

January 7, 2024 E-Newsletter



Message from Alliance *for* Retired Americans Leaders

Debt Commission Legislation Fast Tracks Cuts to Social Security and Medicare

Social Security and Medicare have been the foundation of retirement security for generations of Americans, providing income and health care to millions. Americans earn these benefits, contributing to them with every paycheck.

Rep. Bill Huizenga (MI) and Sens. Joe Manchin (WV) and Mitt Romney (UT) have introduced legislation to establish a 16-member "Fiscal Commission" appointed by congressional leaders. Twelve members of the commission would be members of Congress and the other four would be "outside experts."

The Commission would make recommendations on how to balance the federal budget to address the growth of direct spending and to improve the solvency of Federal trust funds, including Social Security and Medicare, for at least 75 years. There is no requirement that the Commission's deliberations

would be open to the public.

The Commission's recommendations would then be delivered to Congress immediately following the November 2024 elections, with the requirements that each chamber conduct an immediate up or down vote on the recommendations without any opportunities for changes or amendments. The bills only discuss cuts without mentioning consideration of revenue increases.

The House bill is H.R. 5779, the Fiscal Commission Act. The Senate bill is S. 3262, the Fiscal Stability Act.

Alliance for Retired Americans Position

The Alliance for Retired Americans strongly opposes H.R. 5779 and S. 3262, and any other legislation to create committees or commissions to do the work of Americans' elected representatives without input from the American people.

Retirees have earned their Social Security and Medicare benefits over a lifetime of work. The benefits ensure older Americans receive the health care they need, and provide income for more than 66 million Americans. These benefits are critical and they should not be cut.

The Alliance urges Congress to strengthen the solvency of our nation's retirement programs and expand Social Security and Medicare benefits by making the wealthiest pay their fair share into these programs.

Social Security Does Not Contribute to the Deficit

The premise of the commission is flawed. Social Security does not contribute to the federal debt or the deficit. By law, the Social Security Administration cannot borrow funds. The program has its own dedicated revenue source — specifically, payroll contributions from workers, as

well as interest on special interest bonds and revenue from higher earners who pay taxes on their Social Security earnings.

The Commissions Are Anti-Democratic

The bills call for a closed door, fast-track process that dramatically limits public input, excludes the traditional committee process from acting on the legislation, and does not allow amendments or full debate. Additionally, most Americans' elected representatives in Congress will not be able to even debate the proposals, much less amend any commission recommendations. Outcome is Pre-determined The mandate given the commissions is narrow and designed to produce recommendations for cuts to Social Security and Medicare. Any discussion of changes to these programs must include ways to increase revenue instead of exclusively focusing on benefit cuts.

Time To Scrap The Cap On The Federal Insurance Contributions Act (FICA)



People earning over
\$1 billion
stop paying into
Social Security on
January 1st



Billionaires stop paying into Social Security on January 1, 2024.

We should #ScrapTheCap so they pay their fair share into the system.

[https://retiredamericans.org/](https://retiredamericans.org/ourearnedbenefits/)

ourearnedbenefits/

Just Scrap The Cap,

We're Movin in

ADD
YOUR
NAME

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

Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381

riarajap@hotmail.com • <http://www.facebook.com/groups/354516807278/>

3 Medicare Changes In 2024 To Be Aware Of

Kiplinger Personal Finance BY ALEXANDRA SVOKOS

These three Medicare changes in 2024 expand coverage, but carry a cost.

January 1 brings many things: **new tax deadlines**, a **Social Security COLA**, **dogs of the Dow** strategies, and, sure, your own resolutions and hopes for the new year. If you're a Medicare recipient, there are even more changes that automatically kick in with the start of the new year.

These changes range from increased coverage to lower prices — and higher premiums. With the new year starting up, you don't want to be caught off guard by these changes, and you definitely don't want to miss out on what your Medicare plan has to offer. Keep in mind, too, that we're in an election year, so there's sure to be a lot of chatter about what candidates say they'd do with Medicare and Social Security.

While Kiplinger covers Medicare year-round, I'm taking this moment to round up some of the biggest changes to the program in 2024. Take a look to see what's changing.

1. Medicare premiums are rising

Let's start with the biggest basic Medicare change in 2024: premiums are going up, changing **what you'll pay for Medicare in 2024**.

In brief, looking at the **different parts of Medicare** with rising premiums:

Part A: The Part A deductible for hospital admissions will increase by \$32 in 2024 to \$1,632.

Part B: The standard monthly premium will be \$174.70, up \$9.80 from \$164.90 in 2023. The annual deductible for all Medicare Part B beneficiaries will be \$240, which is \$14 more than the 2023 deductible. Surcharges are also increasing for higher earners (see more: **2024 IRMAA for Parts B and D**).

Part D: Part D is somewhat harder to gauge on average, but analyses indicate premiums are up for many. The average enrollment-weighted monthly premium for Medicare Part D is up 21%, according to a **KFF analysis**, but a Health View Services analysis estimates an even higher increase, ranging from a 42% to 57% rise.

Medicare Advantage: The **premiums**



for Medicare Advantage programs in 2024 are also projected to increase, by 3.6%, from an average of \$17.86 in 2023 to \$18.50 in 2024.

2. Drug costs for Medicare recipients in 2024

While your Part D premium may have increased, Medicare is continuing to work on the general cost of drugs for recipients, especially as the Inflation Reduction Act continues to have an impact.

That means insulin is staying at a \$35 cap for a 30-day supply covered by Medicare, and vaccines recommended by the CDC's Advisory Committee on Immunization Practices, like those for shingles, RSV, the flu, COVID-19, pneumonia, hepatitis A, rabies and tetanus, remain covered without out-of-pocket costs, per **AARP**.

Drug prices are continuing to be scrutinized to assess if they rose faster than the rate of inflation. The Department of Health and Human Services recently released a list of 48 **drugs that hiked prices faster than inflation and may be subject to rebates** in the first quarter of 2024. That means Part B beneficiary coinsurances could

be lower for those 48 drugs from January 1 to March 31, 2024, which could save you up to \$2,786 per average dose, per **CMS**, depending on your coverage.

Plus, there are Medicare **negotiations over drug prices**. The negotiated prices won't take effect until 2026, but it's still worth keeping an eye on these updates.

3. Mental health care coverage for Medicare recipients

A big change coming for recipients is the **expansion of mental health care coverage for Medicare**. Starting January 1, you'll be able to access care from mental health counselors as well as marriage and family therapists through Medicare. The expanded coverage extends to an "intensive outpatient program" level of care.

Additionally, the expanded coverage extends to addiction treatment. You can get access through Medicare to addiction, alcohol and drug counselors who meet the requirements of mental health counselors, and the "intensive outpatient program" includes services provided by opioid treatment programs.

