



Message from the Alliance for Retired Americans Leaders

Senate Budget Committee Holds Hearing on Strengthening Social Security; Rep. Larson Re-Introduces the Social Security 2100 Act



Robert Roach, President, ARA

Social Security was in the news this week with Senate Budget Committee Chairman Sheldon Whitehouse (RI)

holding a hearing entitled, "Protecting Social Security for All: Making the Wealthy Pay Their Fair Share," and Rep. John Larson (CT) re-introducing the Social Security 2100 Act as H.R. 4583.

The Senate hearing focused on S. 1174, the Medicare and Social Security Fair Share Act, introduced by Sen. Whitehouse. The legislation extends Social Security's solvency indefinitely while extending Medicare's solvency by 20 years by requiring Social Security taxes to be paid on all wages, self-employment, and investment income above \$400,000. Currently Social Security taxes are only paid on the first \$160,200 in annual earnings. In addition, the Medicare tax rate would be increased for income above \$400,000. Rep. Brendan Boyle (PA) has introduced a House version of the bill, H.R. 4535.

Rep. Larson's bill, H.R. 4583, was re-introduced on Wednesday. It has more than 175 House co-sponsors and would require Social Security taxes to be paid on wage income above \$400,000. It increases benefits by 2% across the board for all Social Security

beneficiaries for the first time in 52 years, expands benefits to boost lower income seniors, and improves benefits for middle-income widows and widowers from two-income households. It also repeals the Windfall Elimination Provision (WEP) and Government Pension Offset (GPO) that currently penalize many public servants. Sen. Richard Blumenthal (CT) introduced the Senate version of the bill, S. 2280.

"The Alliance supports both of these bills. They demonstrate how we can strengthen Social Security and ensure that the vast majority of Americans do not continue paying a much larger percentage of their income into Social Security than billionaires," said Robert Roach, Jr., President of the Alliance. "This is a welcome contrast to the proposals from other members of Congress who talk about raising the full retirement age for Social Security, privatizing it and creating special commissions to slash it."

NIRS: New Report Finds Disturbing Outlook for Generation X in Retirement



Rich Fiesta, Executive Director, ARA

A new report from the National Institute on Retirement Security (NIRS)



finds a dismal retirement outlook for Generation X, the first generation to enter the labor market following the shift from defined benefit

pension plans to 401(k)-style defined contribution accounts.

The report examines current rates of retirement plan coverage, coverage by industry, and retirement account balances, with analyses by race, gender, and marital status. The analysis defines Generation X as those born between 1965 and 1980.

When looking at median retirement savings levels for Generation X, the bottom half of earners have only a few thousand dollars saved for retirement, and the typical household has only \$40,000 in retirement savings. Retirement savings for Generation X is highly concentrated among the highest earners, while Blacks and Hispanics have substantially lower savings and access to retirement plans compared to whites.

"Only 14% of Generation X is covered by a defined benefit pension plan," said Richard Fiesta, Executive Director of the Alliance. "The NIRS report provides further evidence that we need to expand Social Security quickly and increase benefits. This matters for current and future retirees. There is no time to waste."

Movement Advances to Establish Minimum Staffing in Nursing Homes



Joseph Peters ARA Sec.-Trea.

The Biden administration is preparing to address the nursing home staffing crisis by introducing a proposed rule that includes requiring more care

workers per resident. Low staffing often means that workers are forced to manage care for dozens of patients at a time, frequently leading to a higher incidence of falls, rehospitalizations, and missed care. It has also led to higher resident mortality rates.

At the same time, many nursing home corporations have cut costs and reaped huge profits at the expense of workers and residents. This has been exacerbated by an influx of private equity into nursing homes.

The new Biden administration rule is expected to strengthen the nation's long-term care system, improve the lives of residents and prevent unnecessary worker injury and burnout. That should give working families peace of mind that their loved ones are receiving the level of care they deserve.

"The rule will change the minimum number of direct-care-staff per resident," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "That is at the crux of the problem in nursing homes, and residents should see vast improvements in their daily lives once the changes are implemented."

If you are a nursing home worker, have lived in a nursing home, know a loved one who has, or want to improve the state of care in our country, please share your story [here](#).



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Sen. Whitehouse: We can protect Social Security for all without cutting benefits

“If Republicans stand by their commitment not to cut benefits, they must safeguard Social Security solvency by raising revenue.”

Washington, D.C.—U.S. Senator Sheldon Whitehouse (D-RI), Chairman of the U.S. Senate Budget Committee, delivered the following opening statement at today’s hearing, titled *“Protecting Social Security for All: Making the Wealthy Pay Their Fair Share.”*****

Chairman Whitehouse’s remarks, as prepared for delivery:

Since the start of this Congress, my distinguished ranking member and many of the Republican members of this Committee have insisted we should focus only on rising debt and deficits.

Because of what they portend for debt and deficits, I have looked at the enormous costs and economic risks associated with climate change. These risks to our economy are deadly serious.

But we have also held hearings on common sense proposals to raise revenue from large corporations and wealthy individuals, who too often skate in our rigged system. Today, I welcome a conversation with my Republican colleagues about how to protect Social Security, which according to CBO, along with Medicare, will make up more than half of spending growth over the next decade.

With Social Security and Medicare accounting for so much future spending growth, you cannot have a serious conversation about our nation’s fiscal situation if you only focus on non-defense discretionary spending, which represents less than 15% of total federal spending.

Without new revenue, Social Security will only cover 80% of

its projected benefits by 2035. That’s only twelve years away. This hearing will therefore examine how to close that revenue gap to preserve the promise of Social Security for our kids and grandkids, working adults, and current retirees who will be alive in 2035. This is a promise we must not break.

Social Security is the bedrock of retirement security and the nation’s most effective anti-poverty program. It’s a lifeline for millions of seniors, their children, and people with disabilities. In February of this year, that lifeline reached 20% of the entire U.S. population.

And almost every senior in this country will receive payments from Social Security; benefits seniors have *earned* that let them retire in dignity.

One of my constituents, Robert of Pawtucket, said:

“I rely on my Social Security as my only source of income. I would find it impossible to continue to live independently if Social Security were changed, reduced or eliminated. Social Security benefits were a contract between the federal government and its citizens.”

Another Rhode Islander, Antonella of North Providence, said:

“I would be very sad and depressed if there were any cuts to Social Security. I just get by as it is.”

And Laurel of Pawtucket said that without Social Security, she “would have to go back to work and probably have to work until I die.”

For years, Republicans proposed slashing Social Security benefits, letting Wall Street gamble with seniors’ retirement, or even sunseting Social Security



altogether. Then, at the State of the Union, President Biden received a standing ovation from Republicans and Democrats alike when he proclaimed that cutting

Social Security and Medicare was off the table. As he said that night, “We got unanimity!”

