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RI ARA

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Message from the Alliance *for* Retired Americans Leaders

Alliance Mourns the Death of Jo Etta Brown

Robert Roach, Jr
President, ARA

Jo Etta Brown

Jo Etta Brown, who served as Alliance Executive Vice President from 2014 until this year, **passed away on Saturday August 13, 2022** in Nevada after a long career of fighting for seniors and civil rights.

"Jo Etta was beloved not just for her commitment to social justice, but for her warmth and the way she touched everyone who interacted with her," said Robert Roach, Jr., President of the Alliance. "She will be missed but we will always remember her kindness and dedication."

Ms. Brown first joined the Nevada Alliance in 2007 after 30 years in community banking, urban development and affordable housing advocacy, bringing to the Alliance her experience fighting for more women in management roles. She led the Alliance's Community Advocacy Network while serving as Executive Vice President.

In 2016 Nevada Governor Brian Sandoval appointed her to the Nevada Commission for Women, which studies the changing and developing roles of women in society and recommends proposed legislation. In 2020 Governor Steve Sisolak re-appointed her and made her Chair, and he re-appointed her as Chair in 2021.

At their national meeting in July, Alliance members adopted a **resolution** honoring Jo Etta's work in transforming the lives of retirees in Nevada and across the country.

Arizona Alliance, Priorities USA and Voto Latino Challenge Arizona Voter Suppression Law

Rich Fiesta, Executive Director, ARA

The Arizona Alliance for Retired Americans, Priorities USA and Voto Latino announced a legal challenge to Arizona SB 1260. The bill radically alters Arizona's voting laws by threatening the ability of Arizonans to cast a ballot if they have previously registered to vote in another state or another Arizona county. There is no requirement that notice be given to a voter if their registration is purged by a county official. The bill was signed into law in June and is scheduled to take effect on September 24, 2022.

Read full press release from Richard Fiesta, Executive Director of the Alliance for Retired Americans **here**.

Richard Fiesta Addresses APWU Retirees in Maryland

Executive Director Fiesta was in National Harbor, Maryland Saturday to address the American Postal Workers Union (APWU) Retirees Conference. During his presentation he discussed the senior vote in the 2022 midterm elections and the Alliance's Medicare and Social Security anniversary activities. Fiesta thanked APWU for its strong, continuing partnership with the Alliance. He also spoke about the many pro-retiree actions taken by Congress and the Biden Administration, including the IRA, which will allow Medicare to negotiate prescription drug prices and cap insulin at $35 per month for Medicare beneficiaries.

Alliance Celebrates Social Security's Anniversary in the Face of Threats to the Program

Joseph Peters, Jr.
Secretary Treasurer ARA

Alliance members commemorated the 87th anniversary of Social Security on August 14 and throughout the month as a growing number of Republican candidates and elected officials call for dramatic changes to the earned benefits program. Threats include requiring it to be re-approved by Congress every year, sunsetting it in five years, privatizing the system, and reducing benefits.

"Social Security has been a bedrock of our retirement security since FDR signed it into law on August 14, 1935, and this anniversary is an opportunity to remind Americans we cannot take its future for granted," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "As we celebrate the anniversary, we also redouble our efforts with events to make sure voters understand that the benefits they have earned will be on the ballot in November."

The events call for expanding Social Security and protecting it from attempts to cut, eliminate or privatize it. A virtual event in Wisconsin on Monday featured Rep. Mark Pocan. Wisconsin is a key state in the battle to protect Social Security, because Sen. Ron Johnson (WI) favors an **extreme plan** that includes Social Security and Medicare being re-approved on an annual basis by Congress.

Arizona members thanked Rep. Raúl Grijalva on Thursday for his work to expand and protect Social Security. An August 4 event in Arizona focused on the threat posed by Blake Masters, **who won** the Republican primary for Senate in the state and publicly has called for the **privatization** of the program.

A virtual event in Florida on Thursday featured Rep. Charlie Crist. His fellow Floridian, Sen. Rick Scott — the chair of the National Republican Senatorial Committee — has crafted an election-year campaign plan that would sunset Medicare and Social Security in five years.

An event in West Hartford, Connecticut featured Rep. John Larson, who has introduced legislation endorsed by the Alliance to expand Social Security. H.R. 5723, the Social Security 2100: A Sacred Trust Act, increases benefits for all beneficiaries and requires that wealthy Americans pay their fair share of Social Security taxes.

ADD YOUR NAME

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

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Senior Citizens League Update Week Ending August 20, 2022

Congress in Recess – but Much Work Remains When They Return

Congress is now in recess until after Labor Day. If they are running for re-election, all members of the House of Representatives and one-third of the members of the Senate are now back in their states campaigning.

When they return to Washington, they have a tremendous amount of work to do, including passing funding for the federal government for FY 2023. However, even before they left for their recess the expectation among many people in Washington is that they will not be able to pass new funding by the start of the new fiscal year, which is October 1. That means, once again, they will be passing temporary funding measures to keep the government open until they can agree on full funding legislation for the entire fiscal year.

There are also cuts in Medicare looming if Congress does not take action before the end of this year. See more on that below.

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President Signs Law to Lower Prescription Drug Prices into Law

Last week President Biden signed the Inflation Reduction Act into law. That is the legislation that contains the provisions that will allow Medicare to negotiate drug prices with the big drug companies and eventually lower prescription drug prices.

In case you missed it in last week's update, here are the important measures in the bill that will help TSCL supporters, and all seniors in Medicare in the coming years. The provisions of the legislation will kick in over a period of years and we have listed them below in the order in which they will become effective.

Starting next year vaccines will be available with no co-pay or deductible under Medicare Part D.

The measure will exclude insulin products covered under Medicare Part D from applying to Medicare patient deductibles under the program, starting next year. It will also cap insulin copayments for Medicare patients to $35 a month for plan years 2023 through 2025 regardless of whether an individual has reached the initial coverage limit or out-of-pocket threshold. Medicare patients would also receive reimbursement for any excess cost-sharing or copayments made in the first three months of 2023.

It will expand Medicare Part D premium subsidies for low-income seniors to those between 135% and 150% of the poverty line starting Jan. 1, 2024.

The measure will also cap the out-of-pocket cost of prescription drugs under Medicare Part D for beneficiaries at $2,000 a year starting in 2025.

It will direct the Health and Human Services Department to establish a "Drug Price Negotiation Program" to negotiate a maximum price of high-cost prescription drugs beginning in 2026 for Medicare Part B, which covers medicines administered in a medical setting, and Part D, the program's prescription drug benefit.

It will also require the Department of Health and Human Services (HHS) to identify 100 drugs without competition that have been on the market for seven years and biologics that have been on the market for 11 years, and that have the highest spending under Medicare.