United Health now controls 1 in 10 physicians

Steph Weber reports for **Medscape** that UnitedHealthcare's owner, UnitedHealth Group now controls —either owns or otherwise works with—one in ten physicians. Concerns are mounting about corporate control of health care. Treating physicians are no longer in full charge of patient care as insurers increasingly overrule their treating decisions.

Legally, insurers are not allowed to interfere in the practice of medicine. But, what does that really mean? It apparently does not prevent insurers from telling physicians how much time to spend with their patients or who to refer them to if they need to see a specialist—anti-competitive behavior. It also does not stop insurers from providing financial incentives to their physicians to withhold or otherwise delay costly care.

UnitedHealth now controls

around 90,000 of the 950,000 physicians in the US. It is adding multispecialty physician groups in large numbers. These physicians all work for Optum Health, a subsidiary of UnitedHealth.

UnitedHealth's ownership or control of these physicians is endangering people's health. There's no good independent data to evaluate the consequences of UnitedHealth's ownership of these physicians. Based on the horror stories reported in the press—from insurer use of AI to conduct massive denials of care without regard to particular patient needs, to inappropriate withholding of payment to hospitals and "ghost" networks—UnitedHealth is interfering in the practice of medicine to the detriment of its enrollees.

Some experts suggest that there could be some good in what



UnitedHealth is doing. But without data to conduct independent assessments and with mountains of horror stories, these experts are likely dreaming. Insurer control of physicians means putting profits ahead of patient needs, with potentially horrific consequences.

One recent study published in **JAMA** finds that private equity ownership of physician groups has driven up health care prices. That study looked at dermatology, gastroenterology, and ophthalmology practices. Several other studies have had **similar findings**, including one on **private equity ownership of dental practices**. Nursing homes, emergency medicine, urology and cardiology practices are all being taken over by private equity and corporations.

The Biden administration has focused some attention on anti-

trust issues, but it seems that the anti-trust train left the station a long time ago and undoing the damage that has already been wrought would be a very heavy lift. Moreover, when insurers hire physicians, rather than acquiring them, they are not subject to anti-trust laws.

The dangers to patient health from the corporatization of healthcare are potentially massive, with costly care particularly hard to come by. Insurer ownership or control of physician practices is hurting physicians as well. They may no longer be able to practice the medicine they think is in their patients' interest.

Recently, **UnitedHealth** and **Humana** have been sued for using AI algorithms to deny patient care, overruling treating physicians, and overlooking the particular needs of their enrollees in Medicare Advantage plans.

Tell Congress to Prioritize People with Medicare in 2024

Today, the Medicare Rights Center joined 75 national organizations in **urging Congress** to include funding for Medicare low-income outreach and enrollment in the next 2024 spending package. Established in the 2008 Medicare Improvements for Patients and Providers Act (MIPPA), these federal dollars help community-based organizations—Medicare State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging, Aging and Disability Resource Centers, and local Benefits Enrollment Centers—connect Medicare beneficiaries with programs that can make their health care and prescription drugs more affordable, like the Medicare Savings Programs (**MSPs**) and Part D Low Income Subsidy (**LIS/Extra Help**). Medicare cost assistance can be a lifeline, allowing beneficiaries with limited resources to maintain their coverage; get needed care; and afford other necessities, like food and rent. But the programs are also **notoriously hard to access, underadvertised, and underenrolled**. Medicare Rights **often hears** from older

adults and people with disabilities who are unaware of these supports or mired down in **red tape**, and who are struggling financially as a result.

By facilitating low-income program enrollments at the community level, MIPPA can help prevent such experiences, but funding for this work is not automatic. It expires every few years—most recently on September 30—and requires congressional renewal to continue. Those extensions, 11 in total, have historically enjoyed broad, bipartisan support.

Troublingly, MIPPA was excluded from the Continuing Resolution that is funding the federal government through early next year. Though this omission was largely the result of negotiating tactics rather than substantive concerns, it nevertheless puts the program at risk. **Today's letter** asks Congress to correct this, to secure MIPPA's future by including it in the next 2024 spending agreement. Allowing it to lapse would cause widespread harms. With grantees in every state, MIPPA touches millions of lives and



communities each year, and has a proven record of success. Since its inception, it has helped significantly boost enrollment in MSPs (**from 6.4 million in 2008 to 12.2 million in June 2022**) and LIS (**from 9.5 million in 2008 to 13.4 million in 2023**); in the last three years alone, grantees **helped** over three million people with Medicare better understand and afford their coverage. MIPPA also supports the non-profit community-based organizations that conduct these activities, bolstering local economies.

Congressional inaction would also fail to recognize evolving trends and growing needs. Despite MIPPA's improvements to MSP and LIS uptake rates, far too many people who qualify for this assistance **are not getting it**. This is attributable to several programmatic and administrative **barriers**, all of which require long-term campaigns to combat. Further, demographic and policy changes are rapidly reshaping the Medicare landscape, guaranteeing enrollment numbers, coverage complexities, and beneficiary questions will

continue to rise. Most immediately, **Medicaid unwinding**—the end of pandemic-related eligibility rules—is likely to have a sustained fallout, as enrollees, including people dually eligible for Medicare and Medicaid, face **redeterminations and coverage losses**. In addition, historic Inflation Reduction Act **reforms take effect** in January, expanding existing LIS benefits for an estimated **400,000 people** and potentially for millions more, as roughly **3.5 million Medicare beneficiaries** are eligible for but not enrolled in the program. In both instances, targeted, thoughtful, and trusted community-based outreach will be necessary to promote beneficiary participation and well-being, making adequate MIPPA funding and grantee capacity more important than ever.

Weigh in today! Join Medicare Rights in urging Congress to prioritize MIPPA. **Tell your lawmakers** to support these proven community-based outreach and enrollment activities, so that more people with Medicare can access and afford their coverage.

Survey Provides Insights into Experiences of Discrimination, Including in Health Care

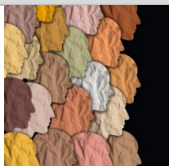
Last week, **KFF released the results** of a large survey on racism and discrimination. The survey covers many scenarios and situations, capturing respondents' general experiences with and the effects of discrimination, including stress, difficulties getting or keeping employment, feeling less safe at home or with the police, and negative interactions in health care settings.

The respondents reported issues in all avenues of life, with women and younger adults somewhat more likely to report discriminatory behavior than men or older adults. In terms of lasting effects, those exposed to discrimination were more likely to report higher levels of worry, stress, loneliness, and depression than their peers. Black and American Indian and Alaska Native (AIAN) respondents reported particularly high rates of

discriminatory behavior, and for Black respondents with darker skin tones, the reported discrimination was even more pronounced.

