, though not affected by these reporting challenges, do not account for changes to insurance coverage in 2020.

Instead, the increases in the rate of people without insurance that have occurred in 2017, 2018, and now 2019, and which followed six years of that rate going down, occurred despite steady job growth that should have improved access to health coverage and decreased the numbers of the uninsured. Particularly worrisome are the more than 720,000 children among the 2.3 million more Americans who were uninsured in 2019 as compared to 2016. In examining causality, advocates like the Center on Budget and Policy Priorities point to Trump administration policies like the so-called "public charge" rule that have "**created a climate of fear** among immigrants and their family members that discourages eligible people from enrolling in Medicaid or Marketplace coverage."

Ensuring access to public health insurance is increasingly important during the public health emergency caused by COVID-19 and the economic crisis that has followed. Enrollment in all types of coverage, including Medicare, Medicaid, and subsidized insurance through the Marketplace should be streamlined and simplified for those eligible, and people should not be discouraged from seeking this or any other coverage and care.

Levels of Care and Costs in Assisted Living

Different communities offer different services, pricing options and costs.

FOR MOST PEOPLE, AS WE age, we start to need a little extra help with everyday tasks. Typically, the human body slows down, gets creaky and often, health issues crop up in the latter years of life. Eventually, some people may need ongoing assistance, and that's where assisted living communities come in.

This **long-term care option** can be a huge benefit to seniors who need some help with the activities of daily living but who don't need as much medical care as you'd find in a **nursing home**.

These activities include:

- Personal hygiene including bathing, grooming and dressing.
- Eating.
- Toileting.
- Moving and getting around.
- Shopping and meal prep.
- Housework.

Life and household management.

But living in an **assisted living community** isn't just about having help with these activities. "It's also about belonging to a community of your papers and being able to have some camaraderie," says Han Hwang, executive vice president of partner sales and success for Caring.com, an online resource for people seeking information and support in caring for aging parents, spouses and other loved ones.

Assisted living communities provide **important social contact** that helps alleviate loneliness, which is "one of the biggest challenges for seniors," Hwang adds.

How Assisted Living Communities Charge for Services

Assisted living communities cost money, and they aren't necessarily cheap. It varies greatly from one place to another, but according to a 2019 survey conducted by Genworth Financial, the median yearly cost for an assisted living community is $48,612, up from $28,800 in 2004.

If you're considering moving into an **assisted living community**, it's important to think about finances and **how you'll pay for that care** in your golden years, especially as your health needs change over time. Part of this means understanding how these facilities charge for their services.

There are two primary ways in which assisted living facilities structure fees:

- **All-inclusive.** An all-inclusive price gives residents one monthly payment to cover everything, from the room itself and food, to utilities, activities, transportation and in some cases, health services. "People who have a lot of needs may want to choose the all-inclusive option," Hwang says, because everything is covered under one monthly bill and you're not adding services as you go and having to think about every dime you spend.
- **Ala carte.** With ala carte pricing, residents select only the services they want and pay for those as individual line items. In some cases, you can add or remove services month to month depending on the contract at the community. "For folks with fewer needs, ala carte might be the better option," Hwang says, because you can pick and choose only what you need and you're not paying for any services you're not using.

With assisted living, a large chunk of what you're paying is covering the rent on the unit where you're living and the food you're eating. Because fewer medical services are provided than at a typical rehab or nursing facility, medical costs may cost extra, depending on how the individual community structures its fees and service contracts.

The available services vary greatly from one community to another. Some facilities offer a lot of medical support on site, while others have only very basic services. Some also offer memory care and escalating levels of health care, but not all do.

Costs similarly range widely from community to community. "The cost really depends upon your level of care. If you need high levels of care and more attention, some assisted living communities can provide that, but it usually becomes more expensive when you need more care," Hwang explains...**Read More**

Government pays Medicare Advantage plans billions extra for members who receive few if any services

The HHS Office of the Inspector General (OIG) released yet **another scathing report** on **Medicare Advantage plans**, the private health plans that contract with the Centers for Medicare and Medicaid Services to offer people Medicare benefits. This time, instead of focusing on widespread and **inappropriate delays and denials of care**, the OIG raises concerns about Medicare Advantage plans bilking the federal government of billions of taxpayer dollars. It also raises concerns about the lack of oversight of Medicare Advantage plans.

