

June 11, 2023 E-Newsletter



Message from Alliance for Retired Americans Leaders

More Workers Are Tapping 401(k)s Early for Help with Financial Emergencies



Robert Roach,
President, ARA

Across the board, many Americans don't have enough short-term savings to cover unexpected or unplanned crises. That could explain why more people are raiding their personal retirement accounts early to pay for financial emergencies, and experts predict that the number of workers drawing on their 401(k)s before retirement may increase.

Two major retirement plan administrators, Fidelity and Vanguard, have noted increases in hardship withdrawals, which may be taken only if there is "an immediate and heavy financial need," according to Internal Revenue Service rules. Fidelity found that 2.4% of 22 million people with retirement accounts in its system took hardship withdrawals in the final quarter of 2022, up half a percentage point from a year earlier. And an

analysis by Vanguard found that 2.8% of five million people with retirement accounts that they administer made a hardship withdrawal last year, up from 2.1% in 2021.

In the first three months of this year, Bank of America found that the number of people taking hardship withdrawals jumped 33% from the same period in 2022, with workers taking out an average of \$5,100 each.

Adding to the stress for people who need to gain access to their cash quickly, they often have to withdraw more money than the amount they need in order to cover federal income tax and a 10 percent early-withdrawal penalty if they don't qualify for a waiver. Waivers can be granted for a limited number of circumstances, such as death or permanent disability.

"The trend is especially frightening because many of these workers will face serious financial trouble later due to their early withdrawals and penalties," said **Robert Roach, Jr., President of the Alliance.**

"There really is no substitute for defined benefit pensions, which offer financial security in retirement and give workers greater peace of mind if they need to access their savings sooner than they had expected. This is also further evidence that we need to expand Social Security."

Alliance Joins Pride at Work in Celebrating LGBTQ+ Pride Month



Joseph Peters
ARA
Sec.-Trea.

The Alliance wishes all of our members a Happy Pride Month this June! The AFL-CIO's LGBTQ+ constituency group, **Pride at Work**, offers a timely reminder that LGBTQ+ people still lack basic federal legal protections in the workplace, making the LGBTQ+ community vulnerable to recent appalling and shameful actions by state legislatures. However, the labor movement is fighting back. And the best tool

is a union contract. Union contracts are legally enforceable in every state. They protect LGBTQ+ workers from harassment, and can mean real progress for workers and their families to gain retirement security, health care, savings and more.

LGBTQ+ workers face retaliation and fear getting fired for standing with their co-workers. It's hard for workers to see the very same corporations that celebrate pride turn around and hire anti-union-busting consultants and deny their workers the promise of a union contract.

"Pride Month is a reminder that all Americans of all ages want to live and work without fear of discrimination or violence," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance.** "We must all continue to fight to make sure this is a reality for all."

Latest Social Security Proposal Would See Millions 'Receive More, and No One Would Receive Less'

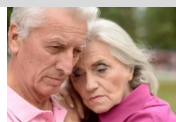
A pair of U.S. senators who are pursuing a bipartisan proposal to **reform Social Security** aimed to calm fears late last week that their plan will lead to reduced benefits for recipients.

The senators — Republican Bill Cassidy of Louisiana and Independent Angus King of Maine, who caucuses with Democrats — are **leading a group of legislators in a proposal to reform Social**

Security on several fronts.

As previously reported by GOBankingRates, their ideas include raising the full retirement age to 70 from 67. They also have proposed creating a sovereign-wealth fund to help pay for Social Security. The fund could be funded with \$1.5 trillion or more in borrowed money.

Another option is changing the



formula that calculates monthly Social Security benefits from one based on a worker's average earnings over 35 years to a formula based on the number of years spent working and paying into Social Security.

These proposals come amid heightened talk of reforming Social Security before the program's Old-Age and Survivors Insurance (OASI) Trust

Fund runs out of money. That could **happen as soon as 2032**, according to one estimate, leaving the program solely reliant on payroll taxes for funding — which might cover only about 75% of benefits.

Many Social Security advocates strongly oppose raising the full retirement age, equating such a move as a cut in benefits....**Read More**

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'This Isn't the End': McCarthy Takes Aim at Social Security, Medicare After Debt Ceiling Deal

"MAGA Republicans want to reach into our pockets and steal our earned Social Security and Medicare benefits," responded one advocacy group. After securing a debt ceiling agreement that caps federal spending and threatens food aid for hundreds of thousands of poor adults, House Speaker Kevin McCarthy made clear Wednesday that Republicans are not finished targeting the nation's safety net programs—and signaled a coming effort by the GOP to slash Social Security and Medicare. In a *Fox News* appearance ahead of the House's passage of the debt limit legislation, McCarthy (R-Calif.) said the measure is just "the first step" of the GOP's broader agenda, which includes further cuts to federal programs and massive tax breaks for the wealthy.

"This isn't the end. This doesn't solve all the problems," the

Republican leader said of the House-passed bill, which would lift the debt ceiling until January 2025—setting up another potential standoff shortly after the 2024 elections.

McCarthy lamented that President Joe Biden "walled off" major components of the federal budget, including Social Security and Medicare, from cuts as part of the debt ceiling agreement—though McCarthy himself agreed to "take those off the table" in late January.

"The majority driver of the budget is mandatory spending. It's Medicare, Social Security, interest on the debt," the Republican speaker said Wednesday, adding that he intends to announce a bipartisan "commission" to examine ways to cut such spending.

