

## August 21, 2022 E-Newsletter

### Message from the Alliance for Retired Americans Leaders



Robert Roach, Jr.  
 President, ARA

Alliance members celebrated passage of the Inflation Reduction Act (IRA) in the U.S. House of Representatives

today, five days after the bill was passed by the U.S. Senate. President Biden has said he will sign the bill.

The bill will help lower prescription drug prices for seniors by:

- ◆ Requiring Medicare to negotiate lower prices for some of the highest priced prescription drugs, using its enormous purchasing power on behalf of seniors and taxpayers;
- ◆ Capping out of pocket costs



for insulin at \$35 per month for Medicare beneficiaries;

- ◆ Making all recommended adult vaccines free for Medicare beneficiaries beginning in 2023;
- ◆ Prohibiting drug corporations from increasing the price it charges Medicare for a drug by more than the rate of inflation; and
- ◆ Capping out of pocket drug spending at \$2,000 per year for Medicare Part D

"I have witnessed seniors at the supermarket, having to leave food at the cash register so they could make ends meet," said Robert Roach, Jr., President of the Alliance. "This legislation is a game-changer that will go a long way to help ensure retirees are not put in that terrible

position."

"I have been paying up to \$480 per month for my insulin," said Maryland/DC Alliance member Pam Parker of Bethesda, Maryland, who needs the drug to treat her diabetes. Ms. Parker previously shared her challenges paying for her medicines at a Capitol Hill news conference. "Capping my insulin cost at \$35 per month and my overall annual out-of-pocket drug spending at \$2,000 will allow me to breathe a huge sigh of relief and eliminate a major source of anxiety for millions of seniors."

Americans pay the highest drug prices in the world, and one in four Americans has reported not taking at least one drug as prescribed because they couldn't afford it.



Rich Fiesta,  
 Executive Director, ARA

"The Alliance has been fighting to give Medicare the right to negotiate lower prices for more than two decades," added Richard Fiesta, Executive Director

of the Alliance. "The action taken by Congress today sends a strong message to seniors that lower drug prices are closer than ever. "Now that the House, the Senate and Vice President Kamala Harris have voted, our members look forward to President Biden quickly making this legislation the law of the land," said Fiesta. "When he does, we will finally be putting seniors ahead of pharmaceutical corporations to deliver lower drug prices for the American people."

### No, Senate inflation bill isn't stripping \$300 billion from Medicare

If you're among the hundreds of thousands—possibly more—who have seen one of [these commercials](#) about Medicare and the latest bill in Congress, I've got some bad news, some good news, and a puzzle for you.

**The bad news is that you're being played.**

The good news is that nobody is "stripping \$300 billion from Medicare" by any calculation that would make sense to you or anyone you know. (More on this below.)

The puzzle is in two parts: Who, exactly, is the "American Prosperity Alliance," the mysterious front organization behind the commercial? And why, exactly, do they want us to pay an extra \$300 billion to

America's drug companies?

I can't say for certain, but I'm hazarding a guess the answer to the second question—who wants us to pay an extra \$300 billion to America's drug companies—might contain a clue to the first question: Who is this mysterious front organization, whose website is registered in Arizona, of all places, whose ownership is "redacted for privacy," and which was updated just two months ago. (I was not able to reach them to comment on this article.)

Hmmm...How about that?

Let me start with [the \\$300 billion claim in the commercial](#). Yes, yes, I know, media "fact checkers" have become so

**MarketWatch** openly partisan and biased that it is hard to take them seriously. But in this case they are actually accurate: And I write as someone who (a) rolls his eyes at media partisanship, (b) is a registered independent, and (c) thinks using Medicare to cut drug prices has some downsides.

What does this bill actually do?

Well, imagine going to the supermarket and being given a voucher worth \$50 off your next shopping trip. Would you then complain that your grocery budget had been *cut* by \$50?

This is what the bill does—and what the American Prosperity Alliance is complaining about.

The bill will cut drug costs, for Medicare and for seniors

directly, **by an estimated \$288 billion over 20 years**. But the losers are the drug companies, not you and not Medicare. It's the drug companies who will be able to charge Medicare and America's seniors an estimated \$288 billion less for the same drugs.

The Senior Citizens League, an independent lobbying group on behalf of seniors, has this to say: "This legislation cuts almost \$300 billion worth of high drug prices in 10 years. That represents savings for taxpayers and more importantly savings for Medicare beneficiaries on their share of prescription drug costs. The Senior Citizens League strongly supports this legislation." ...[Read More](#)

ADD YOUR NAME

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

## Big Pharma Went All In to Kill Drug Pricing Negotiations

For decades, the drug industry has yelled bloody murder each time Congress considered a regulatory measure that threatened its profits. But the hyperbole reached a new pitch in recent weeks as the Senate moved to adopt modest drug pricing negotiation measures in the Inflation Reduction Act. The bill “**could propel us light-years back** into the dark ages of biomedical research,” Dr. Michelle McMurry-Heath, president of the Biotechnology Innovation Organization, said last month. **Venture capitalists and other opponents** of the bill said that it “**immediately will halt private funding of drug discovery and development.**”

Steve Ubl, leader of the ubiquitous Pharmaceutical Research and Manufacturers of America, or PhRMA, called the bill’s Senate passage on Aug. 7 a “tragic loss for patients.” He threatened in an **interview with Politico** to make politicians suffer if they voted for the measure, adding that “few associations have all the tools of modern political advocacy at their disposal in the way that PhRMA does.”

In the past 12 months, PhRMA and closely allied groups spent at least \$57 million — \$19 million of it since July — on **TV, cable, radio, and social media** ads opposing price negotiations, according to monitoring by the advocacy group Patients for Affordable Drugs. PhRMA **spent over \$100 million** this year to unleash a massive team of 1,500 lobbyists on Capitol Hill.

The final bill is weaker than earlier versions, which would have extended negotiations to more drugs and included private insurance plans. The bill would enable only Medicare to negotiate prices beginning in 2026, initially for just 10 drugs.

It would save the Centers for Medicare & Medicaid Services about \$102 billion over a decade, **the Congressional Budget Office estimates**. In 2021 alone, the top U.S. pharmaceutical companies booked tens of billions of dollars in revenue: Johnson & Johnson (\$94 billion), Pfizer (\$81 billion), AbbVie (\$56 billion), Merck & Co. (\$49 billion), and Bristol Myers Squibb (\$46



billion). The **bill authorizes hundreds of millions of dollars** for CMS

to create a drug negotiation program, setting in motion a system of cost-benefit evaluations like those used in Europe to guide price negotiations with the industry. **Americans pay, on average, four times what many Europeans do** — and sometimes far, far more — for the same drugs.

The bill does not affect the list prices companies charge for new drugs, which increased from a median price of \$2,115 in 2008 to a staggering \$180,007 in 2021, **according to recent research**.