The federal government compensates Medicare Advantage plans with extra revenue for members with diagnoses that suggest they would benefit from care coordination. To take advantage of this extra revenue, Medicare Advantage plans send health risk assessors to the homes of their members in the hope they are diagnosed with a condition for which the government will pay the Medicare Advantage plans more. The Medicare Advantage plans do not rely on these members' treating physicians to identify these diagnoses, recognizing that they can bill CMS more if they hire someone to assess their members.

Of course, the diagnoses that lead to higher payments should also lead Medicare Advantage plans to provide more care for these members. But, the OIG found that many Medicare Advantage plans got higher payments for members who never received any care coordination or other follow-up care from them. Rather, it found that the Medicare Advantage plans got $2.6 billion as a result of these self-serving health risk assessments.

The Centers for Medicare and Medicaid Services, for its part, did not concur with the majority of OIG recommendations to address potentially hundreds of millions in overpayments to Medicare Advantage plans. CMS is prepared to do some oversight of Medicare Advantage plans. But, it does not feel the need to require Medicare Advantage plans "to implement best practices to ensure care coordination for health-risk assessments." Nor does it see a need to rethink whether it is appropriate to allow Medicare Advantage plans to do in-home risk assessments for members and to pay them more for these members, even when these members do not use much, if any, health care.

President Trump blows drug deal with Pharma

In the past couple of months, President Trump has issued **four executive orders,** which he claims could lead to lower prescription drug costs. The proof is in the pudding, and there is none. Now, after blowing a deal with the pharmaceutical industry that would have put $150 billion in drug costs back in people's pockets, President Trump is hoping to make drug importation from Canada legal in some instances. He is not likely to succeed at that either.

President Trump appears to believe that lowering drug costs could gain him reelection support, particularly from older adults whose support he has been losing. He recently spent a bunch of time negotiating lower out-of-pocket drug costs with the pharmaceutical industry, including **Medicare Part D** copays, Jonathan Martin and Maggie Haberman report for **The New York Times**. But, to garner additional political support for his reelection, he told the pharmaceutical industry that he also wanted companies to provide everyone in the US with a $100 drug discount card, a "Trump card" before election day. And, with that, the whole deal imploded.

The pharmaceutical industry would not agree to this political maneuver in the weeks before the election. And, they argued $100 in savings would be of little help to people. So, instead, Trump released his fourth executive order, which would test the benefits of Medicare Parts B and D paying the average prices other wealthy countries pay for prescription drugs. But, that order has little chance of implementation.

Perhaps because President Trump wants to be known for having done something effective to lower drug prices and perhaps because he wants to do his state allies a favor, he is now talking about allowing states to import some prescription drugs from Canada, reports Phil Galewitz for **Kaiser Health News**. So far, six states are hoping to get the federal government to allow them to import Canadian drugs, Colorado, Florida, Maine, New Hampshire, New Mexico and Vermont. President Trump and Governor DeSantis of Florida are close allies, and this is something DeSantis wants; among other things, it would save the state $150 million a year**….Read More**

Trump Administration Withdraws Harmful Rule

This week, the Trump administration **withdrew a proposed rule** that would have interfered with some Medicaid funding, forcing states to cut Medicaid coverage and services. The proposed Medicaid Fiscal Accountability Regulation (MFAR) was purported to increase transparency around certain Medicaid funding which the administration said needed to be studied. The proposal, however, did not study certain funding mechanisms but ended them and was widely denounced by states, health care providers, and people with Medicaid and their advocates.

Over 12 million people with Medicare also rely on Medicaid. These individuals often have very high rates of chronic illness and may have extensive long-term services and supports needs that can only be met through Medicaid. With Medicaid's help, they can often stay in their homes and communities safely. But many experts flag the services that keep people safely at home as the most at risk from state budget cuts, which could lead to many people being forced to leave their homes and enter nursing facilities, increasing their risk of contracting COVID-19.

MEDICARE RIGHTS CENTER
Getting Medicare right

Importantly, Medicaid funding generally is already at risk. States face **budgetary shortfalls because of** simultaneous economic slowdowns and **spikes in enrollment** related to the pandemic. This makes it an especially dangerous time to limit Medicaid funding. Even the administration was unsure just how much impact the rule would have. The **proposal stated** that "The fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown."

Especially during the COVID-19 public health emergency, proposals that would cut some unknown amount from Medicaid budgets is simply too risky. We applaud the administration for withdrawing the rule and recognizing that further study is needed before any similar change is made. We must ensure that people with Medicaid are not at risk of losing access to needed services and providers through funding or other changes.