The report dedicates a section to experiences in health care. The majority of respondents had respectful and positive interactions with their health care providers. Sadly, that does not mean there were no reported issues. Compared to white respondents, twice as many AIAN, Hispanic, and Asian survey participants had problems with providers explaining things in a way they could not understand. Black, AIAN, Asian, and Hispanic respondents all reported lower levels of health care providers understanding and respecting their cultural beliefs or involving them in decision-making about their care.

White adults were more likely



to say their providers shared their racial and ethnic background, and Hispanic, Black, and Asian adults who did see providers who shared

their racial ethnic backgrounds reported more positive provider interactions than those who saw providers of other backgrounds. But most respondents didn't think having a provider of the same background would improve their care or that provider race or ethnicity makes much difference in their quality of care.

Black and AIAN adults were more likely to report being disrespected or treated unfairly by providers, and over half of Black, AIAN, and Hispanic respondents said "that they prepare for possible insults from a provider or staff or feel they need to be very careful about their appearance to be treated fairly during health care visits."

As these survey results show, the problem of discrimination deeply affects people in their daily lives and their interactions in health care settings, which is also likely to impact their care experience and well-being. These findings echo **an earlier KFF survey of immigrants** that also showed widespread unfair treatment in health care. Both surveys add to research showing that disparities in the availability and quality of care **persist** across a **variety of settings**, from hospitals to home care.

At Medicare Rights, we urge providers, policymakers, and stakeholders to seek out additional ways to educate those who interact with the public ensure that all people are treated with respect as they navigate specific cultural and societal dynamics.

This Key Social Security Rule Is Poorly Understood -- and That's a Problem

Some people go from working full-time to kicking off retirement and not working at all.

That **"hard stop" approach** might work for some folks. But for others, easing into retirement with a part-time work schedule ends up being a better bet.

And then there are also those who opt to continue working in retirement, whether to keep busy or supplement their senior income. Some retirees, in fact, might go several years without working only to take a job due to an emotional or financial need.

One of the nice things about **Social Security** is that seniors are allowed to receive benefits while also earning income from a job. But there are rules to be aware of in that situation. And **data** from the Social Security Advisory Board finds that many people do not understand the rules as they relate to working and collecting Social Security at the same time. It's important to know how the system works

The Social Security Advisory Board reports that many older Americans follow a non-

traditional retirement path that involves part-time work or a return to work before permanently exiting the labor force. Meanwhile, half of those it surveyed who returned to work reported collecting Social Security before doing so. And of these people, 40% had not yet reached **full retirement age** (FRA) when they returned to work.

Why is that important? FRA is the age at which you're entitled to your complete monthly Social Security benefit based on your personal wage history. That age is 66, 67, or somewhere in between, depending on year of birth.

It's possible to sign up for Social Security as early as age 62. However, many people are generally aware that claiming Social Security prior to FRA results in a permanently reduced monthly benefit.

What a lot of people *aren't* aware of, though, is that there are **earnings-test limits** for those who work and collect Social Security at the same time prior to FRA. And the



forementioned report found that between 25% and 50% of prospective retirees don't know that exceeding that limit could result in withheld Social Security income. Furthermore, many people don't understand that withheld benefits in that situation are returned later in life.

Breaking down the rules

The rules with regard to working and receiving Social Security at the same time can be a little confusing. So if that's a situation you may be looking at this year, here's a breakdown of what you should know:

- Once you reach FRA, you can earn any amount of money from a job without it impacting your Social Security benefits.
- If you're below FRA and won't be reaching FRA this year, you can earn up to \$22,320 without having your benefits withheld. From there, you'll have \$1 in Social Security withheld per \$of earnings.
- If you *will* be reaching FRA

this year, you can earn up to \$59,520 without it impacting your Social Security benefits. From there, you'll have \$1 in Social Security withheld per \$3 of earnings.

Withheld Social Security income is adjusted back into your monthly benefits once you reach FRA so you don't permanently forgo that money. And that's really the gist of it. However, these are important points to know for anyone looking to work and collect Social Security at the same time.

Also, do be aware that the aforementioned earnings-test limits are applicable to 2024 only. Those limits tend to adjust on an annual basis to account for inflation.

All told, Social Security is a complex program, and working while receiving benefits opens the door to even more potential complications. Knowing the rules will help you better manage your financial situation as a retiree. It will also help you better plan for your workforce exit, whether it's an immediate one or a gradual one.

The New Help for Medicare Beneficiaries with High Drug Costs That Few Seem to Know About

The **Inflation Reduction Act** of 2022 includes several provisions to lower out-of-pocket drug costs for people with Medicare. Some provisions of the law have already taken effect, including a \$35 cap on monthly cost sharing for insulin and free vaccines under Part D, Medicare's outpatient drug benefit. Medicare's new **drug price negotiation program** is also getting underway, with negotiated prices first taking effect in 2026. And a new cap on Part D out-of-pocket prescription drug costs for people with Medicare takes effect in January 2024 – a change that will save thousands of dollars for people who take high-cost drugs.

Beginning in 2024, people enrolled in Part D plans will no longer be required to pay 5% coinsurance after they reach the catastrophic threshold. Eliminating this 5% coinsurance requirement means that in 2024, Part D enrollees will pay no more

than about \$3,300 for all brand-name drugs they take – a change KFF estimates will help **well over 1 million Medicare beneficiaries**. And starting in 2025, out-of-pocket drug spending will be capped at a lower amount, \$2,000 (indexed annually for growth in Part D costs.)

To illustrate the impact of Part D's new out-of-pocket cap, consider three drugs taken to treat various forms of cancer – Lynparza, Ibrance, and Xtandi – each with annual retail prices well over \$100,000. In 2023, Medicare Part D enrollees who used any of these drugs for the entire year faced annual out-of-pocket costs around \$12,000, but in 2024, out-of-pocket costs will drop to about \$3,300 for each of these drugs. This translates to annual savings of \$8,100 to \$9,200 compared to 2023. Out-of-pocket costs for these drugs will drop even further beginning in



2025 when the \$2,000 cap takes effect.

The current 5% coinsurance requirement for catastrophic coverage

may seem like a small amount, but with many drugs coming to market priced at **\$150,000 or more**, that 5% translates into thousands of dollars in annual out-of-pocket costs for expensive drugs. Paying this amount can be a particular burden for older adults, many of whom live on fixed incomes and have limited financial resources to tap to pay for high-cost medications.

Although changes to prescription drug costs in the Inflation Reduction Act are underway, recent **KFF polling** finds low levels of awareness among older adults about key features of the law. Only a quarter of all older adults know about the new cap on out-of-pocket prescription drug costs for people with Medicare that takes effect in January. A larger

share, but still less than half, of all older adults knows about the new insulin copay cap for Medicare beneficiaries, and around one-third know about the change that requires the government to negotiate prices for some high-cost drugs in Medicare.

