Rhode Island Alliance for Retired Americans®

RI ARA

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"Fighting for the future of our members."
"NOW, more than ever!!!"

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Message from the Alliance *for* Retired Americans Leaders

New Fact Sheet: Threats to Retirees in House Budget Package

Robert Roach, Jr
President, ARA

This week, the Alliance released a **new fact sheet** detailing how the Republican budget, recently passed in the House of Representatives, will be harmful for seniors.

The One Big Beautiful Bill Act (H.R. 1) will slash $490 billion from Medicare and $715 billion from Medicaid over the next decade. It will also gut food assistance for seniors, remove minimum staffing requirements for nursing homes, and lock in high drug prices.

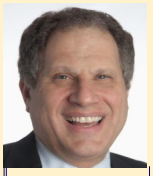
Despite assurances from Speaker Mike Johnson that there will be "no surprises" regarding the bill's passage, it is already receiving **significant pushback** from Republicans in the Senate.

"This bill takes food assistance and health care away from millions of vulnerable Americans, all so Republicans can give the wealthiest Americans more tax cuts," said **Robert Roach, Jr., President of the Alliance**. "It's incredibly cruel, and we must let the Senate know that this legislation cannot become law.

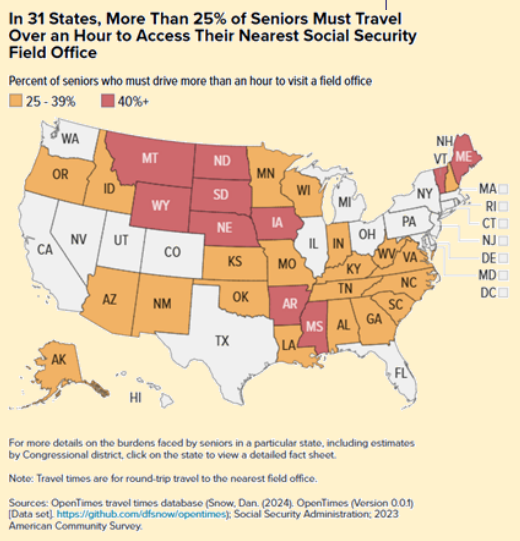
ACTION NEEDED: **Click here to send a message to your senators demanding they vote against draconian cuts.**

Social Security Phone Service Changes Will Create Unnecessary Burdens

The Department of Government Efficiency (DOGE)'s Social Security phone service restrictions will make it harder for seniors to access customer service support, according to new data from the Center on Budget and Policy Priorities. The Social Security Administration (SSA) estimates that the updates will force beneficiaries **to make** more than 1 million additional trips to field offices, exacerbating difficulties for the more than 6 million older Americans who do not **drive**, and almost 8 million seniors who have trouble traveling due to medical conditions or disabilities.



Rich Fiesta,
Executive
Director, ARA



To visit a field office in no traffic, half of all seniors nationally must **drive** at least 33 minutes, and for 13 million seniors it is an hour's drive roundtrip. In ten states, over 40 percent of seniors would have to **drive** more than an hour roundtrip, and in 31 states, over 25 percent of seniors would spend at least an hour traveling. Wyoming **has** the highest percentage of seniors who would need to travel such long distances (71 percent) and Vermont has the second highest (64.4 percent). There are only three field offices in both of those states, making accessible phone services especially critical.

On Thursday, SSA Commissioner **Frank Bisignano announced a new plan** to use artificial intelligence to address long phone waiting times.

"DOGE's systematic dismantling of the SSA has put unreasonable pressures on seniors. Older Americans shouldn't have to travel long distances to ensure that they get the benefits they've earned," said **Richard Fiesta, Executive Director of the Alliance**. "Restricting access to Social Security customer service support in this way is not what Americans have paid for."

The Alliance Celebrates Contributions of AAPI Workers This May

This month, the Alliance joined the AFL-CIO in marking Asian American, Native Hawaiian and Pacific Islander (AAPI) Heritage Month, honoring the AAPI workers who have championed labor rights throughout history.

There **are** nearly 800,000 AAPI union members in the country, and leaders such as Philip Vera Cruz, Gene Viernes, and Silme Domingo were critical in forming organizations like the United Farm Workers Union and the Alaska Cannery Worker's Association. In 1992, more than 500 AAPI labor advocates gathered to found the **Asian Pacific American Labor Alliance (APALA)**. APALA is the first and only national organization of AAPI workers and has been doing essential work in advocating for marginalized communities' rights since its formation.

Joseph Peters, Jr.
Secretary
Treasurer ARA

"AAPI communities have played a vital role in advancing not just labor rights, but rights across the board for vulnerable groups," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "We are proud to support APALA and we look forward to continuing to work with them in the future."

Overhaul of the Federal Government Remains on Hold

Last week, Northern District of California Judge Susan Illston **issued a preliminary injunction** in a lawsuit challenging the Trump administration's efforts to revamp the federal workforce, extending a previous two-week temporary restraining order blocking their plans.

The Alliance is one of the plaintiffs in the case, along with the American Federation of Government of Employees (AFGE), American Federation of State, County and Municipal Employees (AFSCME), Service Employees International Union (SEIU), and several other labor and allied organizations.

The ruling bars 22 government agencies from implementing planned layoffs until lawsuit proceedings conclude. Specified bureaus include the departments of Agriculture, Commerce, Energy, Health and Human Services, Housing and Urban Development, Interior, Labor, State, Treasury, Transportation, and Veterans Affairs.

The Trump administration appealed the temporary restraining order in the Supreme Court and is expected to appeal the preliminary injunction.

More people are claiming their Social Security early

Waiting until age 70 to collect Social Security benefits earns you 25 percent more income each month. But, Tara Siegel Bernard reports for the **New York Times** that more people are taking their Social Security benefits earlier. The Trump administration's restructuring of the Social Security Administration and the shaky economy are leading people to feel anxious and less secure about their retirement.

Last year, 244,000 people filed for Social Security between the start of the fiscal year and April. This year, 276,000 people filed for benefits, a 13 percent increase. Experts are concerned because, for people in relatively good health, claiming benefits early means giving up a bigger check that could be extremely helpful as you age.

Yes, there are more retirees eligible for Social Security with each passing year. But, that does not explain the increase in people claiming benefits.

Some people do not see their savings as being secure at the moment, with the stock market swinging wildly downwards and upwards. They worry that the Trump administration restructuring at the Social Security Administration, including a reduction in field offices and staff, will make it harder for people to get their Social Security benefits. Or, they don't feel as good about the economy as they had.

Social Security expects to get four million retirement benefit claims this year, 15 percent more than in 2024. For the last 12 years, the increase in claims was just 3 percent each year.

You can claim Social Security benefits beginning at age 62. But, you give up about 30 percent of your benefits if you don't wait until your full retirement age, which is now 67 for people born in 1960 or later. For each year you wait after 67, **you collect an extra eight percent in benefits, up to the age of 70**.

