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RIAFL-CIO

AMERICAN FEDERATION OF LABOR & CONGRESS OF INDUSTRIAL ORGANIZATIONS
AFL CIO

Nowadays, many think of the Labor Day holiday in the U.S., which falls on the first Monday in September as a day for cookouts or shopping deals. But its origins date back to two gatherings of another, more politically motivated sort.

One was a "monster labor festival" featuring of a parade of unions and accompanying picnic, which took place on Sept. 5, 1882, in a New York City park. That gathering is thought to have attracted as many as 10,000 marchers, according to Linda Stinson, a former Department of Labor historian. They listened to speeches in support of workers' rights, and — in lighthearted activities more in the spirit of what goes on today — people drank beer, danced and set off fireworks.

The other event was a darker one. On May 11, 1894, in a company town outside Chicago, employees of the railway sleeping car mastermind George Pullman went on strike when their wages didn't go up after the economy tanked. In a show of solidarity, the American Railway Union — said to have boasted 150,000 members at the time and led by famous socialist Eugene Debs — refused to operate Pullman train cars, snarling mail delivery and prompting President Grover Cleveland to send in federal troops to break up the strike. Rioting and arson broke out, and it evolved into what's now considered one of the bloodiest episodes in American labor history.

A national Labor Day holiday was declared within months.

Some experts say Cleveland supported the idea of such a holiday, which already existed in several states, in an effort to make peace with the unions before he ran for re-election. (He would lose anyway.) But perhaps one of the most eloquent explanations of why the federal government saw fit to declare the holiday can be found in a Congressional committee report on the matter.

Sen. James Henderson Kyle of South Dakota introduced a bill, S. 730, to Congress shortly after the Pullman strike, proposing Labor Day be the first Monday in September. Here's how Rep. Lawrence McGann (D-IL), who sat on the Committee on Labor, argued for the holiday in a report submitted on May 15, 1894:

The use of national holidays is to emphasize some great event or principle in the minds of the people by giving them a day of rest and recreation, a day of enjoyment, in commemoration of it. By making one day in each year a public holiday for the benefit of workingmen the equality and dignity of labor is emphasized. Nothing is more important to the public weal than that the nobility of labor be maintained. So long as the laboring man can feel that he holds an honorable as well as useful place in the body politic, so long will he be a loyal and faithful citizen.

The celebration of Labor Day as a national holiday will in time naturally lead to an honorable emulation among the different crafts beneficial to them and to the whole public. It will tend to increase the feeling of common brotherhood among men of all crafts and callings, and at the same time kindle an honorable desire in each craft to surpass the rest.

There can be no substantial objection to making one day in the year a national holiday for the benefit of labor. The labor organizations of the whole country, representing the great body of our artisan population, request it. They are the ones most interested. They desire it and should have it. If the farmers, manufacturers, and professional men are indifferent to the measure, or even oppose it, which there is no reason to believe, that still would constitute no good objection, for their work can be continued on holidays as well as on other days if they so desire it. Workingmen should have one day in the year peculiarly their own. Nor will their employers lose anything by it. Workingmen are benefited by a reasonable amount of rest and recreation. Whatever makes a workingman more of a man makes him more useful as a craftsman.

President Grover Cleveland signed the bill into law on June 28, 1894.

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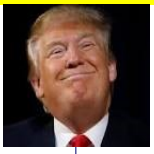
Most People Are Unlikely to See Drug Cost Savings From President Trump's "Most Favored Nation" Proposal

On July 24, 2020, President Trump signed four executive orders related to prescription drug costs. All four orders will require regulatory action by the Administration before they can be implemented. Three of the four executive orders were released publicly – one pertaining to **prescription drug importation**, one pertaining to Medicare Part D **drug rebates**, and one pertaining to the **cost of insulin and injectable epinephrine in federally qualified health centers.** The fourth executive order, referred to by the President as the "most favored nation" proposal, that uses international reference prices to lower drug costs in the U.S., was not released with the others. Instead, the President announced he would give pharmaceutical companies 30 days to come up with an alternative approach before that order would take effect.

Those 30 days have now passed, and the executive order has still not been released. According to **press reports**, the pharmaceutical industry has put together an alternative proposal, but it is not known whether the proposal has been presented to the White House, nor whether the President will accept the industry's proposal and drop the "most favored nation" proposal. The President has continued to **tweet** and talk about this proposal, including at some length on the opening day of the Republican National Convention. **According to the President's** statement at the signing ceremony, the executive order would ensure that the U.S. pays no more for pharmaceuticals than other countries.



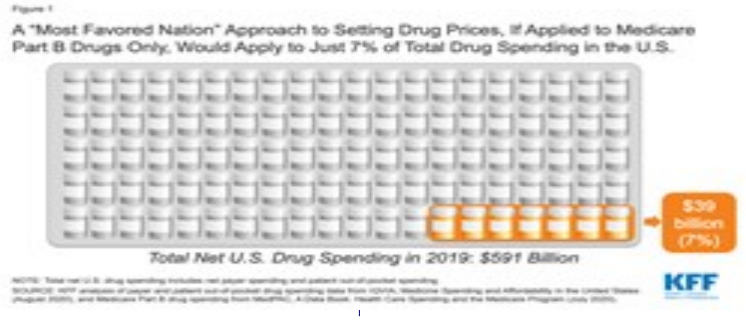
While the content of this executive order has not been released to the public, a portion of the **text that was captured by a photographer** during the President's signing ceremony indicates that it may be similar to a proposal announced by the Administration in October of 2018 in an advance notice of proposed rulemaking (ANPRM). Under the 2018 proposal, Medicare would test a model that uses lower drug prices from several foreign countries to set payments for drugs that are covered under Medicare Part B, with the aim of **paying 126% of what other countries pay, down from 180% currently**. Medicare Part B covers a limited set of prescription drugs that are administered in outpatient settings, such as physician offices and hospital outpatient departments, mainly high-cost drugs used to treat serious illnesses such as cancer or rheumatoid arthritis. As proposed, the model would have no direct impact on the price of drugs covered under Medicare Part D or private insurance.

If the new executive order is similar to the 2018 proposal, and applies only to Medicare Part B drug spending, it would apply to just 7% of total national spending on prescription drugs, according to our analysis (Figure 1).