HHS would select 10 drugs from that list — or the maximum number eligible for negotiation that year if less than that — for negotiation in 2026 increasing to 20 drugs by 2029.

* * * *

Drug Companies to Fight to Block Laws Lowering Drug Prices

While we do not have specifics yet, the big drug companies are already planning to do all they can to stop the new laws that will lower drug prices from taking effect.

According to a report in *STAT News*, "Even before the law passed, the pharmaceutical industry was threatening to sue to block the reforms, with both the brand drug lobby PhRMA and the Biotechnology Innovation Organization issuing veiled promises to 'explore every opportunity' or 'explore all avenues' to stop the law from taking effect."

We will report more as this develops in the future. If they begin efforts to repeal the new laws, TSCL will do all we can to fight to stop them.

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Medicare Cuts Looming

There are significant cuts in Medicare spending that will take place unless Congress takes action before the end of this year. Below is an explanation of why these cuts could come. We realize it is a bit complicated, but we think you should know what could happen because if cuts are made, they may severely impact the healthcare of some, or all seniors.

Health care providers could be facing a significant reduction in Medicare payments if Congress fails to pass legislation to avert these decreases by the end of the year. These looming cuts are the result of several policies that have a combined effect of reducing Medicare payments by as much as 9%.

The first of these policies is the 2% Medicare Sequestration reduction. These are the result of a law passed in 2010 meant to help reduce the federal deficit. Any year that spending on certain government programs increases the federal deficit, cuts in the spending of that program must be made.

Congress paused sequestration cuts in 2020 and 2021 due to the COVID-19 pandemic but began phasing them in again in 2022. Sequestration resumed with a 1% reduction during the second quarter of the year and fully resumed a 2% reduction on July 1.

The second of these cuts is a 4% reduction associated with the American Rescue Plan Act (ARPA) of 2021. ARPA provided $1.9 trillion in economic relief for the COVID-19 pandemic. When passing this bill, Congress failed to include a waiver of the statutory "PAYGO" requirement to offset the cost of legislation that adds to the federal budget deficit.

As a result, cuts required by law were automatically set to take effect in 2022, including a 4% Medicare reduction. While Congress ultimately passed legislation that prevented this cut from taking effect in 2022, it did so by delaying the cut until 2023. *This means that Congress must pass new legislation that either fully waives cuts for the American Rescue Plan Act or pass another delay for implementation.*

The last reason for the looming cuts is the most complicated and we will not even try to explain, except to say that there will be a cut in payments to some medical specialties if Congress does not act.

Between the resumption of the 2% sequestration cut, the prospect of a 4% PAYGO cut, and the expiration of the 3% physician payment increase, providers are looking at a 9% reduction in Medicare payments in 2023 compared to 2022 without Congressional action.

TSCL opposes these cuts, and we will be watching carefully when Congress returns to work next month and do all we can to prevent them.

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The Senior Citizens League supports Social Security 2100: A Sacred Trust because it would expand and protect benefits and repeal WEP/GPO that hurts many of our nation's public servants. To celebrate 87 years of **#SocialSecurity**, let's pass this bill!

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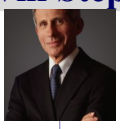
Social Security has lost roughly 40% of its buying power since 2000, according to a 2022 report from The Senior Citizens League. What Everyone Gets Wrong About the Future of Social Security….**Read More**

Dr. Anthony Fauci Will Step Down in December



Dr. Anthony Fauci, who has advised seven presidents and spent more than five decades at the U.S. National Institutes of Health, will step down in December to "pursue the next chapter" of his career, he announced Monday.

Fauci, 81, currently serves as the director of the **U.S. National Institute of Allergy and Infectious Diseases** (NIAID) and is chief medical adviser to President Joe Biden.

"While I am moving on from my current positions, I am not retiring. After more than 50 years of government service, I plan to pursue the next phase of my career while I still have so much energy and passion for my field," Fauci said in a **statement** posted on the NIAID website.

"I want to use what I have learned as NIAID director to continue to advance science and public health and to inspire and mentor the next generation of scientific leaders as they help prepare the world to face future infectious disease threats," Fauci added.

Fauci joined the NIH in 1968 and rose to prominence within the agency during the 1980s **AIDS crisis**. As an HIV/AIDS researcher, Fauci conducted pivotal studies that formed the basis of medicine's current understanding of the disease and continue to inform the therapies used to treat and prevent AIDS.

Fauci became NIAID director in 1984, and has advised every U.S. president on infectious disease emergencies from Ronald Reagan onward.

The COVID-19 pandemic thrust Fauci's career into controversy. President Donald Trump openly floated the idea of firing Fauci, who came under conservative attack for his support of lockdowns, masks and vaccination.

Fauci had considered stepping down after Trump's departure from the White House, but Biden asked him to remain at his post and help deal with COVID.

"So I stayed on for a year, thinking that at the end of the year, it would be the end of COVID, and as it turned out, you know, that's not exactly what happened," Fauci told the *New York Times*. "And now it's my second year here, and I just realized that there are things that I want to do."

In his statement, Fauci pledged to "continue to put my full effort, passion and commitment into my current responsibilities, as well as help prepare the Institute for a leadership transition" in the coming months.

"NIH is served by some of the most talented scientists in the world, and I have no doubt that I am leaving this work in very capable hands," Fauci said.

FDA plans to authorize bivalent boosters by Labor Day, sources say

The Food and Drug Administration plans to authorize updated versions of Pfizer-BioNTech's and Moderna's Covid boosters around Labor Day, said two people familiar with the discussions.

The Biden administration is preparing to distribute the updated booster shots to teenagers and adults as part of its fall booster campaign.

Both Pfizer's and Moderna's so-called bivalent vaccines target the BA.4 and BA.5 omicron subvariants, in addition to the original coronavirus strain in a single shot. BA.5 is responsible for nearly 90% of all new Covid cases in the U.S., according to **data from the Centers for Disease Control and Prevention.**

Pfizer is seeking authorization **for people 12 and older,** while Moderna is seeking authorization **for all adults.**

The FDA does not plan to convene its advisory panel, the Vaccines and Related Biological Products Advisory Committee, ahead of the authorization, one person said.

The FDA's authorization will not be the final step before the shots can be distributed. The CDC must also sign off; the agency plans to convene its advisory panel, the Advisory Committee on Immunization Practices, on Sept. 1 and 2 to discuss Covid boosters, according to the agency.

A Majority of Americans Support These 4 Changes to Social Security

Social Security is a popular program, and most people want to preserve it. Many people are also aware that the program's trust fund is slated to run dry within the coming years so they want to take steps to shore up its finances to avoid automatic benefit cuts.

The big question is, what are people willing to do to protect Social Security? **Recent research** from the Program for Public Consultation at the University of Maryland revealed some key changes respondents were willing to make.