If you can afford to wait to collect benefits, you benefit significantly. Some experts advise people draw down from 401K and other retirement savings rather than file earlier than necessary for Social Security benefits.

Avoid private equity-owned hospitals

Private equity firms are buying up hospitals, and the consequences for patients who use these hospitals are chilling. New research published in **Health Affairs** finds that you have a 42 percent higher likelihood of dying in the 30 days post hospitalization in a private-equity-owned hospital. If you need even a simple surgery on an emergency basis, avoid private-equity-owned hospitals.

Researchers looked at the health outcomes of 298,000 Medicare patients receiving one of four simple surgeries at private-equity-owned hospitals: hernia operation, gall bladder removal, appendix removal, and partial colon removal.

They found that patients in private-equity owned hospitals needing emergency care had a 9.1 percent death rate in the 30 days post surgery compared to a 6.4 percent death rate in hospitals that were not private-equity owned. That additional 2.7 percent translates to a 42 percent greater likelihood of dying post-surgery than had the patients received their emergency surgeries in hospitals that were not private-equity owned.

Researchers did not find meaningful differences between private equity owned hospitals and non-private equity owned hospitals in mortality rates for non-emergency care. This suggests that private equity-owned hospitals might be stinting on emergency services or not hiring adequate emergency room staff.

Two other recent studies also found poorer health outcomes for patients in private-equity owned hospitals. One study of Medicare patients in private-equity owned hospitals, reported in **JAMA Network**, found a 25.4 percent higher incidence of falls and central-line bloodstream infections in private-equity-owned hospitals, which the authors believe suggests "poorer quality care."

Another study published in **JAMA Network** found patients reported worse care in private-equity owned hospitals. The authors conclude that "Patient care experience worsened after private equity acquisition of hospitals."

To be sure, private-equity firms are also buying up **emergency care providers, hospice and home health agencies**, **orthopedic practices,** and more. Several studies suggest that it would be advisable to avoid these health care providers for improved patient safety and health outcomes.

Will older Americans get the long-term care they need?

As Americans age, an increasing number will need long-term care. But, the availability of long-term care is on the decline. Here's how to prepare, according to Mark Miller in a piece for **The New York Times**.

Next year, the first of the baby boomer generation will turn 80. And, in the next ten years, 11 .8 million Americans will be over 85; today there are about six million. In 35 years, 19 million Americans will be over 85.

We don't have enough workers to care for this older population. Salaries are absurdly low, $16.72 an hour in 2023. And, now that the Trump administration is pushing undocumented workers out of the country, we will have even fewer care workers. Today, more than one in four care workers are immigrants.

The cost of long-term care is also rising at a rapid pace, more than three times the rate of inflation. Costs rose ten percent for some services.

Medicare does not cover long-term care. It only covers short-term stays in skilled nursing homes for a narrow group of people who need daily skilled care and who were hospitalized in the 30-days prior to nursing home admission.
Medicare does not cover help with activities of daily living for people who do not need skilled care. Yet, many people simply need help with bathing and toiletting and dressing and eating and do not require skilled care. And, even when you qualify for Medicare coverage of **skilled nursing care** or **home care**, you may struggle to get it, particularly if you are in a **Medicare Advantage plan**

Few people plan for long-term care, even though one in five will have a serious need for long-term care and, of those remaining, more than half will have some need for long-term care.

What can you do to prepare for your long-term care needs?

Understand the costs of long-term care. Cost will depend on how much care you need and where you live. In 2024, care in an assisted living facility cost around $6,000 a month. Care in a private nursing home cost more than $10,000 a month.

Recognize that Medicaid cuts will make it harder for people to qualify for Medicaid. Today, Medicaid pays for long-term care for more than six in ten people. For people with few assets and little income, Medicaid covers long-term care in nursing homes and at home, depending upon the state you live in. That won't be possible if Congress cuts Medicaid by $715 billion, as the House reconciliation bill provides….**Read More**

Justice Department investigating UnitedHealth for Medicare Advantage fraud

The Justice Department's health-care fraud unit is investigating UnitedHealth for Medicare Advantage fraud, reports the **Wall Street Journal**. UnitedHealth denies knowledge of the investigation. Regardless, its stock was down more than 50 percent in the last two months and down eight percent directly after the WSJ published its story.

A slew of investigations into the civil and criminal conduct of UnitedHealth in its administration of its Medicare Advantage HMO plans suggest massive wrongdoing by the company. The HHS Office of the Inspector General has issued several reports showing **widespread and persistent inappropriate delays and denials of care** in Medicare Advantage, perpetrated by corporate health insurers. The **Medicare Payment Advisory Commission** has found overpayments to Medicare Advantage insurers to the tune of $84 billion this year alone.

UnitedHealth is the largest of the Medicare Advantage insurers, covering nearly 10 million older and disabled Americans, 29 percent of people in Medicare Advantage.

Stephen Helmsley just took over from Andrew Witty as the new head of UnitedHealth Group. Helmsley headed UnitedHealth for more than ten years before Witty took over.

The WSJ reported that the Justice Department was undertaking a **civil fraud investigation** into UnitedHealth's Medicare Advantage conduct back in February. That month, Senator **Chuck Grassley** began looking into how UnitedHealth charges the government for its Medicare Advantage enrollees. The evidence suggests that UnitedHealth "upcodes," adding additional diagnoses to patient records, even though it is not treating patients for those diagnoses, in order to generate higher payments from the government.

House passes tax bill that would ban Medicaid from covering transition-related care

The tax bill the House passed Thursday would bar Medicaid coverage of all transgender care and prohibit plans offered under the Affordable Care Act's exchanges from covering such care as an essential health benefit, potentially jeopardizing access to care for hundreds of thousands of trans adults and an unknown number of minors.

The bill initially would have prohibited Medicaid from covering "gender transition procedures" for minors, including puberty blockers, hormone therapy and surgery. However, House Republican leadership **introduced an amendment** late Wednesday that struck the word "minors" and the words "under 18 years of age" from that section, **The Independent** first reported.

The amendment **passed the GOP-led House Rules Committee on Wednesday night** before the full House passed it Thursday morning.

Another part of the bill would prohibit transition-related medical care as an essential health benefit under health care plans offered through the Affordable Care Act's marketplace. Essential health benefits packages vary by state but are required by federal law to **cover 10 categories of benefits.** Nearly **half of states** have prohibited health insurance providers from explicitly refusing to cover transition-related care.

The tax bill's prohibitions could have a significant effect on hundreds of thousands of trans adults in the U.S. A report **published this month** by the Williams Institute at UCLA School of Law found that about 180,000 trans adults use Medicaid as their primary insurance. Another study, published in 2023, found that **nearly 1 in 4 (24.6%)** trans adults are on Medicaid, or about 312,000, based on **one estimate** that there are 1.3 million trans adults in the U.S.