The bill’s champions say that PhRMA’s gloomy prophecies are overblown, and that history is on their side.

“It’s complete bullshit and a scare tactic,” Andy Slavitt told KHN. As a leading federal health official in 2016, he tried to change part of a Medicare program that pays doctors a fixed 6% of the cost of a drug each time they administer it, creating an incentive to use the most

expensive infusion drugs. PhRMA funded most of the loud campaign that defeated his efforts, Slavitt said.

Another scare tactic: The drug industry warns that any price negotiation will kill innovation. Such warnings “constitute the pharma response in literally every instance since 1906,” the year the first drug regulation agency was created, said Dr. Aaron Kesselheim, who leads the Program on Regulation, Therapeutics, and Law at Brigham and Women’s Hospital in Boston. And yet, he said, regulatory changes rarely choked out investment in new drugs.

For example, the drug industry bemoaned a bill to boost generic drugs sponsored by Rep. Henry Waxman (D-Calif.) in 1984. Yet while 50% of prescribed drugs were generics in 2000 — up from 15% in 1980 — approvals of important new drugs also soared during the period, Kesselheim noted. The threat of losing market share to generics, he said, may have induced manufacturers to invest in innovation...**Read More**

## Inflation Reduction Act Contains Important Cost-Saving Changes for Many Patients — Maybe for You

The giant health care, climate, and tax bill expected to pass the House on Friday and be sent to the president for his signature won’t be as sweeping as the Democrats who wrote it had hoped, but it would help millions of Americans better afford their prescription drugs and health insurance.

It can be **republished for free**.

The Inflation Reduction Act **is estimated** to spend about \$485 billion over 10 years on health and alternative energy programs while raising about \$790 billion through tax revenue and savings. The difference would be used to help reduce the deficit.

On the health front, the legislation achieves two key goals of congressional Democrats. First, it would give the federal government the ability to negotiate prices of

some drugs purchased by Medicare beneficiaries, a tool that has long been opposed by the drug industry. Second, it would extend the enhanced premium subsidies for people who buy insurance on the Affordable Care Act marketplaces that Congress put in place last year to help confront the covid-19 pandemic.

“It’s historic. Never before have we been able to negotiate prescription drug prices. This is something we’ve been fighting for [for] decades,” House Speaker Nancy Pelosi said this week. “I want more, of course — we always want more. But this is a great deal.”

The bill extends the enhanced subsidies, which will expire this year if they are not continued, through 2025. The 2021 covid relief bill boosted subsidies for



those people who had already qualified for the aid and provided subsidies to some middle-income people who had found coverage to be too expensive. According to an **analysis by KFF**, about 13 million people will see their premiums jump by more than half, on average, if the enhanced subsidies are not continued. And people who earn more than four times the poverty level will not be eligible for subsidies anymore, on top of seeing their premiums spike.

The subsidies’ extension is expected to cost about \$64 billion.

The bill will also have a major impact on Medicare, including by allowing the program to negotiate prices for some of the most expensive drugs, capping beneficiaries’ out-of-pocket

payments for drugs, limiting their insulin cost sharing to \$35 a month, and barring drug companies from raising prices faster than inflation.

The drug pricing provision, estimated to save the government nearly \$100 billion over 10 years, would require the U.S. Department of Health and Human Services to identify Medicare’s 100 most expensive drugs and then pick 10 for price negotiations starting in 2023. Those prices would take effect in 2026. Another 10 drugs would be added over the next two years, with the savings fully in effect by 2028.

The negotiations would apply first to drugs people get at the pharmacy, but in the later two years, drugs that people get in doctors’ offices could also be covered...**Read More**



## House Passes Historic Legislation to Lower Drug Prices

Last Friday the House of Representatives completed the last Congressional action needed to pass the historic legislation that will, finally, lower some prescription drug prices.

The bill has been sent to the President for his signature, after which it will become law.

The provision to lower drug prices, which is part of a much larger bill called the Inflation Reduction Act, passed the House in a 220-207 party-line vote. As in the Senate, every Democrat voted in favor of the bill and nearly every Republican voted against it. (Four Republicans did not vote.)

It took more than a year of negotiations among Senate Democrats on a spending package to finally pass the bill and just a few weeks ago it appeared to be dead in the water. The legislation will increase taxes on corporations, address climate change and bring down the prices of prescription drugs, all while lowering the deficit.

In brief, the health care provision of the bill will allow Medicare to negotiate lower prices for 10 high-cost drugs starting in 2026. By 2029, that number is expected to grow to 20 drugs. Additionally, the measure allows caps to be placed on some drug costs, but mainly for Medicare. In addition, for the first time, a tax penalty will be imposed on drug companies failing to abide by new prices.

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## Second Republican Senator Proposes Taking Away the Guarantee of Social Security, Medicare

As most voters are aware, there will be elections this fall. All seats in the House of Representatives are up for election as are one-third of the seats in the Senate.

As things appear now, the Republicans are expected to become the majority party in the House and could also become the majority party in the Senate, although in recent days that has become more in doubt.

That is why it is troubling that twice this year Republican

Senators have proposed taking away the guarantees of Social Security and Medicare to seniors.

Here is what that means.

Funding for Social Security, Medicare, and Medicaid are what is known in Congress as “mandatory spending,” meaning the funding for those programs happens automatically every year. Those are the biggest programs with mandatory funding, but others like unemployment compensation, retirement programs for federal employees, student loans, and deposit insurance are also mandatory.

The other type of funding is called “discretionary.” Most of the other large federal government spending programs are in this category, such as defense, education, agriculture, etc. This means that the budgets and funding for those programs must be voted on every year. Although Congress has managed to finally pass budgets every year, it is also true that every year since 1998, Congress has failed to pass a budget on time, and it is often not until the next year that they finally manage to do so.

You may recall times in the recent past when the government shut down for a period because Congress cannot agree on the budgets.

Last spring Senator Rick Scott (R-Fla.) proposed that all mandatory spending programs, including Social Security, Medicare, and Medicaid become discretionary so that every year Congress would have to debate and fight over how much money to spend on them.

Then very recently another Republican Senator, Ron Johnson of Wisconsin, said the same thing.

According to Johnson, “If you qualify for the entitlement, you just get it no matter what the cost,” Johnson said. “And our problem in this country is that more than 70 percent of our federal budget, of our federal spending, is all mandatory spending. It is on automatic pilot. It never — you just do not do proper oversight. You do not get in there and fix the programs going bankrupt. It is just on

automatic pilot.”

We would hope that those multi-millionaire Senators do not mean that if

Congress decides there is not enough money, they would not fully fund Social Security, Medicare, and Medicaid, but under his proposal that is what could happen.

At the very least, under this scheme, if Congress could not approve a new budget until the following year, it is highly unlikely that seniors would get their COLA at the first of each year as they do now.

TSCSL thinks this is a horrible idea and we would fight with every resource at our disposal to defeat it.