The progressive group Our Revolution responded that "it's never enough for the right wing."



"They want it all," the group wrote on Twitter. "We have to tell them NO."

The idea of forming a bipartisan commission to study and propose cuts to Social Security, Medicare, and other non-discretionary spending is hardly new.

In 2021, Sen. Mitt Romney (R-Utah) led a group of Republican and Democratic lawmakers—including Sens. Joe Manchin (D-W.Va.) and Mark Warner (D-Va.)—in unveiling legislation that would establish bipartisan panels to study and recommend changes to the nation's trust funds, a scheme modeled after the Obama-era Simpson-Bowles commission that recommended Social Security cuts.

The changes proposed by the so-called "rescue committees" would then receive expedited votes in the House and Senate. Advocacy groups have described

the Romney legislation, known as the TRUST Act, as an insidious ploy to cut Medicare and Social Security behind closed doors. Republicans have also proposed raising the Social Security retirement age, a move that would slash benefits across the board.

Social Security Works, which has been speaking out against the TRUST Act for years, said Wednesday that "MAGA Republicans want to reach into our pockets and steal our earned Social Security and Medicare benefits."

Jon Bauman, president of the Social Security Works PAC, urged the public to "beware the 'Problem Solvers' and 'No Labels'-style Democrats who would be willing to 'serve' on McCarthy's commission to cut your earned benefits."

"They are problem MAKERS," he wrote.

Can you get Social Security benefits without being a US citizen?

To cash Social Security checks for retirement, a person must have a Social Security number (SSN), which you are given to a US citizen and permanent resident, or can be obtained upon being issued a work permit. In addition, you must meet certain credit, earnings, and retirement age requirements.

Non-citizens of the United States can receive Social Security benefits as long as they are in the

United States legally or if they live abroad and meet certain criteria.

Non-citizens living in the United States may be eligible for Social Security if:

- ◆ They are legal permanent residents.
- ◆ Have a visa that allows them to work in the United States.
- ◆ Were allowed into the country under the Family



Unity or Immediate Relative provisions of United States immigration law.

Non-citizens living abroad may also qualify for Social Security if they ever worked in the United States and earned enough Social Security credits.

Can immigrants receive Supplemental Security Income?

On the other hand, according to SSA, a non-citizen may also be

eligible for Supplemental Security Income (SSI) if they meet the requirements of the non-citizen laws. In general, as of August 22, 1996, most non-citizens must meet two requirements to be potentially eligible for SSI:

- ◆ Be in a qualified alien category
- ◆ Meet a condition that allows qualified aliens to get SSI

HHS Reports on Progress Improving Access for People with Limited English Proficiency

This week, the Office of Civil Rights (OCR) in the Department of Health & Human Services (HHS) released a report summarizing the steps HHS has taken to "improv[e] the provision of meaningful access to language assistance services to persons with limited English proficiency" and the impact of those actions. The report also identifies opportunities for the agency to continue this work.

Language access is critically important in the context of health care and human services. As the report notes, miscommunication may lead to misdiagnosis, improper or delayed treatment, and barriers to needed services

and programs. This report is the first of what are to be annual summaries under Executive Order 13985, *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, and is the first of its kind since 2016.

The report highlights several HHS improvements to date, such as increases in in-language online content and multiple language taglines at the bottom of HHS.gov, along with the creation of language-access positions and committees.

Medicare Rights agrees that improved language accessibility is an important goal for HHS



broadly and for CMS specifically. Understanding Medicare and accessing benefits can be confusing and technical, and accurate in-language information and forms are both necessary and—despite the progress outlined in this report—unfortunately still lacking. The multiple language taglines at the bottom of HHS.gov are not easy to find, and **although this release and report are available in Spanish and Chinese**, it is the only one of the **last 10 press releases** that the agency made available in translated formats.

Similarly, although the "Medicare & You"

handbook and some specific forms and documents are available from Medicare, Medicare Advantage Plans, and Part D plans in languages other than English, many other essential communications, including letters explaining how to appeal denials, are not. We urge HHS and the Centers for Medicare & Medicaid Services (CMS) to continue to ensure that people with limited English proficiency needs are able to make fully informed decisions about their Medicare and are able to access all needed care without unnecessary language barriers.

Many Older Adults Face Unpaid Medical Bills Despite Insurance Coverage

This week, the Consumer Financial Protection Bureau (CFPB) Office for Older Americans released [an issue spotlight](#) on medical billing and collections showing that many older adults have unpaid medical bills and are in collections. This is despite most older adults having health insurance coverage, including Medicare and Medicaid. The findings reveal that these bills are often the result of improper and inaccurate billing.

According to the CFPB data, most people aged 65 and older have health insurance (98%). But nearly four million had medical bills that they were unable to pay in full in 2020. The highest incidence (13%) was among those without insurance, and the lowest was for those with Medicare plus employer-sponsored coverage (4%). Over two-thirds of those with unpaid

bills (70%) had coverage from more than one source such as Medicare, Medicaid, Medigap, employer-based coverage, or Tricare.

While the incidence of unpaid bills is lower for older adults (7%) than younger ones (11%), probably due to near-universal Medicare coverage, the dollar amount unpaid is increasing. In 2019, older adults reported \$44.8 billion in debt; in 2020, that number rose to \$53.8 billion. Those with unpaid bills were more likely to be older adults of color, to be in poor health, to have other debts, or to have incomes between 100 and 200% of the federal poverty level.