At a time when the affordability of health care is among the **key issues** that voters want to hear about from presidential candidates, the results of KFF polling suggest that more work could be done to inform people with Medicare about the prescription drug changes in the 2022 law. But regardless of what people do or don't know about these changes, more older adults will begin to see real savings very soon, particularly those who take high-cost drugs.

Cancer Patients Face Frightening Delays in Treatment Approvals

Marine Corps veteran Ron Winters clearly recalls his doctor's sobering assessment of his bladder cancer diagnosis in August 2022.

"This is bad," the 66-year-old Durant, Oklahoma, resident remembered his urologist saying. Winters braced for the fight of his life.

Little did he anticipate, however, that he wouldn't be waging war only against cancer. He also was up against the Department of Veterans Affairs, which Winters blames for dragging its feet and setting up obstacles that have delayed his treatments.

Winters didn't undergo cancer treatment at a VA facility. Instead, he sought care from a specialist through the Veterans Health Administration's **Community Care Program**, established in 2018 to enhance veterans' choices and reduce their wait times. But he said the prior authorization process was a prolonged nightmare.

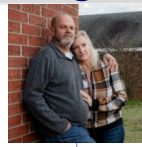
"For them to take weeks — up

to months — to provide an authorization is ridiculous," Winters said. "It doesn't matter if it's cancer or not."

After his initial diagnosis, Winters said, he waited four weeks for the VA to approve the procedure that allowed his urologic oncologist at the University of Texas Southwestern Medical Center in Dallas to remove some of the cancer. Then, when he finished chemotherapy in March, he was forced to wait another month while the VA considered approving surgery to remove his bladder. Even routine imaging scans that Winters needs every 90 days to track progress require preapproval.

In a written response, VA press secretary Terrence Hayes acknowledged that a "delay in care is never acceptable." After KFF Health News inquired about Winters' case, the VA began working with him to get his ongoing care authorized.

"We will also urgently review this matter and take steps to ensure that it does not happen again," Hayes told KFF Health



News.

Prior authorization isn't unique to the VA. Most private and federal health insurance programs require patients to secure preapprovals for certain treatments, tests, or prescription medications. The process is intended to reduce spending and avoid unnecessary, ineffective, or duplicative care, although the degree to which companies and agencies **set these rules varies**.

Insurers argue prior authorization makes the U.S. health care system more efficient by cutting waste — theoretically a win for patients who may be harmed by excessive or futile treatment. But critics say prior authorization has become a tool that insurers use to restrict or delay expensive care. It's an especially alarming issue for people diagnosed with cancer, for whom prompt treatment can mean the difference between life and death.

"I'm interested in value and affordability," said Fumiko Chino, a member of the

Affordability Working Group for the Memorial Sloan Kettering Cancer Center. But the way prior authorization is used now allows insurers to implement "denial by delay," she said.

Cancer is one of the most expensive categories of disease to treat in the U.S., according to the **Centers for Disease Control and Prevention**. And, in 2019, patients spent more than \$16 billion out-of-pocket on their cancer treatment, **a report** by the National Cancer Institute found. To make matters worse, many cancer patients have had oncology care delayed because of prior authorization hurdles, with some facing delays of more than two weeks, according to research Chino and colleagues **published in JAMA** in October. Another recent study found that major **insurers issued "unnecessary" initial denials** in response to imaging requests, most often in endocrine and gastrointestinal cancer cases....**Read More**

Humana sued for inappropriate Medicare Advantage care denials

Humana is the latest of the Medicare Advantage insurers to be sued for using AI to systematically deny care inappropriately. Tina Reed reports for **Axios** on a class action lawsuit filed in Kentucky alleging that Humana violated its government contract and charging Humana with unjust enrichment as well as violating insurance laws in 22 states.

The lawsuit explains that the

Humana AI model—NaviHealth—cut off rehabilitation benefits for patients without regard to their particular recovery trajectories. In one case, Humana denied plaintiff JoAnne Barrows more than two weeks of rehab therapy after she fractured her leg in her home. Her doctor had said she needed six weeks of rehab.

Overruling the opinion of



patients' treating physicians, the complaint alleges that Humana's AI model relies on "rigid and unrealistic predictions for recovery." And, Humana knew that it's AI model for predicting patients' recovery was "highly inaccurate."

A similar suit was brought last month against **UnitedHealth**, which owns NaviHealth.

These lawsuits come on the

heels of a series of independent government and non-governmental reports finding widespread and persistent inappropriate delays and denials of care and coverage in Medicare Advantage plans. The Centers for Medicare and Medicaid Services, which should be overseeing these health plans, lacks the resources and the power to hold them to account for their bad acts.

Help for Seniors: Your Guide to Assistance Programs & Services

Did you know there are literally thousands of programs that provide help for seniors in America? Whether you are struggling with the cost of housing or home repairs, looking for ways to save on prescriptions or hearing aids, or seeking affordable legal guidance, you can probably find senior citizens assistance programs that are designed to address needs like yours. In fact, the range of available services is so vast that the biggest challenge might be identifying the options that work

best for your particular situation.

A good starting point in any search for senior assistance options is to check with your local Area Agency on Aging or use the online **Eldercare Locator** provided by the U.S. Administration on Aging. Either method can direct you to a host of services for older adults in your area. The **directory of resources** at the end of this article includes many more sites that can help you find the benefits and programs that are most applicable



to you.

The following sections provide information on the many different

resources that are available to help older adults meet their needs and improve their quality of life. Check out specific information about 11 different topics, or use the directory of resources to track down additional assistance.

Help related to:

- ◆ **Income and taxes**
- ◆ **Medicare and prescriptions**
- ◆ **Hearing aids**

- ◆ **Mobility aids**
- ◆ **Dental care**
- ◆ **Housing and rent**
- ◆ **Mortgages**
- ◆ **Home repairs, improvements, and modifications**
- ◆ **In-home care**
- ◆ **Downsizing**
- ◆ **Legal matters**
- ◆ **Technology**
- ◆ **An essential directory of helpful resources**

Vietnam War Veterans at No Higher Risk for Suicide: Study

The Vietnam war was a traumatic event in American history, most especially for those who served.

However, there's a glimmer of good news from recent research: Suicide rates for Vietnam veterans over the past four decades were no higher than that of the general population.

Still, between 1979 and 2019 - the period covered by the new study -- almost 100,000 Vietnam War vets did lose their lives to suicide, the researchers noted. Those tragedies "merit the ongoing attention of health policymakers and mental health professionals," they said.

Suicide has long been a concern among U.S. veterans generally. According to background information in the

study, Veterans Administration data for 2022 shows that "although veterans composed only 7.6% of the U.S. population, they accounted for almost 14% of US suicides."

In 2021, VA data showed that suicide accounted for about 32 deaths out of every 100,000 veterans — double the rate of suicide seen among civilians.