So, this hearing proceeds under the premise that Republicans want to extend Social Security solvency, while standing by their commitment not to cut benefits. That of course leaves only one option – raising revenue.

Fortunately, there are win-win common sense solutions that would both extend Social Security solvency indefinitely without benefit cuts while also making our tax system fairer.

Right now, the cap on Social Security contributions means a tech exec making \$1 million effectively stops paying into the program at the end of February, while a schoolteacher making far less contributes through every single paycheck all year.

That’s not fair, and my Medicare and Social Security Fair Share Act would fix that by requiring contributions to Social Security on wages above \$400,000.

Right now, people living off of income from their wealth make *no* Social Security contributions. That’s not fair either, and my bill would also fix that. Those making more than \$400,000 in investment income would contribute just like those who are working.

And right now, some wealthy owners of pass-through businesses like hedge funds and private equity firms avoid paying Medicare taxes entirely on much of their income. My bill would close this loophole.

These reforms raise enough revenue to make Social Security solvent indefinitely, according to a new estimate from the Social Security Actuary, Mr. Steve Goss, who is with us here today. Further, my legislation would extend Medicare solvency by 20 years.

We can protect Social Security for all without cutting benefits. And we get to end unfair tax dodges that let those at the top play by a different set of rules than everyone else.

We could do even better and actually strengthen benefits. I’m an original cosponsor of Sen. Sanders’ and Sen. Warren’s *Social Security Expansion Act*, which would expand benefits by \$2,400 each year while fully funding the program indefinitely.

While I welcome the bipartisan commitment not to cut Social Security, it’s not rock-solid. MAGA Speaker McCarthy wanted Social Security cuts during the debt ceiling negotiations and has pledged to explore them. The House Republican Study Committee released a plan to cut Social Security by \$718 billion over 10 years. The plan would also raise the retirement age to 69, which would effectively cut benefits by 13 percent *every year* and especially harm low-income workers.

Raise revenue or cut benefits. These are the only two options. If Republicans stand by their commitment not to cut benefits, they must safeguard Social Security solvency by raising revenue. There is no other way to honor our promise to older Americans to retire with dignity.

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New study finds you can't meaningfully choose among Medicare Advantage plans

One big problem with corporate health insurance companies is that the less they spend on your care, the more of your premiums they can keep. Another big problem is that states and the federal government generally do not begin to have the resources to oversee them in a meaningful way and protect their enrollees from health plans that inappropriately refuse to cover needed care. Not surprisingly, there's a new report out from the Urban Institute finding that the federal government's star-rating system for Medicare Advantage plans neither promotes quality nor helps people distinguish effectively among their Medicare health plans choices.

In other words, if you're in a Medicare Advantage plan or thinking about enrolling in one, keep in mind that the insurance companies offering these plans have a financial incentive to **inappropriately delay and deny your care**, especially costly care. And, the Office of the

Inspector General's Office has now issued two reports finding that many of them do indeed engage in inappropriate delays and denials of care and coverage. Though the federal government, through the Centers for Medicare and Medicaid Services (CMS), is charged with overseeing these plans and helping you make an informed choice among them, it is withholding important information you need to make an informed choice.

What should you do to avoid unnecessary delays and denials of care and coverage? If you can afford **traditional Medicare**, which the government administers directly, go for it. With traditional Medicare, sometimes called Original Medicare, you should not face barriers to care or inappropriate delays and denials of coverage. But, if you don't have Medicaid or supplemental retiree insurance to fill gaps in coverage, you will need to buy this **"Medigap"**



supplemental coverage, which can cost \$2,500 a year.

If you opt for a Medicare Advantage plan to save the \$2,500 in supplemental insurance costs, keep in mind that a plan with five-stars may inappropriately delay or deny your care. Here's why, according to the Urban Institute's latest report:

- ◆ The rating system is based on an overall assessment of several Medicare Advantage plans an individual corporate health insurer offers. So, if one of those plans is terrible, it could still get a four or five-star rating if others of the plans are deemed to offer better care.
- ◆ The Centers for Medicare and Medicaid Services (CMS) does not take account of certain deficiencies with Medicare Advantage plans in its star ratings, including rates of inappropriate delays and denials of care and coverage.
- ◆ CMS inflates its scores, giving

high star ratings too often.

◆ CMS does not focus its measures on whether Medicare Advantage plans meet the needs of people with costly and complex conditions. Because health insurance is about protecting people from unforeseen health problems, this is a serious flaw.

You should also keep in mind that if you get sick and need costly care, your out of pocket costs in a Medicare Advantage plan can be as high as \$8,300 for in-network care, this year alone.

Advocates are working hard to get CMS to publish delay and denial rates of individual Medicare Advantage plans. Some plans, we are told, have problematically high denial rates. For sure, those plans should be avoided and the government should have a duty to let you know about them, as well as to penalize them heavily and, where appropriate, cancel their contracts.

How a Combination of Covid Lawsuits and Media Coverage Keeps Misinformation Churning

Public health has had its day in court lately. And another day. And another day.

Over the course of the pandemic, lawsuits came from every direction, questioning public health policies and hospitals' authority. Petitioners argued for care to be provided in a different way, they questioned mandates on mask and vaccine use, and they attacked restrictions on gatherings.

Historically, "there's been nothing but a cascade of supportive deference to public

health," said Lawrence Gostin, a professor specializing in public health law at Georgetown University. That changed during the pandemic. "It's the opposite. It's been a torrent."

Even as covid-19 wanes, lawyers representing the health care sector predict their days in court aren't about to end soon. A group of litigators and media companies, among others, are eyeing policy changes and even some profits from yet more lawsuits.



Because such groups can reach millions of people, public health advocates like Gostin and Brian

Castrucci, president of the de Beaumont Foundation, a public health nonprofit, suggest that the result, beyond creating legal setbacks, could spread more misinformation about their work. The imprimatur of a lawsuit, they think, can help spread vaccine skepticism or other anti-public health beliefs, if only through news coverage. "You know, lawsuits have a galvanizing

effect," Gostin said. "They tend to shape public opinion."

Lawyers are organizing to promote their theories. Late in March, a group of them gathered in Atlanta for a debut **Covid Litigation Conference** to swap tips on how to build such cases. "Attention, Atlanta lawyers!" proclaimed an **ad promoting the event**. "Are you ready to be a part of the fastest-growing field of litigation?"...**Read More**

Will My Disability Benefits Change When I Turn 65?

If you've been on Medicare prior to age 65 because of a disability, turning 65 offers another opportunity to review your benefits and coverage selections. If you're younger than 65 and have been on Social Security disability benefits for a while, you may have already navigated the process of **using Medicare as your health insurance provider**.

But what happens when you celebrate your 65th birthday? Do you start the sometimes-laborious process all over again? Let's walk

through how the system works and what to expect.