CFPB flags inaccurate billing as one of the main drivers of unpaid bills, showing that older adults are more likely to have numerous chronic health needs, conditions that are billed at a



higher intensity which require greater documentation, and to rely on coverage from multiple sources. This

combination can lead to delays in payment, errors in who is billed for what services, and providers seeking inappropriate reimbursement from patients.

People who are dually eligible for Medicare and Medicaid see disturbingly high levels of unpaid medical bills. Most dually eligible individuals should have little out-of-pocket exposure to medical costs, but they report both higher incidence of unpaid bills and higher dollar figures for the bills than their non-dual counterparts. CFPB notes that this suggests providers are billing beneficiaries for amounts they do not owe.

Unpaid medical bills cause personal and financial stress, landing people in collections and

having negative effects on credit ratings. [Recently, the three major credit bureaus](#) stopped reporting cleared medical debt, medical debt in collection below \$500, or medical debt in collections for under one year. But this does not alleviate the stress of unpaid bills or eliminate collections activities.

At Medicare Rights, we urge CFPB, Medicare, and policymakers to do more to protect everyone, including older adults and people with disabilities, from [high out-of-pocket costs](#) and inaccurate billing. We support limiting Medicare beneficiary spending, expanding financial assistance, educating providers about billing rules, and improving oversight of providers and insurance payers. Stronger guardrails are needed system-wide.

Will a 'National Patient Safety Board,' Modeled After the NTSB, Actually Fly?

People concerned about the safety of patients often compare health care to aviation. Why, they ask, can't hospitals learn from medical errors the way airlines learn from plane crashes?

That's the rationale behind calls to create a "National Patient Safety Board," an independent federal agency that would be loosely modeled after the [National Transportation](#)

[Safety Board](#), which is credited with [increasing the safety of skies, railways, and highways](#) by investigating why accidents occur and recommending steps to avoid future mishaps. But as worker shortages strain the U.S. health care system, heightening concerns about



unsafe care, one proposal to create such a board has some patient safety advocates fearing that it wouldn't provide the transparency and accountability they believe is necessary to drive improvement. One major reason: the power of the hospital industry.

Two measures are underway to create a safety board: [A bill filed](#) in the U.S. House in December by Rep. [Nanette Diaz Barragan](#) (D-Calif.), which is expected to be refiled this session, calls for the creation of a board to help federal agencies monitor safety events, identify conditions under which problems occur, and suggest preventive measures. [Read More](#)

As Medicaid Purge Begins, 'Staggering Numbers' of Americans Lose Coverage

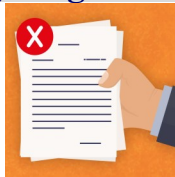
More than 600,000 Americans have lost Medicaid coverage since pandemic protections ended on April 1. And a KFF Health News analysis of state data shows the vast majority were removed from state rolls for not completing paperwork.

Under normal circumstances, states review their Medicaid enrollment lists regularly to ensure every recipient qualifies for coverage. But because of a nationwide pause in those reviews during the pandemic, the health insurance program for low-income and disabled Americans kept people covered even if they no longer qualified.

Now, in what's known as the [Medicaid unwinding](#), states are [combing through rolls and](#)

[deciding](#) who stays and who goes. People who are no longer eligible or don't complete paperwork in time will be dropped.

The overwhelming majority of people who have lost coverage in most states were dropped because of technicalities, not because state officials determined they no longer meet Medicaid income limits. Four out of every five people dropped so far either never returned the paperwork or omitted required documents, according to a KFF Health News analysis of data from 11 states that provided details on recent cancellations. Now, lawmakers and advocates are expressing alarm over the



volume of people losing coverage and, in some states, calling to pause the process.

KFF Health News sought data from the 19 states that started cancellations by May 1. Based on records from 14 states that provided detailed numbers, either in response to a public records request or by posting online, 36% of people whose eligibility was reviewed have been disenrolled.

In Indiana, 53,000 residents lost coverage in the first month of the unwinding, 89% for procedural reasons like not returning renewal forms. State Rep. Ed Clere, a Republican, expressed dismay at those "staggering numbers" in a [May](#)

[24](#) Medicaid advisory group meeting, repeatedly questioning state officials about forms mailed to out-of-date addresses and urging them to give people more than two weeks' notice before canceling their coverage.

Clere warned that the cancellations set in motion an avoidable revolving door. Some people dropped from Medicaid will have to forgo filling prescriptions and cancel doctor visits because they can't afford care. Months down the line, after untreated chronic illnesses spiral out of control, they'll end up in the emergency room where social workers will need to again help them join the program, he said.... [Read More](#)

When will the Medicare Advantage scam end?

Matthew Cunningham-Cook writes for **The Lever** on why Medicare Advantage is a scam, focusing on the \$20 billion in overpayments the insurers offering Medicare Advantage now receive each year. Health insurers are making a killing off of the Medicare Trust Fund, as are their top executives and shareholders. The only question is whether this raiding of Medicare will end in time to save Medicare or whether Congress will sit back and continue to let these excess payments happen.

Humana profits totaled \$2.8 billion last year. The chief reason: Overpayments from Medicare, which resulted in Humana receiving 80 percent of its total revenue from Medicare. Cunningham-Cook pegs the overpayments at \$20.5 billion, a ton. He relies on the calculations of the Medicare Payment Advisory Commission, MedPac.