\* \* \* \*

## Here are the Details of the New Law That Will Lower Drug Prices

As published on the website *Modernhealthcare.com*, an analysis by *Kaiser Health News* says this about the new legislation:

- ◆ The new legislation “... will have a major impact on Medicare, including by allowing the program to negotiate prices for some of the most expensive drugs, capping beneficiaries’ out-of-pocket payments for drugs, limiting their insulin cost sharing to \$35 a month, and barring drug companies from raising prices faster than inflation.
- ◆ The drug pricing provision, estimated to save the government \$100 billion over 10 years, would require the U.S. Department of Health and Human Services to identify Medicare’s 100 most expensive drugs and then pick 10 for price negotiations starting in 2023. Those prices would take effect in 2026. Another 10 drugs would be added over the next two years, with the savings fully in effect by 2028.
- ◆ The negotiations would apply first to drugs people get at the pharmacy, but in the later two years, drugs that people get in doctors’ offices could also be covered.
- ◆ Some of the Medicare changes would kick in next year. One is the cap on price hikes. Under the bill, companies that raise

the price of drugs sold to Medicare faster than inflation must pay rebates back to Medicare, generating an estimated \$101 billion in savings for the government. The inflation protections will also apply to certain drugs, such as biologicals, that patients get in a doctor’s office.

- ◆ New vaccine and insulin cost caps would also take effect in 2023. Under the bill, all vaccines recommended by the federal Advisory Committee on Immunization Practices will be fully covered by Medicare, as well as by Medicaid and the Children’s Health Insurance Program. For Medicare beneficiaries who need insulin, out-of-pocket costs would be capped at \$35, and starting in 2026, the cap would be \$35 or 25% of the negotiated price if that is lower.
- ◆ Another big saver for Americans enrolled in Medicare would be a \$2,000 cap on out-of-pocket drug costs, which would begin in 2025. According to an analysis by the Council for Informed Drug Spending Analysis based on data from 2012, about 3.5 million beneficiaries would likely save more than \$1,500 a year.
- ◆ Starting sooner, in 2024, people whose out-of-pocket drug costs reach the “catastrophic” threshold of \$7,050 will not have to pay any additional money on drugs that year. Currently, there is no cap, and people must pay 5% of the cost of extremely expensive drugs after hitting the threshold.
- ◆ Also starting in 2024, Medicare would extend low-income subsidies to about 500,000 beneficiaries who earn between 135% and 150% of the poverty level (\$18,347 to \$20,385 for a single person). Premium hikes on drug plans would also be limited in 2024 to 6% for all beneficiaries through 2029.
- ◆ The bill could have reached far more people, but Democrats’ attempts to slow the increase in drug prices and cap insulin copays outside of Medicare were blocked.”

# Social Security SSI Updates To Know for August 2022

For many Americans, Social Security is all about retirement benefits. But Social Security as a whole actually encapsulates a number of programs designed to assist qualifying Americans.

One of the most important of these is the Supplemental Security Income program, or SSI. As the name implies, SSI provides supplemental income for those most in need. Those who qualify can receive SSI benefits in addition to Social Security retirement payouts. Changes to the SSI generally only occur at the start of every year. However, just as with Social Security retirement benefits, there are indicators in the latter half of the year that can foretell potential changes coming in 2023.

Here's an overview of the SSI program in general, along with a look at [specific information](#)

## pertaining to August 2022.

### Who Qualifies for SSI?

The SSI provides benefit payments for those with low income and few resources who are also disabled, blind or at least age 65. For 2022, singles must earn less than \$861 per month in unearned income to qualify, and \$1,767 in total income. Those figures jump to \$1,281 and \$2,607, respectively, for couples.

There is also a resource limit to qualify for SSI. For 2022, a person must own no more than \$2,000 in assets to qualify, or \$3,000 for a couple. However, numerous real-world assets are excluded, including a primary residence, household goods and personal effects, one car, property used in a trade or business, and funds up to and including \$100,000 in an ABL account.



### When Are the Payment Dates for SSI in August and Beyond?

Unlike Social Security retirement benefits, which are paid on varying Wednesdays depending on your date of birth, everyone in the SSI program receives benefits on the same date. In most cases, this is the 1st of the month, and that is true for August 2022 as well.

However, in some months, SSI benefits are paid both on the 1st of the month and the last Friday of the month, with no payment on the 1st of the following month. For 2022, this is true for April, September and December, with no payment on the 1st of May, October or January 2023.

### How Much Are the Payments for SSI?

Eligible individuals receive \$841 per month for 2022, or \$10,092.40 per year. Eligible

couples receive \$1,261 per month, or \$15,136.93 per year. Those defined as "essential persons" receive \$421 per month, or \$5,057.77 per year. An "essential person" is basically someone who lives with an SSI recipient and provides them with basic care.

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## 5 Likely Changes to Social Security Over the Next 10 Years

Sam Cook wasn't referring to Social Security in his classic song "A Change Is Gonna Come." However, the sentiment definitely seems applicable to the federal program.

The reality is that Social Security **can't stay the same without steep benefit cuts**. But it's unlikely that the U.S. Congress will want to face the wrath of seniors if they let that scenario happen.

What specific modifications to Social Security might be made? The smart money would be on the ideas that have the most support among both Democrats and Republicans.

In June, the University of Maryland's Program for Public Consultation published results from a survey that identified the most popular steps to prevent Social Security from having a shortfall. Here are five likely changes to the program over the next 10 years based on the survey's findings.

### 1. Increase the salary cap for the payroll tax

Both Democrats and Republicans in the University of Maryland survey especially liked one idea to help fix Social Security. An overwhelming majority -- 81% -- of survey

respondents supported an increase in the salary cap for the payroll tax that funds Social Security. The proposed change was viewed favorably by 88% of Democrats and 79% of Republicans.

Currently, only wages up to \$147,000 per year are subject to the payroll tax. The proposal included on the survey is to also make all wages of more than \$400,000 per year subject to the tax. Doing so would eliminate roughly 61% of the projected Social Security shortfall.

Whether or not legislators ultimately go with the \$400,000 threshold remains to be seen. However, with this idea garnering significant bipartisan support among the American public and its making a big difference in bolstering Social Security, it seems to be close to a slam-dunk change at some point in the not too distant future.

### 2. Reduce benefits for high earners

Wealthier Americans could be in store for another hit. Eighty-one percent of survey respondents liked the idea of reducing benefits for high earners. Democrats were more supportive of the alternative,



with 86% support, compared with 78% of Republicans.

Who would be considered a high earner under this plan? The survey's question's wording asked about reducing benefits for the top 20% of earners. If this plan were implemented, it would eliminate close to 11% of the projected Social Security shortfall.

### 3. Raise the retirement age

Democrats and Republicans give nearly equal support to raising the retirement age. Seventy-six percent of Republicans favor the plan, while 76% of Democrats like it.