What Is Medicare?

Medicare, the federal health insurance program established in 1965, was designed to provide coverage for American adults over age 65. At the time, most Americans retired at about that age, so Medicare was meant to kick in when coverage from an employer-based insurance plan ended.

In 1972, Medicare was expanded to cover people younger



than 65 – if they receive Social Security disability benefits. Since then, qualifying for such benefits has meant meeting several requirements and completing a 24-month waiting period before coverage kicks in. Two specific conditions are exempt from the 24-month waiting period: Those with **end-stage kidney disease** and those with Lou Gehrig's disease, which is more formally called **amyotrophic lateral**

sclerosis, or ALS. Individuals with these diseases can qualify for Medicare no matter their age and without having to fulfill the two-year waiting period.

No matter which disability you have, once you meet the outlined requirements, you can access federally subsidized health insurance coverage via Medicare. This way, you can help you get the care you need when you're unable to secure health insurance through an employer....**Read More**

Medicare Should Come With These 4 Warning Labels

Medicare enrollment can present an overwhelming variety of choices. Here are pitfalls to avoid as you compare specific plans.

You can think of enrolling in Medicare as an enormous dinner out with very filling starters. But before you order, you must choose one of two menus: Do you prefer Original Medicare or Medicare Advantage?

Original Medicare starts with two courses of alphabet soup: Medicare Parts A, B and D followed by your choice of Medigap supplemental insurance plan types: Plans A, B, D, G, K, L, M and N.

Go for the other menu, Medicare Advantage, and you'll get a blue-plate special bundling together the coverage of Parts A, B and D. But from there, the options can still overwhelm. Those from Ohio, for example, can choose among 216 Medicare Advantage plans offered by 20 insurers.

Given all this complexity, many first-time enrollees feel uncomfortably full — at least their heads do — before they even address the big question: How can they ensure 5-star health care for the rest of their lives?

The key is to avoid a handful of fundamentally bad choices that can only be reversed at a high cost, if at all.

And just how steep can your health care costs be under Medicare? One measure is the proportion of Medicare-eligible folks who find themselves mired in debt related to their care. Some 22% of people age 65 and up said they owed money on medical or dental bills, according to a 2022 survey by KFF, a health policy

nonprofit.

1. Don't enroll late, even if current health care needs are modest

Know this: If you fail to enroll in any part of **Medicare** during your initial enrollment period, **you will pay one or more penalties** not just once, but month after month, often for the rest of your life.

Consider Medicare Part B, your coverage for doctor bills, outpatient services and so on. In 2022, the Centers for Medicare & Medicaid Services average Part B late-enrollment penalty was 27% higher than the base premium. That penalty amounted to \$45.93 per month. With Part B, you pay the penalty — which is proportional to how long you delayed enrolling — every month, for as long as you have Medicare.

If you currently take only cheap generic prescription drugs, you may be tempted to delay enrollment in Medicare Part D. But think about the long term: There's a strong chance you'll eventually need more expensive medications.

"People get into hot water with brand-name specialty medications, which can cost thousands of dollars," says Sarah Murdoch, director of client services at the Medicare Rights Center, a nonprofit consumer advocacy organization. "Some Part D plans are very inexpensive."

The bottom line: If you go without Parts A, B or D for months or years, you may pay less now — but you will likely pay much more later when you do enroll and the penalties kick in. This is an unrealistic strategy for most retirees, who can't reasonably expect their real



income to grow significantly. What if you can't afford Medicare premiums?

There are **programs and services for those who need help.**

2. Don't go without Medigap if you choose Original Medicare

"It's shocking how many people have no idea that they need a **Medigap plan**," says Charles Weeks, founding partner at Barrister Wealth Management in Philadelphia. Indeed, there are approximately 6 million people with Original Medicare who lack Medigap coverage, per a 2022 analysis from KFF.

According to Weeks, "the problem is, they're not aware that Part B only covers 80% of the charges" for outpatient medical services such as doctor visits, chemotherapy infusions or joint-replacement surgeries, costing tens of thousands of dollars. Without Medigap, you could be saddled with 20% of some large bills — and Medicare Part B has no limit on what you must pay out of pocket.

Be forewarned: For residents age 65 and older in most states, your guarantee of enrolling in Medigap, regardless of pre-existing conditions, expires six months after you enroll in Medicare.

3. Don't assume you can get Medigap if you later switch to Original Medicare

Beware the strategy of initially signing up for free or cheap Medicare Advantage, then switching to costlier Original Medicare if you need extensive treatment.

"It's true that if people sign up for a **Medicare Advantage plan**,

in a later annual open enrollment period they can switch to Original Medicare," says Tricia Neuman, a senior vice president at KFF. "But it's not well understood that Medicare Advantage enrollees may not be able to sign up for a Medigap policy. I have friends who have found out about this the hard way."

Here's the troubling scenario: A Medicare Advantage beneficiary receives a diagnosis of a serious illness requiring expensive outpatient treatment.

To gain access to specialists outside their Medicare Advantage network, the beneficiary switches to Original Medicare. But when they seek a Medigap policy to cover Part B's 20% coinsurance costs, insurers in most states are permitted to evaluate their health status and either deny coverage or quote an astronomical premium.

So if you think you'll ever want Medigap coverage, choose it during your initial enrollment.

4. Don't expect comprehensive, unbiased advice from an insurance agent or a friend

Insurance agents' interests don't always align with your own, and friends might not understand all the complexities of Medicare as they apply to your situation. So before enrolling, seek advice from a professional whose sole mission is to help you make the best Medicare choices. Medicare Rights Center's **Helpline** answers questions from people in all 50 states. And the **State Health Insurance Assistance Program** (SHIP), which links to all state health insurance assistance programs, is "a neutral source of information,"

Medicare Advantage overpayments continue to balloon

Here are ways policymakers could address the problem.

When Paul Ginsburg, Ph.D., Steve Lieberman and other experts **co-authored a study** about Medicare Advantage (MA) earlier this year, they pointed out that MA enrollment exploded by 337% between 2006 and 2022.

However, neither the Centers for Medicare & Medicaid Services (CMS) nor lawmakers

adjusted MA payment policies as membership grew, and that's one of the main reasons the Medicare system stays on a course **toward insolvency**, the experts said.

MA plans are paid based on the average cost per beneficiary in traditional Medicare in each county. When this system was developed in 2003, MA members accounted for about 15% of



beneficiaries. Now, about 50% of Medicare beneficiaries belong to MA plans.

Strategies to address this challenge include delinking MA payments from fee-for-service spending in Medicare or forcing insurers to undergo a competitive bidding process. That's not likely to happen anytime soon, though, the experts said, as health plans have lobbied heavily against even

a demonstration project to weigh how competitive bidding could work.