But, other moderate analysts believe they are **closer to \$60 billion a year.**

Cunningham-Cook also fails to mention that the government is responsible in large part for these overpayments. It adjusts payments to Medicare Advantage plans based on the diagnosis codes insurers ascribe to their enrollees—a measure of how sick the enrollees are. And, it pays Medicare Advantage plans more for each diagnosis code, even when those codes have no bearing on the number or cost of services the Medicare Advantage plans are delivering to their enrollees.

The insurers offering Medicare Advantage take advantage of this defective payment system. Why not? They are allowed to, for the most part. And, it earns them greater revenues.

Cunningham-Cook rightly



charges the Medicare Advantage plans with overbilling—they are hunting for diagnosis codes, even when the diagnoses have no bearing on the services their enrollees need. But, in many cases, the insurers are acting within the framework the government gives them to charge for their enrollees.

The underlying issue is that the government seems to want to privatize Medicare, turn it over to the profiteer corporate health insurers and let older Americans and people with disabilities fend for themselves. It's a good gig for the enrollees, so long as they're relatively healthy. Their out-of-pocket costs are lower than they would be if they were in traditional Medicare where they would need to buy supplemental coverage to protect themselves financially. They also almost always get Part D prescription

drug coverage at no additional cost, as part of the Medicare Advantage benefit package.

But, people in Medicare Advantage are playing with fire. They get sick and all bets are off. They are likely to face large administrative and financial barriers to care, inappropriate delays and denials of care, and restricted access to specialty care. In 2022, the Office of the Inspector General reported that Medicare Advantage plans wrongly denied about 1.5 million claims.

While people are told they can go back to traditional Medicare, most are locked into their Medicare Advantage plans once they sign up. The supplemental coverage they need to protect themselves financially is often not available or, when it is, it is not affordable....**Read More**

What happens when Medicare Advantage overpayments end?

Tens of billions of dollars a year in Medicare Advantage overpayments are taking a huge toll on the Medicare Trust Fund and driving up Medicare Part B premiums. They also are not deterring Medicare Advantage plans from inappropriately delaying and denying care and coverage. So, what happens when the administration or Congress ends these overpayments?

Becker's Payer Issues reports that Aetna Medicare Advantage plans are losing as much as \$2 billion in 2024, in part because many fewer of them will receive a four-star rating or better. As it is, the **stars are a joke** and do not reflect, for example, whether a Medicare Advantage plan

engages in widespread inappropriate delays and denials of care. But, a four or five-star rating means real money to the Medicare Advantage plans. Without that money, these Medicare Advantage plans might look for other ways to maximize profits. Will inappropriate delays and denials increase? Will the quality of the provider networks suffer?

CVS Health owns Aetna. It is losing money because of the reduction in number of its four and five-star Medicare Advantage plans. It is also losing money because of a contract it lost with its PBM, Centene.

Here, you should take note: If you are in a Medicare Advantage



plan and get prescription drug coverage, **don't assume you are getting the lowest price.** Always check for other ways to get your drugs that could possibly save you more money, such as through Costco mail-order or CostPlus Pharmacy. The full cost of the drug without insurance could be less than your Medicare Part D copay.

CVS Health is investing heavily in getting more Medicare Advantage enrollees, notwithstanding this revenue loss. The flawed Medicare payment system pays their Medicare Advantage plans more when their enrollees have more diagnosis codes, even when they do not

cost their Medicare Advantage plans more to treat.

Today, CVS Health has 3.4 million Medicare Advantage members. And, it expects a 12 percent increase next year. UnitedHealth and Humana are the two insurers with the highest Medicare Advantage enrollment.

CVS Health recently purchased Oak Street Health, a primary care provider group, which will help ensure that they have more control over the diagnosis codes providers give to their patients. CVS Health also says it will enable them to improve their star ratings.

When Is It Time to Move From Independent to Assisted Living?

Discover the telltale signs for transitioning from independent to assisted living, and learn the right time to start the conversation with your loved one.

Aging is more art than science. Each person ages at a different rate and may face varying health challenges as the years march on.

So, navigating health care decisions later in life isn't

always a straightforward proposition. One of those decisions may be trying to decide when it's time to move from independent living to **assisted living.**

- ◆ **Independent Living vs. Assisted Living**
- ◆ **Costs of Senior Living**
- ◆ **When Is It Time to Move to Assisted Living?**



- ◆ **Sample Scenarios**
- ◆ **Planning a Move**
- ◆ **Transitioning to Assisted Living**
- ◆ **Talk to Your Loved Ones About Senior Living**

- ◆ **Do Your Homework The Bottom Line**

Keep in mind that moving sooner sometimes offers seniors the opportunity to actually get excited about new possibilities.

When this is done right, it can be a really powerful experience for the whole family.

"Moving to a community that meets your social, mental and physical needs may not only improve your quality of life, it might even improve your health," Goldwater says....**Read More on each bullet.**

I'm a Beneficiary. Can I Sue an Executor?

When someone dies, others may be called on to manage their estate. An executor is charged with overseeing the distribution of someone's assets according to the will or state inheritance laws if they die without a will. The deceased person's beneficiaries, meanwhile, get to receive assets from the estate. In terms of executor vs. beneficiary rights, there are several differences with regard to what type of authority each one has. A financial advisor with estate planning expertise can help you make a plan for distributing your assets to family, friends and other

beneficiaries.

What Is an Estate Beneficiary?

An estate beneficiary is someone who is designated, usually through a will, to inherit assets from someone else. Beneficiaries and heirs may be the same individuals or different people.

A beneficiary is typically named in some type of legal document, such as a will or trust. It's also possible to name beneficiaries for life insurance policies, retirement accounts or bank accounts. The person making beneficiary designations



has the right to change them in most cases.