Small non-profit helps lower price of some ineffective drugs

Caroline Humer reports for **Reuters** on the value of the Institute for Clinical and Economic Review (ICER) in holding drug prices down. ICER is a small not-for-profit research organization that determines the value of particular drugs and what they should cost. ICER has been effective at helping to lower the price of some prescription drugs.

Most other wealthy countries partner with independent research organizations like ICER to set prices for virtually all prescription drugs. The US government does not have its own agency or a partnership with an independent agency that determines the value of drugs. In this research vacuum, ICER has developed influence.

For example, some people thought that Gilead could charge as much as $10,000 for **remdesivir** because it was found to be helpful in treating COVID-19 patients. But ICER said that the drug did not justify a price of more than $5,000. Gilead ended up charging $5,700 for a ten-day supply.

ICER's budget is not large enough to establish the value of all drugs or even most drugs. But, some say it has helped reduce the cost of almost 100 drugs. And, some health insurers keep off of their formularies certain drugs that ICER deems do not offer good value.

Drugs that ICER has determined cost way too much and are not cost-effective include Aubagio, for the treatment of multiple sclerosis, Ninlaro, for the treatment of multiple myeloma, Austedo, for the treatment of Huntington's disease, and Rebif, an anti-inflammatory for the treatment of multiple sclerosis.

Not surprisingly, the pharmaceutical industry is not accepting ICER's influence, which is reducing its profits. It is attacking the non-profit **any way it can**. Often, it relies on **non-profits that are funded by pharmaceutical companies** to attack ICER.

ICER's goal is simply to help insurers and other prescription drug purchasers choose drugs that are cost-effective for a given condition, assessing the drug's price and benefit to quality of life. To establish the fair value of a drug, it relies on a time-tested formula, QALY or quality-adjusted life year, what it costs to extend someone's life with one year of good health. That is what other countries' health systems do.

The federal government does not negotiate drug prices for Medicare or Medicaid. In fact, Congress forbade the federal government from using QALY to negotiate drug prices. ICER has been taking on that role, in a way.

Unfortunately, the pharmaceutical industry holds so much sway over pharmacies and other health care providers that CVS Health Corp was not successful at keeping drugs, which ICER has determined are not cost effective, off its formulary for employers.

ICER plans to look at prices for the novel coronavirus vaccine and COVID- 19 treatments with the goal of helping to ensure they are fair.

Cory Gardner's Bill Has as Much to Do With Politics as Preexisting Conditions

Sen. Cory Gardner (R-Colo.) said he authored legislation "to guarantee coverage to people with pre-existing conditions — no matter what happens to Obamacare."

Sen. Cory Gardner, a Republican running in a tight race for reelection in Colorado, says he wants to protect people with medical conditions.

In a mid-September tweet released by his campaign, he promoted legislation he introduced in August that he says will do just that.

"People like my mother who battle chronic diseases are heroes," read the **tweet**. "I authored the bill to guarantee coverage to people with pre-existing conditions — no matter what happens to Obamacare — because some things matter more than politics."

Gardner has voted repeatedly to repeal the Affordable Care Act, the first federal law to guarantee people with health problems that they could buy insurance when shopping for their own coverage — at the same cost as for healthier consumers.

Polls show **broad public support** for keeping the ACA's preexisting condition protections, while also indicating a consistent, if narrow, majority **favoring** the overall law.

The popularity of those protections has led Gardner, as well as other **GOP candidates** facing tough challengers, to swear their allegiance to protecting people with medical conditions, despite their records. In previous fact checks, we found Sen. Martha McSally's promise always to protect preexisting conditions to be False. President Donald Trump also has made related statements, which have ranged from **False** to **Pants on Fire**.

That got us thinking: Would Gardner's legislation, dubbed "The Pre-Existing Conditions Protection Act," actually guarantee these protections if the ACA didn't exist? We decided to investigate.

The **bill**, which was introduced in August, still has no co-sponsors. It's very short, only 117 words in total.

The main section is a single very long sentence: "A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any pre-existing condition exclusion with respect to such plan or coverage, factor health status into premiums or charges, exclude benefits relating to pre-existing conditions from coverage, or otherwise exclude benefits, set limits, or increase charges based on any pre-existing condition or health status."

We reached out to the Gardner campaign to ask for more information.

A campaign spokesperson reiterated in an email that Gardner's goal is "to guarantee coverage for individuals with preexisting conditions and ensure they cannot be charged more as a result of their underlying medical conditions."