Did the trauma faced by soldiers in the Vietnam conflict lead to even higher rates of suicide?

To find out, **Tim Bullman** and colleagues at the U.S. Department of Veterans Affairs in Washington, D.C., analyzed health data for over 9.5 million Vietnam veterans.



Almost all were men, and close to 2.5 million served directly (were deployed) in Vietnam during the conflict.

Tracking rates of suicide between 1979 and 2019, Pullman's team found a total of 22,736 suicides among veterans who had been deployed to Vietnam.

However, compared to the general population "Vietnam War deployment was not associated with an increased risk of suicide," the study concluded. That was true whether or not a veteran had seen action in the theater of war.

Still, a total of 94,497 Vietnam-era veterans (whether deployed to Vietnam or not) did lose their lives to suicide in those 40 years,

the VA team noted.

"This loss of life deserves not only to be noted on behalf of these veterans and their survivors, but also merits the ongoing attention of health policymakers and mental health professionals, especially given that suicide rates have increased over 41 years among all Vietnam War-era veterans, veterans of other eras of military service, and the wider U.S. population," the VA investigators wrote.

The study was published Dec. 28 in the journal **JAMA Network Open**.

If you or a loved one is in mental health crisis, immediate help is at hand at the **988** Suicide & Crisis Lifeline.

Dozens of drug companies owe Medicare rebates

The Biden Administration just announced that dozens of drug companies owe Medicare rebates from raising prices higher than the rate of inflation. As a result, hundreds of thousands of people with Medicare will save as much as \$2,786 per dose of their prescription drugs.

The Inflation Reduction Act (IRA) prevents drug price gouging—defined as price increases greater than the rate of inflation—by pharmaceutical companies. The IRA also caps out-of-pocket costs for each insulin drug at \$35 a month and limits total out-of-pocket drug costs for people with Medicare

through Medicare Part D to \$2,000 a year beginning in 2025. Yet, Republicans are trying to repeal the IRA.

In total, the Administration reports that pharmaceutical companies raised prices on 64 drugs more than inflation. For example, the price of Signifor, which treats an endocrine disorder, went up so much that people who use it could see a savings of \$311 for a monthly dose of the drug beginning in January.

President Biden is also heralding his Administration's decision to allow the government



to "March-in" and help bring down the price of drugs developed with federal funding, if the price is unreasonable.

This march-in right has always existed but prior administrations have been reluctant to take the position that the government could step in if a pharmaceutical company charged an excessive price for the drug. Of course, the proof of this Administration's commitment here is in determining that the price of a drug developed with federal money is too high and taking action. Time will tell.

Meanwhile a story in Becker's exposes extreme drug price increases for eight drugs, according to ICER. The story suggests that insurers spent more than \$1.3 billion in these drugs in one year. It's not clear if that means that individuals paid higher premiums to cover the cost of the drugs, but presumably so. The question left unanswered is whether the insurers recouped that money they spent for these drug, through rebates, and left their enrollees' holding the bag, a likely scenario.

Can I Switch a Social Security Benefit to a Spousal Benefit?

Social Security benefits can provide you with a stream of retirement income that is reliable. Deciding when to take benefits is an important question, especially if you're married and hope to qualify for spousal benefits. If you're already taking Social Security, you might be wondering if it's possible to switch to a spousal benefit later. The answer depends on whether your spouse is receiving Social Security benefits yet.

How Do Social Security Spousal Benefits Work?

Calculating Social Security benefits as a married couple is a bit different than doing it as a

single person. When someone files for Social Security benefits, their spouse may be able to claim a spousal benefit. The benefit is based on their spouse's contributions to Social Security and is capped at 50% of their benefit amount at full retirement age. For example, if they were to receive \$2,200 per month at full retirement age, their spousal benefit would max out at \$1,100 per month.

In order to receive spousal Social Security benefits, you must:

- ◆ Be at least 62, the earliest age



at which you can receive Social Security benefits OR

- ◆ Be a caretaker for a child under age 16 or a child who's **receiving Social Security disability benefits**
 - ◆ Be married for at least one year to someone who has filed for their retirement benefits
- When you apply for spousal benefits, the Social Security Administration calculates your benefits based on your own work and earnings record as well. If you're eligible to receive your retirement benefit as well as spousal benefits, then you'd get

the higher of the two.

If your spouse hasn't filed for retirement yet, then you can't get spousal benefits. You can, however, file for your own retirement benefits if you're at least 62 years old.

Taking Social Security at age 62 will reduce your benefit amount, below the amount you'd be entitled to if you had waited until you reached full retirement age. Delaying benefits until age 70, on the other hand, increases your benefit amount....**Read More**

Put Down That Salt Shaker to Spare Your Kidneys

Folks who habitually add an extra sprinkle of salt to their meals are doing no favors for their kidneys, new research confirms.

The finding held even after researchers accounted for other health issues, such as being overweight, not exercising or smoking and/or drinking.

The bottom line: "Adding salt to foods is associated with increased risk of chronic kidney disease in the general population," concluded a team led by **Dr. Lu Qi**, of Tulane University's Obesity Research Center, in New Orleans.

Qi and his colleagues recently published studies showing that adding salt to meals upped people's odds for heart disease, type 2 diabetes and shortened life spans.

However, links between table salt and the odds of kidney disease in the general population hadn't been well-researched, Qi's group noted.

To remedy that, they analyzed data on more than 465,000

people, averaging 56 years of age, who didn't have kidney disease when they registered for a British health database known as the UK Biobank. Participants' health and lifestyle were tracked from 2006 to 2023.

According to the researchers, over 22,000 cases of kidney disease emerged over the study period.

Compared to folks who never or rarely added salt to their food, people who did so had a higher odds of developing kidney trouble. The risk rose with the frequency at which people said they used table salt.

For example, compared to never-users, folks who said they "sometimes" added extra salt had a 4% higher risk of kidney disease; those who "usually" added salt had a 7% higher risk, and those who "always" added salt saw their risk rise by 11%.

Those risk estimates came after Qi's team accounted for lifestyle factors that often accompany heavy salt intake -- overweight/



obesity, smoking, drinking, lack of exercise, diabetes, hypertension and other issues.

The study was published in the Dec. 28 issue of the journal ***JAMA Network Open***.

There are many physiological issues linking high sodium intake and poorer kidney function, the researchers noted, including hormonal changes and "increased oxidative stress" on the twin organs.

According to the Tulane investigators, their findings "support the reduction of adding salt to foods as a potential intervention strategy for chronic kidney disease prevention."

Folks who habitually add an extra sprinkle of salt to their meals are doing no favors for their kidneys, new research confirms.

The finding held even after researchers accounted for other health issues, such as being overweight, not exercising or smoking and/or drinking.