An heir is someone who is identified by state inheritance laws as having the right to receive assets from an individual's estate. Heirs are typically spouses, children and other relatives.

What Is an Executor?

An executor is someone who is appointed either through a will or by the court to oversee the probate process. Probate is a legal process in which someone's assets are inventoried, their outstanding debts are paid and any remaining assets are distributed to their heirs if they

die intestate (without a will) or to the beneficiaries of their will.

When writing a will, it's possible to name a beneficiary as the executor. However, there are pros and cons to doing so.

Having an executor who stands to benefit from your will could simplify things if you have a relatively straightforward estate. On the other hand, it could lead to legal trouble if you have a larger estate or other beneficiaries decide to challenge the will....[Read More](#)

National WEP/GPO Repeal Task Force Rapid Repeal Review

This is the first issue of Rapid Repeal Review, a short summary of major activities of the National WEP/GPO Repeal Task Force. It will be sent out each month prior to our Monthly Task Force meeting. If you have any questions or comments about these activities, please contact Bette Marafino at eam48460@gmail.com.

Please feel free to distribute to your groups.

1. Current Status of H.R 82/ S.597, the Social Security Fairness Act of

2023: As of 6/2/2023, there are **278 cosponsors for HR 82 in the House and 44 in the Senate.**

We encourage everyone to keep reading the Legislature Updates that are emailed to all Task Force members and act on the recommendations of the Legislative Workgroup.

2. Date Set for the WEP/GPO Repeal Advocacy Summit Day: September 13, 2023, is the day that advocates will gather for meetings with



our elected officials to discuss full repeal of the WEP and GPO. Mark your calendars to come to DC and show your support for repeal. Remember, we are known in DC for our grassroots efforts representing many different fields and professions! More information will come soon.

3. WEP/GPO Informational Presentation Available: Mary Moninger-Elia and Tammy Gowash have put together an excellent, interactive presentation

on the impact of the WEP and GPO. If you have a group that you would like to show this to, or ask Mary to present it, please contact Mary

at marveliaawh@gmail.com or Tammy at tgowash@artct.org.

Please indicate WEP GPO Presentation Request in the subject line.

Respectfully submitted by the Internal Communications Workgroup, National Repeal WEP & GPO Task Force.

8 Disappointing Realities of Medicare

For millions of people, Medicare is one of the pillars of retirement. The program provides health insurance for most Americans from the age of 65 through the rest of their lives.

However, Medicare is not perfect. Some beneficiaries are surprised to learn of the program's shortcomings.

Following are some of the disappointing realities of Medicare.

1. Your premiums might be higher than expected

The vast majority of people who qualify for Medicare Part B — which covers outpatient care such as physician services, outpatient hospital services and durable medical equipment — will pay a premium of \$164.90 per month in 2023.

2. Many things are not covered

You can count on Medicare to cover the vast majority of your health care needs in retirement. But not everything.

As we report in "[Medicare Will Not Cover These 10 Medical Costs](#),"

the services not covered by Original Medicare, which is the type of Medicare offered directly by the federal government, include:

- ◆ Dental and routine vision care
- ◆ Care you receive outside the U.S.
- ◆ Long-term care
- ◆ Chiropractic care

3. You might need to purchase a supplement plan

If you sign up for Original Medicare, don't stop there. You might need to also purchase a Medicare supplement insurance plan, known as a Medigap plan. This type of plan can cover costs such as:

- ◆ Copayments
- ◆ Coinsurance
- ◆ Deductibles



4. You only get one shot at guaranteed Medigap coverage

When you first sign up for a Medigap plan, no insurer that sells this coverage can deny you a policy or charge you more due to your having a pre-existing condition.

However, the rules can change fast if you ever drop your Medigap coverage, such as you might do if you switch from Original Medicare to Medicare Advantage.

5 Without a supplement plan, there is no limit on out-of-pocket costs

This likely will come as a big surprise to many people, but if you sign up for Original Medicare and do not purchase a supplement plan, there is no yearly limit on your out-of-pocket costs.

That means you could be on the hook for a lot of money if you encounter a serious and

costly health issue.

6. You still have to pay for long-term care

Long-term care can be brutally expensive, but don't expect Medicare to cover the cost. Most people who need this form of care will need to dig deeply into their wallets to pay for it.

7. If you sign up late, you could be penalized — for life If you are tardy in signing up for benefits, Uncle Sam is not very forgiving. In fact, he holds a grudge — forever.

8. Medicare Advantage plans typically limit your provider choices

Millions of Americans have signed up for Medicare Advantage, the private-insurance alternative to Original Medicare.

While both types of Medicare have their pros and cons, one big con of Medicare Advantage is that you might be limited to seeing doctors in your plan's network....[Read the full article](#)

UnitedHealthcare shifts colonoscopy requirements from controversial 'prior authorization' to 'advance notification'

On the day when UnitedHealthcare requirement was set to start a new requirement for endoscopy services, including colonoscopies, the insurance company shifted to a different approach.

UnitedHealthcare confirmed Thursday that starting this month, it will no longer require "prior authorizations" for commercial beneficiaries seeking non-screening colonoscopies and other gastroenterology endoscopy services. Rather, the insurer is requiring "**advance notification**" for such services.

The advance notification requirement involves providers collecting and submitting patient data to UnitedHealthcare online or by phone before performing a

procedure. There are no changes to the insurer's policy regarding colonoscopy procedures for routine screenings.