Thomas Miller, a resident fellow at the **American Enterprise Institute**, a think tank in Washington, D.C., quipped that the main goal might be something else entirely.

"It's probably about 100 words too long," Miller said. "It could have said, 'I'm running for election. I'll do whatever is necessary.'"

Past Votes, Present Messages

Proponents of the ACA emphasized that the law would help people with medical conditions as they worked to get it passed by Congress, which happened in 2010 following a yearlong failed effort by Democrats to win Republican support. Among a host of other provisions, the law bars insurers from rejecting applicants with medical conditions, as they routinely did when considering individual applicants before the law passed. Nor can insurers charge the sick more than the healthy.

Since the law went into effect in 2014, it has faced many efforts by Republicans in Congress, including Gardner, to repeal it.

It has also faced three Supreme Court challenges. It survived the first two, although one ruling allowed states to opt out of its expansion of Medicaid programs for the poor. The still-pending case was first brought in 2018 by 20 states and is supported by the Trump administration. That case could **overturn the entire law**, although the court won't hear arguments on the issue before the election...**Read More**

What is Fall Open Enrollment?

Dear Marci

Dear Marci,
I enrolled in Medicare about six months ago. My friend told me that the Fall Open Enrollment Period for Medicare is coming up. What is Fall Open Enrollment, and is there anything I need to do during this time?
-April (Montpelier, VT)

Dear April,

Fall Open Enrollment runs from October 15 through December 7 each year. During this time, you can make changes to your health insurance coverage, including adding, dropping, or changing your Medicare coverage. Even if you are happy with your current health and drug coverage, Fall Open Enrollment is the time to review what you have, compare it with other options, and make sure that your current coverage still meets your needs for the coming year.

You can make as many changes as you need to your Medicare coverage during Fall Open Enrollment. The changes you can make include:

1. Joining a new Medicare Advantage Plan
2. Joining a new Part D prescription drug plan
3. Switching from Original Medicare to a Medicare Advantage Plan

Switching from a Medicare Advantage Plan to Original Medicare (with or without a Part D plan)

Regardless of how you receive your Medicare coverage, you should consider:

- Your access to health care providers you want to see
- Your access to preferred pharmacies
- Your access to benefits and services you need

The total costs for insurance premiums, deductibles, and cost-sharing amounts

If you have Original Medicare, visit **www.medicare.gov** or read the 2021 Medicare & You handbook to learn about Medicare's benefits for the upcoming year. You should review any increases to Original Medicare premiums, deductibles, and coinsurance charges.

If you have a Medicare Advantage Plan or a stand-alone Part D plan, read your plan's Annual Notice of Change (ANOC) and/or Evidence of Coverage (EOC). Review these notices for any changes in:

- The plan's costs
- The plan's benefits and coverage rules

The plan's formulary (list of drugs your plan covers)

Make sure that your drugs will still be covered next year and that your providers and pharmacies are still in the plan's network. If you are unhappy with any of your plan's changes, you can enroll in a new plan. If you want assistance reviewing your options, contact your State Health Insurance Assistance Program (SHIP) for unbiased counseling. To contact your SHIP, visit **www.shiptacenter.org** or call 877-839-2675.

Even if you are happy with your current Medicare coverage, consider other Medicare health and drug plan options in your area. For example, even if you do not plan to change your Medicare Advantage or Part D plan, you should check to see if there is another plan in your area that will offer you better health and/or drug coverage at a more affordable price. Research shows that people with Medicare prescription drug coverage could lower their costs by shopping among plans each year; there could be another Part D plan in your area that covers the drugs you take with fewer restrictions and/or lower prices.

-Marci

A Pandemic Upshot: Seniors Are Having Second Thoughts About Where to Live

Alissa Ballot, 64, is planning to leave her 750-square-foot apartment in downtown Chicago and put down roots in a multigenerational cohousing community where neighbors typically share dining and recreation areas and often help one another.

"What I've learned during this pandemic is that personal relationships matter most to me, not place," she said.

Kim Beckman, 64, and her husband, Mike, were ready to give up being homeowners in Victoria, Texas, and join a 55-plus community or rent in an independent living apartment building in northern Texas before COVID-19 hit.

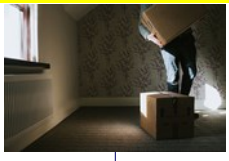
Now, they're considering buying an even bigger home because "if you're going to be in the house all the time, you might as well be comfortable," Beckman said.