The bottom line: "Adding salt

to foods is associated with increased risk of chronic kidney disease in the general population," concluded a team led by **Dr. Lu Qi**, of Tulane University's Obesity Research Center, in New Orleans

Qi and his colleagues recently published studies showing that adding salt to meals upped people's odds for heart disease, type 2 diabetes and shortened life spans.

However, links between table salt and the odds of kidney disease in the general population hadn't been well-researched, Qi's group noted.

To remedy that, they analyzed data on more than 465,000 people, averaging 56 years of age, who didn't have kidney disease when they registered for a British health database known as the UK Biobank. Participants' health and lifestyle were tracked from 2006 to 2023**Read More**

America's Doctors Offer 10 Health Resolutions as You Start a New Year

Still weighing whether to make a New Year's resolution? Or perhaps regretting letting your healthy habits slide during the holidays?

Either way, the American Medical Association (AMA) has ten recommendations to help Americans improve their health in 2024.

"It is quite common after the holidays to think about all you've eaten or your reduced physical activity and get discouraged," said AMA President **Dr. Jesse Ehrenfeld**.

"But the good news is you don't have to make major health changes in one fell swoop. You can make small, positive health choices right now that can have long-lasting effects," Ehrenfeld added in an AMA news release.

The AMA's recommendations for a healthier new year include:

- ◆ **Increase physical activity.** Exercise is essential to physical and mental health. Adults should get at

least 150 minutes of moderate-intensity activity or 75 minutes of vigorous activity each week.

- ◆ **Eat healthier.** Reduce intake of sugary drinks and processed foods, instead drinking more water and eating more nutritious whole foods like fruits, vegetables, whole grains, nuts and seeds, low-fat dairy and lean meats.
- ◆ **Get up-to-date on vaccinations.** Vaccines are available to protect people against COVID, influenza and RSV during this winter's cold and flu season. Make sure all members of your family have all their recommended jabs.
- ◆ **Go to your scheduled health screenings.** Millions of screenings for breast, colorectal and prostate cancers might have been missed due to pandemic-



related disruptions, researchers estimate. Check with your doctor to find out if you're due for a screening.

- ◆ **Know your blood pressure numbers.** Getting high blood pressure under control can reduce your risk of heart attack or stroke.
- ◆ **Learn your risk for type 2 diabetes.** A simple online two-minute self-screening test at **[DoIHavePrediabetes.org](https://doi.org/10.1186/1745-6215-13-1)** can flag your diabetes risk, giving you a chance to take steps to prevent developing the chronic condition.
- ◆ **Drink moderately.** Stick to guidelines recommending two drinks a day for men and one drink for women.
- ◆ **Quit smoking.** Tobacco and vaping can trigger a nicotine addiction and affect your health. Your doctor can offer resources and guidance for

quitting.

- ◆ **Use prescription drugs safely.** Follow your doctor's instructions when taking prescription meds, especially antibiotics. Not finishing the full course of antibiotics can contribute to antibiotic-resistant germs. Also store prescribed opioids safely, take them as directed and properly dispose of any leftover pills.
- ◆ **Manage stress.** Get sufficient sleep -- between seven and eight hours a night -- and seek help from a mental health professional if necessary.

Another tip for a healthy New Year -- make sure that you have health insurance coverage.

The AMA encourages people to visit healthcare.gov to sign up for health coverage, given that recent changes have improved access and affordability. The deadline to enroll for 2024 coverage is Jan. 16.

Poor Vision & Falls: A Deadly Combo for Seniors

Seniors with vision issues are at much higher risk for dangerous falls, new research confirms.

Compared to seniors with good vision, the odds for a fall rose by 38% for seniors with glaucoma, 36% for those with cataracts and 25% for seniors with age-related macular degeneration (AMD), say a team reporting Dec. 28 in the journal **JAMA Ophthalmology**.

Worldwide, over 650,000 people lose their lives to falls each year, the research team noted, and falls can be especially deadly for the frail elderly. In the

United States, medical costs for falls top more than \$23 billion annually.

Impaired vision is an obvious risk factor for falling, and a team at the University of Manchester in the U.K. wanted to quantify that risk.

They looked at data on vision health, falls and fractures from a national British database on over 410,000 people. Participants were typically in their 70s at the time of the study.

Besides the increased risk of falls associated with various vision ailments, the study also



found a rise in risk for bone fractures.

Compared to their peers with good vision, folks with glaucoma had a 31% higher odds for a fracture, those with cataracts had a 28% increased risk and people with AMD faced an 18% higher risk, the Manchester group found.

Injuries included fractures of the hip, spine, forearm, skull or facial bones, pelvis, ribs or sternum and lower legs.

While impaired vision upped the risk for these injuries, "the majority of these eye diseases are preventable or treatable," noted

the team, which was led by **Jung Yin Tsang**, of the university's Centre for Primary Care and Health Services Research.

Regular eye exams may be crucial for seniors, since "in early stages of eye disease, patients are often asymptomatic and unaware of visual impairment," the researchers noted.

Besides getting early diagnosis and treatment of vision issues, seniors with AMD, cataracts or glaucoma may also "benefit from improved advice, access and referrals to falls prevention services," Tsang's group added.

Early-Onset Dementia: Health, Lifestyle Factors May Boost Your Risk

From alcohol use to social isolation, poor hearing and heart disease, researchers have identified more than a dozen non-genetic factors that up the risk of dementia for people under 65.

Though about 370,000 new cases a year of young-onset dementia are diagnosed worldwide, it hasn't been well-researched.

Now, a large study from scientists in the U.K. and the Netherlands suggests that targeting health and lifestyle factors may help lower the risk.

Researchers followed more than 350,000 people under 65 who were part of the U.K. Biobank study.

They found that those with less education, lower economic status, lifestyle factors such as alcohol use disorder and social isolation, and health issues including

vitamin D deficiency, depression, stroke, impaired hearing and heart disease had significantly higher odds for a dementia diagnosis.

While particular gene variants did play a role, the findings challenge the idea that genetics alone are to blame.

"This is the largest and most robust study of its kind ever conducted," said study co-author **David Llewellyn**, director of research and impact at the University of Exeter Medical School in the U.K. "Excitingly, for the first time, it reveals that we may be able to take action to reduce risk of this debilitating condition, through targeting a range of different factors."

Young-onset dementia exacts a high toll, according to study co-author **Stevie Hendriks**, a



researcher at Maastricht University in the Netherlands.

"The people affected usually still have a job, children and a busy life," she pointed out in an Exeter news release. "The cause is often assumed to be genetic, but for many people we don't actually know what the cause is. This is why we also wanted to investigate other risk factors."

Her Maastricht colleague and co-author **Sebastian Köhler** pointed out that research on older dementia patients had already uncovered some risk factors.

"In addition to physical factors, mental health also plays an important role, including avoiding chronic stress, loneliness and depression," said Köhler, an associate professor of psychiatry and neuropsychology.