It's unclear how many trans adults are enrolled in insurance through the health care marketplace. The Department of Health and Human Services reported that **nearly 24 million people had enrolled** in marketplace coverage by January. An additional 300,000 youth ages 13 to 17 identify as transgender, and it's unclear how many of them are on Medicaid or marketplace insurance plans.

President Donald Trump has made curtailing access to care for trans people a priority of his administration. In the first few weeks of his presidency, he has signed several executive orders targeting trans people, including proclaiming that the **government will recognize only** two unchangeable sexes, prohibiting trans women and girls from playing on female sports teams, **barring transgender people from serving openly in the military** and **restricting access to gender-affirming care** nationwide for trans people younger than 19.

Trump and other Republicans oppose access to transition-related care for minors, arguing that they are too young to make informed decisions about receiving such treatments and that the long-term effects of some of the treatments **have not been well studied**. LGBTQ advocates and medical professionals who treat trans people say those arguments aren't accurate and that they spread misinformation, and most major medical associations, such as the **American Medical Association,** the American Academy of Pediatrics and the **American Psychological Association**, support access to such care…..**Read More**

Trump administration cancels $766 million Moderna contract to fight pandemic flu

The Trump administration has canceled $766 million awarded to drugmaker Moderna Inc., to develop a vaccine against potential pandemic influenza viruses, including the H5N1 bird flu.

The company said it was notified Wednesday that the Health and Human Services Department had withdrawn funds awarded in July 2024 and in January to pay for development and purchase of its investigational vaccine.

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The funds were awarded through the Biomedical Advanced Research and Development Authority, or BARDA, a program that focuses on medical treatments for potential pandemics.

The new vaccine, called mRNA-1018, used the same technology that allowed development and rollout of vaccines to fight Covid-19 in record time.

Health Secretary Robert F. Kennedy Jr. has expressed deep skepticism regarding mRNA vaccines, despite real-world evidence that the vaccines are safe and saved millions of lives….**Read More**

CMS updates hospital price transparency guidance following executive order

CMS **updated** its hospital price transparency guidance May 22, requiring hospitals to post the actual prices of items and services, not estimates. The update comes after President Donald Trump **issued** an executive order Feb. 25 aimed at boosting healthcare price transparency.

In the updated guidance, CMS said hospitals must display payer-specific standard charges as dollar amounts in their machine-readable files (MRFs) whenever calculable. This includes the amount negotiated for the item or service, the base rate negotiated for a service package and a dollar amount if the standard charge is based on a percentage of a known fee schedule.

CMS also said hospitals should discontinue encoding "999999999" (nine 9s) in the estimated allowed amount data element within the MRF, and instead encode an actual dollar amount.

CMS said it is aware there are "infrequent scenarios" where a hospital has limited historical claims data to derive the estimated allowed amount, such as when a hospital has just negotiated contracts with new payers. In the past, CMS recommended that hospitals encode nine 9s in the data value to indicate there is not sufficient reimbursement history. But after reviewing the MRF files of 68 large hospitals, CMS determined that hospitals are employing the workaround "much more frequently than expected."

Hospitals are now being asked to use electronic remittance advice data from the previous 12 months to calculate the "estimated allowed amount." CMS outlined three scenarios for encoding charges:

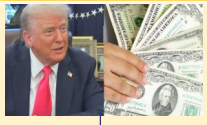
1. If the negotiated rate was used for only part of the past year, use the average from that period.
2. If a service was used at least once, average those charges and note "one or more instances" in the file.
3. If a service was not used within the 12-month timeframe, the hospital should encode an expected value in dollars and note that there were "zero instances" of use in the file.

CMS is also **seeking** public input on how to improve hospital compliance and enforcement, and ensure data shared is accurate and complete. The comment period runs through July 21.

What happened to Trump's promise to eliminate Social Security taxes?

One of the most notable campaign promises made by former President Trump was the complete elimination of **taxes on Social Security benefits**. This pledge resonated with many seniors who saw it as a potential financial relief. However, the reality of legislative processes has led to a different outcome. The House of Representatives passed a fiscal bill, often referred to as the 'One Big Beautiful Bill,' which includes a temporary deduction rather than a full tax elimination.

Instead of the promised total elimination, the legislation offers a **temporary $4,000 deduction** for individuals over 65. This measure, set to be in effect from 2025 to 2028, aims to reduce the tax burden for many seniors. A White House spokesperson described the bill as providing 'historic tax relief' for older Americans. Representative Jason Smith emphasized that this move aligns with Trump's promise to support seniors,



ensuring they can afford essentials and enjoy a dignified retirement.

Despite these efforts, the measure falls short of making Social Security benefits tax-free. Many individuals will continue to pay taxes on their benefits, highlighting a significant contrast to the original promise. The $4,000 deduction is available to single filers with incomes up to $75,000 and joint filers up to $150,000, phasing out at higher income levels.

The deduction is likely to benefit those with modest incomes. However, retirees with lower incomes already do not pay federal income taxes, and those with higher incomes may not qualify. Additionally, the provision does not assist individuals receiving survivor or disability benefits under 65. For most whose sole income is Social Security, their federal tax obligation is zero, rendering the deduction ineffective for them….**Read More**

How to Manage Anxiety with Rising Medicare Costs

For most of her adult life, New York City resident Samuella Becker didn't have to think twice about **health insurance**. Coverage was provided as part of her job, her husband's job or both. But the safety net vanished as she approached her 65th birthday in 2019.

Like millions of Americans aging into **Medicare**, she was suddenly faced with a dizzying **array of plans,** unfamiliar terms and critical decisions that would impact her health and finances.

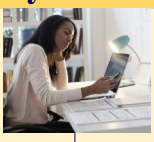
After carefully choosing a **Medicare Advantage** plan that provided her needed benefits, Becker was suddenly informed that Aetna was cancelling her plan earlier this year. She worked through her initial feelings of shock and disbelief and immediately became concerned about finding a plan with the right doctors and coverage benefits.

"My main concern was whether I would find another plan where my doctors were in the network," Becker recalls.

Thankfully, Becker had already been working with a no-fee Medicare Advantage broker, Michael Krantz with Avid Benefits in New York City. He navigated her through several options and found a solid alternative on day one of **enrollment.**

Becker represents the experience of millions of seniors navigating a wide range of Medicare choices – and feeling overwhelmed, intimidated and fearful about their current and future health care coverage.

For many older adults, the complexity and unpredictability of Medicare can be a significant source of anxiety.



"The combination of increasing costs and possible modifications creates anxiety, but seniors can find practical methods to take back control," says Abdullah Boulad, a behavioral and holistic health expert and founder and CEO of the Balance RehabClinic.

Seniors are paying more for Medicare in 2025, as the federal program adjusts costs in response to projected increases in utilization, inflation and health care prices.