"Everyone I know is talking about this," said Wendl Kornfeld, 71, who lives on the Upper West Side of Manhattan. She has temporarily tabled the prospect of moving into a continuing care retirement community being built in the Bronx.

"My husband and I are going to play it by ear; we want to see how things play out" with the pandemic, she said.

In Kornfeld's circles, people are more committed than ever to staying in their homes or apartments as long as possible — at least at the moment. Their fear: If they move to a senior living community, they might be more likely to encounter a COVID outbreak.

"All of us have heard about the huge number of deaths in senior facilities," Kornfeld said. But people who stay in their own homes may have trouble finding affordable help there when needed, she acknowledged….**Read More**



Questions to Ask

For those able to consider senior housing, experts suggest you ask several questions:

- How is the facility communicating with residents and families? Has it had a COVID outbreak? Is it disclosing COVID cases and deaths? Is it sharing the latest guidance from federal, state and local public health authorities?
- What protocols have been instituted to ensure safety? "I'd want to know: Do they have a plan in place for disasters — not just the pandemic but also floods, fires, hurricanes, blizzards?" Milner said. "And beyond a plan, do they have supplies in place?"
- How does the community engage residents? Is online programming — exercise classes, lectures, interest group meetings — available? Are one-on-one interactions with staffers possible? Are staffers arranging online interactions via FaceTime or Zoom with family? Are family visits allowed? "Social engagement and stimulation are more important than ever," said David Schless, president of the American Seniors Housing Association.
- What's the company's financial status and occupancy rate? "Properties with occupancy rates of 90% or higher are going to be able to withstand the pressures of COVID-19 significantly more than properties with occupancy below 80%, in my opinion," said Mace of the National Investment Center for Seniors Housing & Care. Higher occupancy means more revenues, which allows institutions to better afford extra expenses associated with the pandemic.

"Transparency is very important," Schless said.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Wildfires' Toxic Air Leaves Damage Long After the Smoke Clears

SEELEY LAKE, Mont. — When researchers arrived in this town tucked in the Northern Rockies three years ago, they could still smell the smoke a day after it cleared from devastating wildfires. Their plan was to chart how long it took for people to recover from living for seven weeks surrounded by relentless smoke.

They still don't know, because most residents haven't recovered. In fact, they've gotten worse.

Forest fires had funneled hazardous air into Seeley Lake, a town of fewer than 2,000 people, for 49 days. The air quality was so bad that on some days the monitoring stations couldn't measure the extent of the pollution. The intensity of the smoke and the length of time residents had been trapped in it were unprecedented, prompting county officials to issue their first evacuation orders due to smoke, not fire risk.

Many people stayed. That made Seeley Lake an ideal place to track the long-term health of people inundated by wildfire pollution.

So far, researchers have found that people's lung capacity declined in the first two years after the smoke cleared. **Chris Migliaccio,** an immunologist with the University of Montana, and his team found the percentage of residents whose lung function **sank below normal thresholds** more than doubled in the first year after the fire and remained low a year after that.

"There's something wrong there," Migliaccio said.

While it's long been known that smoke can be dangerous when in the thick of it — triggering asthma attacks, cardiac arrests, hospitalizations and more — the Seeley Lake research confirmed what public health experts feared: Wildfire haze can have consequences long after it's gone.

That doesn't bode well for the **78 million people** in the western United States now confronting historic wildfires.

Toxic air from fires has blanketed California and the Pacific Northwest for weeks now, causing some of the **world's worst air quality**. California fires have burned roughly **2.3 million acres** so far this year, and the wildfire season isn't over yet. Oregon **estimates 500,000 people** in the state have been under a notice to either prepare to evacuate or leave. Smoke from the West Coast blazes has drifted as far away as **Europe.**

Extreme wildfires are predicted to become a regular occurrence due to climate change. And, as more people increasingly settle in **fire-prone places**, the risks increase. That's shifted wildfires from being a perennial reality for rural mountain towns to becoming an annual threat for areas across the West.

Dr. **Perry Hystad**, an associate professor in the College of Health and Human Sciences at Oregon State University, said the Seeley Lake research offers unique insights into wildfire smoke's impact, which until recently had largely been unexplored. He said similar studies are likely to follow because of this fire season.

"This is the question that everybody is asking," Hystad said. "'I've been sitting in smoke for two weeks, how concerned should I be?'"...Read More

In Face of COVID Threat, More Dialysis Patients Bring Treatment Home

NIPOMO, Calif. — After Maria Duenas was diagnosed with Type 2 diabetes about a decade ago, she managed the disease with diet and medication.