"The fact that this is also evident in young-onset dementia came as a surprise to me, and it may offer opportunities to reduce risk in this group, too."

The findings were published Dec. 26 in the journal **JAMA Neurology**.

Funding was provided in part by Alzheimer's Research UK. **Leah Mursaleen**, head of clinical research for the organization, said the findings shed much-needed light on factors that can influence young-onset dementia risk.

"In recent years, there's been a growing consensus that dementia is linked to 12 specific modifiable risk factors such as smoking, blood pressure and hearing loss," she said. "It's now accepted that up to four in 10 dementia cases worldwide are linked to these factors."

What is a retinal tear?

A retinal tear is a small split or hole in the lining of the back of the eye. The condition is not painful and may not damage a person's eyesight. However, a torn retina can progress to a retinal detachment, which can lead to permanent loss of vision.

A retinal tear may occur when the vitreous begins to shrink and recede. The vitreous is the clear, gel-like substance between the retina and lens of the eye. As it does so, it may adhere to the retina firmly enough to pull and tear it.

If the retina tears, it may result in fluid traveling into the

opening, which could cause the retina to detach. This is a potentially severe issue that can result in permanent vision loss.

This article looks at the symptoms, causes, risk factors, and diagnosis of retinal tears. It also looks at treatment and prevention, when to contact a doctor, and outlook for the condition.

A torn retina does not cause pain, and a person may not experience noticeable symptoms.

Symptoms people may experience include:

◆ **floaters**, dark spots, or wavy



lines that float across a person's vision

◆ **flashes** or streaks of light in the field of vision

◆ a shadow in a person's peripheral vision

◆ a gray curtain across part of the field of vision

Causes

A gel-like fluid called **vitreous** fills the back of the eye. This fluid helps maintain the shape of the eye, absorbs shock, and helps perform functions that assist vision.

Vitreous makes up **80%** of the total volume of the eye.

As people age, the vitreous shrinks and can move around within the eye. The vitreous comes away from the retina, which is a normal process called **vitreous detachment**. In some people, the vitreous is **stickier than usual**, and the fluid can adhere to the retina. As the vitreous shrinks and pulls away from the retina, it **can cause** a tear.

Read More on:

Risk factors, Diagnosis Treatment, Cryopexy Photocoagulation, Prevention, When to contact a doctor

JN.1 Variant Now Behind Nearly Half of U.S. COVID Cases

As Americans travel far and wide to see family and friends this holiday season, a new COVID variant named JN.1 has become dominant across the country.

A descendant of the variant BA.2.86, JN.1 now accounts for 44 percent of COVID cases, up from roughly 7 percent in late November, the latest **data** from the U.S. Centers for Disease Control and Prevention shows.

"Variants take some time to get going," **Dr. William Schaffner**, an infectious disease specialist at Vanderbilt University Medical Center, told the *New York Times*. "Then they speed up, they spread widely, and just when they're doing that, after several months, a new variant crops up."

The holiday season is likely fueling the rise of JN.1, he added. "When people are gathered

inside close to each other, having parties and traveling and the like, those are the kind of circumstances where all respiratory viruses, including JN.1, have opportunities to spread," Schaffner said.

Still, the speed at which the JN.1 variant has spread this month suggests it may spread more easily and be better at evading people's immune systems than other circulating variants, according to a recent **CDC report**.

"It is too early to know whether or to what extent JN.1 will cause an increase in infections or hospitalizations," the CDC said in its report.

Luckily, JN.1 does not seem to be causing more severe illness yet, Schaffner noted.

The other good news? The updated COVID vaccines that



were **released in September** produce antibodies that work against JN.1, which is distantly related to the XBB.1.5 variant the tweaked vaccines target.

"For those who were recently infected or boosted, the cross-protection against JN.1 should be decent, based on our laboratory studies," **Dr. David Ho**, a virologist at Columbia University in New York City, told the *Times*.

Ho led **research** published on the preprint server bioRxiv in early December that showed the latest COVID vaccines produce a strong antibody response to JN.1.

Despite the fact that JN.1 may not cause more severe disease than other variants, hospitalizations have started creeping up recently, the *Times* reported.

For the week of Dec. 10, there

were just under 26,000 COVID-linked hospitalizations, a 10 percent increase from about 23,000 hospitalizations the week before. However, those numbers are still far lower than they were during the peak of the tripledemic last winter, when COVID, flu and R.S.V. cases all surged simultaneously.

JN.1 will most likely remain the dominant COVID variant through spring, Schaffner said.

How can you protect yourself?

Experts said everyone should consider getting vaccinated, especially those who are over 65, are immunocompromised, have health conditions that put them at higher risk of severe illness or are visiting loved ones who may be vulnerable.

"Give yourself a New Year's present by getting this vaccine if you haven't done it yet," Schaffner said.

Seniors, Here Are the Meds That Can Harm Your Driving Skills

Some common medications -- including antidepressants, sleep aids and painkillers -- may dull the driving skills of seniors, a new study finds.

Many different medication classes have been linked to the risk of driving impairment, as anyone who has ever read the label warning "do not operate heavy machinery" might have guessed.

But the new study took a particularly rigorous approach to investigating the issue -- following older adults for up to 10 years and testing their driving skills with annual road tests.

And it turned out that those

using certain classes of medications were at greater risk of failing the road test at some point.

When older folks were taking either antidepressants, sedative/hypnotics (sleep medications) or non-steroidal anti-inflammatory drugs (NSAIDs), they were nearly three times more likely to get a failing or "marginal" grade than non-users.

The findings do not prove the medications are to blame, said lead researcher Dr. David Carr, a specialist in geriatric medicine at Washington University's School of Medicine in St. Louis.



It can be hard, he said, to draw a direct line between a particular medication and diminished driving skills: Is it that drug, or the medical condition it's

treating or another medication an older adult is taking?

In this study, though, Carr and his colleagues were able to account for many factors, including participants' medical conditions, memory and thinking skills, vision problems and whether they lived in more affluent or disadvantaged neighborhoods.

And certain medication groups were still linked to poorer driving

performance.

Beyond that, Carr said, many of the medications in question are known to act on the central nervous system -- with potential side effects, like drowsiness and dizziness, that could affect driving.

"The bottom line is, we need to pay attention to this and advise our patients," Carr said, adding that he doubts this is happening routinely.

Unfortunately, he added, during busy, time-limited doctor visits, discussions of medication side effects may fall by the wayside....**Red More**

New Clues To Origins of Lower Back Pain

Some people might be prone to low back pain because of specific cells contained in their spinal disks, a new study suggests.

The research could explain why only certain people develop back pain due to the degeneration of their spinal discs, which are jelly-filled spacers that act as shock absorbers between the small bones of the vertebrae.