This isn't a new idea, of course. In 1983, the **full retirement age** was raised from 65 to 67. The change was phased in, with a higher age applying to anyone born in 1960 and later.

The University of Maryland survey proposed raising the retirement age by one year to 68. This change would wipe out 14% of the projected Social Security shortfall.

### 4. Increase the payroll tax

Seventy-three percent of survey respondents favored increasing the payroll tax. Democrats liked the idea a little more than Republicans did, with

78% and 70% support, respectively, among the two groups.

We're not talking about a huge increase, though. The proposal presented in the survey was to bump up the payroll tax from 6.2% to 6.5%. That relatively modest change would have a sizable impact, however. It would eliminate around 16% of the projected Social Security shortfall.

### 5. Raise the minimum benefit

Not all of the most popular Social Security changes will help bolster Social Security. Sixty-four percent of survey respondents supported raising the minimum benefit. Democrats were more favorably disposed toward the idea, with 71% supporting it, versus only 59% of Republicans.

The University of Maryland survey proposed increasing the minimum monthly Social Security benefit from \$951 to \$1,341 for anyone who has worked 30 years. While this change received broad support, it would increase the projected Social Security shortfall by 7%.

## Drug provisions in the reconciliation bill should lower your costs

*Written by Diane Archer*

Last week, I laid out the Medicare prescription drug **provisions in the reconciliation bill**. They are noteworthy. Among other benefits, for the first time, people with Medicare Part D prescription drug coverage will spend no more than \$2,000 out of pocket for their drugs, and Medicare will be allowed to negotiate the price of 100 prescription drugs through 2030. If you're taking costly medicines, these provisions should lower your drug costs significantly.

Beginning in 2023, Medicare drug prices cannot rise faster than inflation. If they do, the manufacturer must pay a rebate to the federal government. So, you should no longer see your Part D prescription drug costs rise more than the rate of inflation. The base year for measuring cumulative price changes is 2021.

- In 2024:
- ◆ if you reach the catastrophic coverage phase of your Part D coverage, meaning that you have spent **\$7,050 out of pocket** for covered drugs, you will no longer have to pay five percent of the cost of your drugs. You will have no drug copay.
  - ◆ if your income is under 150 percent of the federal poverty level, you will be eligible for full Extra Help benefits, which cover your Part D out-

of-pocket costs.

- ◆ your Part D premium cannot increase more than six percent a year.

In 2025, your maximum out-of-pocket Part D drug costs will drop to \$2,000 a year.

In 2026, Medicare will begin negotiating drug prices for 10 Part D brand-name drugs. The law is silent as to the drugs for which Medicare will negotiate prices, other than that they must be high-cost and have been on the market for at least nine years since FDA approval. The Secretary of Health and Human Services will choose the drugs for which prices will be negotiated.

In 2027, Medicare will negotiate drug price for 15 Part D drugs.

In 2028, Medicare will negotiate another 15 drugs in Medicare Part D and Part B.

In 2029, Medicare will negotiate the price of 20 drugs.

It's not clear when we will know which drugs will have negotiated prices or how these prices will affect people who take these drugs. Even today, each Medicare Part D drug plan might charge you a different amount out of pocket for a particular drug, depending upon a variety of factors.

Steve Maas points out in the **Washington Post**, that a blood pressure medicine, lisinopril, could cost you nothing or as much as \$29 at the same



pharmacy with Part D. Without insurance, it costs \$4 at Walmart. Maas takes a basket of drugs and reveals that, overall, at least for the five drugs he chooses, you will save a lot of money using the pharmacy at your local Giant supermarket over going to CVS, \$11 v. \$46.55.

**How will the Secretary of HHS arrive at the negotiated price?** We don't know yet whether the Secretary will be able to achieve the deep discounts that other wealthy countries are able to negotiate or a much smaller discount. But, most likely the latter, given politics in the US. And, then there's the question of how much of the discounts the Part D plans will pass along to their members in terms of out-of-pocket costs.

**There is a price ceiling for drugs whose prices are negotiated**, which depends upon how long the brand-name drug has been on the market. The lowest ceiling is 40 percent of the drug's fair price (which there's a formula for calculating), for drugs that have been on the market for at least 16 years. The highest ceiling is 75 percent for drugs on the market between nine and 12 years.

**There is a penalty on manufacturers for non-compliance**. Manufacturers must pay an excise tax of 65 percent of the prior year's sales of that drug, which increases by 10 percent every quarter up to 95 percent. And, if the drug has a

negotiated price that the manufacturer opts not to charge, the manufacturer could pay a penalty of as much as 10 times the difference between the price it charges and the negotiated price.

**What does this all mean for the Medicare Part D plans?** If there's any way they can avoid including the negotiated drugs on their pharmacies, they might try to do so, because they might not profit as much from them. We know that **CVS excludes some generics from its formularies**, forcing enrollees to pay more for their brand-name equivalents, surely because CVS maximizes profits in that fashion.

Part D prescription drug plans have way too much freedom to take advantage of the system and drive up costs for their enrollees. Enrollees are at an enormous disadvantage because drug tiers and coverage can change at almost any time. People truly cannot choose the Part D plan that's right for them.

Unfortunately, Congress does not have the authority to include drug price negotiation for working people in the reconciliation bill. It can only include provisions that affect the federal budget directly. As a result, millions of Americans will continue to **import drugs from abroad for personal use**. While it is not technically legal, to date, the government has never prosecuted anyone for doing so.

## U.S. Nursing Homes Are Understaffed, But Minority Communities Have It Worst

Staffing shortages at nursing homes across the United States are severe in disadvantaged areas where needs may be greatest, researchers say.

The study — recently published in the **Journal of the American Geriatrics Society** — looked at staffing before the COVID-19 pandemic. It found that skilled clinical workers such as registered nurses (RNs) and physical therapists were in short supply at nursing homes in poorer neighborhoods, potentially putting residents' safety at risk. Those same

neighborhoods are more likely to serve vulnerable populations, including racial and ethnic minorities.

While some areas have established minimum staffing standards to address **shortages**, that alone won't fix care, said senior author Jasmine Travers, an assistant professor at New York University Rory Meyers College of Nursing.

"We have to address and invest in these neighborhoods that these nursing homes are in," she said.



**This study** looked to expand on existing research that looked at deprivation in terms of one factor, poverty. Instead, researchers used a measure of disadvantage in income, education, employment and housing known as an area deprivation index. They zeroed in not on counties or ZIP codes but on smaller areas called census blocks, each representing 600 to 3,000 residents.

"In early research that we did during the pandemic, we found poor quality of care for residents

in nursing homes that were located in neighborhoods that were severely deprived," Travers said. As a result, she said, the researchers realized other disparities may be driving that problem.