If a "most favored nation" approach was limited to setting prices for prescription drugs covered by Medicare Part B only, it could lower drug costs for approximately **4 million Medicare beneficiaries**, based on the number of people who used Part B drugs in 2018 (just 7% of all 60 million beneficiaries covered by Medicare). However, it would have no direct impact on the lion's share of drug spending under Medicare for prescriptions filled by the **45 million beneficiaries covered under Medicare Part D**, nor would it lower drug costs for the 157 **million people** with employer coverage or for millions more with other insurance coverage or no coverage whatsoever.

Methods

To calculate the share of total drug spending accounted for by Medicare Part B drug spending, we used data from IQVIA, **Medicine Spending and Affordability in the United States: Understanding Patients' Costs for Medicines** (August 2020) and MedPAC, **A Data Book: Health Care Spending and the Medicare Program** (July 2020). According to IQVIA, total net payer spending on prescription drugs in 2019, including both retail and non-retail settings, was $509 billion, and patient out-of-pocket spending on drugs, both retail and non-retail, was an additional $82 billion, for a total of $591 billion in total net payer and patient drug spending in 2019. According to MedPAC, Medicare Part B drug spending was $35 billion in 2018. We trended this 2018 estimate forward to 2019 using the 11% average annual growth rate in Part B spending between 2009 and 2018, as reported by MedPAC, to derive an estimated Part B drug spending amount for 2019 of $39 billion. This $39 billion estimate formed the numerator and the $591 billion IQVIA estimate formed the denominator for our calculation of total drug spending accounted for by Medicare Part B drug spending in 2019.



Defying Reality, Postmaster General Denies Purposefully Weakening Mail-In VotingSystem

The House passed a bill on Saturday to grant $25 billion to the USPS and ban operational changes that have slowed mail service around the country. Over two dozen Republicans joined Democrats in support of the bill, and the Delivering for America Act (H.R. 8015) **passed by a vote of 257-150.**

The bill was introduced due to a number of policy changes the Administration made to the USPS. Among those changes were removing high-volume sorting machines from USPS facilities, disallowing overtime for employees, and taking away mail boxes.

Postmaster General **Louis DeJoy** has failed to provide a report that would back up his claim that changes began earlier in the year due to the onset of Coronavirus, furthering allegations that these changes were made after he took the job to affect mailed ballots during election season.

In his testimony on Monday before the U.S. House, DeJoy vehemently **denied** making any of these changes, saying, "I am not engaged in sabotaging the election." He even refused to acknowledge the removal of sorting machines despite ample evidence. He said he was unaware of who was responsible for those changes, and refused to commit that he would reverse them.

Joseph Peters, Jr.
ARA Security-Treasurer

"Senate Majority Leader **Mitch McConnell** (KY) needs to bring the House bill up for a vote now," said **Joseph Peters, Jr.**, Secretary-Treasurer of the Alliance. "Not doing so will prevent citizens from getting vital packages like medications and amounts to voter suppression during election season."

CMS agrees to cover 'breakthrough' medical devices

Medicare patients will have coverage for medical devices the FDA designates as breakthrough technology under a proposed rule released this morning.

Once the Medicare Coverage of Innovative Technology (MCIT) final rule goes into effect, national Medicare coverage will begin on the date of a breakthrough device's FDA market authorization would begin and continue for 4 years.

The **proposed rule**, scheduled to be published September 1 in the Federal Register, has been under discussion for years and would remedy a nationwide patchwork of Medicare coverage for such devices. Currently, a breakthrough device may be covered in one state or area of a state and not another, depending upon a local coverage determination made by a Medicare administrative contractor.

The MCIT pathway would be voluntary and device manufacturers would notify the Centers for Medicare and Medicaid Services if they want to use this coverage option.

"This coverage pathway delivers on the Administration's commitment to give Medicare beneficiaries access to the newest innovations on the market, consistent with the statutory definitions of Medicare benefits," U.S. Department of Health and Human Services administrator Alex Azar said in the proposed rule.

Medtech trade group AdvaMed hailed the publication of the proposed rule as a big step in a long struggle by the industry.

"In order to incentivize innovative medical breakthroughs, the federal government must ensure those breakthrough technologies are covered by Medicare," said AdvaMed President and CEO Scott Whitaker in an email to ***MassDevice***. "We are pleased that this proposed rule gets us closer to this goal, as it would help ensure the patients who need these innovative technologies have access to them."

MCIT-covered devices would also have to fit Medicare statutory definitions of "reasonable and necessary" for treating patients. To that end, the proposed rule would refine the definitions of "reasonable and necessary." Among the requirements, devices would need to be considered:

- Safe and effective.
- Not experimental or investigational.
- Appropriate for Medicare patients, including the duration and frequency that is considered appropriate and whether it is covered by commercial insurers.

"Stakeholders have expressed interest in codifying a definition of 'reasonable and necessary' for many years," Azar said in the proposed rule. "This proposed definition is familiar and functional, can satisfy that interest and meet (an October 2019 executive order to make Medicare coverage of breakthrough devices widely available) while also aligning with the goals of MCIT by providing clarity and predictability for innovation, including for beneficiaries and innovators."

CMS will accept public comment on the proposed rule through October 30, 2020.

Health Officials Worry Nation's Not Ready for COVID-19 Vaccine

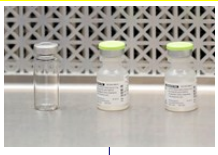
Millions of Americans are counting on a COVID-19 vaccine to curb the global pandemic and return life to normal.

While one or more options could be available **toward the end of this year** or early next, the path to delivering vaccines to 330 million people remains unclear for the local health officials expected to carry out the work.

"We haven't gotten a lot of information about how this is going to roll out," said Dr. Umair Shah, executive director of Texas' Harris County Public Health department, which includes Houston.

In a **four-page memo** this summer, the federal Centers for Disease Control and Prevention told health departments across the country to draft vaccination plans by Oct. 1 "to coincide with the earliest possible release of COVID-19 vaccine."

But **health departments** that have been **underfunded for decades** say they currently lack the staff, money and tools to educate people about vaccines and then to distribute, administer and track hundreds of millions of doses. Nor do they know when, or if, they'll get federal aid to do that.



Dozens of doctors, nurses and health officials interviewed by KHN and The Associated Press expressed concern about the country's readiness to conduct mass vaccinations, as well as frustration with months of inconsistent information from the federal government.

The gaps include figuring out how officials will keep track of who has gotten which doses and how they'll keep the workers who give the shots safe, with enough protective gear and syringes to do their jobs.