1. Increasing Social Security taxes on the wealthy

According to the survey, 79% of Republicans and 88% of Democrats wanted to see wealthy people pay more **Social Security** taxes in order to deal with the retirement program's funding problems.

Currently, **Social Security taxes** apply on all wages up to a set amount of earnings called the wage base limit. For 2022, workers pay Social Security tax on up to $147,000 in income but no more. A total of 81% of Americans across all parties want to make wages above $400,000 also subject to Social Security tax.

This would be a big change. Right now, benefits are directly linked to the total taxes you pay in. If this shift occurred, wealthy Americans would be taxed on income above $400,000 but wouldn't see a resulting increase to their benefits. The extra money they bring in would eliminate 61% of the program's shortfall.

2. Increasing Social Security taxes on everyone

Americans aren't just willing to make the rich pay more taxes. They're OK with everyone paying more if necessary.

A total of 73% of people, including 70% of Republicans and 78% of Democrats, said they would be in favor of increasing the current Social Security tax from 6.2% of employee wages to 6.5%. This change would also eliminate 16% of the shortfall.

3. Raising the retirement age

A total of 3/4 of Americans would be willing to wait longer to get their full benefit if necessary. Both 75% of Republicans and 76% of Democrats said the **full retirement age** (FRA) should gradually go up to 68. This is the age when you can get your standard benefit without seeing it reduced by early filing penalties.

FRA is currently between 66 and four months and 67 for those born in 1956 or later. Changing it to 68 would reduce 11% of the shortfall. This would be a de facto benefits cut for everyone, since people who claimed early would get a smaller monthly benefit for life. And those who waited until FRA would miss at least a year of extra benefits if FRA is changed.

4. Reducing retirement benefits for higher earners

Finally, 81% of Americans, including 78% of Republicans and 86% of Democrats, indicated they'd be OK with higher earners getting less benefits. Specifically, people are on board with cutting the Social Security checks available to the top 20% of earners. This change would eliminate 11% of the shortfall.

This would also be a big change because, as mentioned above, currently benefits are directly based on how much you earn and pay taxes on.

It's not clear if lawmakers will heed the public's call to make any of these modifications. But the survey provides some encouraging news in that it shows people are willing to do what it takes to protect Social Security for future generations, even if that requires sacrifice.

President Biden Signs the Inflation Reduction Act into Law

The Medicare Rights Center thanks President Biden for signing—and the House and Senate for passing—the Inflation Reduction Act (IRA) of 2022. This landmark legislation includes policies we have long championed to make health care and prescription drugs more affordable.

Thanks to the IRA:

- **More low-income Medicare beneficiaries will be able to afford coverage and care.** The bill eliminates the partial Part D Low-Income Subsidy (LIS) benefit—which left enrollees exposed to high costs—and extends eligibility for the more comprehensive full subsidy to those who would have qualified: individuals with incomes between 135% and 150% of poverty and resources at or below the **partial LIS limits.** In 2020, over **400,000** Part D enrollees received partial LIS benefits, including a **disproportionate** number of Black and Hispanic enrollees. Under the IRA, these individuals will receive more robust assistance; their annual out-of-pocket (OOP) costs will fall by $300, on average. Those who take expensive specialty drugs, where the program's 15% coinsurance rate can be a burden, will see even greater savings. For example, partial LIS enrollees would have paid around $1,700 for a year's worth of Humira or Enbrel in 2020, while full LIS enrollees would have paid less than $20.
- **All 48 million Part D enrollees will finally be protected from limitless and uncertain prescription drug costs.** The bill creates a $2,000 cap on annual OOP drug spending and allows these costs to be paid monthly. It also eliminates the 5% coinsurance requirement for catastrophic coverage and holds Part D premium growth at no more than 6% per year. **1.4 million** non-LIS enrollees spent $2,000 or more OOP in 2020, and 1.3 million reached the catastrophic coverage threshold ($6,350). These new financial protections will be especially helpful for beneficiaries who take high-cost drugs and may spend **thousands of dollars** in the catastrophic coverage phase.
- **Insulin will be more affordable**. The IRA limits insulin co-payments to $35 per month for Part-D covered products and for insulin furnished under Part B, with no deductible. Currently, over **3 million** Part D enrollees use insulin, and **one in three** have diabetes. On average, in 2020, they paid $600 OOP for insulin. But some had considerably higher costs—25% spent over $800 and 10% spent over $1,300.
- **People with Medicare will be able to receive critical vaccines free of charge**. The IRA eliminates cost-sharing and deductibles for Part D vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP), such as shingles, and under Medicaid. This policy already applies to **Medicare Part B** and **most private plans**. Its expansion will save costs and improve access to necessary preventive care. This will help the approximately **4 million** Medicare beneficiaries who receive a Part D-covered vaccine each year—including the **3.6 million** who received the shingles vaccine in 2020, at an average cost of over $100. However, it will also reach millions more. **Research** shows Part D immunization rates are well below those for Part B, likely due to cost sharing. The additional expense is a well-established **barrier** to beneficiary receipt of recommended vaccines.
- **Marketplace plans will remain affordable**. The IRA temporarily extends the Affordable Care Act premium subsidies that have helped an unprecedented number of Americans gain coverage, often easing Medicare transitions and costs. These enhanced tax credits **have allowed** over 80% of older adult Marketplace enrollees (ages 55-64) to qualify for a plan with a monthly premium of $50 or less. Consumers ages 50-64 have saved over $950 on annual premiums, on average. The IRA ensures even more older adults will have access to this affordable, high-quality coverage.

Critically, the bill also begins to address the drivers of Medicare prescription drug unaffordability by requiring Medicare to negotiate drug prices, penalizing manufacturers for price hikes that outpace inflation, and better-aligning Part D pricing incentives. While the number of beneficiaries who will see lower drug costs in any given year under these provisions, and the magnitude of those savings, will depend on a myriad of to-be-determined factors, these reforms are widely expected to strengthen Medicare and enrollee financial security.

For millions of current and future Medicare beneficiaries the IRA's consumer protections and structural improvements will be nothing short of lifesaving. Every day on Medicare Rights' national helpline, we hear from older adults and people with disabilities who are struggling to pay for care. They may go without or may cut back on other basic needs, like food or rent, just to fill a prescription. The IRA will help ensure fewer people face these impossible choices. We applaud these successes and look forward to working with advocates, stakeholders, and policymakers to build upon them.

Medicare Part A is facing a shortfall. Here's how that could affect you

At its current pace, Medicare's Hospital Insurance trust fund will run out of money in 2028, according to the **June 2022 Medicare trustees report**. That's a two-year extension on the previous estimate, but experts say it's still not good news, and the government needs to stop twiddling its thumbs. Here's what you should know.

What happens if the trust fund is depleted?