"The only change related to competitive bidding that I perceive is more agreement by economists in the merits of this approach," Ginsburg, a senior fellow at the USC Schaeffer Center, told Fierce Healthcare in an email.... **Read More**

Need a shrink? Your Medicare Advantage plan might not think so

Reed Abelson reports for the **New York Times** on the difficulty people in Medicare Advantage plans can have getting mental health care. Too often there are no psychiatrists in their Medicare Advantage plan network, according to a new study published in **Health Affairs**. If you would like to see a shrink and have your care covered—truly, if you'd like to get any specialty care and have it covered—traditional Medicare is likely to be a better option than a Medicare Advantage plan.

Researchers were not able to find even one psychiatrist in more than half of the Medicare Advantage plan networks they analyzed. Even in the networks with psychiatrists, psychiatrists were few and far between. Less than one in four psychiatrists in

the area were in network. And, of course, that doesn't speak to whether these psychiatrists were taking new patients.

Loneliness is a huge challenge for many older adults, only aggravated by the **Covid-19 pandemic**. Many older adults need to see a psychiatrist for their mental well-being. About 25 percent of people with Medicare suffers from depression, anxiety or another mental illness. But, the **Commonwealth Fund** has found that not even half of them get mental health care.

There are too few psychiatrists in the US. So, it can be hard to find a psychiatrist no matter what health insurance coverage you have. But, people with Medicaid and people in state health insurance exchange plans created



by the Affordable Care Act have considerably better access to psychiatrists than people in Medicare Advantage.

The researchers in the Health Affairs study are not alone in their findings about the lack of access to mental health care in Medicare Advantage plans. Senator Ron Wyden's team did its own study of Medicare Advantage plans in Oregon and could not find a single psychiatrist taking new patients in any of their networks. He called them "ghost networks" at a recent **Senate Finance Committee hearing**. In Medicare Advantage plans outside Oregon, in a secret shopper survey, **Senate Finance staff** could not get an appointment with a mental health

provider more than 80 percent of the time.

A psychiatrist from the American Psychiatric Association testified at the Senate Finance Committee hearing that as hard as it is for psychiatrists to deal with insurance company paperwork, it is all the harder for them to deal with administrative requirements imposed by Medicare Advantage plans. "Many of the challenges and frustrations are emphasized in the Medicare Advantage plans."

The researchers who published the Health Affairs study found that some insurers offering Medicare Advantage plans pay mental health providers less than the Original Medicare rate. That impedes access to care for people in Medicare Advantage plans and should be prohibited.

Biden proposes to ban junk health plans

The Affordable Care Act (ACA) set forth a long list of requirements for corporations offering health insurance, including rules that guarantee health insurance to individuals through state health insurance exchange health plans. But, Trump opened the door to short-term "junk" health plans that might look good but too often take your money and give you little if anything in return. Now, the Biden administration is proposing to reverse Trump's rule and ban junk health plans that last longer than three months, reports **Fierce Healthcare**.

Critics of "short-term" health plans rightly call them junk health plans. They have serious limitations as to what they cover. They do not need to cover preexisting conditions or even essential health benefits—the basic benefits, like cancer care, that any regular health insurance policy must cover. Yet, people think that they are paying for good coverage.

President Trump's rule allowed the junk health plans to be sold to individuals for one year and then renewed for up to three years. His argument was that they allowed people without the



means to buy comprehensive health insurance to get some health insurance at less cost. But, if paying less for health insurance means not getting the coverage you need, what is the value of the coverage?

In short, short-term policies often mislead people into believing that they are getting the health insurance coverage they need. President Biden explains that his administration's "new proposed rules would close loopholes that the previous administration took advantage of that allow companies to offer misleading insurance products

that can discriminate based on pre-existing conditions and trick consumers into buying products that provide little or no coverage when they need it most." "These plans leave families surprised by thousands of dollars in medical expenses when they actually use health care services like a surgery."

President Biden hopes to finalize his rule. It would only allow people to buy short-term plans for a really short period of time and help ensure that people who signed up for these plans better understood the limitations of the coverage they were buying.

Private equity buying up specialists and driving up health care costs

Reed Abelson and Margot Sanger-Katz report for **The New York Times** on private equity's growing role in health care. The New York Times story is based on a new report from the **Antitrust Institute** finding that private equity is buying up specialist practices and driving up health care prices and expenses in the process.

Private equity sees big dollars in health care and is buying up physician practices left and right, all over the country, at a rapid rate. In 13 percent of the country, private equity owns more than 50 percent of physician practices and that means higher costs for

everyone. In markets with the highest private equity penetration, health care costs are rising most dramatically. In cases where private equity controlled more than 30 percent of the market, gastroenterology, dermatology, and obstetrics and gynecology costs rose by double digits.

Private equity firms appear to see value in owning many, if not all, physician specialists as well as primary care practices. Private equity firms have focused on urology, ophthalmology, cardiology, oncology, radiology and **orthopedics**. Once they have a solid share of the specialty



market they demand higher prices from insurance companies. Insurance companies, in turn, must pay these private-equity owned practices higher prices in order to meet requirements of having enough specialists in their networks. And, if insurance companies are paying more, you better believe that your health insurance premiums are rising, along with deductibles and copays.

Thankfully, Traditional Medicare has fixed rates. But, if Medicare Advantage takes over Medicare, (as it will likely do if Congress does not act soon.)

Medicare Advantage plans will not have the leverage to negotiate Medicare rates and costs will rise dramatically in Medicare Advantage.

Alternatively, the federal government could require Medicare Advantage plans to stop negotiating with providers and pay Medicare rates. The private equity-owned practices would likely have to honor those rates. Because the Medicare population makes up such a significant portion of specialists' patients, they need Medicare patients to generate needed revenue.

Why Your 2024 Social Security COLA May Not Be Much to Write Home About

The 8.7% Social Security raise seniors got at the start of 2023 has no doubt helped many retirees stay afloat and keep up with their living costs as inflation has continued to surge. That 8.7% cost-of-living adjustment, or COLA, was the largest to come down the pike in decades, well surpassing the 5.9% COLA seniors received at the beginning of 2022.

But while this year's COLA may be helping seniors on **Social Security** regain their financial footing, next year's raise might look very different. In fact, it has the potential to be negligible, or even nonexistent.

It's a matter of inflation

Many seniors routinely rely on Social Security to cover the bulk

of their bills. And for some, those benefits are their only source of income. As such, many recipients depend on generous COLAs to maintain their buying power in retirement.

For many years, those COLAs have disappointed. And come 2024, seniors on Social Security might land in a similar boat.

The reason? Social Security COLAs are based on changes in inflation, as measured by the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), a subset of the more broadly tracked Consumer Price Index.