With **only about half** of Americans saying they would get vaccinated, according to a poll from AP-NORC Center for Public Affairs Research, it also will be crucial to educate people about the benefits of vaccination, said Molly Howell, who manages the North Dakota Department of Health's immunization program.

The unprecedented pace of vaccine development has left many Americans skeptical about the safety of COVID-19 immunizations; others simply don't trust the federal government.

"We're in a very deep-red state," said Ann Lewis, CEO of CareSouth Carolina, a group of community health centers that serve mostly low-income people in five rural counties in South Carolina. "The message that is coming out is not a message of trust and confidence in medical or scientific evidence."

Paying for the Rollout

The U.S. has committed more than **$10 billion to develop new coronavirus vaccines** but hasn't allocated money specifically for distributing and administering vaccines.

And while states, territories and 154 large cities and counties received billions in congressional emergency funding, that money can be used for a variety of purposes, including testing and overtime pay.

An ongoing investigation by KHN and the AP has detailed how state and local public health departments across the U.S. have been starved for decades, leaving them **underfunded and without adequate resources** to confront the coronavirus pandemic. The investigation further found that federal coronavirus funds have been **slow to reach** public health departments, forcing some communities to cancel non-coronavirus vaccine clinics and other essential services.

States are allowed to use some of the federal money they've already received to prepare for immunizations. But KHN and the AP found that many health departments are so overwhelmed with the current costs of the pandemic — such as testing and contact tracing — that they can't reserve money for the vaccine work to come. Health departments will need to hire people to administer the vaccines and systems to track them, and pay for supplies such as protective medical masks, gowns and gloves, as well as warehouses and refrigerator space….**Read More**

New Data Show COBRA Enrollees Tend to Have Higher Health Care Needs

When people lose job-based insurance, they can in some cases keep their health insurance coverage because of COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985, which requires employers and insurers to make available a time-limited continuation of coverage, at the employee or former employee's expense. Not everyone who is eligible for COBRA purchases a plan. New **data** from the **Employee Benefit Research Institute** (EBRI) indicates those who do tend to have higher health care needs, spending, and utilization rates than people with employer-sponsored health insurance.

According to the report, which is based on previous EBRI **analysis**:

- **COBRA Enrollees are Older**. Among those with individual coverage, the average COBRA enrollee is 50 years old, while the average full-time covered employee is 42.6.
- **COBRA Enrollees Use Health Care More Frequently**. COBRA claimants are heavier users of both inpatient and outpatient services. They had almost five times more hospital days than those covered through work and filled nearly twice as many prescriptions.

- **COBRA Enrollees Have More Chronic Conditions**. People with COBRA are more likely than those with employer-based coverage to have certain chronic health conditions, such as COPD, diabetes, cancer, high blood pressure, high cholesterol, mental health disorders, and musculoskeletal disorders.
- **COBRA Enrollees Spend More on Health Care**. In 2018, full-time workers with individual employer-based coverage used an average of $6,724 in health care services, while those with COBRA used an average of $18,752. It's not immediately clear from the EBRI data if these amounts are total or out-of-pocket.

A **summary** of the underlying report notes these findings may be evidence of adverse selection, meaning those who need and use health coverage may be more likely than their peers to select COBRA. EBRI also states that subsidizing COBRA benefits for those who are newly eligible due to the COVID-19 crisis—as outlined in the House-passed HEROES Act—could improve the risk pool for COBRA claimants. That is, by making the policies more affordable, more people may be incentivized to select COBRA instead of other available coverage, such as through Medicaid, Medicare, or the Marketplace.

However, making COBRA cheaper would not automatically make it the best choice for everyone. This is especially true for people who are Medicare-eligible, for whom costly COBRA premiums are not the only factor that should be considered. For example, COBRA plans also tend to have more limited provider networks, higher deductibles and copayment obligations, and greater use of utilization management controls than Medicare. Further, because of **the way Medicare and COBRA interact**, people who delay Part B in reliance on COBRA can face lengthy coverage gaps, high out-of-pocket costs, and lifetime late enrollment penalties.

To make the right coverage choice for their unique circumstances, Medicare Rights encourages people who are losing their job-based insurance to carefully review all of their options. We strongly support the inclusion of strategies to empower such decision-making in any legislation that subsidizes COBRA. This critical protection was also included in the HEROES Act, and we urge lawmakers to maintain it in any final package.

Read the EBRI one-pager, ***COBRA Beneficiaries Are Less Healthy and Spend More.***

Read more about COBRA and Medicare from Medicare Interactive.

Though negotiations on the next COVID-19 relief bill are stalled, your lawmakers still need to hear from you. **Act Today! Ask your Senators to include key policies in the COVID relief bill**.

Post Office Delays Threaten Access to Mail-Order Medications

A **data note** by the Kaiser Family Foundation (KFF) shows possible trouble ahead for people with Medicare who rely on the US Postal Service (USPS) to deliver their prescription medications. Recent **changes at the USPS have begun to slow delivery of many types of mail**, and these delays threaten prescription drug access. Across the nation, there are reports of people **going without their medications**, which could have dire consequences for those with chronic or severe illnesses.

According to KFF, 17% of people with Medicare who used their Part D prescription drug coverage in 2018—around 7.3 million people—had at least one medication delivered via USPS. These numbers were up sharply in the first half of 2020, likely due to the COVID-19 pandemic. As a result, millions of beneficiaries currently rely on mail or pharmacies for timely delivery of their medications.

Consumers choose mail-order pharmacies for a host of reasons, including cost, access, safety, and convenience. For example, the Department of Veterans Affairs **makes widespread use of mail-order pharmacies**. Some Medicare plans encourage the use of mail-order pharmacies by offering large savings for using that option. This could leave people with those plans in a bind if they must switch to a retail pharmacy.

Retail pharmacies may also not be an option for people with limited mobility, transportation issues, and specialized or compounded drug needs. In addition, many people with Medicare fall into higher-risk categories for significant COVID-19 repercussions and may feel unsafe picking up their prescriptions in person.

At Medicare Rights, we are deeply concerned when people with Medicare, and others who rely on prescription medications, face dangerous delays in drug access that may put them at risk for severe consequences. Those who currently use mail-order delivery and want to investigate whether there are safe and affordable retail options should contact their drug plan directly. We recommend asking what local pharmacies are available and how any changes may impact current costs. Since transferring a prescription can take some time, it's best to begin this process with plenty of medication on hand.