If the Medicare Hospital Insurance trust fund is depleted, it doesn't mean **Medicare Part A** will implode. But **the program won't have enough revenues to cover all operating costs, by a shortfall of about 10% starting in 2029.**

"This part of the Medicare program won't be able to make payments to health care providers and health insurers that are due, and those payments will become increasingly delayed over time," says Matthew Fiedler, a senior fellow with the USC-Brookings Schaeffer Initiative for Health Policy.

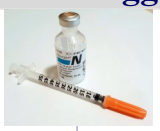
This backlog could result in a big financial shock to hospitals that rely on Medicare revenues to operate. Ultimately, Fiedler says, "hospitals might rethink the extent to which they want to participate in the Medicare program."

It's important to understand that Medicare's Hospital Insurance trust fund doesn't finance all of Medicare — it funds Medicare Part A, or hospital insurance. **Medicare Part B**, which covers doctor's appointments and outpatient care, and **Medicare Part D**, which covers prescription drugs, are funded mainly out of patient premiums and the government's general revenues.

What are the most likely fixes?

There are several ways the government could handle the situation, from tweaking service coverage to redirecting revenues. Here are a few options:,,,**Read more**

One in seven diabetics struggle to pay for insulin



About nine percent of Americans–30 million people in the US–have diabetes. A new **Yale study** finds that 14 percent insulin users—-almost one in seven of them–struggle to pay for insulin. Democrats in Congress tried to include a provision in the **Inflation Reduction Act** that would have limited the cost of insulin to $35 a month for everyone, but only the limit on insulin costs for people with Medicare survived.

Seven million Americans use insulin every day. Its price has doubled in the last ten years. After covering costs for food and housing, 14 percent of diabetics must spend at least 40 percent of their remaining income on insulin.

The Yale researchers found that **1.2 million diabetics reached "catastrophic spending" on insulin** in a single year. Of those, 800,000 were people with Medicare.

To be sure, people with diabetes have health care costs related to their treatment beyond insulin. For example, they also need glucose monitors and insulin pumps. These costs are too often prohibitive.

Notably, people with Medicaid, who have more comprehensive coverage than people with Medicare, were less than half as likely to reach catastrophic spending on insulin.

Prices for insulin have soared since Eli Lilly launched Humalog, an insulin brand. Back in 1996, a vial cost $21. Today, that same vial costs more than $210. The Yale study's lead author believes that prices are likely to keep rising.

The researchers also found that people with Medicare felt the burden of high insulin costs more than any other cohort of people with diabetes because their average annual income is lower. Provisions in the **Inflation Reduction Act** are intended to keep insulin prices from rising more than the rate of inflation for people with Medicare as well as to cap out-of- pocket insulin costs at $35 a month. Already, at least one Part D plan in every state covers insulin at **$35 a month**. But, $35 a month for insulin alone is prohibitively expensive for a lot of people with Medicare.

The researchers argue that any government savings from not making insulin affordable to people with Medicare in the short -term will mean much higher health care costs in the long-term. We can expect to see greater disabilities among people with diabetes who can't afford their insulin, more hospital admissions, and more emergency room visits stemming from complications.

What's wrong with market innovations in health care?

Our federal government counts on market innovations in health care. It also allows companies to abandon these innovations as they please, with little concern for the harm it can cause Americans who depend on them. In an op-ed for **Stat News**, Claudia Jazwinska explains how the health care marketplace and the government can fail Americans who rely on health care innovations.

Hundreds of Americans rely on an innovative medical device in order to see. The Argus II is a retinal implant. But, its manufacturer Second Sight has stopped manufacturing it to avoid possible bankruptcy.

When Second Sight discontinued the Argus II, people using it were left without vision and with an extremely expensive implant in their brain. They had no clue whether the device should be removed and, if so, who had the skills to remove it. They were left at serious risk because they had opted to use cutting edge technology.

Thousands of different implantable devices are in use around the globe, helping people. But, market pressures mean that these devices might not be reliable over the long-term.

No one wants to inhibit meaningful innovation, which regulation can do. But, people who rely on these innovations also need protections.

The National Institutes of Health is continuing to support research from Second Sight even though it failed to continue the Argus II. The NIH is not supporting the patients who relied on its implantable device. And, it does not seem concerned about investing in companies that are not able to continue to service innovations that Americans rely upon them.

Why does our government allow companies to sell costly devices to Americans and then abandon them, especially when these devices are implanted into their bodies? At the very least, companies should be held accountable for doing so. Isn't it negligence or malpractice to leave these people in the lurch?

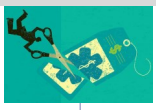
One solution would be to require these companies to make their proprietary devices open-source if they are discontinuing them. Others should be allowed to replicate them. Americans should not bear the burden of a company's inability to continue a valuable technology.

Government proposes cuts to Medicare home health care

In an opinion piece for **Stat News**, Krista Drobac writes about a proposed government cut to Medicare home health care that, if finalized, will take a toll on older adults and people with disabilities. Since the Covid-19 pandemic, more people with Medicare have been receiving a wide range of care at home. They benefit from home health care and value their ability to get care at home.

Home care is particularly valuable because it allows people who might otherwise need to move into a nursing home to age in place. But, the Centers for Medicare and Medicaid Services has proposed a $810 million reduction in Medicare home health care spending beginning in 2023. If the cut goes through, it will reduce the number of people with Medicare able to get physical therapy, skilled nursing care and home health aide services in their home.

As it is, the **Medicare home health benefit** is quite limited. Only people who are effectively homebound–for whom leaving home requires a considerable and taxing effort–are eligible for the benefit. To qualify for Medicare covered home health care, they must also require either skilled nursing care or physical therapy on an intermittent basis–either daily for a short term or longer term for only a few days a week.



The Medicare home health benefit should be expanded, not cut.

Cutting home care benefits would make aging in place even harder for older adults and people with disabilities. It would also undermine the government's purported goal of promoting health equity, innovation and health care affordability. Home-health services help drive accountable care.

Home-health services are particularly valuable for people who live in rural areas. Cuts to Medicare home health care could make it harder to help ensure people in rural communities receive needed care.

If Medicare finalizes its proposed cuts to its home health benefit, home care services will become less affordable and accessible to people with Medicare.

Editor's note: The federal government is overpaying Medicare Advantage plans tens of billions of dollars a year, and they are profiting wildly. Yet, CMS is planning to increase payments to these plans by 8.5 percent in 2023. Rather than continue to put money into the pockets of Wall Street investors, CMS should be helping to assure good affordable home care for people with Medicare.

Requiring primary care coordination could cause patients needless harm

There is a government move afoot to have primary care doctors "manage" care for everyone with Medicare. The benefits of primary care coordination can be tremendous but must be balanced against the risks. Given the shortage of primary care doctors, requiring primary care coordination could cause patients needless harm.