Specifically, third-quarter CPI data is aggregated every year and compared to third-quarter data



from a year prior. If the rate of inflation rises on an annual basis, Social Security benefits go up. If the rate of inflation slows down, Social Security's COLA follows suit. Meanwhile, inflation has cooled this year since peaking in mid-2022. And while we don't know what the next number of months have in store, there's a good chance we'll be looking at a much lower level of inflation during the third quarter of 2023 than in 2022.

In many regards, that's a good thing. Higher living costs have been putting a strain on consumers of all ages. They've been burdening retirees, hurting workers, and forcing many people to halt **retirement plan**

contributions.

On the other hand, a slowdown in inflation could lead to a minimal Social Security COLA in 2024 -- or potentially no COLA at all. And that's a possibility senior need to brace for.

Of course, the good news is that Social Security recipients can't see their benefits go down from one year to the next. This holds true even if Medicare premium rate hikes outpace their COLA. But still, given how generous this year's Social Security raise was, many seniors are no doubt hoping for a repeat in 2024. Those who don't keep tabs on inflation data, however, may be in for a rude awakening....**Read More**

Senator Sanders wants a commitment from President Biden to lower drug prices

Senator Bernie Sanders is refusing to join with President Joe Biden and fellow Democrats to support the president's nominee to head the National Institutes of Health. The Washington Post reports that Sanders, who heads the Senate HELP committee, first wants a commitment from President Biden to lower drug prices. Smart move, Senator Sanders.

We need "a very clear" government strategy on how to bring down prescription drug prices, says Sanders. Americans pay many times more than people in other countries for our drugs. And, not only is that insane, it is

unconscionable. High drug prices are literally killing people, keeping them from taking heart and cancer medications they need to stay alive. High prices are also driving up federal health care spending.

As chair of the Senate HELP committee, Senator Sanders decides whether to confirm nominees for positions at the Department of Health and Human Services. He should use his power to pressure the administration to act. Without pressure, we've seen for far too long, there is no action.

President Biden says he is



concerned about the price of prescription drugs. He signed the Inflation Reduction Act, which allows Medicare to negotiate some drug prices. But, that's only for people with Medicare and only covers a small number of drugs.

A recent report from the Department of Health and Human Services found that in the year between 2021 and 2022, the price of more than 1,200 medications rose more than 31 percent. The pharmaceutical industry blames Pharmacy Benefits Managers (PBMs) for high drug prices. They are to blame, and so are pharmaceutical companies.

PBMs pocket most of the savings they secure from bulk purchasing of drugs rather than using the savings to reduce drug costs appreciably. Pharmaceutical companies charge high prices.

Senator Sanders' team just issued a report finding that even when taxpayer dollars go to funding pharmaceutical company research that leads to the development of new drugs, Americans pay a lot more than people in other countries for those drugs. Americans pay for those drugs to be developed and are then expected to pay again in spades for them when they need them....**Read More**

Washington State's New Payroll Tax Helps Fund Long-Term Care. Could It Be a Model for the Nation?

Vicki Bickford is a professional caregiver, but lately she's been worried more and more about her own aging.

Bickford, 66, has aggressive arthritis that has required hip replacements and has now spread to her knees, as well as degenerative disc disease in her spine.

She's made modifications to help her stay in her home -- sliding glass doors, a ramp, a day basement -- but it has cost her more than \$30,000.

"We had to open up a wall to get the door, which cost a lot of money. There's a lot of concrete work, a lot of demolition, some

plumbing. It all added up, and I didn't even hire the good people. I ended up getting what I could afford," said **Bickford**, who lives in Vancouver, Wash. "I had to refinance the house, and it raised my mortgage by a couple hundred a month, which has been a struggle."

Lucky for her, Washington state has embarked upon an experiment that could change the way America supports its elderly and disabled -- and help Bickford in her pursuit of independent living.

Starting July 1, it became the first state to start independently



funding a long-term care program called **WA Cares**.

Washington now deducts 0.58% pre-tax from each worker's paycheck, and funnels the money into a state long-term care insurance fund.

"It's about \$24 a month for a typical worker who makes a little over \$50,000 a year," said **Ben Veghte**, director of the WA Cares Fund at the Washington State Department of Social and Health Services.

By July 2026, the fund will be ready to make long-term care benefits available to any Washingtonian who needs the help, Veghte said.

The program has drawn national attention, given that every U.S. state currently has a patchwork system to help families afford long-term care, said **Gretchen Jacobson**, vice president of the Medicare program at the Commonwealth Fund, a health care policy think tank.

"To put it in context, long-term care expenses comprise about a third of Medicare beneficiaries' out-of-pocket expenses, and so it's not an insubstantial cost for people," Jacobson said. "This would hopefully be a much more comprehensive patch for people living in Washington.".....**More**



Triple-Digit Heat Wave a Danger to Those With Dementia

As extreme heat continues to blanket numerous parts of the United States, Americans with dementia may be particularly challenged.

"Triple-digit temperatures and heat indexes are especially dangerous for someone with a dementia-related illness such as Alzheimer's disease, because the effects of dementia can impair their ability to notice if they are developing heat stroke or dehydration," said **Jennifer Reeder**, director of educational and social services for the Alzheimer's Foundation of America.

"Taking a few simple steps will go a long way to help caregivers keep their loved one with dementia safe during the heat wave," Reeder said in a foundation news release.

Watch out for wandering, a common behavior in individuals with dementia. They can become lost or disoriented and not know whom to call for help. This can

be a particularly concerning behavior during a heat wave because in extreme heat conditions heat stroke can develop within minutes.

A way to reduce the chances of wandering is to help someone feel purposeful indoors, while also reducing excessive stimuli and ensuring basic needs are met.

Create walking paths around the home with visual cues and stimulating objects. Help the person stay engaged with simple tasks or activities such as music, crafts and games.

Just in case your loved one still does wander, be sure you have recent photo and medical information close at hand to provide to emergency responders. Also keep a list of familiar destinations that someone might try to wander to.

Hydration is also important. Alzheimer's disease can affect someone's ability to know when they're thirsty, so monitor fluid intake and encourage the person



to drink frequently. Avoid alcohol and caffeinated beverages, which can contribute to dehydration.

Watch for heat stroke warning signs. They include excessive sweating, exhaustion, muscle cramps, rapid pulse, headaches, dizziness, nausea, sudden changes in mental status, or hot, dry or red skin.

If your loved one is showing the signs of heat stroke, you can help them to an air-conditioned room, remove clothing, apply cold compresses and provide fluids to help cool down their body. If the person faints, exhibits excessive confusion or is unconscious, call 911 immediately, the foundation advises.

Know where to cool down if you or your loved one does not have air conditioning.

Some cities open air-conditioned "cooling centers" during heat waves. These may be offered in senior centers,

libraries, community centers and other municipal/public buildings.