Providers who submit advance notifications will be eligible for UnitedHealthcare's **Gold Card program**, which is expected to be implemented next year and, for care provider groups that meet eligibility requirements, will eliminate prior authorization requirements for most procedures, the company says.

"To provide an opportunity for physician education and to allow us to collect more data on which physicians should be eligible for our previously announced 2024 gold card program, effective



immediately, we will be implementing an Advance Notification process, rather than Prior Authorization, for non-screening and non-emergent GI procedure," a UnitedHealthcare spokesperson said in a statement Thursday. "This Advance Notification will not result in the denial of care for clinical reasons or for failure to notify and will help educate physicians who are not following clinical best practices. Provider groups who do not submit advance notification during this period will not be eligible for the UnitedHealthcare Gold Card program."

Under its prior authorization

plan, UnitedHealthcare would have had to preapprove a procedure, or the enrollee would have had to pay out of pocket for it.

In a **fact sheet for providers**, UnitedHealthcare said that "advance notification" does not result in the denial of care for clinical reasons or failure to notify and will help educate providers who are not following clinical best practices, as "up to one-third" of upper gastrointestinal procedures and "almost half of non-screening colonoscopies" performed for common clinical conditions are not consistent with clinical guidelines, it says....**[Read More](#)**

Heart disease is on the rise, especially for people over 65

Cardiovascular disease, which includes heart disease and coronary artery disease **kills more than 800,000 people each year**. It's the number one killer for people over 65. And, Judith Graham reports for **Kaiser Health News** that it is not going away soon.

People with cardiovascular disease have blocked arteries. Blocked arteries can lead to stroke, heart attacks and other heart failure. People with high blood pressure, people who are

overweight, people with diabetes, people with high cholesterol, and people who don't exercise are most likely to end up with heart disease.

More than four in five people who die of coronary artery disease are over 65. Death rates were down in the first decade of this century. People smoked less and new treatments helped. But, beginning in 2011, deaths were on the rise again. And, Covid-19 also contributed to more deaths



because it worsened people's heart conditions and people were less inclined to seek medical care.

Cardiovascular disease is one powerful example of health inequities in the US. Black and Hispanic Americans are more likely to be diagnosed with cardiovascular disease than other individuals. Black men are at the greatest risk of getting cardiovascular disease. Their plight will only worsen without

better education, more prevention efforts and treatments.

In many instances, individuals are not personally responsible for cardiovascular disease. Stressors, including systemic racism, can contribute to high blood pressure and other conditions that increase people's risk of heart disease.

Treatments are available for cardiovascular disease. But, people need to have primary care doctors who screen them for cardiovascular disease and help treat underlying conditions.

Consistent Breast Cancer Screening Cuts Odds of Dying From the Disease by 72%

Screening mammograms saves lives, and consistency counts for a lot.

That's the main message from a new study that looked at how regularly women received mammograms before a breast cancer diagnosis. The closer a woman adhered to guidelines on a year-to-year basis, the less likely she was to die of breast cancer.

"It is quite common for women to not receive their mammography exams on time, or they need to reschedule, and that extends the time between the most recent mammogram and the next one," said study co-

author **Robert Smith**, senior vice president for early cancer detection science at the American Cancer Society. But "if a woman has developed breast cancer, these delays can contribute to being diagnosed with advanced disease and may be life-threatening."

Most organizations recommend that women begin regular screening for breast cancer in their 40s. The ACS recommends that women should start annual screening with a mammogram at age 45. Women 55 and older can continue yearly screenings or opt for every other year.



These guidelines are for women who are not at high risk for breast cancer, meaning they don't have a personal or strong family history of breast cancer, a gene known to increase the risk of breast cancer, or a history of chest radiation therapy before the age of 30.

For the study, researchers looked at data on more than 37,000 women ages 40 to 69 from nine Swedish counties who had between one and five opportunities for screening mammograms during the study. Of these, 4,564 subsequently died of breast cancer that was

diagnosed between 1992 and 2016.

The risk of dying from breast cancer was 72% lower among women who underwent all five screening exams as per guidelines when compared to women who had no mammograms. The more guideline-suggested mammograms women missed, the greater their risk of dying from breast cancer, the study showed.

Mammograms are low-dose x-rays that can help find breast cancer at an early stage, when it is easier to treat....**[Read More](#)**

U.S. Has Lagged Other Rich Nations in Life Expectancy for Decades

Americans aren't living as long as people in dozens of other developed nations — and the problem is worse than previously thought, a new study reveals.

People in more than 50 countries on six continents have been outliving Americans for more than 70 years, according to the new research.

"The new study challenges two assumptions that have influenced previous research on the U.S. life expectancy disadvantage," said study author **Dr. Steven Woolf**, director emeritus of the Center on Society and Health at Virginia Commonwealth University (VCU).

"First, past studies have usually only compared the United States with a select group of 15 to 20 'peer countries,' largely Anglo-Saxon or Western European countries with high incomes," Woolf said. "Second,

experts typically consider the 1980s or 1990s as the inflection point when growth in U.S. life expectancy began underperforming compared with other countries. However, this analysis shows that premature deaths among Americans are a much larger and older public health issue than previously believed."

Woolf tracked 80 years of trends using life expectancy estimates from the United Nations, the Human Mortality Database and the U.S. Mortality Database.

He found that in 1933, U.S. life expectancy ranked eighth highest among 16 populous countries. Woolf then examined the pace of growth in life expectancy from 1950 through 2021 in more than 200 countries.