The shortage of primary care doctors could mean dangerous delays for people who need care urgently. And, when primary care doctors work for insurers or private equity firms, as they increasingly do, financial incentives can pose risks to patient health and well-being.

The Centers for Medicare and Medicaid Services, CMS, is on a mission to have everyone with Medicare in what it calls an "Accountable Care Organization" or "ACO" by 2030. With ACOs, the government pays entities an upfront fixed fee to treat patients. It's up to the entity to decide what care to provide and when.

What could be wrong with an ACO? For now, ACOs are accountable in name only. They are largely unaccountable for the care they provide. The limited oversight of their performance coupled with their large financial incentive to withhold care–they profit more–suggests huge cause for concern, especially when Wall Street entities, private equity firms and insurers are calling the shots.

Accountable Care Organizations, like Medicare Advantage HMOs, can leave patients waiting a very long time to see a primary care doctor. If people need to see a primary care physician in order to get specialty treatment, their conditions can worsen when care is delayed. That's often what happens to people in Medicare Advantage HMOs.

Pre-pandemic, **Kevin MD** reports that fewer than one in five physicians were taking new patients. More than eight in ten had no ability to see new patients. We are likely to be **short 48,000 primary care physicians** in the near future.

Of course, the shortage of PCPs would not be as pronounced if doctors spent less time on administrative functions. One study found that about half of a physician's time is spent on administrative work. Less administrative work would make it far easier for doctors to see more patients. Right now, **the US fares poorly relative to other countries in ensuring people see primary care doctors in a timely fashion.**

We need to invest more in primary care before insurers are allowed to require people to see a primary care doctor in order to see a specialist. Kevin MD reports that a lot of unnecessary medical treatment stems from the fact that primary care physicians do not have the time to oversee patient care. Of course, a lot of inappropriate delays and denials of care also result from a weak primary care infrastructure and financial disincentives for insurers to provide appropriate care.

Hospitals speak out against corporate health insurance

Americans have a new ally in the fight for health care reform. The **American Hospital Association** is speaking out against corporate health insurance. Hospitals are feeling the squeeze from corporate health insurers and making clear that patient safety is at risk, as costs increase.

With nearly half of the Medicare population now enrolled in corporate health insurance plans–Medicare Advantage–hospitals are increasingly dealing with corporate health insurer shenanigans. It comes in many forms.

- Insurers often require prior authorization when it can delay patient care and jeopardize health, while also raising administrative costs for providers.
- Insurers often require patients to get less expensive treatment that physicians know will not work before agreeing to cover the care people need. They are using "step therapy" or "fail-first policy" more frequently in order to save money. At the same time these policies add to administrative costs for providers as well as keep people from getting the care they need.
- Insurers often design coverage policies that override physicians as to care that is medically necessary.
- Insurers often prevent physicians and hospitals from treating patients with medications they have in stock–"white bagging"–and require them to use medications from an outside pharmacy. This practice can harm patient safety.
- Insurers use electronic payment methods that sometimes require hospitals to pay money in order to receive reimbursement.

The American Hospital Association recognizes the needs for Congressional fixes. Unfortunately, short of ending the filibuster or having 60 Democratic votes in the Senate, these fixes will not happen.

1. The AHA wants to measure unnecessary administrative costs resulting from corporate health insurer requirements that are inappropriate.
2. The AHA wants standardization and reform of administrative policies in order to reduce the large administrative burden on providers and their patients.

Until we move to Medicare for all, it is more likely that insurance premiums will continue to increase, that more patients will not be able to afford health care, and that more hospitals will fail. Insurance premiums are up 47 percent since 2011.

Number of Older Adults Receiving Low Income Assistance May Have Doubled Since the Start of the Pandemic

Roughly 37% of older adults who participated in TSCL's latest survey, the "Seniors Priority Plan," had some startling information for us as well as for Members of Congress. This group indicated that they receive low-income assistance such as SNAP (food stamps), rental subsidies, and help with Medicare costs. That's more than double the number of older adults who were receiving assistance from these programs in 2019 before the start of the COVID-19 pandemic, according to the U.S. Census Bureau. The fact that these safety net programs have grown so rapidly over the past two years is an indication that Social Security and Medicare are not enough for many retirees to depend on alone, especially during a period of exceptionally high inflation

These assistance programs form a critical means of supplementing Social Security and Medicare but qualifying for benefits isn't easy. Each state has its own rules including limits to the resources or savings that beneficiaries may have and remain eligible for benefits. There are also income restrictions. The federal poverty guidelines allow individuals an annual income of $13,590 per year or $18,310 for 2 person households, although the maximum allowed in each state varies.

One would think that low-income Social Security recipients would benefit the most when the annual cost-of-living adjustment (COLA) is high, but that's not always the case. In fact, a high COLA, such as the 5.9% adjustment that Social Security beneficiaries received this year can boost incomes above eligibility levels for these low-income program limits. Enrollees in these programs often experience benefit trims or in some cases, a loss of benefits altogether. ...**Read More**

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RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Bedsores Can Cause Serious Harm — Are U.S. Nursing Homes Hiding Cases?

People might want to think twice before relying on federal quality ratings to help choose a nursing home for an elderly or frail relative, a new study warns.

The U.S. Centers for Medicare and Medicaid Services (CMS) established the Nursing Home Compare website in the 1990s to publicly report patient safety indicators for every nursing facility in the nation.

But the site appears to drastically underreport the number and severity of bedsores suffered by Medicare residents in specific nursing homes, researchers reported recently in the journal ***Medical Care.***

These findings jibe with a 2020 study that found similar underreporting of nursing home falls that resulted in a major injury, said senior researcher Prachi Sanghavi, an assistant professor of public health sciences at the University of Chicago.

In both studies, researchers compared data from the CMS site directly against claims that hospitals filed with Medicare to reimburse treatment for either **falls** or **bedsores**, Sanghavi said.

"We're actually taking an individual person's claim and linking it to that individual person's nursing home assessment," she said. "We know they had a fall because we have a hospital claim saying this is the reason for their admission. Then we say, did the nursing home report it?"

The **new study** found that about 30% of bedsores suffered by short-term nursing home residents and about 40% of bedsores in long-term residents were not reported to the Nursing Home Compare database, Sanghavi said.

Similarly, the 2020 study found that more than 40% of major injury falls that resulted in hospitalization weren't reported, the researchers said in background notes.

"These measures that CMS publicly reports really are substantially underreported and inaccurate," Sanghavi said. "And so they should come up with other ways to get a different, more objective measure of patient safety in nursing homes."

The researchers also found no consistency in the underreporting — the number of hospitalizations for bedsores did not seem to track at all with a nursing home's overall rating.