Plan ahead for other issues that can happen during heat waves, such as blackouts and power failures. Keep cellphones, tablets and other electrical devices fully charged. Keep flashlights where you can easily grab them. Also keep a list of easily accessible emergency contact numbers for local utility providers, police and fire departments.

If you don't live near your loved ones, arrange in advance for someone nearby to check on them. Make sure this helper has information on emergency contacts and knows where your loved one keeps important medical information, such as an insurance card. Through this helper, make sure your loved one has plenty of water, and has access to air conditioning or other cooling.

Quality Care for People With Parkinson's Is Lacking Across the U.S.

People with Parkinson's disease often aren't getting the care they need for the debilitating movement disorder, a new study report.

Three in 10 are relying on primary care doctors to treat their disorder, and 1 in 10 aren't seeing a doc at all, analysis of Medicare data reveals.

And fewer than 1 in 10 are seeing a neurologist specifically trained in treating Parkinson's, researchers said.

"That's a real concern because while I think every clinician wants to do the best for their patient, not every clinician really has that experience that they can bring to bear to help a person with Parkinson's, especially as their disease progresses," said senior researcher **James Beck**, chief scientific officer for the Parkinson's Foundation.

For this study, Beck and his colleagues analyzed 2019 claims data from Medicare.

About 90% of people with Parkinson's are covered by Medicare, the researchers noted.

An estimated 1 million Americans have been diagnosed with Parkinson's, which causes a progressive loss of motor control over the body. There is no cure, and nearly 90,000 new cases are diagnosed each year in the United States.

The Medicare data showed that about 11% of Parkinson's patients on Medicare received no medical care at all in 2019, either from a neurologist or a family doctor.

That means that fully 2 out of 5 Parkinson's patients covered by Medicare did not see a neurologist at all, after adding in the 29% who only received care from a primary care physician.

Only 9% of Parkinson's patients saw a movement disorder neurologist. These doctors have expert training that allows them to tailor treatment to the distinct nuances of each individual, Beck said.

Finally, about half of people with Parkinson's received treatment by a general neurologist.



"We were just really surprised to see that so few people are able to see

a movement disorder neurologist, a neurologist who has specialized training for the care of a person with Parkinson's," Beck said.

The researchers also found that disparities in care access persist for women, people of color, and patients living in rural areas.

Parkinson's patients also were not regularly using other specialists that can help ease their difficulties, such as physical therapists, occupational therapists, speech therapists or mental health providers, the study says.

For example, only 20% of people with Parkinson's were seeing a physical therapist; 10% an occupational therapist; and 7.5% a speech therapist, researchers found.

And even though about one-third of people with Parkinson's have depression, only around 2% received treatment from a mental health professional, the study shows.

"Many people with Parkinson's can benefit from seeing those specialists," Beck said.

He couldn't say exactly why Parkinson's patients aren't getting the care they need, but he has a few theories.

First, the United States has a real shortage of movement disorder neurologists.

"There's maybe 650 to 700 in North America," Beck said. "When you have a population of a million people with Parkinson's, not everyone can receive this highly specialized care."

And in rural America, there's even less chance that a person will have access to even a general neurologist, let alone one specializing in Parkinson's, Beck added.

"We know already that there are neurology deserts," he said. "We may have a certain number of neurologists in the country, but they're not evenly distributed. They're usually in population clusters, as you would expect -- big cities where there's lots of people."...[Read More](#)

Psychiatrists Tough to Find for Seniors in Medicare Advantage Plans

U.S. seniors with mental health needs may not have much access to psychiatrists who could help them, new research shows.

Despite an overall heightened demand for mental health services, nearly two-thirds of Medicare Advantage psychiatrist networks included less than 25% of all psychiatrists in a given service area.

"This means that many people who have coverage through Medicare Advantage plans may not actually have access to psychiatrists, given how few are considered in-network," said lead study author **Dr. Jane Zhu**, an assistant professor of medicine in the School of Medicine at Oregon Health & Science University.

And that data may not fully

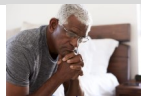
reveal the extent of the limitations.

Even when a psychiatrist is in-network, that doesn't mean they aren't already fully booked and not taking new patients, Zhu said, since the United States has a shortage of psychiatrists.

"It's likely a rosier picture than reality," Zhu said in a university news release. "We know the actual number of psychiatrists available to see patients is much lower."

In some areas, not even one psychiatrist who accepted Medicare Advantage patients was taking new patients.

The effect on patients is that they may have to pay higher out-of-pocket costs, experience



delays in care or not get the care they need at all, Zhu said.

"More than half of the counties for which we had data did not have a single [Medicare Advantage]-participating psychiatrist," the authors wrote in their study. "Our findings offer upper-bound estimates of network breadth, raising concerns about MA enrollees' access to mental health services amid the growing prevalence of mental health conditions among older adults."

Medicare provides health insurance for people 65 and up. Medicare Advantage covers 28 million Americans through private insurance plans backed by Medicare.

These findings suggest it's necessary for insurers to incentivize more psychiatrists and mental health professionals to accept health insurance, Zhu said. Another option would be to expand coverage of services delivered by other health care professionals such as psychologists, counselors or primary care physicians who provide mental health care.

The findings were published in the July issue of the journal *Health Affairs*. The research was supported by the U.S. National Institute of Mental Health, the Agency for Healthcare Research and Quality and the U.S. National Institute on Drug Abuse.

Excessive Drinking During the Pandemic Increased Alcoholic Liver Disease Death Rates

In California and across the U.S., the number of alcoholic liver disease deaths per 100,000 residents rose steadily from 2006 through 2019, then jumped quickly during the pandemic. Excessive drinking during the covid-19 pandemic increased alcoholic liver disease deaths so much that the condition killed more Californians than **car accidents** or **breast cancer**, a KFF Health News analysis has found.

This story also ran on [The Sacramento Bee](#). It can be [republished for free](#).

Lockdowns made people feel isolated, depressed, and anxious, leading some to increase their alcohol intake. Alcohol sales rose during the pandemic, with especially **large jumps in the**

consumption of spirits.

While this led to a rise in all sorts of **alcohol-related deaths**, the number of Californians dying from alcoholic liver disease spiked dramatically, with 14,209 deaths **between 2020 and 2022**, according to provisional data from the Centers for Disease Control and Prevention. Alcoholic liver disease is the **most common cause** of alcohol-induced deaths nationally. In California, the death rate from the disease during the last three years was 25% higher than in the **three years before the pandemic**. The rate peaked at 13.2 deaths per 100,000 residents in 2021, nearly double the rate from two decades ago.



The disease is usually caused by years of excessive drinking, though it can sometimes occur after a short period of heavy alcohol use. There are often no symptoms until late in the disease, when weakness, confusion, and jaundice can occur.