Medicare Part A. The **Part A** deductible for hospital inpatient care increased to $1,676, and the coinsurance rates for extended hospital stays and skilled nursing facility stays have also risen.

Medicare Part B. The standard monthly premium for **Medicare Part B** rose to $185, up from $174.70 in 2024. The annual deductible for Part B increased to $257, compared to $240 last year.

- **Medicare Part C (Medicare Advantage plans).** Medicare Advantage premiums were stable last year, but the average deductible under Medicare Advantage went up 139%.

Medicare Part D. Under the **Part D prescription plan**, premiums increased 25% in the last year, the biggest jump in the eight years of tracking this statistic, according to **research**. A separate report found drug costs ranked among the most common worries for 50% of Medicare beneficiaries.

What's ahead for 2026? Seniors will have to wait to learn what they'll pay for Medicare coverage next year.

To help keep anxiety at bay, follow these expert-backed tips: **Read More**

Congressional Budget Office (CBO)

Surprisingly, the Congressional Budget Office (CBO) has projected that Medicare's Hospital Insurance (HI) Trust Fund will remain solvent until 2052, extending the previous estimate of 2030. This extension is attributed to stronger economic growth, higher payroll tax revenues, and lower-than-expected healthcare spending. However, the CBO also warns that, without legislative action, Medicare will face a 6.4% benefit reduction in 2053, escalating to 6.9% by 2055, unless reforms are implemented to align expenditures with revenues.

In contrast, the Supplementary Medical Insurance (SMI) Trust Fund, which covers Medicare Parts B and D, is projected to remain solvent indefinitely due to its funding structure, which adjusts premiums and federal contributions annually to meet costs.

Negotiations are taking place for the prices of 15 high-cost prescription drugs under Medicare to reduce beneficiaries' costs. These new negotiated prices are expected to take effect in 2027 as part of the Inflation Reduction Act, which aims to lower prescription drug prices through direct negotiations between Medicare and pharmaceutical companies.

The drugs chosen for negotiation include:

Ozempic, Rybelsus, Wegovy
- Trelegy Ellipta
- Xtandi
- Pomalyst
- Ibrance
- Ofev
- Linzess
- Calquence
- Austedo, Austedo XR
- Breo Ellipta
- Tradjenta
- Xifaxan
- Vraylar
- Janumet, Janumet XR
- Otezla

Looking ahead, Medicare plans to negotiate prices for additional drugs in the following years:
- 15 drugs under Part B and Part D in 2026, with new prices taking effect in 2028.
- 20 drugs under Part B and Part D in 2027, with new prices set for 2029.
- 20 drugs under Part B and Part D each year starting in 2028.

Manufacturers who fail to comply with the negotiation guidelines will be subject to tax and penalties for not meeting other Medicare requirements.

As we move through the year, the issue of prescription drug affordability for seniors is unlikely to go away anytime soon. While there have been significant strides in tackling high drug prices, especially through Medicare negotiations, more work is needed to ensure that the most vulnerable populations, including seniors, can access the medications they need without fear of going broke. Advocacy groups, such as The Senior Citizens League (TSCL), continue to push for further reforms, including expanding Medicare's bargaining power and more robust cost control measures in the pharmaceutical industry.

The ongoing increase in healthcare expenses continues to be a primary concern for seniors and budget hawks.

House reconciliation bill would push millions off Medicaid

Last week, the Republican-controlled US House of Representatives passed a reconciliation bill, which includes an estimated $715 billion in Medicaid cuts over the next 10 years. These cuts will help cover the cost of reducing taxes for ultra-wealthy Americans. In an opinion piece for **The New York Times**, Pamela Heard and Donald Moynihan explain how the bill is designed to push millions of low-income Americans off of Medicaid, even though they qualify for coverage.

Proof of Medicaid eligibility twice yearly: The House reconciliation bill requires people on Medicaid to prove, through paperwork, twice a year, that they continue to qualify for Medicaid. Imposing this paperwork burden on some of our nation's most vulnerable citizens is tantamount to pushing them off the program. In addition to the difficulty of producing all the needed documents, it can be extraordinarily challenging to contact Medicaid offices. And, without funding to increase staffing, there are sure to be huge backlogs. States are not likely to hire more people to review people's applications twice a year.

More burdensome Medicaid application process: The House bill also undoes a series of Biden administration rules which make it easier for people who are eligible for Medicaid to enroll in Medicaid.

Copays at the doctor's office: The House bill requires people with Medicaid to pay a copay at the doctor's office. Copays keep people with limited incomes from getting needed care. And, copays do not save money. One study in **NBER** found that a small prescription drug copay led to a high proportion of preventable deaths. More than 20 percent of people stopped taking their heart medications. They had heart attacks and strokes….**Read More**

Social Security

In April 2025, several significant legislative actions and policy changes impacted Social Security, particularly concerning overpayment recovery, identity verification, and the taxation of Social Security Income.

Overpayment Recovery Policy Adjustments

The SSA reversed its controversial policy of recovering 100% of overpaid benefits, often due to agency errors, which had caused financial hardship for many seniors. Effective April 25, 2025, the recovery rate was reduced to 50%, offering partial relief to beneficiaries. Despite this adjustment, advocates argue that the new policy still imposes undue hardship, especially on Social Security Disability Insurance (SSDI) recipients.

TSCL believes overpayments should be recouped, but remains concerned about the impact of any recovery rate on the less financially stable retirees. For some retirees, it won't matter if it's 1% or 100%. Any amount of clawback could be catastrophic for them.

TSCL emphasizes that retirees affected by a clawback payment can request a lower repayment rate if they cannot afford the 50% deduction. They also have the right to appeal the overpayment decision or the amount. Additionally, retirees can apply for a waiver if repaying the overpayment would cause financial hardship. These options provide relief and flexibility for those struggling to manage the deductions.

Identity Verification Policy Changes

On March 18th, the Social Security Administration announced that individuals who could not use their personal My Social Security account, which requires online identity proofing, would be required to visit a local Social Security office to prove their identity in person.

That decision was reversed effective April 14, with the following statement from SSA.

"We have listened to our customers, Congress, advocates, and others, and we are updating our policy to provide better customer service to the country's most vulnerable populations," said Lee Dudek, Acting Commissioner of Social Security. "In addition to extending the policy's effective date by two weeks to ensure our employees have the training they need to help customers, Medicare, Disability, and SSI applications will be exempt from in-person identity proofing because multiple opportunities exist during the decision process to verify a person's identity."

Dear Marci: Am I eligible for Extra Help?

Dear Marci,
I have Medicare Part D, and my doctor recently prescribed me a few new medications that I'm struggling to afford. I heard that the Extra Help program can help pay for Part D costs. What is Extra help and how do I know if I'm eligible for it?
Deepa (Warba, MN)

Dear Deepa,

You are correct! **Extra Help,** also called the Low-Income Subsidy (LIS), is a program that lowers Part D costs—both premiums and out-of-pocket expenses. Your income and assets (meaning your savings and other resources) determine if you're eligible for Extra Help. Keep reading for a more detailed explanation of the benefits of Extra Help and its eligibility criteria.