"If everybody was consistently underreporting across nursing homes, then whatever CMS is putting up could still be useful because it allows you to still make comparisons. Everybody's underreporting, but consistently," Sanghavi said. "Of the nursing homes in 2017 that have the most [bedsore hospitalizations], about 22% of them have a four- or five-star rating."

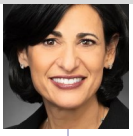
The American Health Care Association/National Center for Assisted Living (AHCA/NCAL) — the nation's largest association representing long-term care providers — took exception to the new report….**Read More**

CDC Director Says Agency Needs Major Overhaul

The U.S. Centers for Disease Control and Prevention failed to respond quickly enough during the COVID-19 pandemic and needs an major overhaul, Director Dr. Rochelle Walensky said Wednesday.

With her rebuke, she sketched out a plan to prioritize action on public health needs, ***The New York Times*** reported.

"For 75 years, CDC and public health have been preparing for COVID-19, and in our big moment, our performance did not reliably meet expectations," Walensky said. "My goal is a new, public health, action-oriented culture at CDC that emphasizes accountability, collaboration, communication and timeliness."



Walensky ordered **an external review of the agency** in April amid widespread criticism of its pandemic response. Its public messages on masking and other COVID-19 measures were often confusing or abruptly modified, the *Times* noted, making them seem more like rough drafts than carefully considered official positions.

A briefing document provided by the agency called the guidance "confusing and overwhelming."

In a meeting with senior staff, Walensky described plans to prioritize public health needs, including on continuing outbreaks, and de-emphasize publication of scientific papers about rare diseases. Walensky said she would ask staff to "produce data for action" as opposed to "data for publication."

And, she said, she wants guidance to be issued in "plain language, easy to understand."

James Macrae — who has held senior positions at the U.S. Department of Health and Human Services, which oversees the CDC — led the review.

The *Times* said he interviewed more than 100 people inside and outside the agency.

Among concerns turned up in the review: Some data were released too slowly to influence public health recommendations, such as whether to recommend more booster shots. COVID team leaders were also rotated out after a few months, leaving other senior federal health officials unsure who was in charge, the *Times* said.

Walensky told the *Times* in an interview on Monday that she had pushed staff to produce data quickly….**Read More**

Why Coffee & Cigarette Is a Morning Ritual for Millions

Smokers in the throes of nicotine withdrawal when they wake up in the morning may crave not just a cigarette but a cup of coffee along with it.

Science can explain that.

Researchers have identified two compounds in coffee that directly affect certain nicotine receptors in the brain.

Study author Roger Papke, a pharmacology professor in the University of Florida College of Medicine, said he wondered why the two habits seemed to go hand in hand, similar to the way people enjoy both alcohol and tobacco in the evening.

"Many people look for coffee in the morning because of the caffeine. But was the coffee doing anything else to smokers? We wanted to know if there were other things in coffee that were affecting the brain's nicotine receptors," Papke said in a university news release.

The researchers applied a dark-roasted coffee solution to cells that give off a particular human nicotine receptor. The team concluded that an organic compound in coffee may help restore a receptor dysfunction that triggers nicotine cravings in smokers.

Papke suspects that one compound in brewed coffee, known as n-MP, may help to ease those morning nicotine cravings.

The findings still need to be tested in humans.

Papke called the research an important step in better understanding how coffee and cigarettes affect the brain's nicotine receptors, and a good foundation for studying **nicotine withdrawal** in animal models.

The findings were published online recently in the journal ***Neuropharmacology***.

Taking a Shot at Pain Relief After Knee Replacement

Researchers may have found a new way to help ease the pain of knee replacement surgery: infusing morphine directly into the shin bone.

The findings come from a **recent study** of 48 patients undergoing **total knee replacement**. The investigators found that giving a morphine injection into the shin bone during the operation controlled patients' post-surgery pain better than standard treatment alone.

It also lessened their reliance on potentially addictive opioid pain medications.

For now, the tactic is only being done at a limited number of medical centers. So people having their knees replaced in the near future are unlikely to have it as an option.

But there is no reason the approach could not be widely adopted, according to senior researcher Dr. Kwan "Kevin" Park, an orthopedic surgeon at Houston Methodist Hospital.

Total knee replacement, which is usually done to treat severe arthritis, is a common procedure, Park noted. A couple of decades ago, patients would spend days in the hospital afterward, receiving high-dose opioids to control the pain.

Things have changed since then, Park said: Pain control has improved, with the help of medications that are injected before and during surgery, for example. And patients now are often discharged on the same day as surgery.

But there's still room for improvement, he noted.

One goal is to reduce the need for **opioid painkillers**, such as oxycodone and hydrocodone, in the days to weeks after surgery. Besides their addictive potential, the drugs can have side effects like nausea and constipation.

Opioids, Park said, "still have a role. But we want to minimize their use, and get patients off of them as soon as possible."

For the new study, Park's team used a technique called intraosseous infusion, in which medication is directly injected into bone marrow. The researchers had already studied the infusions as a way to deliver antibiotics to the shin bone during total knee replacement; the point there was to reduce the risk of infection — a rare but serious complication, Park said.

It worked. So the researchers wanted to see whether adding **morphine** to the infusion could help control patients' post-surgery pain. In the study, 48 patients were randomly assigned to one of two groups. In one, patients received standard pain control and an antibiotic infusion into the shin bone; the other group was given the same, but morphine was added to the bone infusion.

All of the patients received general anesthesia plus regional **nerve blocks**, which help with post-surgery pain. They were also prescribed painkillers to use after surgery — either acetaminophen (Tylenol) for milder pain, or opioids for more severe pain.

On average, the study found, patients given the morphine infusion reported less pain in the two days after surgery: Their pain ratings on a standard scale were 40% to 49% lower — a difference that waned a bit but persisted through day nine. The patients also used fewer opioids in the two weeks after surgery.

An orthopedic surgeon who was not involved in the study said the results sound "potentially promising."

"It's always exciting to see new studies coming out about controlling post-op pain after total knee replacement," said Dr. Cynthia Kahlenberg, a hip and knee surgeon at the Hospital for Special Surgery in New York City.

Like Park, she said that despite strides made in pain control, "many patients experience more pain than we'd like after knee replacement surgery."

Kahlenberg said larger studies are needed to see if the current findings can be replicated. She also said that many hospitals, including her own, have begun using an additional regional nerve block during surgery — one that was not employed in this study.

"I'm not sure how much of a difference this new technique would make if the (researchers) were incorporating both of the commonly used regional anesthesia blocks rather than just one," Kahlenberg said.

Park said further studies are planned.

For now, it's not completely clear why a single bone infusion of morphine, which has quick but temporary effects, helps control post-surgery pain for days. But Park said his team believes the blunting of the initial pain is key.