For the study, the investigators mapped area deprivation index scores for just over 12,600 **nursing homes**, about 16% of which were in severely disadvantaged neighborhoods. They analyzed nursing home quality and payroll-based staffing data....**Read More**

## Dear Marci: Should I choose Original Medicare or a Medicare Advantage Plan?

Dear Marci,  
I have Original Medicare but have been seeing a lot of ads for Medicare Advantage Plans that seem great. I don't want to fall for just good marketing, though. Are Medicare Advantage Plans better than Original Medicare? How should I choose  
-Lauren (Chicago, IL) Dear Marci,

Dear Lauren,  
It's great that you are taking the time to learn about your options before enrolling in a plan. There are many important choices to make about your health care coverage, and being informed can help you make the best decisions for your own needs. People with Medicare can get their health coverage through either **Original Medicare** or a **Medicare Advantage Plan** (also known as a Medicare private health plan or Part C). While there are many differences between the two, remember that Medicare Advantage Plans must provide the same benefits offered by Original Medicare, but may

apply different rules, costs, and restrictions.

Let's review some of the main differences between these two ways to get your Medicare: **Costs**

- ◆ Original Medicare: You will be charged for standardized **Part A and Part B costs**, including a monthly Part B premium (\$170.10 in 2022). You are responsible for paying a 20% coinsurance for Medicare-covered services if you see a participating provider and after meeting your deductible.
- ◆ Medicare Advantage: Your cost-sharing varies depending on plan. You usually pay a copayment for **in-network** care. Plans may charge a monthly premium in addition to Part B premium.

### Supplemental insurance

- ◆ Original Medicare: Have the choice to pay an additional premium for a **Medigap policy** to cover Medicare cost-sharing.



Dear Marci

- ◆ Medicare Advantage: Cannot purchase a Medigap

policy.

### Provider access

- ◆ Original Medicare: Can see any provider and use any facility that accepts Medicare (participating and non-participating).
- ◆ Medicare Advantage: Typically can only see in-network providers.
- ◆ Referrals
- ◆ Original Medicare: Do not need referrals for specialists.
- ◆ Medicare Advantage: Typically need referrals for specialists.

### Drug coverage

- ◆ Original Medicare: Must sign up for stand-alone prescription drug plan.
- ◆ Medicare Advantage: In most cases, plan provides prescription drug coverage (you may be required to pay a higher premium).
- ◆ Other benefits

- ◆ Original Medicare: Does not cover vision, hearing, or dental services.
- ◆ Medicare Advantage: May cover additional services, including vision, hearing, and/or dental (additional benefits may increase your premium and/or other out-of-pocket costs).

### Out-of-pocket limit

- ◆ Original Medicare: No out-of-pocket limit.
- ◆ Medicare Advantage: Annual out-of-pocket limit. Plan pays the full cost of your care after you reach the limit.

Between the two options, one is not better than the other. Medicare Advantage and Original Medicare are just different, and you may prefer one over the other depending on your needs and priorities. To review the differences and receive counseling on your options, I recommend calling your local **State Health Insurance Assistance Program (SHIP)**.  
-Marci

## Social Security benefits should rise around 9 percent in 2023

It is looking as if 2023 will bring some good news to the vast majority of people who rely on Social Security for all or a significant share of their retirement income. Paul Brandi reports for **Marketwatch.com** that Social Security benefits should increase by 9 percent or so in 2023. For a change, the increase in benefits—a **monthly average of about \$150**—should cover people's increased costs.

This year, the Social Security benefit increase was 5.9 percent. That was big, bigger than in a very long time. But, it was not big enough, since inflation turned out to be significantly higher than

the increase. Consequently, Social Security recipients ended up with about 3 percent less, from an inflation-adjusted perspective, than they received the prior year.

Social Security increases are **pegged to general cost of living increases**, which usually are lower than cost of living increases for older adults. Older adults tend to spend a lot more on health care, and health care prices tend to rise more quickly than prices for other basic goods. As of now, however, likely because of negotiated rates pre-inflation, health care costs have not risen as



much as other market basket items.

If you are still working and claiming Social Security or plan to start working again, the high inflation rate should help you a little. Social Security benefits are withheld for people who earn more than a certain amount. Because inflation is high, the amount you can earn without affecting your Social Security benefits is rising appreciably. In other words, you can earn more without losing Social Security income.

It's also possible that if the Federal Reserve increases interest rates, inflation will come down some. If that happens after the

Social Security Trustees lock in the increase in benefits for people receiving Social Security, they will end up ahead. But, if inflation comes down in August and September, the Social Security increase will also come down. The Social Security Administration calculates the increase based on the average of July, August and September inflation numbers.

Congress still needs to address the need for **higher Social Security benefits** and for strengthening the Social Security Trust Fund, which is now scheduled to pay out more than it has, beginning in 2034.

## SSFairness.org: Alert—Yes, We Have Progress!

We're Ready for a House vote; Time to Lean on Senators; Building State Coalitions

We now have 294 Members of the House of Representatives who have co-signed H.R. 82, to fully repeal the WEP and GPO—more than what we need! Sponsors, Davis and Spanberger, have formally requested a House

VOTE on their bill. Call your Member of Congress and thank them or tell them why you still need them to co-sign H.R. 82. You can see if they have signed on by clicking on the link near the top of our website—**ssfairness.org**.

Here's why we need to keep



**Social Security Fairness**

up the pressure:

“House rules allow a member of Congress to file a motion with the House Clerk to place their legislation on the Consensus Calendar once their legislation has accumulated at least 290 cosponsors. If the legislation maintains at least 290 cosponsors for 25 legislative

days, and the committee of jurisdiction does not report the legislation, it will be placed on the Consensus Calendar. (Bold added) House Speaker Nancy Pelosi has the authority to bring legislation on the Consensus Calendar to the floor for a vote before the full House of Representatives.” ...**Read More**

## CDC eases Covid-19 quarantine and testing guidelines as it marks a new phase in pandemic

People who are not up to date with their Covid-19 vaccines and who are exposed to someone infected with the coronavirus no longer need to quarantine, according to updated recommendations issued Thursday by the Centers for Disease Control and Prevention.

Instead, they should just wear a mask for 10 days in indoor settings and test on day 5, according to the guidance. They were previously recommended to stay home.

The new guidelines could also ease the testing burden on schools. While people showing symptoms of Covid should be tested, the recommendations say broader screening "might not be cost-effective in general community settings, especially if Covid-19 prevalence is low." Such widespread testing could still be done in certain settings like long-term care facilities,

correctional facilities, and homeless shelters.

The agency is no longer recommending "test-to-stay" policies for schools, when unvaccinated children exposed to someone with Covid could stay in school as long as they tested negative instead of having to quarantine.

Sarah Lee, a school health expert at the CDC, said the agency removed the "test-to-stay" guideline because the agency no longer recommended quarantine broadly. But she said on a press call that schools could still consider using widespread testing during outbreaks or during periods of high Covid-19 prevalence for events like sport tournaments and proms or for after school breaks.