Those who switch to a retail pharmacy may want to select one with delivery or curbside pickup options that make their location safe and accessible. While plans can generally provide this information, we suggest contacting potential retail pharmacies to verify it, in case any policies have recently changed.

Beneficiaries may also want to request a 90-day prescription, to minimize their exposure and the need for more frequent mail deliveries. Part D plans are generally required to allow these longer-term fills during the public health emergency. Again, we recommend making this request early and by contacting the plan directly.

Above all, we must work together to preserve safe and timely access to medications through the USPS. If you experience problems or have questions about your coverage, we encourage you to call our national helpline at 800-333-4114. You can also reach out to 1-800-Medicare or a **SHIP counselor** in your area.

Read more about the risk to Medicare beneficiaries' access to mail-order drugs.

The Postal Service and Prescription Drug Deliveries

As most people are aware the United States Postal Service (USPS) was in the headlines most of last week. While the primary issue was its ability to handle an increased number of mail-in ballots for the election, there were also reports that the delivery of some prescription drug and other medical supplies have been slowed, and some animals and plants arrived dead at their destinations because their delivery was delayed.

As far as we can tell the reports of prescription drugs arriving late were anecdotal and they were limited, and major pharmacies and pharmacy groups said they have not yet been impacted.

According to a report in *The Hill*, a newspaper in Washington, D.C., that reports primarily on Congressional news,

- "A Rite Aid spokesman said the company uses multiple vendor delivery partners and we are not experiencing delays."
- "An ExpressScripts spokeswoman also said the company was not currently experiencing any unusual delays in deliveries."
- "A CVS spokesman said the company is closely monitoring the current situation, and will continue to do everything in our power to ensure deliveries are made on time."
- "OptumRx, which primarily uses the Postal Service to fill its 500 million mail-order prescriptions a year, said it will make adjustments as needed."
- "B. Douglas Hoey, CEO of the National Community Pharmacists Association, said community pharmacies have not seen any recent increases in people coming into the pharmacies for emergency prescriptions due to a delayed mail order."

According the National Association of Letter Carriers, the Postal Services normally handles 1.2 billion prescription drug shipments a year. However, mail-order prescription delivery volume has expanded rapidly since the coronavirus outbreak. According to recent analysis, the number of mail-order prescriptions increased by 21 percent in March 2020 alone because of the pandemic.

Of course, delays in mail and things sent by mail can happen anytime and have probably happened at one time or another to everyone reading this. But it is the consistent, chronic late delivery of mail that we must all be on the look-out for. If it does start happening to you, we recommend you contact both your local post office and your U.S. Representative and Senators.

2019 PROFILE OF OLDER AMERICANS

The Profile incorporates the latest data available, but not all items are updated on an annual basis, so there is a combination of data ranging from 2015 to 2019 presented herein.

This report is prepared by the Administration on Aging (AoA), part of the Administration for Community Living, an operating division of the U.S. Department of Health and Human Services. AoA serves as an advocate for older adults within the federal government and is working to encourage and coordinate a responsive system of family- and community-based services throughout the nation. AoA helps states develop comprehensive service systems which are administered by a national network of 56 state agencies on aging, 629 area agencies on aging, nearly 20,000 service providers, and 282 Title VI grantees representing over 400 Federally recognized tribes, made up of 281 Tribal organizations and 1 Native Hawaiian organization.

Principal sources of data are the U.S. Census Bureau, the National Center for Health Statistics, and the Bureau of Labor Statistics. A complete list of sources appears at the end of this report. This report includes data on the American population age 65 and older unless otherwise noted. The phrases "older adults" and "older persons" refer to that population. Age-adjusted estimates are used when available. The data presented refer to the noninstitutionalized population except where noted. Some numbers in this report may not add up due to rounding**…..Read the full report.**

Does Medicare cover long-term care?

Dear Marci

Dear Marci,

My husband and I both have Medicare. As we get older, we've started to think about the possibility that we'll need personal care and other long-term care services in the future. Will Medicare cover the long-term care services that we may need? If not, where can we find help accessing and paying for long-term care?

-Sebastian (Dallas, TX)

Dear Sebastian,

Long-term care (LTC) refers to a range of services and support that help you perform everyday activities. LTC can be provided in a nursing home, assisted living facility, or other setting, and may include medical care, therapy, 24-hour care, personal care, and custodial care (homemaker services). Medicare usually does not cover LTC services. However, if you need care, there are other organizations and forms of insurance you can try:

- Medicaid is a state and federal program that provides health coverage if you have a limited income. Medicaid is the country's largest payer of LTC services and will pay for nursing home care. Medicaid benefits also coordinate with Medicare.
- An Area Agency on Aging may be able to provide counseling and connect you with services in your area. Visit **www.eldercare.acl.gov/Public/About/Aging_Network/AAA.aspx** to find your local AAA.
- Local senior centers may have programs that can deliver meals, provide transportation and shopping assistance, and offer case management. To find senior centers in your area, call your local AAA.
- Faith-based organizations and charities may offer services, financial assistance, and/or referrals to other organizations in your area.
- Geriatric care managers are health and human services professionals who work privately with you and your family to create a plan of care that meets your needs.

In certain areas, you can dial 2-1-1 to ask for referrals to community services. You can also contact your State Health Insurance Assistance Program (SHIP) for assistance and counseling.

Visit **www.shiptacenter.org** or call 877-839-2675 to contact your SHIP.

If you are unsure what kind of care you need, you may want to start by asking your provider.

-Marci

Trump Administration Seeks Cuts in Payments to Surgeons

In an opinion piece published last week, David B. Hoyt, MD, FACS, the executive director of the American College of Surgeons, stated that the Centers for Medicare & Medicaid Services (CMS) has proposed that starting on January 1 of next year, "payments for surgeons seeing Medicare patients be cut, declining, for instance, by 9% for cardiac surgery, 8% for thoracic surgery and 7% for vascular surgery. The law currently mandates any CMS changes to be budget neutral, so the cuts are required in order to increase spending in other places, such as telehealth. But telehealth is no replacement for surgical care, and the health care system simply cannot absorb cuts of this magnitude right now."

CMS is part of the Department of Health and Human Services, one of the federal departments under President Trump.

The doctor pointed out that "The country's doctors and health care workers have been on the frontlines for the past six months, often working longer hours without any added pay, sleep or complaint to meet the overwhelming demands of this outbreak. Our health care system has suffered greatly due to Covid-19, and now surgeons could be faced with ill-advised and dangerous pay cuts."