But Duenas' kidneys started to fail just as the novel coronavirus established its lethal foothold in the U.S.

On March 19, three days after Duenas, 60, was rushed to the emergency room with dangerously high blood pressure and blood sugar, Gov. Gavin Newsom implemented the nation's first statewide stay-at-home order.

Less than one week later, Duenas was hooked up to a dialysis machine in the Century City neighborhood of Los Angeles, 160 miles from her Central Coast home, where tubes, pumps and tiny filters cleansed her blood of waste for 3½ hours, doing the work her kidneys could no longer do.

In the beginning, Duenas said she didn't understand the severity of COVID-19, or her increased vulnerability to it. "It's not going to happen to me," she thought. "We're in a small little town."

But she was unable to find a spot in a dialysis clinic in, or near, Nipomo. So, with her husband, Jose, at her side, Duenas made long road trips to Century City for more than two months.

In May, Duenas' doctor told her she was a good candidate for home dialysis, which would save her drive time and stress — and reduce her exposure to the virus.

Now, Duenas assiduously sterilizes herself and her surroundings five nights a week so she can administer dialysis to herself at home while she sleeps.

"There's always a chance going in that somebody's going to have COVID and still need dialysis" in a clinic, Duenas said. "I'm very grateful to have this option."

The increase in home dialysis has accelerated recently, spurred by social-distancing requirements, increased use of telehealth and remote monitoring technologies — and fear of the virus. While recent, comprehensive data is hard to come by, experts confirm the trend based on what they're seeing in their own practices. Fresenius Medical Care North America, one of the country's two dominant dialysis providers, said it conducted 25% more home dialysis training sessions in the first quarter of 2020 than in the same period last year, according to **Renal & Urology News.**

"People recognized it would be better if they did it at home," said Dr. Susan Quaggin, president-elect of the American Society of Nephrology. "And certainly from a health provider's perspective, we feel it's a great option."

Nearly **half a million** people in the United States are on dialysis, according to the National Institute of Diabetes and Digestive and Kidney Diseases. **Roughly 85%** of them travel to a clinic for their treatments.

Dialysis patients are at higher risk of contracting COVID-19 and getting seriously ill with it, said Dr. Anjay Rastogi, director of the UCLA CORE Kidney Program, where Duenas is a patient.

In an analysis of more than 10,000 deaths in 15 states and New York City, the Centers for Disease Control and Prevention found about **40% of people** killed by COVID-19 had diabetes. That percentage rose to half among people under 65.

But people on dialysis are also vulnerable to COVID-19 because they usually visit dialysis clinics two to three times a week for an average of four hours at a time, exposing themselves to other patients and, potentially, the virus, Rastogi said.

"Now even more so, we are strongly urging our patients to consider home dialysis," he said….**Read More**

Obesity associated with a higher risk for dementia, new study finds

A recent NIA-supported study published in the *International Journal of Epidemiology* suggests that obesity may be associated with an increased risk for developing dementia. Obesity, like cardiovascular disease and stroke, is a modifiable risk factor for dementia since it generally can be countered through lifestyle changes such as diet and exercise.

For the study, researchers at University College London analyzed a group of participants from the English Longitudinal Study of Ageing (ELSA) who were at least 50 years old when enrolled in the study. Baseline measurements, including body mass index (BMI) and waist circumference, were collected when the participants enrolled. The participants were followed up on average 11 years later to determine whether they had developed dementia.

The researchers found that participants who had a BMI corresponding with overweight or obese were more likely to develop dementia. This outcome supports previous studies that indicate obesity is a risk factor. The research team also found that abdominal obesity, associated with high waist circumference, at baseline is a risk factor that affects women more than men. In addition, the study found that the association between obesity and dementia was independent of whether a person was a smoker, had hypertension or diabetes, or carried the *APOE* ε4 gene, a genetic risk factor for Alzheimer's disease and related dementias.

Obesity continues to be a major public health issue across the world, so further study could help determine whether early interventions and lifestyle changes could reduce dementia risk. There is also a need to understand the mechanism by which obesity increases the risk for dementia, such as through inflammation or genetic factors. Subsequent studies should involve frequent check-ins to monitor the development of dementia and potentially find common symptoms or factors among obese participants.

Next Steps After an Alzheimer's Diagnosis

A diagnosis of Alzheimer's disease can be difficult, but getting accurate information and support can help you know what to expect and what to do next. Use this checklist to help you get started.