Taken together, the new guidance no longer comes across as a list of things to do or to avoid and instead offers more general guidelines about what



settings present more of a threat of transmission (indoor, crowded settings with poor ventilation) and who is at higher risk for a more severe outcome of a Covid infection — essentially, older people and those with other health issues, particularly if they are unvaccinated or not up to date with shots.

For example, the guidelines deemphasize physical distancing as a specific strategy people should adhere to, instead framing it as just one step people can employ to decrease their risk of getting Covid. People can assess their need to take precautions like distancing and masking based on local transmission levels and how well ventilated the area they're in is, the guidelines say.

One recommendation that remains the same: people with Covid-19 should isolate for at least five days and perhaps

longer, depending on how sick they get and whether their symptoms persist. If people leave isolation on day 5, they should wear a mask through day 10, or test negative twice over 48 hours before they stop wearing a mask.

The CDC portrayed its updated guidance as a "streamlining" of policies, a framework that can help people move on from the acute phase of the pandemic while still trying to protect themselves against the ongoing spread of the SARS-CoV-2 virus.

"This guidance acknowledges that the pandemic is not over, but also helps us move to a point where Covid-19 no longer severely disrupts our daily lives," Greta Massetti, one of the authors of the CDC guidelines, said in a statement.

## Three At-Home COVID Tests Needed to Confirm Negative Result, FDA Says

(HealthDay News) -- People who test at home after being exposed to COVID-19 should take the test three, not two, times to make sure they're not infected, the U.S. Food and Drug Administration said Thursday.

In issuing its new safety communication, the agency said the latest research suggests that taking just two **antigen tests** misses too many infections and could result in people inadvertently spreading the virus

to others, especially if they don't develop symptoms.

In its announcement, the agency pointed to a preliminary government **study** that found adding a third test improved accuracy from 62% to 79%.

"The FDA's new recommendations for at-home COVID-19 antigen tests underscore the importance of repeat testing after a negative test result in order to increase the



chances of detecting an infection," said Dr. Jeff Shuren, director of the FDA's Center for Devices and Radiological Health, said in an agency **news release** on the recommendation.

The FDA recommended taking the three tests every 48 hours, until you have a negative test and no symptoms.

The recommendations were made after the FDA collaborated with government and academic

partners to assess the performance of at-home antigen tests, Shuren said.

"Throughout the pandemic, we have continued to learn about COVID-19 and the impact of variants on the performance of diagnostic tests designed to detect the virus, and we are committed to keeping the public updated so they can make the most informed health care decisions," Shuren noted.

## Veterans Often Reluctant to Admit Struggles With Sleep, Addictions

A new study of U.S. military veterans reveals they are more comfortable getting help for physical ills than for mental health issues.

"The majority of participants indicated they would be willing to seek treatment for both physical and mental health problems. However, they reported significantly greater willingness to seek treatment for physical than mental health conditions," said principal

investigator Mary Beth Miller. She's an assistant professor of clinical psychiatry at the University of Missouri School of Medicine. The researchers worked with 334 veterans from 46 states, screening them for 15 medical conditions, including **insomnia, alcohol abuse**, drug use, **post-traumatic stress disorder** (PTSD), **anxiety** and **depression**.



The research team also rated the importance of treatment for each health condition and the vets' willingness to seek treatment.

Willingness to seek treatment was greatest for chronic pain, chronic medical conditions and brain injuries. Willingness was lowest for alcohol or drug use and sleep disorders, the investigators said.

"We speculate that because sleep and alcohol problems are

common, they may be normalized or minimized to the extent that they are no longer viewed as problems -- or at least problems that warrant treatment," Miller said in a university news release...

About 66% of the study participants were men, and 70% identified themselves as a person of color. **Read More**

## Poliovirus Discovered in NYC Wastewater

State and local health officials have detected the **poliovirus** in New York City's wastewater, a finding that indicates the virus has spread widely since first being discovered in the wastewater of a neighboring county last month.

The New York State Department of Health and the New York City Department of Health and Mental Hygiene both **advised** New Yorkers to get vaccinated now if they have not already completed their series of polio shots.

The discovery of poliovirus in sewage samples suggests there is already community transmission of the virus that can lead to permanent **paralysis** of the arms and legs, as well as death in some cases.

"For every one case of paralytic polio identified, hundreds more may be undetected," said State Health Commissioner Dr. Mary Bassett.

"The detection of poliovirus in wastewater samples in New York City is alarming, but not surprising. Already, the State Health Department — working with local and federal partners — is responding urgently, continuing case investigation and aggressively assessing spread,"

Bassett said in a Department of Health news release.

"The best way to keep adults and children polio-free is through safe and effective immunization — New Yorkers' greatest protection against the worst outcomes of polio, including permanent paralysis and even death," Bassett added.

"The risk to New Yorkers is real, but the defense is so simple — get vaccinated against polio," said New York City Health Commissioner Dr. Ashwin Vasani. "With polio circulating in our communities, there is simply nothing more essential than vaccinating our children to protect them from this virus, and if you're an unvaccinated or incompletely vaccinated adult, please choose now to get the vaccine. Polio is entirely preventable and its reappearance should be a call to action for all of us."

This discovery is the latest in the state, where a case of polio was **confirmed** July 21 in Rockland County. Poliovirus was also found in wastewater samples from both Rockland and Orange counties in May, June and July.

Most adults were already vaccinated for polio as children.



Those who did not receive their vaccines should talk to their health care providers, as should parents of children, to schedule an appointment for vaccination against polio, health officials said.

All children should receive four doses of the polio vaccine, typically with the first dose between the age of 6 weeks and 2 months of age, followed by doses at 4 months, sometime between 6 and 18 months, and again between 4 and 6 years old.

Those who are unvaccinated or unsure if they've been vaccinated should receive a total of three doses if starting the vaccine series after age 4.

Adults who have had one to two doses of polio vaccine should get one to two more doses. It does not matter how long it has been since the earlier doses, officials said.

Lower vaccine coverage rates have put communities at risk for outbreaks. Only about 86% of New York City children ages 6 months to 5 years have received three doses of the polio vaccine. Neighborhoods where coverage is less than 70% of children are of particular concern, public health officials said.

In Rockland County, vaccine rates are even lower, at just over 60%. In Orange County, the rate is just under 59%. Statewide, the rate is nearly 79% among children who have received three polio immunizations before the age of 2, officials said.

In addition to paralysis in the arms and legs, polio can be fatal if paralysis occurs in muscles used to breathe or swallow. Most people infected with the virus do not have any symptoms. Some will have flu-like symptoms, including sore throat, fever, tiredness, nausea and stomach pain.

About one in 25 people infected with poliovirus will get **viral meningitis**, and about one in 200 will become paralyzed.