"The impact of Covid-19 on both surgical practices and their patients has been devastating. Months-long bans on non-emergency but medically necessary surgeries led to worsening outcomes, as conditions that could have been treated with a minor intervention instead caused disability or even death.

Meanwhile, one in three private surgical practices are at risk of closing permanently due to the financial impact of Covid -19, according to a recent nationwide survey. These additional Medicare cuts will force more surgeons to close their practices, reducing patients' timely access to quality care.

"America's surgical care system was already facing significant structural challenges. Surgeons contend with high fixed costs and debt, and now face plummeting revenue. Over the last 20 years, the costs of being a surgeon have increased while Medicare's surgical payments have not only failed to keep up with inflation but have actually declined in nominal terms. It costs more to operate a surgical practice, but Medicare is paying less."

The doctor stated that it will likely require action by Congress to stop these devastating cuts, which TSCL is opposed to.

He concluded his piece with this: "Our doctors and health care workers have been there for the American people during this pandemic. Now doctors need Congress to help them."

We urge you to contact your own Senators and Representative to tell them you opposed these and any other cuts to medical personnel and services, especially those affecting senior citizens, and especially during this pandemic crisis.

Back when he was campaigning in 2016, then-candidate Trump said this: "I'm not a cutter. I'll probably be the only Republican that doesn't want to cut Social Security."

Health agencies' credibility at risk after week of blunders

WASHINGTON (AP) — The credibility of two of the nation's leading public health agencies was under fire this week after controversial decisions that outside experts said smacked of political pressure from President Donald Trump as he attempts to move past the devastating toll of the coronavirus ahead of the November election.

The head of the Food and Drug Administration grossly misstated, then corrected, claims about the lifesaving power of a plasma therapy for COVID-19 authorized by his agency. Then the Centers for Disease Control and Prevention quietly updated its guidelines to suggest fewer Americans need to get tested for coronavirus, sparking outrage from scientists.

Trump's own factual misstatements about COVID-19 are well documented, but the back-to-back messaging blunders by public health officials could create new damage, eroding public trust in front-line agencies. That's already raising concerns about whether the administration will be forthcoming with critical details about upcoming vaccines needed to defeat the pandemic.

"I do worry about the credibility of the FDA and CDC, especially at a time when the capacity of the federal government to advance public health should be a priority for all policymakers," said Daniel Levinson, former longtime inspector general of the Department of Health and Human Services, which oversees both the FDA and the CDC.

On Friday, FDA Commissioner Stephen Hahn removed a conservative public relations official involved in the botched plasma announcement from her role heading the agency's press office, according to a person familiar with the matter, who spoke on condition of anonymity to describe private conversations.

The move came less than two weeks after the White House tapped Emily Miller for the role. Miller previously worked as a reporter for the right-wing One America News Network and as a staffer for Sen. Ted Cruz's reelection campaign. She did not return calls seeking comment Friday.

An FDA spokesperson said late Friday that Miller remains an appointee within the agency.

Trump administration officials said Wednesday that the CDC testing guidance was revised by the White House virus task force "to reflect current evidence," but did not detail what that was. The new recommendations say it's not necessary for most people who have been in close contact with infected people, but don't feel sick, to get tested. Outside experts said that flies in the face of the scientific consensus that wide-scale testing is needed to stamp out new infections.

The week began with Hahn forced to backtrack after using an erroneous statistic describing the effectiveness of the blood plasma therapy granted emergency use for COVID-19, as Trump twisted the facts and inflated the significance of the move.

Hahn "hurt his own credibility, he hurt that of his agency and he probably hurt the credibility of the next vaccine that will get approved," said Daniel Carpenter, a Harvard University professor of government.\

The U.S. has invested billions of dollars in efforts to quickly develop multiple vaccines against COVID-19. But public fears that a vaccine is unsafe or ineffective could be disastrous, derailing the effort to vaccinate millions of Americans.

The American Medical Association urged the FDA to set up new processes to keep the medical community in the loop on vaccine developments, warning that public confidence is at stake. The group has also challenged the CDC to produce scientific data to back up its new testing recommendation.

"We need to see light," said Dr. Susan Bailey, AMA's president. "There is a concern that if you are not seeing the data, you have to wonder why." ….**Read More**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

COVID + Influenza: This Is a Good Year to Get a Flu Shot, Experts Advise

Flu season will look different this year, as the country grapples with a coronavirus pandemic that has killed more than 172,000 people. Many Americans are reluctant to visit a doctor's office and public health officials worry people will shy away from being immunized.

Although sometimes incorrectly regarded as just another bad cold, flu also kills tens of thousands of people in the U.S. each year, with the very young, the elderly and those with underlying conditions the most vulnerable. When coupled with the effects of COVID-19, public health experts say it's more important than ever to get a flu shot.

If enough of the U.S. population gets vaccinated — more than the 45% who did last flu season — it could help head off a nightmare scenario in the coming winter of hospitals stuffed with both COVID-19 patients and those suffering from severe effects of influenza.

Aside from the potential burden on hospitals, there's the possibility people could get both viruses — and "no one knows what happens if you get influenza and COVID [simultaneously] because it's never happened before," Dr. Rachel Levine, Pennsylvania's secretary of health, told reporters this month.

In response, manufacturers are producing more vaccine supply this year, **between 194 million and 198 million doses,** or about 20 million more than they distributed last season, according to the Centers for Disease Control and Prevention.

As flu season approaches, here are some answers to a few common questions:

Q: When should I get my flu shot?

Advertising has already begun, and some pharmacies and clinics have their supplies now. But, because the effectiveness of the vaccine can wane over time, the CDC **recommends against a shot in August**.

Many pharmacies and clinics will start immunizations in early September. Generally, influenza viruses start circulating in mid- to late October but become more widespread later, in the winter. It takes about two weeks after getting a shot for antibodies — which circulate in the blood and thwart infections — to build up. "Young, healthy people can begin getting their flu shots in September, and elderly people and other vulnerable populations can begin in October," said Dr. Steve Miller, chief clinical officer for insurer Cigna.

The CDC has recommended that people "get a flu vaccine by the end of October," but noted it's not too late to get one after that because shots "can still be beneficial and vaccination should be offered throughout the flu season."