What is Extra Help?

Extra Help is a federal program that lowers premiums and helps pay for out-of-pocket costs associated with Medicare prescription drug coverage. The Extra Help program:

- Pays your Part D premium for a basic Part D plan up to a **state-specific benchmark amount**.
- **Lower your costs for prescription drugs** by eliminating the deductible period and capping coinsurance and copays.
- Allows you more flexibility to change your Part D plan during the year through a Special Enrollment Period.
- Eliminates the Part D late enrollment period (LEP), if you have one.

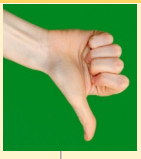
Extra Help Eligibility

- In 2025, you may be eligible for Extra Help if your monthly income is up to $1,976 ($2,664 for couples) and your assets are below $17,600 ($35,130 for couples). See the **Extra Help income and asset limit chart** for details.
  - Even if your income or assets are above the eligibility limits, you could still qualify for Extra Help because certain types of income and some assets are not counted.
- If you have Medicaid, Supplemental Security Income (SSI), or a Medicare Savings Program (MSP), you **automatically qualify for Extra Help** regardless of whether you meet Extra Help's income and asset eligibility requirements.

Keep in mind that Extra Help is not a replacement for Part D or a plan on its own. Extra Help works with your plan by reducing your costs. You must still have a Part D plan to have Medicare prescription drug coverage. Hope this helps!

-Marci

UnitedHealth accused of preventing nursing home residents from getting needed hospital care



UnitedHealth stock has fallen precipitously in the last few months. And, its stock continues to fall with new charges of illegal conduct against it. This time, **The Guardian** is alleging that UnitedHealth made extra payments to nursing homes to keep Medicare Advantage enrollees from being readmitted to the hospital. The less care UnitedHealth enrollees receive, the more money UnitedHealth generates for its shareholders.

According to The Guardian, UnitedHealth paid nursing homes bonuses when they did not transfer residents requiring urgent and emergency care to hospitals. UnitedHealth placed company providers in the nursing homes in an effort to prevent enrollees needing hospital care from getting it, saving money for the company.

The Guardian's evidence for UnitedHealth's betrayal of its duty to provide its Medicare Advantage enrollees with medically necessary care includes thousands of enrollee medical records, corporate records, conversations with nursing home employees working for UnitedHealth and two whistleblower declarations.

For its part, UnitedHealth claims that the Guardian's allegations have "significant factual inaccuracies." Good luck fighting this one, UnitedHealth.

In the past, whistleblowers have charged UnitedHealth with **delaying and denying** its Medicare Advantage enrollees medically necessary skilled nursing care and rehabilitation care. UnitedHealth has used **Artificial Intelligence** to make sweeping denials, against the interests of its patients, according to former UnitedHealth staff.

The government has charged UnitedHealth with overcharging Medicare for its Medicare Advantage enrollees to the tune of as much as tens of billions of dollars a year. UnitedHealth adds codes to enrollees' medical records, which generate larger payments to the company. But, UnitedHealth does not provide additional services to its enrollees with these additional codes.

Pharmaceutical companies take more advantage of their monopoly pricing power

Among a plethora of zany US public policies that could never die is pharmaceutical companies' legal right to price life-saving drugs however high they please. Insurers often have no choice but to cover these drugs, driving up people's premiums and copays.

A **Reuters** analysis finds that pharmaceutical companies have doubled the initial price of their new drugs treating rare diseases in the three years between 2021 and 2024.

Pharmaceutical companies have always taken advantage of their monopoly pricing power. The US is the only country that does not regulate the price of prescription drugs. And, not surprisingly, on average, we pay **three times more** than people in other wealthy countries for our drugs.

President Trump has not yet used his executive authority to lower drug prices or to direct Congress to lower drug prices. Time will tell if he will. Though, right now, he could direct Congress not to touch Medicaid in its reconciliation package and, instead, bring down drug prices. And, he has not.

President Biden pushed the provisions in the Inflation Reduction Act that allow for some Medicare drug price negotiation. That was a step forward in preventing drug companies from controlling prices. However, the law only applies to Medicare and only for a small number of drugs. President Trump has called for a change in the law that would significantly narrow that already small number of drugs.

No one should be surprised that the median launch price for a new drug treating a rare disease in 2024 was a whopping $370,000, $70,000 more than in 2023. In 2021, the median launch price for one of these new drugs was a whopping $180,000. Insanity. These drugs often treat different cancers.

Some drugs treating rare diseases cost more than $1 million dollars today. One of the highest-priced drugs treats a genetic disorder harming the brain and nervous system. The single treatment–which is all you need, thankfully–costs $4.25 million.

RI ARA HealthLink Wellness News

Please Note: All Articles In This Section Are For Information Only And Not Medical Advice

HealthLink Wellness "Taking Control"

FDA Warns of Heart Risk With Pfizer, Moderna COVID Vaccines

The U.S. Food and Drug Administration (FDA) has ordered Pfizer and Moderna to expand their warning labels on COVID-19 vaccines.

The updated warnings highlight a rare risk of heart inflammation in teen boys and young men, *CBS News* reported.

The warning applies to males ages 16 to 25 and is based on new data from FDA safety monitoring and a 2023 study. This includes both Pfizer's **Comirnaty** and Moderna's **Spikevax** vaccines.

The updated label will note that "the highest estimated incidence of myocarditis and/or pericarditis was in males 16 through 25 years of age."

Myocarditis is inflammation of the heart muscle, while pericarditis is inflammation of the lining around the heart.

For every million doses in 16- to 25-year-old males, there were 38 cases of these heart conditions, the warning adds. For all people under 65, the rate was about 8 cases per million doses, *CBS News* reported.

The U.S. Centers for Disease Control and Prevention (CDC) says most of these cases happen soon after the shot and tend to improve quickly.

The FDA's new warning also says that heart MRI scans in affected people usually showed signs of "improvement over time in most people."

"It is not known if these heart MRI findings might predict long-term heart effects of myocarditis," the FDA said. "Studies are underway to find out if there are long-term heart effects in people who have had myocarditis after receiving an mRNA COVID-19 vaccine."

Both vaccine makers have 30 days to respond to the FDA's letter.

Neither company has made a public statement yet, *CBS News* said.

The FDA made the letters public just before a U.S. Senate hearing on "how health officials downplayed and hid myocarditis and other adverse events associated with the COVID-19 vaccines."

FDA spokesperson **Andrew Nixon** said in a statement that transparency is key.

"Americans deserve radical transparency around the safety and efficacy of COVID vaccines and the FDA is delivering on their promise to do just that," the statement said. "Moderna and Pfizer should take steps to ensure that individuals are aware of COVID vaccine-related adverse events resulting in myocarditis and pericarditis."