**Inactivated poliovirus vaccine** (IPV) is the only polio vaccine that has been given in the United States since 2000, according to the U.S. Centers for Disease Control and Prevention. It protects 99% of children who get all the recommended doses.

**More information**  
The U.S. Centers for Disease Control and Prevention has more on **poliovirus**.

## Who Fares Worse After Multiple Sclerosis Strikes?

For people with multiple sclerosis, certain factors early in their disease may determine their quality of life in the years to come, a new study suggests.

In medicine, there are ways to objectively measure a disease's course, such as whether a medication is keeping it under control. And then there's health-related **quality of life** -- the way people with a medical condition feel about their day-to-day physical and mental functioning.

Many studies have asked people with **multiple sclerosis (MS)** about their quality of life. But few have followed them over time, tracking how things change over the years.

The new study — published online Aug. 10 in **Neurology** — did look at that long-term trajectory and whether any factors early on could predict a worse course.

It turned out there were a few:

People who were relatively older when they were diagnosed with MS and those with more fatigue or physical impairments tended to have a poorer outlook in terms of physical well-being.

Meanwhile, people with a relatively lower income or no college education tended to fare worse on measures of mental well-being.

"Early factors, within the first three years of diagnosis, can help predict the long-term trajectory," said lead researcher Julia O'Mahony, of the Health Sciences Centre Winnipeg in Manitoba, Canada.

That's important, she said, because if doctors know certain patients have risk factors for poorer quality of life down the road, they can try to intervene.

MS is a neurological disorder caused by a misguided immune



system attack on the body's own myelin -- the protective sheath around nerve fibers in the spine and brain. Depending on where the damage occurs, symptoms include vision problems, muscle weakness, numbness and difficulty with balance and coordination.

Most people with MS have the **relapsing-remitting form**, in which symptoms flare for a time, then recede. Over time, the disease becomes more steadily progressive.

The latest study involved 4,888 U.S. adults with MS who completed questionnaires on quality of life at least three times over 27 years.

Looking at long-term trajectories, the study found people fell into different groups: A little over half consistently had low or "moderately" low quality of life, but many others saw

changes. When it came to mental well-being, almost half of patients either consistently reported "normal" quality of life or showed positive change.

"Some people start low, then improve," O'Mahony said.

As for physical well-being, age at diagnosis was important. MS often arises in young adulthood, and in this study, people with poorer physical quality of life tended to be diagnosed relatively later -- at age 46, on average.

It's possible, O'Mahony said, that those individuals had additional health conditions.

On the flip side, she noted, older age at diagnosis was tied to better mental well-being.

"This is just speculation," O'Mahony said, "but greater life experience may help people deal with the diagnosis."...**Read More**

## Everyday Activities That Can Cut Your Odds for Dementia

(HealthDay News) -- Reading, doing yoga and spending time with family and friends might help lower your risk of **dementia**, a new study suggests.

"Previous studies have shown that leisure activities were associated with various health benefits, such as a lower cancer risk, a reduction of **atrial fibrillation**, and a person's perception of their own well-being," said study author Lin Lu, of Peking University Sixth Hospital in Beijing, China.

"However, there is conflicting evidence of the role of leisure activities in the prevention of dementia. Our research found that leisure activities like making crafts, playing sports or

volunteering were linked to a reduced risk of dementia," Lu added.

For the new study, Lu and his team reviewed 38 studies that included more than 2 million people who did not have dementia. Of those, 74,700 developed **dementia** during the three-year follow-up.

After taking into account factors such as age, sex and education, the investigators found that people who engaged in leisure activities had a 17% lower risk of dementia than those who didn't.

The study looked at mental, physical and social activities.

Mental activities included reading, writing for pleasure, watching television, listening to



the radio, playing games or musical instruments, using a computer and making crafts. Folks who did these activities had a 23% lower risk of dementia.

Physical activities — including walking, running, swimming, bicycling, using exercise machines, playing sports, yoga and dancing — were linked to a 17% lower dementia risk, the researchers found.

Engaging in social activities — such as staying in touch with others, taking classes, joining clubs, volunteering, spending time with relatives or friends, or attending church — was associated with a 7% lower risk.

This study can't prove that these activities **lower the risk for**

**dementia**, only that there may be a connection, the team noted.

"This meta-analysis suggests that being active has benefits, and there are plenty of activities that are easy to incorporate into daily life that may be beneficial to the brain," Lu said in a news release from the American Academy of Neurology. "Our research found that leisure activities may reduce the risk of dementia. Future studies should include larger sample sizes and longer follow-up time to reveal more links between leisure activities and dementia."

The report was published online Aug. 10 in the journal **Neurology**.

## Health Conditions a Dentist Might Find That Have Nothing to Do With Your Teeth

A visit to the dentist's office could provide a glimpse into your heart and brain health.

More than an estimated 100 diseases can show symptoms in the mouth. For instance, periodontal disease, which results from infections and inflammation of the gums and bone that support and surround the teeth, is more common and may be more severe in people with diabetes.

Other times, prescription drugs may affect the mouth. For instance, some drugs used to treat hypertension can cause swollen, inflamed gums.

"We see a lot of systemic diseases with oral signs and symptoms," said Dr. Jennifer Perkins, executive director of clinical education at the University of California San Francisco School of Dentistry.

Dentists might be able to pick up on red flags about a patient's overall health before they even start poking around in the mouth. Perkins teaches in several courses that focus on evaluating and following up on patients' medical health histories.

"Through that process, we sometimes come across important medical findings," she said. Students who work with faculty at UCSF find symptoms or concerns in patients every day that might need a consult or referral to a health care

professional. The following are some examples.

### Hypertension

A person's blood pressure may be taken before a cleaning or a dental procedure that requires a local anesthetic, Perkins said. Most dental offices ask first-time visitors to fill out medical history forms that are updated periodically, much like at the doctor's office.

"Every contact that a patient makes with the health care system is another opportunity for prevention, and hypertension is a classic example of a condition where this may make all the difference," said Dr. Dhruv Satish Kazi, associate professor of medicine at Harvard Medical School in Boston. Many dental clinics will check blood pressure, he said, "and can therefore identify patients who need to be connected with care."

Dentist offices, he added, can serve as a touchpoint for other services, especially for residents of lower-income or rural areas that may not have as many health care professionals.

For people already diagnosed with high blood pressure, some hypertension drugs can cause dry mouth. When the salivary glands don't produce enough saliva to keep



the mouth wet, tooth decay accelerates, since saliva protects against decay. In those cases,

Perkins said, dentists work with the patient's health care professional to manage side effects.

### Diabetes

Untreated diabetes can lead to serious medical problems, including cardiovascular disease. In some patients, Perkins said high average blood sugar can lead to disruptions in the oral microbiome — the vast collection of friendly bacteria, viruses and other microbes that live in the mouth. That could mean gum disease, bone loss and losing teeth, she said.