Even so, some experts say not to wait too long this year — not only because of COVID-19, but also in case a shortage develops because of overwhelming demand.

Q: What are the reasons I should roll up my sleeve for this?

Get a shot because it protects you from catching the flu and spreading it to others, which may help lessen the burden on hospitals and medical staffs.

And there's another message that may resonate in this strange time.

"It gives people a sense that there are some things you can control," said Eduardo Sanchez, chief medical officer for prevention at the American Heart Association.

While a flu shot won't prevent COVID-19, he said, getting one could help your doctors differentiate between the diseases if you develop any symptoms — fever, cough, sore throat — they share.

And even though flu shots won't prevent all cases of the flu, getting vaccinated can lessen the severity if you do fall ill, he said.

You cannot get influenza from having a flu vaccine.

All **eligible people**, especially essential workers, those with underlying conditions and those at higher risk — including very young children and pregnant women — should seek protection, the CDC said. It recommends that children over 6 months old get vaccinated….**Read More**

Legally blind: Everything you need to know

Blindness refers to an absence of vision or a loss of vision that tools such as glasses or contact lenses cannot correct. Legally blind is a term that the government uses to describe a person with vision below a certain measurement.

A person who is completely blind is unable to see anything, while a person who is partially blind or has a visual impairment may have limited vision.

In 2015, an estimated 1 **million** people in the United States were legally blind, while 3.2 million had some form of visual impairment.

In some cases, a person is born blind. In other cases, a person becomes blind or develops a visual impairment due to a condition, eye trauma, factors relating to aging, or **cataracts**.

This article will define blindness and visual impairments, discuss different types of visual impairment, and see which government benefits and treatment options are available.

According to the **National Eye Institute,** the U.S. defines blindness as having a visual acuity of 20/200 or less, with the best vision correction in the better-seeing eye.

Visual acuity refers to the clarity of a person's vision. To test a person's visual acuity, an eye care professional may ask them to read letters on a Snellen chart. The Snellen chart contains several lines of letters that start large and get smaller with each line.

A Snellen visual acuity of 20/20 is what eye professionals consider normal. This means that a person with 20/20 vision can see what an average person sees when standing 20 feet away from an object.

However, legally blind people will have a Snellen visual acuity of 20/200, meaning that at 20 feet, they can see objects that most people are able to see clearly from 200 feet.

Some people may assume that the term blindness refers to a complete lack of vision, but depending on the severity, some legally blind people may still retain some vision.

Visual impairment

The **American Foundation for the Blind** state that there is no exclusive definition of visual impairment. However, there are different levels of classification based on the severity of the impairment.

The following sections will discuss these levels in more detail.

Moderate visual impairment

People with a moderate visual impairment will have a Snellen visual acuity of 20/70 to 20/160.

Severe visual impairment

A person who has a severe visual impairment will have a Snellen visual acuity of 20/200 to 20/400.

Alternatively, an eye doctor may regard someone as having a severe visual impairment if they have a visual field of 20 degrees or less. The visual field is the area a person can see without moving their eyes to the left or right.

Profound visual impairment

Profound visual impairment occurs when a person has a visual field of 10 degrees or less or a Snellen visual acuity level of 20/500 to 20/1000...**Read More**

CDC director clarifies change in coronavirus testing guidelines after backlash

The director of the Centers for Disease Control and Prevention (CDC) on Thursday issued a clarification of earlier guidance on coronavirus testing, days after a quiet change sparked protests from the scientific and medical communities.

In a statement, Director Robert Redfield said those who come into contact with confirmed or probable COVID-19 patients could be tested themselves, even if they do not show symptoms of the virus.

"Testing is meant to drive actions and achieve specific public health objectives. Everyone who needs a COVID-19 test, can get a test. Everyone who wants a test does not necessarily need a test; the key is to engage the needed public health community in the decision with the appropriate follow-up action," Redfield said.

A spokeswoman for the Department of Health and Human Services later said Redfield was "amplifying and explaining" the guidance, rather than walking back the earlier change.

The CDC revised its testing guidance on Monday, limiting tests to those who show symptoms. That change prompted backlash among public health experts who pointed to the role asymptomatic people play in spreading the virus, and concern that the revision had been dictated by political appointees outside of CDC.

Former CDC Director Tom Frieden was among those critical of the new guidelines.

"Not testing asymptomatic contacts allows Covid to spread. The CDC guidance is indefensible," Frieden wrote on Twitter. "No matter who wrote it and got it posted on the CDC site, it needs to be changed."

The revised guidelines on the agency's website from Monday were not changed after Redfield's clarifying statement on Thursday.

Before the revision, the CDC had recommended contacts of those infected with the virus be tested specifically because of the threat of asymptomatic or presymptomatic transmission.

Redfield said the new guidelines were drafted in coordination with the White House coronavirus task force. The guidance comes as the number of coronavirus tests across the United States has fallen in recent weeks.

After reaching a peak of nearly a million new tests a month ago, the number of tests conducted on a daily basis has declined to fewer than 700,000 over the last four days, according to data maintained by the COVID Tracking Project, an independent group of researchers.

Are Opioids Prescribed Too Freely as Patients Are Moved to Nursing Homes?

(HealthDay News) -- When hospital patients are moved to a skilled nursing facility, they are too often given a prescription for a high-dose opioid painkiller, new research suggests.

For the study, researchers at the Oregon State University College of Pharmacy looked at nearly 4,400 hospital patients in Portland sent to nursing facilities to receive either short-term rehabilitative care or long-term care in a residential setting.

The investigators found that seven out of 10 of these patients received an opioid prescription when they left the hospital, and most were for oxycodone (OxyContin).

Over half of the prescriptions dispensed were high-dose -- equivalent to 90 milligrams of morphine or higher -- a threshold that the U.S. Centers for Disease Control and Prevention advises doctors to "avoid" prescribing, according to a university news release.

Most of the patients who received an opioid prescription were over 65 years of age, an age group that is highly vulnerable to opioid-associated harm, the study authors noted.

The findings were published online recently in the journal *Pharmacoepidemiology and Drug Safety*.

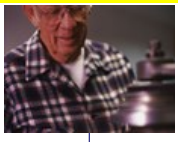
The results emphasize the need for more attention to be paid to safely managing the pain of this patient group, the researchers concluded.

"Increased efforts are likely needed to optimize opioid prescribing among patients transitioning from hospitals to skilled nursing facilities," said study author Jon Furuno, an associate professor at the university and the interim chair of the department of pharmacy practice.