Increases in U.S. life



expectancy started slowing from 1950 to 1954. They slowed even further between 1955 and 1973.

Life expectancy for Americans rebounded between 1974 and 1982, slowed for the next 27 years, "flatlined" between 2010 and 2019, and plummeted in 2020 and 2021 because of the COVID-19 pandemic, Woolf's research shows.

U.S. life expectancy ranked 46th among populous countries by 2020.

"We may be one of the richest countries in the world, and we certainly outspend every country on health care, but Americans are sicker and die earlier than people in dozens of countries. We'll keep falling behind unless we get serious about policy solutions," said Woolf, who is also a

professor of family medicine and population health at the VCU School of Medicine.

At one point or another along the study time frame, 56 countries achieved higher life expectancy than the United States. Among them, 17 countries outranked the United States for more than 50 years.

Most countries that outperformed the United States were in northern and western Europe before 1950, but several southern and eastern European countries surpassed the United States in the 1950s and 1960s.

Asian countries began outliving Americans as early as the 1960s. Several Middle Eastern countries did, too, beginning in the 1990s and continuing into the 2010s....[Read More](#)

Medicare Will Cover New Class of Alzheimer's Drugs if Fully Approved by FDA, With Limits

Medicare will soon cover a new class of Alzheimer's drugs if they receive full approval from the U.S. Food and Drug Administration, with some key limits.

Along with being full approved, drug makers will also have to gather and keep data in a registry showing how the drugs are working in the real world, the U.S. Centers for Medicare and Medicaid Services announced Thursday.

"Alzheimer's disease takes a toll on not just the people suffering

from the disease but also on their loved ones and caregivers in a way that almost no other illness does. CMS has always been committed to helping people obtain timely access to innovative treatments that meaningfully improve care and outcomes for this disease," CMS Administrator **Chiquita Brooks-LaSure** said in a [statement](#) announcing the change. "If the FDA grants traditional approval, CMS is prepared to ensure anyone with



Medicare Part B who meets the criteria is covered."

The drugs in question -- Lecanemab (Leqembi) and Aduhelm -- have already been given accelerated approval to "fill an unmet medical need" while drug makers continue research on their effectiveness and safety. But neither drug has have received full, traditional approval.

Not everyone was thrilled with the idea of collecting real-world data in a registry.

In a [statement](#), the Alzheimer's Association called the registry requirement "an unnecessary barrier," adding that the registry "should not be a requirement for coverage" of an FDA-approved treatment.

But the CMS said there is a "strong precedent" for using registries.

About 6 million Americans live with Alzheimer's disease, which affects memory and cognitive abilities. There is no cure.

Prostate Cancer: The Basics Every Man Needs to Know

No man wants to hear that he has prostate cancer, but if he is diagnosed he will need to learn about the disease and how it is treated.

Prostate cancer affects one in seven men. According to the [American Cancer Society](#) (ACS), it is the second most common type of cancer among men after skin cancer. With an estimated **288,300** new cases in the United States in 2023, it is important to know more about prostate cancer and what you can expect if you are the one in seven.

What is prostate cancer?

The prostate, a walnut-shaped

organ, is part of men's reproductive organs, providing some of the seminal fluid. Living below the bladder, it surrounds the urethra through which urine drains and the seminal tube through which semen flows. As with other cancers, it begins when cells mutate, grow out of control and eventually damage and steal nutrients from the surrounding healthy cells, according to the ACS.

Prostate cancer causes

While specific prostate cancer causes have not been identified, the U.S. Centers for Disease Control and Prevention lists



several [prostate cancer risk factors](#). These include:

- ◆ Age: The most common risk factor. The older you are, the more likely you are to develop prostate cancer
- ◆ Race: Black men are more likely to get prostate cancer, get it at a younger age, have advanced disease before it is diagnosed, and are twice as likely to die from prostate cancer
- ◆ Weight: Being overweight can increase your risk
- ◆ Genetics: Having a close family member who's been

diagnosed with prostate cancer raises your risk.

Prostate cancer symptoms
According to [Mayo Clinic](#),

prostate cancer symptoms are rare in the early stages. Once prostate cancer signs are noticed, it usually signals worsening of the disease. These signs include:

- ◆ Trouble urinating or decreased force of urination
- ◆ Blood in urine or semen
- ◆ Bone pain
- ◆ Erectile dysfunction
- ◆ Unexplained weight loss
- ◆ Unexplained fever...[Read More](#)

FDA Approves Pfizer's RSV Shot for Older Adults

Older adults may have a second vaccine option for RSV following the U.S. Food and Drug Administration's approval of a Pfizer vaccine on Wednesday.

The other shot for adults 60 and up is made by GSK. It was approved May 3.

Both should be available by fall, before the seasonal spread of respiratory syncytial virus (RSV), *The New York Times* reported.

The Pfizer vaccine, known as Abrysvo, has effectiveness of nearly 67% when a patient has two symptoms of RSV, such as a sore throat and cough. It's 86% effective when three or more

symptoms surface.

Its GSK competitor — named Arexvy — was about 83% effective against severe RSV, the *Times* reported.

The study on the Pfizer vaccine did include a concern about autoimmune syndromes. One patient among the 34,000 who received the vaccine in the study developed a life-threatening case of Guillain-Barré syndrome a week after receiving the shot. Another developed Miller Fisher syndrome, which is a subtype of that condition.