"We do see this phenomenon where people who perceive themselves to be healthy may not go to the doctor," Perkins said. "Because (undiagnosed) diabetes and hypertension can present without clear symptoms, we may just happen to see them first. Unfortunately, it's not uncommon for us to see."

### HIV

Perkins has treated people later diagnosed with HIV after finding lesions in their mouth that would not appear in someone with a functioning immune system. The risk of cardiovascular disease for people living with HIV is about 1.5 to two times greater than for people without the virus,

according to an American Heart Association scientific statement about cardiovascular disease and HIV.

### COVID

Perkins said the UCSF School of Dentistry has tested patients for COVID-19 before dental procedures since shortly after the pandemic began in 2020 to protect students, staff and other patients from infection. Her clinic only recently shifted to not requiring testing before procedures for people who are fully vaccinated and boosted.

Research shows the coronavirus can hurt the heart and brain. And conditions such as HIV, diabetes and possibly high blood pressure are among those that can lead to severe illness from COVID-19, according to the Centers for Disease Control and Prevention.

Although dentists can pick up on various health conditions, Kazi cautioned against thinking dentists are a one-stop shop for health.

"It's magical thinking that our dental colleagues have the bandwidth to talk at length about heart disease, just like our cardiology colleagues don't have the time to talk about dental health more broadly," Kazi said. "But there are enough synergies for the two to connect and improve cardiovascular screening and care."

## Watch Out for the Warning Signs of Heart Failure

(HealthDay News) -- Heart failure can develop at any age, but it can be prevented or treated, one cardiologist says.

**Heart failure** happens when the heart becomes too stiff or weak, no longer able to keep up with the body's demands for pumping blood. The primary cause is heart disease, but the heart muscle can also stiffen because of poorly controlled high blood pressure or diabetes. More rarely, **cardiomyopathies** or **myocarditis** from a virus can cause the condition.

Some other risk factors include sleep apnea, some cancer medications and poor lifestyle behaviors.

"Maintaining a healthy diet, treating obesity, avoiding tobacco use and secondhand smoke, and avoiding alcohol can help prevent heart failure," said Dr. Gosia Wamil, a cardiologist at Mayo Clinic Healthcare in London.

Wamil's heart failure research includes studies aimed at understanding and breaking the connection between diabetes and heart disease, as well as using novel medical imaging methods to spot heart failure early.

Among the symptoms of heart failure are ankle swelling, breathlessness, chest pain, fatigue during exercise and a



rapid or irregular heartbeat. "There are other symptoms that people may not associate with heart failure.

Those include a persistent cough, abdominal swelling, rapid weight gain, nausea and a lack of appetite," Wamil said in a Mayo Clinic news release. "People who experience any of these symptoms should contact their health care provider."

Treatments may differ depending on what's causing a person's heart failure. It can't be cured, but the symptoms can often be controlled for years.

"After heart failure is diagnosed, patients will need to manage the condition for the rest

of their lives, usually through care at specialized heart failure clinics," Wamil said.

Treatments include medication, surgically implanted devices and, in advanced cases, **heart transplants**. Researchers are also working to discover new therapies.

"Over the last few years, we have observed significant advances with the introduction of new classes of medications to manage heart failure," Wamil said. Those include drugs called **SGLT2 inhibitors**, initially developed to lower blood sugar levels in patients with diabetes.

## Nerve Block Plus Lidocaine Clears Psoriasis in Small Study

Spinal injections of a common anesthetic may help clear the inflammatory skin condition psoriasis, a small pilot study suggests.

**The study** involved four patients with severe psoriasis, and researchers are describing it as a "proof-of-concept" — specifically, the idea that targeting certain sensory nerves might help treat the skin disease.

Much more research is needed before the tactic could be used as a psoriasis treatment, experts said.

But for the four patients treated — up to four times over a few months — the lidocaine injections led to a significant reduction in skin symptoms.

Psoriasis is a chronic skin condition that affects more than 8 million Americans, according to the National **Psoriasis Foundation**. The disease arises from an abnormal immune response that triggers rapid turnover of skin cells, causing them to pile up on the skin's surface.

Most people have a form called **plaque psoriasis**. They periodically develop red, scaly patches on the skin that can be itchy and painful.

Standard treatments target the inflammation — topical corticosteroids being the most common. For people with more



severe psoriasis, some options include light therapy (exposing the skin to natural or artificial light) and injection medications that suppress the immune system.

For the new study, researchers in China tried an entirely different approach: **Injecting lidocaine**, a commonly used local anesthetic, to block sensory nerves that carry pain signals.

The researchers decided to try the tactic based on some unusual observations about patients with **psoriasis**.

"Case studies have shown that psoriasis patients have experienced significant symptom relief after receiving epidural

anesthesia during surgery," said lead researcher Honglin Wang of Shanghai Jiao Tong University School of Medicine.

That, he said in a written statement, suggests the nervous system might play a "pivotal role" in causing psoriasis.

For the study, Wang's team recruited four patients with severe psoriasis; two had psoriasis patches all over their bodies, while the other two had the condition mainly on their legs. All received epidural lidocaine — where a small, flexible tube is inserted into the lower back to deliver the medication to the fluid-filled space outside the spinal cord...**Read More**

## Cheaper Over-the-Counter Hearing Aids Should Be in Stores by October, FDA Says

Affordable over-the-counter hearing aids will bring relief to millions of Americans suffering from hearing loss by mid-October, under a landmark proposal just announced by the U.S. Food and Drug Administration.

The **final rule** announced Tuesday creates a category of hearing aids that could be sold directly to consumers, without either a medical exam or a fitting by an audiologist.

"The rule will allow consumers to have greater control over their **hearing aid** purchasing decisions at stores nationwide or online without a professional hearing

test, fitting adjustment or a prescription," FDA Commissioner Dr. Robert Califf said during a media briefing. "People with hearing impairments, especially older Americans, could see over-the-counter hearing aids available as early as mid-October."

Until now, folks with hearing loss have typically had to fork out thousands of dollars for a device that could only be adjusted by a professional audiologist.

That's been a barrier that left close to 30 million U.S. adults



Woman Wearing Bose Sound Control Hearing Aid

without the hearing help they need. While roughly 15% of Americans report some trouble with their hearing, the FDA estimates that only 1 in 5 people who could benefit from a hearing aid actually use one.

President Joe Biden praised the FDA's announcement.

"This action makes good on my commitment to lower costs for American families, delivering nearly \$3,000 in savings to American families for a pair of hearing aids and giving people more choices to improve their health and

wellbeing," Biden said in a **statement issued by the White House**.

The over-the-counter category established in the new rule applies to hearing aids intended for people 18 or older who have mild to moderate hearing impairment. Other types of hearing aids -- including those for children or people with severe hearing problems -- will remain prescription devices.

The FDA received more than 1,000 public comments on the proposed rule when it was first issued on Oct. 20, 2021...**Read More**