Get regular medical care

Make regular **appointments** with your primary care doctor or specialist (neurologist, neuropsychiatrist, geriatric psychiatrist).

Consider going to a memory disorders clinic. Ask your doctor for a referral if desired.

Find local services and support

Find local services by contacting **Eldercare Locator**: 800-677-1116

Find local chapters, organizations, and support groups through the **Alzheimer's Association** (800-272-3900) or the **Alzheimer's Foundation of America** (866-232-8484)

Contact your local Alzheimer's Disease Research Center

Do some legal, financial, and long-term care planning

Get information to help you plan.

Prepare or update your will, living will, health care power of attorney, and financial power of attorney. To find a lawyer, contact your local bar association or the **National Academy of Elder Law Attorneys.**

Learn about care you may need in the future and how to pay for it.

Explore getting help to pay for medicines, housing, transportation, and more.

Get help as needed with day-to-day tasks

- Use simple memory aids like a notepad or sticky notes to jot down reminders, a pillbox to keep medications organized, and a calendar to record appointments.
- Ask family members or friends or find local services to help with routine tasks, such as cooking, paying bills, transportation, or shopping.
- Consider using technology solutions for medication management, safety (e.g., emergency response, door alarms), and other care.

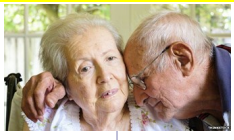
See tips about coping daily, changes in relationships, and more.

Be safe at home

Get home-safety tips.

- Ask your doctor to order a home-safety evaluation and recommend a home health care agency to conduct it. Medicare may cover the cost.

Consider wearing a medical ID bracelet or necklace in case you get lost or need help, or joining the **MedicAlert and Alzheimer's Association's Wandering Support program.**



Stay safe on the road

- Talk with your doctor if you become confused, get lost, or need lots of help with directions, or if others worry about your driving.

Get a driving evaluation. Ask your doctor for names of driving evaluators, or visit the **American Occupational Therapy Association.**

Learn about driving safety.

Consider participating in a clinical trial

- Ask your doctor about trials or studies.
- Contact an **Alzheimer's Disease Research Center** for assessment and potential research opportunities.
- Search for a clinical trial or study near you:
- **NIA Clinical Trials Finder**
- Learn more about clinical trials:

NIA Clinical Trials Information

National Institutes of Health

Stay healthy

Be active! Getting exercise helps people with Alzheimer's feel better and helps keep their muscles, joints, and heart in good shape.

Eat a well-balanced diet that includes fruits, vegetables, and whole grains.

Continue to enjoy visits with family and friends, hobbies, and outings.

If you live alone

- Identify someone who can visit you regularly and be an emergency contact.
- If you are at risk of falling, order an emergency response system. A special pendant or bracelet lets you summon help if you fall and can't reach the phone.
- Consider working with an occupational therapist. This person can teach you ways to stay independent. Ask your doctor for more information.
- Stick with familiar places, people, and routines. Simplify your life.
- **Get tips about self-care, safety, staying connected, and more.**
- If you are working
- If you have problems performing your job, consider reducing your hours or switching to a less demanding position.
- Consider consulting your employer's HR department or employee assistance program about family leave, disability benefits, and other employee benefits.

Find out if you qualify for Social Security disability benefits through "compassionate allowances." Call 800-772-1213.

Print the next step after an Alzheimer's diagnosis guide

Fall Risk Rises Even in Alzheimer's Early Stages

(HealthDay News) -- In older people a fall can sometimes be a sign of oncoming Alzheimer's disease, even in the absence of mental issues, new research suggests.

Although falls are common among older people, in some cases they can be a sign of hidden mental problems that can lead to dementia, according to researchers at Washington University School of Medicine in St. Louis.

Older people who have had falls should be screened for Alzheimer's, the study authors said.

"In the world of fall research, we generally say that you're at risk of falling if you lose strength and balance," said co-senior author Susan Stark. She's an associate professor of occupational therapy, neurology and social work.

"If you lose strength and balance, the recommended treatment is to work on strength and balance. But if someone is falling for another reason, maybe because his or her brain has begun accumulating Alzheimer's-related damage, that person might need a different treatment entirely," she explained in a university news release.

Stark said it's not yet clear what that treatment might be, but researchers hope the information will lead to new recommendations to reduce the risk of falls.