Furuno pointed out that patients in nursing facilities may also be undertreated for their pain, showing the complexity of this issue.

"Prescribers and pharmacists need to work together to ensure patients' pain is managed safely, and knowing which patients are most at risk can inform the best use of resources like medication counseling and other interventions," Furuno said.

Seniors With Depression Show Resilience in Face of Pandemic



(HealthDay News) Older Americans with depression have held up well to the threat of COVID-19, a new study finds.

Researchers saw no increase in their depression and anxiety during the early days of the coronavirus pandemic. And they said these seniors showed resilience to the stress of physical distancing and isolation.

"We thought they would be more vulnerable to the stress of COVID because they are, by [U.S. Centers for Disease Control and Prevention] definition, the most vulnerable population," said study co-author Dr. Helen Lavretsky, professor-in-residence of psychiatry and biobehavioral sciences at the University of California, Los Angeles.

"But what we learned is that older adults with depression can be resilient. They told us that coping with chronic depression taught them to be resilient," she said in a university news release.

The researchers, from UCLA and four other universities, interviewed people older than 60, average age 69, during the first two months of the pandemic. Participants lived in Los Angeles, New York, Pittsburgh and St. Louis, and were enrolled in studies of treatment-resistant depression. The study was funded by the University of Pittsburgh.

The researchers found that the volunteers' depression and anxiety levels, or risk of suicide, were the same before and during the pandemic.

In general, participants were more concerned about the risk of contracting the coronavirus than the risks of isolation. Also, while all maintained physical distance, most didn't feel socially isolated and were using virtual technology to keep in touch with friends and family.

Still, many participants said their quality of life was lower, and that they worried their mental health will suffer with continued physical distancing. Some said they were unhappy with the government response to the pandemic.

The study was published online recently in the *American Journal of Geriatric Psychiatry*.

Further research is needed to determine how the pandemic affects seniors over time, said Lavretsky, who added that the findings could help others coping with the pandemic.

"These older persons living with depression have been under stress for a longer time than many of the rest of us. We could draw upon their resilience and learn from it," she said.

5 Things to Know About Convalescent Blood Plasma

President Donald Trump told the American people this week that convalescent plasma is a potential new treatment for COVID-19. His announcement followed the Food and Drug Administration's decision Sunday to grant **fast-track authorization** for its emergency use as a treatment for hospitalized COVID patients.

This "emergency use authorization" triggered an outcry from scientists and doctors, who said the decision was not supported by adequate clinical evidence and criticized the FDA for what many perceived as bowing to political pressure.

With all the news swirling around convalescent plasma this week, we thought we'd break it down for you.

1. Convalescent plasma contains antibodies against disease. Donations are being promoted as a potential COVID-19 treatment.

"Convalescent" refers to recovery from a disease. And plasma is the yellowish, liquid part of blood in which blood cells are suspended.

When someone is infected with a virus, the body generates antibodies to fight off the viral particles. Enter COVID-19. If an individual who has recovered from this virus donates their plasma, scientists can isolate the antibodies from the plasma and give it to patients who are still in the early stages of their COVID-19 infection. This infusion, in theory, should help people fight off the virus while their own body catches up and makes its own supply of antibodies.

It's not a new concept. An infusion of antibodies via plasma has been used as a treatment for other types of diseases, such as rabies.

2. Some experts took issue with the data presented to approve the treatment and thought the FDA action crossed a political line.

An FDA emergency use **authorization** allows companies and medical providers to deploy unapproved treatments or medical products in a crisis. The FDA said health care providers would be authorized to distribute COVID convalescent plasma to treat suspected or confirmed patients with COVID-19 while in the hospital.

Before the authorization, some top **researchers and clinicians** at the National Institutes of Health felt there was not sufficient scientific evidence to support pushing the treatment forward.

"A randomized placebo control trial is the gold standard," said **Dr. Howard Koh**, who was an assistant secretary at the Department of Health and Human Services from 2009 to 2014 under President Barack Obama. "If you don't have that standard and don't have some evidence from a high-quality study or [a randomized controlled trial], you are left with suboptimal science and treatments in the long run that may not prove to work."

Koh also said that for other COVID-19 treatments including the medication remdesivir, a **randomized clinical trial** had been done before the FDA OK'd it for emergency use.

When the emergency authorization for convalescent plasma was **announced**, HHS officials pointed to findings from a **Mayo Clinic preliminary analysis** as the rationale. The analysis has not been reviewed by other scientists and doctors.

Suspicions of a political motive behind the decision were heightened because the authorization came one day before the start of the Republican National Convention.

"The timing raises so many questions," said Koh, also a professor of the practice of public health leadership at Harvard University. "I think this announcement shakes the confidence of the medical community in the rigor of the FDA decision-making process."

Trump **tweeted** just a day before the FDA's action, "The deep state, or whoever, over at the FDA is making it very difficult for drug companies to get people in order to test the vaccines and therapeutics. Obviously, they are hoping to delay the answer until after November 3rd. Must focus on speed, and saving lives!"

Scott Gottlieb, a former Trump administration FDA commissioner, offered his take in **a tweet the day after** the announcement: "Plasma may provide a benefit, and it could be meaningful for certain patients, but we need more evidence to prove it. The data FDA had supports an authorization for emergency use, where the standard is 'may be effective' but we need better studies to confirm preliminary findings**."...Read More**

Could Long Naps Shorten Your Life?

A frequent need to nap could be a red flag for future heart problems and a higher risk of early death, a new analysis concludes.

Long naps lasting more than an hour are associated with a 34% elevated risk of heart disease and a 30% greater risk of death, according to the combined results of 20 previous studies.

Overall, naps of any length were associated with a 19% increased risk of premature death, a Chinese research team found. The study results were released Wednesday for presentation at the virtual annual meeting of the European Society of Cardiology.

"If you want to take a siesta, our study indicates it's safest to keep it under an hour," lead researcher Zhe Pan of Guangzhou Medical University said in a society news release. "For those of us not in the habit of a daytime slumber, there is no convincing evidence to start."

For their study, the researchers analyzed data from 20 studies involving more than 313,000 participants. About two in five people in the studies said they nap.

The investigators found that the connection was more pronounced in people aged 65 and older: These older folks had a 27% higher risk of death associated with napping and a 36% greater risk of heart disease. Women also had a stronger association between napping and poor health, with a 22% greater risk of death and a 31% greater risk of heart problems.