"We've identified for the first time particular cells that could be the key to understanding disk pain," said senior study author **Dmitriy Sheyn**, a research

scientist in the Board of Governors Regenerative Medicine Institute at Cedars-Sinai Medical Center in Los Angeles.

"Learning more about how these cells work could lead to the eventual discovery of new treatment options," Sheyn added in a Cedars Sinai news release.

About 40% of adults experience low back pain due to degenerating disks in the spine, but up to now it's not been clear exactly why the disks become painful.

The jelly in spinal disks tends



to dry out and degenerate as people age, but that doesn't automatically trigger back pain, the researchers noted.

"This is because the inner jelly-like layers of the disks contain no nerve endings," Sheyn said. "But sometimes, when disks degenerate, nerve endings from the surrounding tissues invade the disk, and we believe this causes pain."

For this study, researchers first compared spinal disks from patients with low back pain against healthy disks from pain-

free folks.

They found that patients experiencing low back pain had disks containing greater numbers of a certain type of cell that might be associated with their pain.

Researchers then subjected healthy disk cells to conditions that simulated disk degeneration - inflammation, acidity, tension, compression -- and found that the cells could indeed transform into the type associated with pain....**Read More**

High-Tech Screening Might Spot More Cancer Patients Who'd Benefit From Immunotherapy

More patients could benefit from immunotherapy, a highly effective treatment for some cancers, new research suggests.

Revising current testing guidelines so that a more sophisticated test could be used more often would enable 6,000 more people in the United States to receive the treatment, a team from Brigham and Women's Hospital in Boston contend.

Immunotherapy is highly effective for those whose cancers have mismatch repair deficiency - in which errors in DNA occur due to a lack of certain proteins. This impairs DNA's ability to repair itself and can lead to many types of cancer, the researchers pointed out.

"In colorectal cancer and endometrial cancer, which are the two types of cancer where mismatch repair deficiency is

most commonly seen, immunotherapy is not the standard treatment unless a patient has this condition,"

study author **Dr. Elias Bou Farhat**, a postdoctoral research fellow in Brigham's Division of Pulmonary and Clinical Care Medicine, said in a hospital news release. "But in patients with this condition, even in late-stage cancer, those who receive immunotherapy can live for years and in some cases be potentially cured."

Previous research has shown that patients with mismatch repair deficiency typically do well with immunotherapy, which uses a person's own immune system to fight cancer. But some of these patients are missed in testing.

This study looked at 1,655 patients with either colon or endometrial cancer who received



current lab testing (immunohistochemistry) for the deficiency as well as next-generation sequencing. Current lab tests missed

nearly 6% of patients with endometrial cancer and 1% of those with colon cancer who had the deficiency. But next-generation sequencing detected the deficiency in these cases, the study found.

Because next-generation sequencing looks for more genetic mutation characteristics, the researchers said it is a more sensitive test. Still, they said further studies are needed to confirm and generalize the findings.

The data also showed that in patients with the same cancer at the same stage, those who did not receive immunotherapy had worse outcomes.

The findings were published Dec. 28 in the journal *Cell*.

"Including next-generation sequencing as a complimentary testing practice could benefit patients in all phases of cancer, from pre-treatment to advanced stages," Farhat said.

More than 150,000 Americans are diagnosed with colon cancer and more than 65,000 with endometrial cancer each year.

"We don't want to miss these patients, or we could be depriving them of a treatment that can have long-term benefits," said senior study author **Dr. Amin Nassar**, a member of Yale Cancer Center who did the work as a resident at Brigham and Women's Hospital. "We also want to avoid giving patients treatments that could be more toxic and/or less effective -- we want to treat patients with the appropriate therapy."

What's long flu and are you at risk?

Over the last few years, we've heard a lot about people with "long Covid," who cannot shed the Covid virus and develop chronic and serious symptoms that can last a long time. We've heard little about "long flu," another chronic condition that can develop after having had a bad case of influenza. **Time Magazine** reports on a study published in **The Lancet** on the risks of long flu for older adults.

Nearly one in seven people who get Covid end up with long

Covid. Who ends up with long flu and what are the consequences? Relative to Covid, it appears that long flu is less severe. You are less likely to die and you are less likely to experience scores of challenging symptoms that many people with long Covid experience, including exhaustion, brain fog, breathing issues, heart issues and gastrointestinal issues.

Though long Covid symptoms are worse and more plentiful



than long flu symptoms, long flu symptoms are nothing to sneeze at. (Pun intended). It's

common to experience long flu symptoms. Researchers found 615 health issues for every 100 people they studied with Covid and 537 health issues for every 100 people they studied with the flu. All of the people studied had been hospitalized for their conditions, and they were all older, with an average age of 70.

The Lancet study findings are

aligned with earlier findings. In a 2021 study of people, some of whom were hospitalized and some not, about four in ten of those with influenza continued to experience at least one long Covid symptom in the six months following their influenza.

To protect yourself, get your **vaccines**—Medicare covers them—wear a mask when you are surrounded by other people, and stay home when you are feeling ill.

Anxiety Attacks: Symptoms and Calming Techniques

Anxiety attacks can seem overwhelming when you're in the middle of one, but with the right coping tools you can come out the other side.

What is an anxiety attack?

According to the **Detroit Medical Center**, an anxiety attack is a stretch of time during which you experience "intense" anxiety symptoms, especially fear. It can last anywhere from minutes to weeks.

So, what does an anxiety attack feel like?

A racing heart, dizziness and being out of breath are common experiences for people who are having an anxiety attack, according to **Harvard Health**. In

addition, this "fight-or-flight" response that is triggered by worry or fear can cause more fear to develop, creating a negative loop of panic.

"If you're feeling lightheaded, your heart racing and chest tightening, it really contributes to a sense that something terrible is going to happen," said **Jacqueline Bullis**, an assistant psychologist at Harvard-affiliated McLean Hospital, told Harvard Health. "But physical symptoms themselves aren't the problem. It's really the way we respond to them. We want people to learn that these distressing physical sensations aren't



dangerous and they can learn ways to tolerate them."

Anxiety attack symptoms According to Harvard Health, anxiety attacks

occur when your symptoms become so intense that they interfere with everyday activities.

- ◆ These anxiety symptoms may include:
- ◆ Steadily increasing feelings of fear or worry
- ◆ Panting or gasping for breath
- ◆ Extreme nervous and restless sensations
- ◆ A racing, pounding heart
- ◆ Sweating hands

- ◆ Sensations of dizziness and nausea
- ◆ Feeling panicked because you think something awful is about to occur
- ◆ Feeling like you're having a heart attack or stroke

It's always recommended to seek medical care if you're experiencing symptoms that could indicate a life-threatening medical condition. However, if your doctor finds no signs of an underlying health issue, these symptoms may be markers of an anxiety attack.

Panic attack versus anxiety attack: what's the difference?...[Read More](#)