Many who increased their drinking during the pandemic were already on the verge of **developing severe alcoholic liver disease**, said **Jovan Julien**, a postdoctoral researcher at Harvard Medical School. The extra alcohol sped up the process, killing them earlier than they would have otherwise died, said Julien, who **co-wrote a modeling study** during the pandemic that predicted many of the trends that

occurred.

Even before the pandemic, lifestyle and dietary changes were contributing to more deaths from alcoholic liver disease, despite little change in alcohol sales, said **Brian Lee**, a hepatologist and liver transplant specialist with Keck School of Medicine of the University of Southern California.

Lee and other researchers found a connection between alcoholic liver disease and metabolic syndrome, a condition often characterized by excess body fat around the waist. Metabolic syndrome — often caused by poor diet and an inactive lifestyle — has risen across the country....[Read More](#)

Could the Bacteria in Your Gut Play a Part in How Clogged Your Arteries Are?

Your gut bacteria could affect your risk for the fatty deposits in heart arteries -- and future heart attacks, researchers say.

A new study finds a link between the levels of certain microbes in the gut and these coronary atherosclerotic plaques.

Led by researchers from Uppsala and Lund Universities in Sweden, the study analyzed gut bacteria and cardiac images from nearly 9,000 Swedish patients ages 50 to 65 with no known heart disease.

"We found that oral bacteria,

especially species from the *Streptococcus* genus, are associated with increased occurrence of atherosclerotic plaques in the small arteries of the heart when present in the gut flora," said researcher **Tove Fall**, a professor of molecular epidemiology at Uppsala University.

"Species from the *Streptococcus* genus are common causes of pneumonia and infections of the throat, skin and heart valves," she said in a



university news release. "We now need to understand whether these bacteria are contributing to atherosclerosis development."

The authors said advanced technology that allows for sequencing and comparing DNA content in biological samples aided the analysis. At the same time, improved imaging techniques enable researchers to detect and measure early changes in the small vessels of the heart.

"The large number of samples

with high-quality data from cardiac imaging and gut flora allowed us to identify novel associations," said lead author **Sergi Sayols-Baixeras**, a postdoctoral researcher at Uppsala University. "Among our most significant findings, *Streptococcus anginosus* and *S. oralis* subsp. *oralis* were the two strongest ones.".... [Read More](#)

Study shows the long-term effects of redlining on veterans' cardiovascular health

U.S. military veterans who lived in what were once known as "redlined" areas had a higher risk for heart attacks and other cardiovascular issues, according to a new study by researchers at Case Western Reserve University, University Hospitals and the Cleveland VA Medical Center.

In the 1930s, the federal government-sponsored Homeowners' Loan Corp. (HOLC) established maps of U.S. neighborhoods that identified levels of mortgage risk. This practice led to disinvestments and segregation in "redlined" neighborhoods.

Judicial rulings--and, later, federal legislation--prohibited such government practices, but research has shown their impact has had lasting effects on educational and economic opportunities--as well as health outcomes. Nevertheless, few studies have targeted the association between redlining and cardiovascular disease.

The study was conducted primarily by Sadeer Al-Kindi, formerly an assistant professor at the Case Western Reserve School of Medicine and co-director of the Center for Integrated and Novel Approaches in Vascular Metabolic Disease at University Hospitals; Salil Deo, an associate professor of surgery at the School of Medicine and cardiac surgeon at the VA Northeast Ohio Healthcare System; and Yakov Elgudin, director of lung transplantation at UH Cleveland Medical Center and an associate professor of surgery at the School of Medicine.

Their findings were published **July 11 in *JAMA Network Open***.

"While we know these communities were historically disadvantaged," Deo said, "limited information is available whether this decades-old practice still influences cardiovascular health today."



The researchers used information from 80,000 U.S. veterans--some living, others deceased--with pre-existing cardiovascular disease who lived in census tracts color-coded by the HOLC and were enrolled in ongoing care at Department of Veterans Affairs Medical Centers nationwide.

They observed that, over a five-year study period, those who lived in redlined neighborhoods were 14% more likely to suffer from an adverse cardiac event like a stroke or heart attack. And this effect remained even after adjusting for known cardiovascular risk factors and other social determinants of health.

The researchers said their findings "underline the important fact that, despite improvements in public health, access to care--and citizen health in the United States overall--significant gaps exist between communities, and progress has not been uniform across all neighborhoods."

They added that, "while thought-provoking and hypothesis-generating," the data doesn't explain what caused such higher rates of cardiovascular issues in redlined areas.

"Historical residential policies, such as redlining, may have a long-lasting effect on community health," Al-Kindi said. "This study builds on emerging literature linking redlining with a host of present-day health issues."

"Our nationwide study demonstrates that a century-old practice like redlining still affects our nation's health today," Deo said. "Future studies should aim to better define the reasons for the observed relationships between intergenerational inequities and cardiovascular health. These can then be targeted to improve the wellbeing for all individuals."

Fibromyalgia Tied to Higher Risk of Death From Many Causes

For years, people with the widespread pain disorder fibromyalgia were told their symptoms were all in their heads, but now the illness is being taken much more seriously with good reason.

Folks with fibromyalgia are more likely to die early from accidents, infections and by suicide, new research suggests.

"Fibromyalgia is often called an 'imaginary condition,' with ongoing debates on the legitimacy and clinical usefulness of this diagnosis," concluded researchers led

by Yulia Treister-Goltzman of Ben-Gurion University of the Negev, in Beer-Sheva, Israel.

"Our review provides further proof that fibromyalgia patients should be taken seriously, with particular focus on screening for suicidal ideation, prevention of accidents, and prevention and treatment of infections," they wrote.

Exactly how fibromyalgia may contribute to early death is not fully understood, but this condition often travels with other diseases and conditions, which



can increase the risk of dying early.

For the new report, the researchers reviewed six studies comprising just shy of 189,000 adults, all of whom had fibromyalgia plus other conditions. People with fibromyalgia were 27% more likely to die early from all causes if they were diagnosed according to the latest criteria.

The way that doctors diagnose fibromyalgia has changed dramatically over time. In 1990, a fibromyalgia diagnosis only took widespread pain and tender

points into account. Today, doctors cast a wider net to include fatigue, mental fogginess, headaches, stomach pain or cramps, and depression.

When using the latest criteria, people with fibromyalgia were 44% more likely to die from infections, including pneumonia and sepsis, and more than three times as likely to die by suicide than people without this condition. Folks with fibromyalgia were also 5% more likely to die in an accident, the study found....[Read More](#)

WHO Agency Declares Aspartame a Possible Carcinogen

In findings that are likely to fuel the debate over the safety of aspartame, one World Health Organization (WHO) agency announced Thursday that the artificial sweetener is a possible carcinogen while another stood firm in saying that aspartame is safe in recommended doses.