Battling Multiple Chronic Illnesses Can Double Risk Of Depression

Battling chronic disease really takes it out of a person, leaving them vulnerable to **depression**.

And people with multiple long-term health problems are even more likely to fall prey to depression, a new study says.

Some combinations of illnesses can more than double the likelihood a person will eventually be diagnosed with depression, researchers reported this month in the journal ***Nature Communications Medicine***.

"Healthcare often treats physical and mental health as completely different things, but this study shows that we need to get better at anticipating and managing depression in people with physical illness," co-researcher **Bruce Guthrie**, a professor of general practice at the University of Edinburgh in the U.K., said in a news release.

For the study, researchers tracked more than 142,000 participants in the ongoing U.K. Biobank study who had at least one chronic health problem but no history of depression. The people ranged in age from 37 to 73.

Researchers found that those with the highest rates of physical illnesses had a 2.4 times higher risk of depression, the highest found in the study. These patients had on average more than four chronic health problems.

Depression risk was doubled in people suffering from migraine disorders or chronic lung problems, while heart disease combined with diabetes increased risk by 78%, results show.

Digestive conditions like irritable bowel syndrome (IBS), **celiac disease** and liver disease also increased risk of depression 83% in women and double in men, researchers found.

"Almost all physical morbidity clusters are associated with higher risk of subsequent depression than the group with no physical conditions at baseline," researchers wrote.

Overall, about 1 in 12 people in the highest-risk groups developed depression over the next 10 years, compared with about 1 in 25 people without physical conditions, researchers found.

"We saw clear associations between physical health conditions and the development of depression, but this study is only the beginning," lead researcher **Lauren DeLong**, a doctoral student at the University of Edinburgh, said in a news release. "We hope our findings inspire other researchers to investigate and untangle the links between physical and mental health conditions."

Dementia in decline: The new old age

Amy Dockser Marcus reports for the **Wall Street Journal** on how people in their 80's and 90's are redefining old age. Notably, research of older people that began more than 30 years ago shows that fewer older people today are being diagnosed with dementia than ten, twenty and thirty years ago. Dementia appears to be on a decline.

About 18 percent of Americans are 65 or older. Lots of older Americans continue living for more than a dozen years after their health deteriorates. But, today, having arthritis, diabetes or high blood pressure does not keep people from having a high quality life.

People are taking better care of themselves as they grow old. To the extent they keep their blood pressure, blood sugar and cholesterol levels in control, they reduce their risk of dementia and Alzheimer's disease.

Experts in aging believe that older people have control over the last years of their lives. To live longer, it's important to engage socially and move as much as possible. Volunteering can improve longevity. Lifestyle changes can make a big difference in strength, balance and more.

At Stanford, a research lab looking at aging reports that older people are more likely today to experience emotional well-being compared to younger people.

Of late, older people who lose their ability to bathe, dress or walk because of a fall or health condition are able to regain their independence, generally within six months. People who had been in good shape before their loss of independence and have good cognition are more likely to regain their independence. People who walked 20-30 minutes each day reduced their likelihood of having a serious fall and disability.

Additional Breast Cancer Scans Can Triple Detection In Women With Dense Breasts

Louise Duffield, 60, was relieved to receive a normal mammogram result in 2023, but agreed to undergo an additional MRI scan recommended as part of a clinical trial.

Her mammogram showed she had very dense breasts, which can sometimes prevent detection of breast cancer. The clinical trial was intended to test whether extra scans would help.

For Duffield, it certainly did. The MRI found a small lump deep inside one of her breasts.

"When they rang to say they'd found something, it was a big shock," Duffield, a grandmother of four from Ely, U.K., said in a news release. "You start thinking all sorts of things but, in the end, I just thought, at least if they've found something, they've found it early."

Women with dense breasts would indeed benefit from additional scans on top of their standard mammograms, the clinical trial has now concluded.

Extra imaging tests could more than triple breast cancer detection among women with dense breasts, researchers reported May 21 in the journal *The Lancet*.

These additional scans — which use injected contrast dyes to highlight tumors — detected 85 cancers among more than 9,000 U.K. women with dense breasts who'd had a clean mammogram result, including Duffield, study results show.

"Getting a cancer diagnosis early makes a huge difference for patients in terms of their treatment and outlook," lead researcher **Dr. Fiona Gilbert**, a professor of radiology at the University of Cambridge, said in a news release.

National screening programs should consider including these extra scans "so we can make sure more cancers are diagnosed early, giving many more women a much better chance of survival," Gilbert added.

About 10% of 50- to 70-year-old women have very dense breasts with low levels of fatty tissue. These women are up to four times more likely to develop breast cancer compared to women with low breast density, researchers said in background notes.

But current breast cancer screening guidelines in both the U.S. and U.K. don't consider breast density, instead recommending standard mammograms for all.

Reporting of breast density for women is mandated in the U.S., but there's no consensus regarding how women with dense breasts should be screened, researchers said.

For this clinical trial, researchers recruited nearly 9,400 women with dense breasts who'd gotten a clean mammogram between October 2019 and March 2024.

Three-fourths of them were randomly assigned to one of three additional screening tests — CEM (contrast enhanced mammography), AB-MRI (abbreviated magnetic resonance imaging) or ABUS (automated whole breast ultrasound). The remaining participants did not get an extra scan.

For each 1,000 women scanned:

- 19 cancers were detected with CEM, which uses an injected contrast agent to improve the visibility of tumors.
- 17 cancers were detected with AB-MRI, which also uses a contrast dye to highlight abnormalities.
- 4 cancers were detected by ABUS, which uses sound waves to produce images.

Mammograms already detect about 8 cancers for every 1,000 women with dense breasts, researchers said. That means these extra scans could more than triple early breast cancer detection in these women.

All told, CEM and AB-MRI were three times more effective than ABUS, researchers found.

The research team concluded that CEM and AB-MRI should be considered as an additional screening measure for women with dense breasts.

"This study shows that making blood vessels more visible during mammograms could make it much easier for doctors to spot signs of cancer in women with dense breasts," senior researcher Stephen Duffy, an emeritus professor with Queen Mary University in London, said in a news release.

"More research is needed to fully understand the effectiveness of these techniques, but these results are encouraging," he said.

Duffield's tumor would have been tough for her to find through self-examination, given its location within her breast. Under U.K. guidelines, it would have been at least three years before she would have gotten another mammogram.

Soon after her MRI, she underwent a biopsy that confirmed she had very early-stage breast cancer.

Six weeks later, she had surgery to remove the tumor; during that wait, the lump had already grown larger than it appeared on the scans.

Following a short course of radiation therapy, Duffield is now cancer-free, doctors said. They'll continue to monitor her for several years.

"It's been a stressful time and it's a huge relief to have it gone," she said.