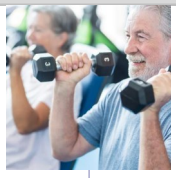
Want to Maintain Muscle? Frequency of Workouts Is Key

Whether the goal is bulging biceps or just a bit more strength and mass, a relatively light workout several times a week beats a more intense one done just once a week.

That's the conclusion of a small Australian **study** in which researchers spent a month tracking muscle-building progress among 36 college students.

"We have shown that a very small amount of exercise is still effective to increase **muscle strength,**" as long as it's done frequently, said study author Ken Kazunori Nosaka, lead professor of exercise and sports science at Edith Cowan University in Joondalup, Australia.

"So we hope," he added, "that this would encourage people to start a daily exercise from a small amount. It is not difficult to find a time for daily muscle-strengthening exercise."



In a report published online recently in the ***Scandinavian Journal of Medicine & Science in Sports***, Nosaka and his colleagues noted that the World Health Organization and the American College of Sports Medicine both recommend doing muscle-strengthening activities at least twice a week — whether at home or at the gym — in order to maintain and improve fitness and health.

"However, many people do not meet this recommendation," Nosaka said. The main excuse: not enough time.

So the researchers decided to assess the potential of so-called "minimal exercise" among young, healthy adults.

They enlisted 24 men and 12 women for the month-long study, which focused on the impact of bicep contractions on both arm strength and size. Before being assigned to one of three groups, none of the participants had engaged in any kind of resistance training of the arms for at least six months. Nosaka described the participants as "sedentary."

The first group performed six muscle contractions once per week. Exercises were performed on a machine designed to measure muscle strength, with measurements taken during the so-called "eccentric" portion of each bicep contraction — meaning the time spent slowly lowering a dumbbell during a curl.

The other two groups performed 30 such contractions a week. One group did six a day for five days each week, while another performed all the lifts in a single day.

In the end, the first group saw no strength or size benefit of any kind.

Those who did all 30 lifts on a single day fared better. As a group, they achieved a roughly 6% increase in muscle size, but no boost in muscle strength.

As it turned out, six lifts a day on five days of the week was the sweet spot, the findings showed.

These volunteers gained just as much size as the single-day group — plus a 10% increase in muscle strength, the researchers found.

Because the participants were relatively inactive before the study, Nosaka said the benefits they achieved from frequent moderate exercise would likely be greater than those for people who already do a lot of resistance exercises….**Read More**

Need Advice on Medical Pot for Cancer Care? Don't Ask Local Dispensary

Cancer patients who use cannabis to relieve **pain** and improve appetite may be getting bad advice from dispensary staff, a new study suggests.

Doctors usually offer only spotty advice about pot to their patients and, although well-intentioned, staff at many cannabis dispensaries aren't well-versed or trained in what advice to give, the researchers said.

"If other studies replicate our results, then the medical establishment may need to standardize their approach to medical cannabis care in order to satisfy this widespread unmet need," said researcher Dr. llana Braun, chief of adult psychosocial oncology at the Dana-Farber Cancer Institute, in Boston.

For **the study**, Braun's team interviewed 26 workers at cannabis dispensaries in 13 states.

While the investigators found that workers were dedicated, their level of knowledge about the therapeutic use of cannabis was inconsistent. In many cases, dispensaries hire people for their selling skills, not their expertise in cannabis therapeutics. The researchers also found that dispensaries offered little or weak training on cannabis therapeutics.

Yet patients rely on the advice they get from dispensary staff, because many doctors say they don't feel qualified to offer advice about medical pot, research shows. In a previous study, Braun's team found that 80% of oncologists surveyed discussed medical cannabis with patients, but only 30% felt qualified to offer recommendations for its use.

"We know from other scientific studies that some physicians don't consider themselves competent to offer clinical advice about medical cannabis," said co-author Manan Nayak, a senior project director at Dana-Farber.

"Patients instead consult non-medical sources, including the cannabis dispensary, for advice and know-how. Medical professionals who defer making clinical recommendations may be relying on a group of professionals who view themselves as unevenly trained for the task," Nayak explained.

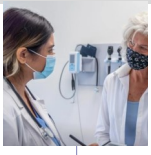
Paul Armentano, deputy director of the NORML Foundation, which advocates for the legalization of responsible use of marijuana by adults, reviewed the findings.

Armentano said that despite the changing cultural acceptance of cannabis and its legal status under state law, many physicians remain reluctant to speak with their patients about cannabis treatment options.

There are many reasons for their hesitancy, he said.

"In many instances, medical professionals have received little or no professional training on the topic," Armentano said. "In other instances, medical professionals may be formally discouraged from conversing with their patients about cannabis by their HMOs [health maintenance organizations]."...**Read More**

New Report Details What to Know About Cardiovascular Disease Symptoms



(American Heart Association News) -- Symptoms of cardiovascular problems run the gamut. Some – like chest pain during a heart attack or a droopy face during a stroke – are sudden and severe, while others last years with varying intensity. Factors such as sex, cognitive function and depression can complicate the recognition or diagnosis of symptoms.

In a new report, experts detail the latest knowledge on cardiovascular disease symptoms with the goal to improve patient care and identify where more research is needed.

"Symptoms are a big part of how we assess a patient when they come to see us in clinic and how we make decisions about what the best treatment is for an individual," said Megan Streur, a nurse practitioner at the Heart Institute at UW Medical Center in Seattle. "But at the same time, there's a lot that we still don't understand about the variability of symptoms in the same condition across different individuals."

Streur, also an assistant professor of nursing at the University of Washington, helped write the new scientific statement from the American Heart Association, published Thursday in its journal Circulation.

Part of the challenge of evaluating and studying symptoms is they're subjective, said Corrine Jurgens, an associate professor of nursing at Boston College and head of the panel that wrote the report.

An objective measure of heart health, such as blood pressure or heart rhythm, can be measured over and over and tracked over time. "But symptoms aren't like that," Jurgens said. "We have to have the patients tell us how they're feeling."

Health care professionals should consider factors that might affect which symptoms a person describes, the report says. For example, although chest pain is the most common symptom of a heart attack in both women and men, women are more likely to also experience nausea, shoulder pain and upper back pain.

With peripheral artery disease, a narrowing of the vessels that carry blood to the arms and legs, women are more likely than men to have no symptoms at all. But when they do, women's symptoms may be wrongly attributed to other conditions such as osteoarthritis, or even dismissed under the false assumption that peripheral artery disease is more common among men.

Such differences have consequences. "It's still the case that women are often diagnosed with illnesses later than they would have been diagnosed if they were men," said nurse scientist Christopher Lee, associate dean of research at Boston College and vice chair of the report's writing committee.

There are also differences in how people interpret symptoms based on cultural norms, the report said. And in terms of race, research shows Black people with a type of irregular heartbeat called atrial fibrillation experience more palpitations, shortness of breath and dizziness compared to white or Hispanic people with AFib.