"Cancer is one of the leading causes of death globally. Every year, 1 in 6 people die from cancer. Science is continuously expanding to assess the possible

initiating or facilitating factors of cancer, in the hope of reducing these numbers and the human toll," Dr. Francesco

Branca, director of the WHO's department of nutrition and food safety, said in an agency [news release](#).

"The assessments of aspartame have indicated that, while safety is not a major concern at the doses which are commonly used, potential effects have been



described that need to be investigated by more and better studies," Branca added.

How much aspartame is unsafe?

"The average 150 lb. person would need to consume about 14 12-oz cans of diet beverages or about 74 packets of aspartame-containing tabletop sweetener every day over the course of their life to raise any safety concern," Calorie Control

Council (CCC) president Robert Rankin said in a CCC statement. "Obviously, that level of consumption is not realistic, recommended, nor is it aligned with the intended use of these ingredients."

Several other industry groups issued statements challenging the new ruling, and even the U.S. Food and Drug Administration took issue with it....[Read More](#)

Melanoma an Even More Deadly Disease in Black Men

Black men are more likely to die of melanoma, new research shows, and one reason why may be the unusual places where the deadly skin cancer is likely to show up on their bodies.

Even though the disease is more common in white men, the new report shows that Black men are 26% more likely to die from it, the *Washington Post* reported.

"The purpose of our study was to dive deeper into why we are seeing these differences in survival rates and the factors that may be driving this," study co-author [Ashley Wysong](#), chair of

dermatology at the University of Nebraska Medical Center, told the *Post*.

The researchers analyzed more than 205,000 cases and discovered that melanoma in Black men is often found in areas that have not had a lot of sun exposure, including the soles of the feet, toes, toenails, fingernails, fingernail beds and palms, the *Post* reported.

About 51% of Black men with melanoma have it on their lower extremities. In white men, only about 10% of those with



melanoma have it on their lower extremities, while 35.5% have it on their trunk and nearly 26% have it on their head and neck, the study found. Only about 13% of cases in Black men were on the trunk and just under 10% were on the head.

"I think this is significant," [Ali Hendi](#), a specialist in skin cancer surgery in Chevy Chase, Md., told the *Post*. "This study doesn't give us the answer as to why, but it sheds light on the numbers."

Black men also tended to be diagnosed later, with nearly 49%

diagnosed at late stages of the disease. Just over 21% of white men are diagnosed with late-stage disease, as are about 40% of Hispanic men, 38% of Asian men and 29% of Native American men, the study found.

The findings were published July 11 in the *Journal of the American Academy of Dermatology*.

The five-year survival rate of melanoma is 99% when the cancer is found early, but it's only 32% after it has spread, the *Post* reported....[Read More](#)

AI Tool 'Reads' Brain Tumors During Surgery to Help Guide Decisions

Scientists have developed an **artificial intelligence** (AI) tool capable of deciphering a brain tumor's genetic code in real time, during surgery — an advance they say could speed diagnosis and personalize patients' treatment.

The researchers trained the AI tool to recognize the different genetic features of gliomas, a group of tumors that constitute the most common form of brain cancer among adults.

Not all gliomas are the same, however. Most people are diagnosed with one of three subtypes that each have different genetic features — and, critically, different degrees of aggressiveness and treatment options.

Right now, doctors called pathologists can analyze gliomas for those genetic markers, in what's known as molecular diagnosis. But the process takes days to weeks, said [Dr. Kun-Hsing Yu](#), the senior researcher on the new study.

In contrast, the AI tool his team is developing can enable molecular diagnosis in 10 to 15 minutes. That means it could be done during surgery, according to Yu, an assistant professor of biomedical informatics at Harvard Medical School, in Boston.

The technology, called CHARM, also appears high on the accuracy scale. When Yu's team put it to the test with glioma



samples it had never "seen" before, the AI tool was 93% accurate in distinguishing the three different molecular subtypes.

Being able to make such distinctions in the operating room is critical, Yu and other experts said, because it could change how a patient is treated.

Some gliomas are less aggressive, and surgeons can be more conservative in removing brain tissue — which can minimize side effects.

Other gliomas, such as glioblastoma, are highly aggressive. So surgeons will try to remove as much of the cancer as possible, and sometimes implant "wafers" of slowly released chemotherapy drugs

directly into the brain.

"This breakthrough technology has the potential to guide surgical decisions by providing real-time molecular diagnosis during brain tumor surgeries," said [Atique Ahmed](#), an associate professor of neurological surgery at Northwestern University Feinberg School of Medicine in Chicago.

Ahmed, who was not involved in the study, called the tool's 93% accuracy "impressive," but noted that it can be improved.

"It's important to remember that the 7% inaccuracy is not just a number," he said. "It represents patients with very aggressive diseases who could benefit greatly from more precise diagnoses." [Read More](#)

New Type of Treatment Tackles Tough-to-Treat Prostate Cancer

A preclinical study offers a potential new therapy for treatment-resistant prostate cancer, offering new hope for men with the disease.

The study used the chemotherapy drug cisplatin, administered orally, to disrupt the metabolism of prostate cancer cells and bring the medication directly into treatment-resistant cells.

University of Miami researchers validated their targets in human prostate cancer biopsies. Then they tested the treatment in human cancer cells and a mouse model of prostate cancer, to show it could be safe and effective in shrinking these cancers.

Cisplatin is a potent drug but it has not been effective in treating

prostate cancer.

For this study, the researchers used a compound called Platin-L to break down a process that malignant prostate cancer cells use to fuel their growth and also to deliver the cisplatin directly into treatment-resistant cancer cells.

"We believe Platin-L can circumvent these resistance mechanisms," said senior study author [Shanta Dhar](#), assistant director of technology and innovation at the university's Sylvester Comprehensive Cancer Center.

Prostate cancer differs from most other cancers. While most cancers use a biochemical reaction to turn glucose into energy to support their growth



and spread, as prostate cancer advances, it instead alters enzymes that enable it to get energy from fat instead of sugar. That process is called fatty acid oxidation (FAO).

Platin-L targets CPT1A, a protein that is a part of this process.

"We are also making prostate cancer cells choose a less favorable metabolic pathway, which is insufficient to their needs, making it difficult for them to survive," Dhar said.

The researchers treated patient prostate tumor samples as well as cisplatin-resistant animal models. Platin-L destroyed the cancer cells by robbing them of their energy source, dismantling both mitochondrial and nuclear DNA.

The medication is what's known as a "prodrug" because it only activates when the body metabolizes it, the study authors explained in a university news release.

For the study, Platin-L was encapsulated in nanoparticles targeting a protein called prostate-specific membrane antigen (PSMA). This made it possible to administer the drug orally.

Side effects in other parts of the body were limited. In the study's mouse models, tumors shrank and the treated mice had steady body weight, increased survival rates and little evidence of the peripheral nerve damage that often results from cisplatin treatment....[Read More](#)