"I feel very lucky, it almost doesn't feel like I've really had cancer," Duffield added. "Without this research I could have had a very different experience."

She said the experience has highlighted for her the importance of screening.

"If I hadn't had the mammogram, I wouldn't have been invited to the trial," Duffield concluded. "Getting treated was so quick because they found the cancer early."

FDA Approves Zynyz as First-Line Treatment for Advanced Anal Cancer

The programmed death receptor-1-blocking antibody is approved as a single agent or in combination with chemotherapy

The U.S. Food and Drug Administration has approved the humanized monoclonal antibody, Zynyz, (retifanlimab-dlwr) as the first first-line treatment for advanced anal cancer.

Zynyz is a programmed death receptor-1 inhibitor, approved in combination with carboplatin and paclitaxel (platinum-based chemotherapy) for adults with inoperable, locally recurrent, or metastatic squamous cell carcinoma of the anal canal (SCAC). Additionally, the FDA granted approval for Zynyz as a single agent for patients with locally recurrent or with metastatic SCAC with disease progression on or intolerant to platinum-based chemotherapy.

The approval is based on results from the phase 3 POD1UM-303/InterAACT2 trial, which showed a clinically meaningful 37 percent reduction in the risk of progression or death in patients with SCAC. Compared to placebo, patients in the Zynyz and chemotherapy combination group achieved a longer median progression-free survival (9.3 versus 7.4 months), as well as a 6.2-month improvement in median overall survival at an interim analysis. No new safety signals were reported.

Serious adverse reactions occurred in 47 percent of patients receiving Zynyz in combination with chemotherapy, including sepsis (3.2 percent), pulmonary embolism (3.2 percent), diarrhea (2.6 percent), and vomiting (2.6 percent).

"Patients with anal cancer often face a troubling lack of public awareness and understanding when it comes to risk factors, symptoms, and their overall cancer journey," David Winterflood, chief executive officer of the Anal Cancer Foundation, said in a press release. "The approval of Zynyz marks a step forward for advanced SCAC treatment, brings attention to a long-overlooked condition with limited treatment options and offers patients whose anal cancer has returned or spread an option to treat their disease."

Approval of Zynyz was granted to Incyte.

Alcohol-Related Cancer Deaths Double In The U.S.

Alcohol-fueled **cancer** deaths nearly doubled in the United States during the past three decades, with cases among men driving this surge, a new study says.

Between 1990 and 2021, deaths from alcohol-related cancers leaped from just under 12,000 deaths per year to just over 23,000, researchers are slated to report Saturday at a meeting of the American Society of Clinical Oncology in Chicago.

Men accounted for about 70% of the alcohol-related cancer deaths in 2021, with more than 16,500 such deaths, results show.

"That's a big and concerning rise," said lead researcher **Dr. Chinmay Jani,** a hematology and oncology fellow at the University of Miami's Sylvester Comprehensive Cancer Center.

"We need to increase awareness of this link among the general population and even in the medical field," Jani added in a news release. "There's a lot of awareness about, for example, tobacco and the risk of cancer. But for alcohol, that awareness isn't there."

Earlier this year, the U.S. Surgeon General's office issued an advisory, warning Americans of the strong evidence linking alcohol to cancer, researchers said in background notes.

In fact, alcohol has been classified as a cancer-causing substance by the International Agency for Research on Cancer since 1987, notes the **National Cancer Institute**. The U.S. National Toxicology Program has considered alcohol a known human carcinogen since 2000.

Despite this, many folks still don't think of alcohol as a cancer risk factor.

A 2019 survey from the American Institute for Cancer Research found that while 89% of Americans know that tobacco is linked to cancer, only 45% of people know alcohol is as well, researchers said in background notes.

For the new study, researchers analyzed data from the Global Burden of Disease database, a public dataset that captures disease information from around the world and estimates risk factors that likely contribute to illness and death.

The research team looked at all cancer deaths, as well as at specific cancer types known to be influenced by drinking. These include breast, liver, colon, throat, voice box, mouth and esophageal cancers.

Most alcohol-related cancer deaths in 2021 were caused by liver cancer (7,408 deaths), followed by colon cancers (4,687 deaths) and esophageal cancers (3,948 deaths), researchers report.

And among all cancers combined, the percentage of deaths likely to due to alcohol increased by nearly 50% between 1990 and 2021, researchers reported.

Alcohol consumption is responsible for a larger percentage of cancer deaths than in the past, even as improved screening and treatment drive down the overall number of deaths, researchers said.

The increase in alcohol-related deaths appears to be entirely due to an increase among men, researchers found. Deaths among women have declined slightly since 1990.

Alcohol can increase cancer risk by causing damage to DNA and altering levels of hormones, researchers said.

But more research is needed on how biological differences between people might affect their individual risk for alcohol-related cancer, researchers said.

"We hope that our study will help educate the public on the impact of alcohol on individual cancer risk, as this is a potentially modifiable factor," senior researcher **Dr. Gilberto Lopes**, chief of medical oncology at the University of Miami's Sylvester Comprehensive Cancer Center, said in a news release.

Findings presented at medical meetings should be considered preliminary until published in a peer-reviewed journal.

Knee Pain Relief Through The Ear? New Study Says It's Possible

"It's easier to put your elbow in your ear" is a time-tested way to describe the impossibility of any given task.

But the route to easing knee pain might indeed wend through the ear, a new study says.

Stimulating the vagus nerve through the ear improved knee pain for some patients, according to early trial results published recently in the journal ***Osteoarthritis and Cartilage Open***.

The vagus nerve plays an important role in the parasympathetic nervous system, which controls the body's ability to rest and digest, researchers said. It is countered by the sympathetic nervous system, which manages the "fight-or-flight" response.

"The current evidence suggests that individuals with osteoarthritis knee pain have an imbalance of sympathetic versus parasympathetic activity in the body, which can cause pain," said lead researcher **Kosaku Aoyagi,** an assistant professor of physical therapy and movement sciences at the University of Texas at El Paso.

"By stimulating the vagus nerve, we hypothesized that our treatment may rectify this imbalance," Aoyagi said in a news release.

For the small-scale trial, researchers recruited 30 patients with knee pain and treated them with a transcutaneous auricular vagus nerve stimulation (tVNS) device for an hour.

The device rests on the ear and sends electrical pulses to the branch of the vagus nerve that runs through the ear. It's already approved by the U.S. Food and Drug Administration to treat conditions like epilepsy and depression, researchers noted….**Read More**

Obtaining Second Opinion Delays Treatment for Breast Cancer, but Not Appreciably

For patients with newly diagnosed breast cancer, obtaining a second opinion is associated with increased overall time from diagnosis to treatment; however, time to treatment still falls well within the guidelines, according to a study presented at the annual meeting of the American Society of Breast Surgeons, held from April 30 to May 4 in Las Vegas.