But many measures of cardiovascular symptoms are based on studies of white men, Lee said. The report calls for more research on symptoms among different groups.

A person's mental health also can affect how they report symptoms. Depression and cardiovascular disease often coincide, Lee said, and that can lead to "a general blunting of someone's ability to detect what may otherwise be a very large change in their condition." Cognitive function also can affect symptom detection, making it important to regularly measure a patient's cognitive and depression levels, the report said.

Jurgens said more precise ways to track and evaluate symptoms are needed, both for the sake of research and to help health professionals better identify patients' needs. Lee agreed.

"A lot of cardiovascular research is focused on illness itself, and not really the human response to illness," he said. "So focusing on symptoms is very much capturing what the experience is like for the people living with these conditions."

While better measures are being designed and put into use, people with cardiovascular disease can take steps to ensure they're communicating their own experiences clearly.

Patients should take time to prepare for appointments, Lee said. The AHA, American College of Cardiology and Heart Failure Society of America offer tools that can help….**Read More**

Cases of Advanced Cervical Cancer Keep Rising Among U.S. Women

New research points to a conundrum with **cervical cancer**: While rates of early-stage disease have been dropping in the United States ever since the human papillomavirus (HPV) vaccine was introduced, advanced cases have been on the rise.

Which women are being hit the hardest? The steepest uptick in advanced cervical cancer is occurring in white women who didn't get the **HPV shot** and who weren't up-to-date with their screening tests, a finding that suggests vaccination works but more women need to get the shots.

Approved by the U.S. Food and Drug Administration in 2006, the HPV shot protects against certain strains of **HPV**, the most common sexually transmitted infection in the United States. HPV has been linked to several cancers, including cervical cancer, vaginal cancer, vulvar cancer, head and neck cancers, anal cancer and penile cancer. Everyone between the ages of 9 and 45 can get the HPV shot.

"In previous research, we saw a steeper decline in cervical cancer in women who would have been eligible for the vaccine, indicating a possible association between the vaccine and cervical cancer rate," said study author Dr. Alex Andrea Francoeur, an obstetrician and gynecologist at the University of California, Los Angeles.

But HPV vaccination rates still lag behind other childhood vaccinations, Francoeur noted.

For the study, the researchers analyzed cervical cancer data from the U.S. Cancer Statistics program and national survey findings on screening and vaccination from 2001 to 2018. During this timeframe, 29,715 women were diagnosed with advanced cervical cancer. Overall, the rate of advanced cervical cancer increased by nearly 1.5% every year, the investigators found.

When cervical cancer is advanced and has spread, it is much harder to cure. Only about 17% of those women diagnosed with it will survive at least five years, compared with 92% of women who are diagnosed with early cervical cancer, Francoeur noted.

Black women aged 55 to 59 who lived in the South were most likely to be diagnosed with advanced cervical cancer, but the largest increase — a rate of 4.5% — was seen among white women aged 40 to 44 from the South, the findings showed….**Read More**

Moving Away From Opioids to Treat Dental Pain

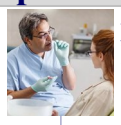
Many **opioid abusers** cite short-term, legitimate use of an opioid for relief of joint or dental pain as their "gateway" into addiction.

Now, research done at one New York State clinic finds that dentists can cut their use of opioids down to zero, using other painkillers for patients instead.

The end result: "No opioids were prescribed for dental pain from March 2021 to February 2022," reported a team of dentists at the University of Rochester Medical Center.

"Considering that 1,800 patients received more than 20,000 opioid pills annually in our clinic before implementation of the opioid reduction strategy, eliminating opioid prescriptions may mean that approximately 105 individuals annually will not develop new and persistent opioid use associated with treatment at our clinic," concluded the team led by Dr. Yanfang Ren. He is professor and clinical chief at the university's Howitt Urgent Dental Care.

They published their findings in the July 17 issue of ***JAMA Network Open***.



An epidemic of opioid abuse -- everything from OxyContin and Percocet to heroin -- still plagues the United States. In response, medical specialties are cutting back on the use of prescription opioids, especially for the relief of short-term pain.

Dental pain is one of those scenarios. As Ren and his colleagues noted, "although the American Dental Association recommends nonsteroidal anti-inflammatory drugs (NSAIDs) for managing pain, opioids continue to be used more than non-opioids." NSAIDs include drugs such as Advil (ibuprofen), Aleve (naproxen) and Celebrex (celecoxib).

In many cases, however, patients cannot be treated with NSAIDs because of their medical histories, the Rochester dentists explained.

So they turned to what they called a "multimodal" pain relief strategy, "with NSAIDs, acetaminophen and **gabapentin.**" It was hoped that this array of choices might fill the gap once opioids were no longer used.

"We hypothesized that using a combination of the non-opioid pain medications and adding gabapentin to the mix for pain would be an effective strategy to minimize or eliminate opioids for dental pain," Ren said in a University of Rochester news release….**Read More**

Pfizer Asks FDA to Approve Omicron-Specific Booster Shot

Pfizer Inc. said Monday that it has asked the U.S. Food and Drug Administration to approve the emergency use of an updated booster shot that targets several versions of the Omicron variant.

Animal studies show that the new mRNA vaccine produces an immune response against both BA.4 and BA.5 subvariants, with clinical trials set to begin this month, the company said in a **news release** announcing the application.

"The agility of the mRNA platform, together with extensive clinical experience with the Pfizer-BioNTech COVID-19 Vaccine, has allowed us to develop, test and manufacture updated, high-quality vaccines that align to circulating strains with unprecedented speed," said Pfizer Chairman and CEO Albert Bourla.

"Having rapidly scaled up production, we are positioned to immediately begin distribution of the bivalent Omicron BA.4/BA.5 boosters, if authorized, to help protect individuals and families as we prepare for potential fall and winter surges," he said in the release.

The **BA.5 subvariant** accounts for nearly 90% of new U.S. COVID cases, **according** to the U.S. Centers for Disease Control and Prevention.

The FDA plans to review the data in September. If authorized, the vaccine can be distributed immediately, *NBC News* reported.

Harvard epidemiologist Bill Hanage told *NBC News* that the turnaround time for this new vaccine was "remarkably quick." It usually takes years for vaccines to be developed and distributed, and the latest Omicron subvariants only began spreading in the United States widely in early June.

The new vaccine will be "important," especially for people vulnerable to severe infections, such as the elderly, Hanage said.

The new shots are expected to be available before an expected winter surge of COVID cases, White House COVID coordinator Dr. Ashish Jha said last week.

The FDA is allowing Pfizer to submit less data on the shot than it has for other COVID vaccines, because modified vaccines that target emerging strains of COVID can be approved without lengthy clinical trials, *NBC News* reported.