For the study, the researchers followed 83 people over age 65 for one year. All participants had normal thinking and memory at the outset, and kept monthly calendars recording any falls. Each person had brain scans to look for amyloid plaque (which has been tied to Alzheimer's) and signs of brain shrinkage.

The researchers found that amyloid in the brain alone did not put people at increased risk of falling, but neurodegeneration (brain shrinkage) did.

Participants who fell had smaller hippocampi brain regions devoted to memory. Those regions shrink in Alzheimer's. Brain networks involved in receiving sensory inputs and controlling movement also showed signs of decay, the findings showed.

Co-senior author Dr. Beau Ances, a professor of neurology and radiology and biomedical engineering, said, "Since I started working on this project, I've started asking my patients about falls, and I can't tell you how often that has helped me start understanding what is going on with the individual."

When mobility is being diminished, it could be a sign that something needs a closer look, Ances said.

Stark said a lot of falls can be prevented by simple changes in the environment. They include making sure the tub or shower isn't slippery; making sure a senior can get up easily off the toilet; balance and strength training; and reviewing prescriptions to see if any increase the risk of falling.

"Until we have specific fall-prevention treatments for people with preclinical Alzheimer's, there are still plenty of things we can do to make people safer," she said.

Battle Rages Inside Hospitals Over How COVID Strikes and Kills

Front-line health care workers are locked in a heated dispute with many infection control specialists and hospital administrators over how the novel coronavirus is spread — and therefore, what level of protective gear is appropriate.

At issue is the degree to which the virus is airborne — capable of spreading through tiny aerosol particles lingering in the air — or primarily transmitted through large, faster-falling droplets from, say, a sneeze or cough. This wonky, seemingly semantic debate has a real-world impact on what sort of protective measures health care companies need to take to protect their patients and workers.

The Centers for Disease Control and Prevention injected confusion into the debate Friday with guidance putting new emphasis on airborne transmission and saying the tiny aerosol particles, as well as larger droplets, are the "main way the virus spreads." By Monday that language was gone **from its website**, and the agency explained that it had posted a "draft version of proposed changes" in error and that experts were still working on updating "recommendations regarding airborne transmission."

Dr. Anthony Fauci, the top U.S. infectious disease expert, addressed the debate head-on in a **Sept. 10 webcast** for the Harvard Medical School, pointing to scientists specializing in aerosols who argued the CDC had "really gotten it wrong over many, many years."

"Bottom line is, there's much more aerosol [transmission] than we thought," Fauci said.

The topic has been deeply divisive within hospitals, largely because the question of whether an illness spreads by droplets or aerosols drives two different sets of protective practices, touching on everything from airflow within hospital wards to patient isolation to choices of protective gear. Enhanced protections would be expensive and disruptive to a number of industries, but particularly to hospitals, which have fought to keep lower-level "droplet" protections in place.

The hospital administrators and epidemiologists who argue that the virus is mostly droplet-spread cite studies that show it spreads to a small number of people, like a cold or flu. Therefore, N95 respirators and strict patient isolation practices aren't necessary for routine care of COVID-19 patients, those officials say.

On the other side are many occupational safety experts, aerosol scientists, front-line health care workers and their unions, who are quick to note that the novel coronavirus is far deadlier than the flu — and argue that the science suggests that high-quality, and costlier, N95 respirators should be required for routine COVID-19 patient care.

The highly protective respirators have been in short supply nationwide and have soared in price, from about $1 to $7 each. Meanwhile, research has shown high rates of asymptomatic virus transmission, putting N95s in high demand among front-line health care workers in virtually every setting.

The debate has come to a head at hospitals from coast to coast, as studies have emerged showing that live virus hangs in COVID-19 patients' hospital rooms even in the absence of "aerosol-generating" procedures (such as intubations or breathing treatments) and has contributed to outbreaks at a **nursing home, shuttle bus** and **choir practice.**

KHN and The Guardian U.S. **are examining** more than 1,200 health care worker deaths from COVID-19, including many in which their family or colleagues reported they worked with inadequate personal protective gear.

Yet some front-line workers and managers disagree about exactly how and why health care workers are getting sick.

The hospital infection-control and epidemiology leaders cite studies suggesting that many health care workers are contracting the **virus outside of work** and at rates that mirror what's happening in their communities.

A group of **Penn Medicine epidemiologist**s in late July characterized research on aerosol transmission as unconvincing and cited "extensive published evidence from across the globe" showing the "overwhelming majority" of coronavirus spread is "via large respiratory droplets."...**Read More**