Pooja Varman, M.D., from the Cleveland Clinic Foundation, and colleagues compared time to first treatment between patients with newly diagnosed breast cancer who seek a second opinion (external) and those diagnosed within the same institution (internal) in a retrospective cohort study. Participants with new stage 0 to III breast cancer diagnosed externally and internally (113 in each group) and treated at a single cancer center between January and July 2024 were included.

The researchers found that the median time from biopsy to first treatment was 35 days, with a significant difference between external and internal patients (41.5 versus 31 days). The median time from first surgical oncology clinic appointment at the study institution to first treatment (TCT) was 21 days, with no significant difference between external and internal patients (20 and 21 days, respectively). Compared with internal patients, external patients required additional imaging and biopsies significantly more frequently (90.3 versus 68.1 percent). There was a correlation between the need for additional workup and increased median TCT. A correlation was also seen for the need for a plastic surgeon consultation with increased median TCT.

"Cleveland Clinic internal patients had an even shorter time to treatment, but external patients' average time to treatment was still well within guidelines," Varman said in a statement.

Microplastics build up in our blood

Nina Agrawal reports for **The New York Times** on the build-up of microplastics in our blood and tissues. Microplastics are super tiny plastics that come from the plastic containers we eat and drink from, among many other objects present in our lives.

In addition to accumulating microplastics in our systems from food and drink, we absorb microplastics from plastic tubing, packaging, phones, sunscreen, cosmetics and clothes. They also line aluminum and paper containers. You can steer clear of some of these microplastics sources. But, there's no avoiding the microplastics in our air, soil and water.

To some extent, our bodies eliminate microplastics. But, what we don't excrete can end up living in our liver and brains. The latest thinking is that we have a plastic spoon's worth of microplastics in our brains. No one yet fully understands how it is affecting us, but it can affect our health, including our reproductive systems.

How to minimize your intake of microplastics?

1. Avoid drinking from plastic bottles, particularly ones that have been exposed to the sun or other heat sources.
2. Avoid putting food in plastic containers when using the microwave. Use ceramic containers.
3. Store food in glass and stainless steel containers.
4. Avoid eating ultraprocessed foods, including meat and fish. Eat fresh fruits and veggies.
5. Use an air purifier.
6. Clean surfaces in your home with water, to wash away microplastics.
7. Before wearing synthetic clothing, wash the clothing to eliminate microplastics in the manufacturing process. Wear natural fibers, such as cotton and silk.

Sugar, Fat and Salt on the Rise in U.S. Breakfast Cereals, Study Shows

They're a go-to breakfast for millions of kids and adults. They're brightly colored, packed in enticing boxes and often marketed as healthy — but many cereals today are actually less nutritious than they were a decade ago, a new study has found.

Breakfast cereals in the U.S. now contain more sugar, fat and salt, while key nutrients like protein and fiber are on the decline, according to research published May 21 in ***JAMA Network Open***.

The study looked at 1,200 newly launched or reformulated cereals sold between 2010 and 2023.

Researchers found that while these cereals are often promoted as healthy, their nutrition labels tell a different story.

"What's most surprising to me is that the healthy claims made on the front of these products and the nutritional facts on the back are actually going in the opposite direction," study co-author Shuoli Zhao, a professor of agricultural economics at the University of Kentucky, told *The New York Times*.

The study found that, per serving, total fat in breakfast cereals rose by 34%, sodium by 32%, and sugar by nearly 11% over the 13-year period.

This trend concerns experts because ready-to-eat cereals are a major part of the American diet, especially for kiddos, *The Times* reported.

Nearly one-third of children eat cereal each morning, according to the **U.S. Department of Agriculture**. But only 15% eat fruit with their meal, and just 10% of kids eat eggs.

Dr. Peter Lurie, head of the nonprofit Center for Science in the Public Interest, called the results surprising.

"It's extraordinary that, at a time when Americans are becoming more health conscious, a product often marketed as offering a healthy start to one's day is actually getting less healthy," Lurie told *The Times*.

Some nutrition experts say the food industry creates confusion.

"It reinforces my belief that the food marketplace is very confusing, and that's not by accident," said **Josephine Connolly-Schoonen**, head of the nutrition division at Stony Brook Medicine in New York, who was not involved with the study. "The food industry engineers the confusion."

She encourages families to focus on whole foods like overnight oats, eggs, fruit and whole-grain bread.

The three largest cereal makers in the U.S. — Kellogg's, General Mills and Post — did not respond to *The Times'* requests for comment.

U.S. cereal makers do produce healthier versions of some brands in countries like Canada and in Europe.

Meanwhile, cereals served in U.S. schools have become more nutritious thanks to a 2010 federal law. New rules limiting sugar in school cereals take effect this summer, with even stricter rules coming in 2027, the **School Nutrition Association** says.

Diane Pratt-Heavner, a spokesperson for the group, said she hopes food makers will offer these healthier products to the general American public.

"If we're encouraging kids to eat healthier at school," she said, "then we want them to be eating healthier at home too."

FDA Approves Topical Foam for Plaque Psoriasis of the Scalp and Body

The U.S. Food and Drug Administration has approved Zoryve (roflumilast) topical foam 0.3 percent for the treatment of plaque psoriasis of the scalp and body in adult and pediatric patients 12 years of age and older.

Through a supplemental new drug application, Zoryve foam was approved as a once-daily, steroid-free topical treatment.

The approval was based on results from the ARRECTOR phase 3 trial and Trial 204, a phase 2 trial, that together randomly assigned 736 adults and adolescents aged 12 years and older with mild-to-severe plaque psoriasis of the scalp and body to either Zoryve foam 0.3 percent or vehicle foam applied once daily for eight weeks (2:1). Treatment effectiveness was gauged using the Investigator Global Assessment (IGA) clinical scale.

In the ARRECTOR trial, 66.4 percent of individuals treated with Zoryve foam versus 27.8 percent treated with a matching vehicle foam achieved Scalp-IGA success ("clear" or "almost clear" plus a 2-point improvement from baseline) at week 8, while 45.5 and 20.1 percent, respectively, achieved Body-IGA success at week 8. Similar benefits were seen in Trial 204 at week 8, with 56.7 percent of individuals treated with Zoryve foam achieving Scalp-IGA success versus 11.0 percent of individuals treated with a matching vehicle foam, and 39.0 versus 7.4 percent, respectively, achieving Body-IGA success.

"In clinical trials, Zoryve foam not only effectively cleared psoriasis plaques on the body and scalp, but also provided rapid itch relief. Zoryve can be safely used for any duration and offers two highly convenient formulations, cream or foam, for health care providers to choose from," Jennifer Soung, M.D., director of clinical research at Southern California Dermatology in Santa Ana, and one of the clinical trial investigators, said in a statement. "Zoryve foam allows patients to treat their whole body with one prescription, transforming the treatment landscape for scalp and body psoriasis."

Approval of Zoryve was granted to Arcutis Biotherapeutics.