Interestingly, long naps were linked with an increased risk of death in people who sleep more than six hours a night. That would seem to rule out poor sleep as an explanation for the increased risk of death and heart health issues.

Adults who get less than seven hours of sleep each night are more likely to say they've had a heart attack, according to the U.S. Centers for Disease Control and Prevention. Poor sleep also has been linked to high blood pressure, type 2 diabetes and obesity, all of which increase the risk of heart disease, heart attack and stroke.

Pan speculated that long naps might affect the body because they are associated with higher levels of inflammation.

But heart health experts said that just because you're sleeping through the night doesn't mean you've gotten a good night's sleep -- something for which this study doesn't account.

Regarding how well you're resting at night, napping "might be a sign that there's something else going on," said Dr. Nieca Goldberg, a cardiologist and director of the NYU Langone Center for Women's Health, in New York City.

"What kind of sleep were these individuals getting?" Goldberg said of the study participants. "Were they waking up at night? Did they have sleep apnea?"...**Read More**

FDA authorizes plasma treatment despite scientists' objections

The Food and Drug Administration issued an emergency authorization for blood plasma as a coronavirus treatment, the agency and President Donald Trump announced Sunday — one day after Trump attacked the drug regulator for moving too slowly to back the treatment.

The agency held off on the decision last week over concerns from government scientists that evidence for the treatment's effectiveness is thin, prompting Trump to accuse the FDA of **slow-walking the therapy to harm his reelectio**n chances without offering any evidence to support his claim. It is not clear whether the FDA has received additional clinical trial data in the last week that would support the therapy's use.

Trump in a brief Sunday evening news conference appeared to oversell the FDA's assessment, claiming the agency found plasma "safe and very effective." The agency itself said more rigorous study is needed to prove whether the treatment effective. Janet Woodcock, the head of FDA's drug division who is now working on Operation Warp Speed, an interagency effort to accelerate coronavirus treatments and vaccines, on Friday told POLITICO that plasma has not been "proven as an effective treatment."

Trump also returned to his recent accusations that government scientists were holding up potential coronavirus treatments for political reasons. "We broke the logjam over the last week," he said. "I think there are people in the FDA and actually in [the larger health] department that can see things being held up."

An emergency authorization normally paves the way for expanded use of an experimental therapy. But FDA distanced itself from a full endorsement of plasma — which more than 70,000 Americans have already received — because patients have largely received it outside of randomized, controlled clinical trials that could prove whether the approach is effective.

Unlike Gilead's remdesivir, which received an emergency use authorization months ago and has shown to benefit hospitalized patients, convalescent plasma "does not yet represent a new standard of care based on the current a

The Infectious Diseases Society of America says plasma treatment shows "some powerful signals" but noted there is still not enough data to understand its effectiveness for Covid-19.

Trump announced the emergency authorization alongside his health secretary, Alex Azar, and FDA Commissioner Stephen Hahn, in a press conference one day before the start of the Republican National Convention. While Trump called it a "historic announcement," experts have said the treatment is unlikely to be a game-changer in the fight against a pathogen that's killed more than 170,000 in the United States.

Hahn, who took over as FDA chief in December, said Trump "has asked FDA to cut back red tape and try to speed medical products into the hands of providers, patients and American consumers."

Outside experts and former officials **have accused FDA of caving to White House pressure** during the pandemic — most notably in its decision to authorize emergency use of hydroxychloroquine for treating Covid-19 infection despite limited evidence. The agency later pulled the authorization after randomized clinical trials found it provided no benefit, but Trump as recently as this weekend complained about the agency's reversal.

Hahn, a longtime cancer doctor, declined to contradict the president's claims about plasma being "very effective" on the press briefing stage Sunday night. "If you are one of those 35 out of 100 people who these data suggest survive as a result of it, this is pretty significant," he said….**Read More**

Blood tests show promise for early Alzheimer's diagnosis

With the aging of the U.S. population, the incidence of Alzheimer's disease continues to rise. The disease is currently the most common cause of dementia in older adults.

Brain changes associated with Alzheimer's include abnormal clumps (amyloid-β plaques), tangled bundles of fibers (tau tangles), and the eventual death of nerve cells. These changes can lead to a progressive decline in memory and thinking skills.

Treatments don't yet exist to slow or reverse Alzheimer's disease progression. Researchers are working to test new therapies in clinical trials. But no blood tests can currently diagnose Alzheimer's before symptoms develop. This complicates studies of early treatments or preventive strategies.

PET imaging and tests that use cerebrospinal fluid (CSF) can be used to identify Alzheimer's before dementia develops. But PET imaging is expensive, and collecting CSF is invasive. Recent research found that **measurements of a substance in the blood called ptau181** showed promise as an Alzheimer's test.

Scientists have been examining whether another form of the tau protein, called ptau217, can also serve as an early marker of Alzheimer's development. Both are found in the tau tangles that accumulate in the brain and can spill into the bloodstream. Two new studies tested different ways of measuring ptau217 in blood samples. The research teams were funded in part by NIH's National Institute on Aging (NIA), National Institute of Neurological Disorders and Stroke (NINDS), and Office of the Director (OD).

In the first study, researchers led by Dr. Oskar Hansson from Lund University in Sweden tested blood samples from three studies comprising about 1,400 people. These included people with known Alzheimer's and other dementias, as well as those without cognitive problems. The researchers used antibodies produced by the immune system to detect tau proteins in the samples. Results were published on July 28, 2020, in *JAMA*.

The team found that ptau217 measurements were almost 90% accurate at distinguishing people who later had Alzheimer's damage found in their brains after death. Blood measurements of ptau217 were also about 90% accurate at distinguishing people who later developed symptoms of dementia. In both study groups, ptau217 was better than ptau181 — and as good as PET imaging and CSF testing — at pinpointing Alzheimer's development.

Finally, the team tested ptau217 in samples from people who carry a genetic mutation that causes early-onset Alzheimer's. Levels of ptau217 correlated with those who later developed the disease, up to 20 years before symptoms were seen.

In the other study, a team led by Drs. Nicolas Barthélemy and Randall Bateman from Washington University in St. Louis tested a method that used mass spectrometry to measure ptau217 in the blood of 126 volunteers. The technique they developed can measure extremely small amounts of ptau217 in the blood. Results were published on July 28, 2020, in the *Journal of Experimental Medicine*. ….**Read More**