That means the incidence rate for these syndromes is 1 in 9,000, higher than the 1 in 100,000 seen



in the general population. FDA advisors voted 7 to 4 in favor of the vaccine's safety and efficacy. It had voted 10 to 2 for the GSK vaccine, which was linked to similar cases.

Advisers for the U.S. Centers for Disease Control and Prevention will meet this month to talk about their recommendations for health care providers. They have suggested that the vaccines may be recommended for those aged 65 and older, according to the *Times*.

The vaccines come after a winter season in which COVID-19, the flu and RSV all spread.

While RSV infection is generally mild and cold-like in healthy people, it can be fatal in infants and the elderly. In the United States, about 60,000 adults aged 65 and up are hospitalized with RSV, and 6,000 to 10,000 die each year, the FDA estimated.

To prevent one of these deaths, about 21,000 to 25,000 older adults would have to be vaccinated against RSV, depending on the vaccine.

Seniors on Medicaid and Medicare will not have a co-pay for a vaccine deemed medically necessary, a Pfizer spokeswoman said.

Cancer Survivors Who Keep Smoking Have Double the Risk for Heart-Related Death

Quitting smoking after a cancer diagnosis can deliver a big payoff for another major health concern: the risk of heart attack or stroke.

Cancer patients who kept smoking had a nearly doubled risk of either of those emergencies, as well as death from cardiovascular disease, new research showed.

"A cancer diagnosis is an extremely stressful life event, which often leads to significant changes in a person's lifestyle. Smoking, in particular, is a health-related behavior that can be heavily influenced by mental distress," said study author **Dr. Hyeok-Hee Lee**, of Yonsei University College of Medicine in Seoul, South Korea.

For the study, published May 30 in the *European Heart Journal*, researchers analyzed

data from a Korean national health claims database for more than 309,000 cancer

survivors who had never had a heart attack or stroke. Participants had each answered questions about smoking and had health exams.

The research team split participants into groups based on their change in smoking habits after receiving a cancer diagnosis. Groups were sustained nonsmokers, quitters, initiators/relapsers and continuing smokers.

About 250,000 (80.9%) were sustained nonsmokers; just over 10% quit smoking; 1.5% initiated or relapsed to smoking, and 7.5% continued smoking after their cancer diagnosis.

Then the researchers assessed



the risk of cardiovascular events for each group during a median of 5.5 years,

adjusting for other characteristics that could influence these risks.

Compared with sustained nonsmoking, the risk of having a heart attack, stroke or cardiovascular-related death during follow-up was 86% among continuing smokers. It was 51% higher among initiators/relapsers and 20% higher among quitters. These findings were consistent for women and men.

Quitting smoking was associated with a 36% reduction in the risk of cardiovascular events compared with continued smoking, the study showed.

About 20% of patients who kept smoking cut back by at least 50% after being diagnosed with

cancer. Still, they had the same risk of cardiovascular events as those who continued smoking with no reduction.

"Some individuals may find solace in successfully reducing their smoking without completely quitting," Lee said in a journal news release. "However, our results imply that smoking less should not be the ultimate goal and that smokers should quit altogether to gain the benefits of kicking the habit entirely."

About 2% of nonsmokers started or resumed smoking after finding out they had cancer. This was associated with a 51% elevation in the risk of cardiovascular disease compared with sustained nonsmoking... [Read More](#)

Tips to Checking Your Skin for Skin Cancer

Skin cancer can pop up anywhere on your skin, including the soles of your feet and even under your fingernails.

That's what happened to Isabel Lievano, who was diagnosed with melanoma when her dermatologist determined that a persistent black spot under her fingernail was the deadliest form of skin cancer.

Lievano, 69, lost her nail, but not her finger or her life.

"Skin cancer is the most common form of cancer in the United States. Anyone can get skin cancer, which is why

Isabel's story shows how important it is to perform a skin self-exam," said board-certified dermatologist **Dr. Hope Mitchell**, who is in private practice in Ohio. "Checking your skin can help catch skin cancer early when it's highly treatable. I encourage my patients to regularly check their skin for anything that is new or changing."

Mitchell recommended a skin self-exam using what are called the ABCDEs of melanoma.



A: is for asymmetry, in which one half of the spot is unlike the other.

B: is for border, which can be irregular, scalloped or poorly defined.

C: is for color, which can vary from one area to the next with shades of tan, brown or black or areas of white, red or blue.

D: is for diameter. Melanomas are usually greater than 6 mm, or about the size of a pencil eraser, when diagnosed. But they can be smaller.

E: is for evolving. The spot looks different from the rest or is

changing in size, shape or color.

This video walks you through a skin cancer self-exam:

It's also important to check for other types of skin cancer: basal cell carcinoma, which is the most common; and squamous cell carcinoma, a type that grows slowly and deeply.

Basal cell carcinoma can be a dome-shaped growth; a shiny, pinkish area; a black or brown growth; a white or yellow waxy growth; or a sore that heals then returns.... [Read More and watch the self-exam video.](#)

Prostatitis: What It Is, Symptoms, Causes & Treatment

When most men think about their prostate, it's to worry about whether they have prostate cancer or not. But another condition is far more common and plenty painful.

Prostatitis involves inflammation of the prostate gland and sometimes the areas around it. Not only is prostatitis highly treatable, but it is highly prevalent among men. According to the Prostate Cancer Foundation, it is the **leading cause of urinary tract infections in men, resulting in approximately 2 million doctor's visits each year in the United States**. In fact, it's estimated that half of all men will experience prostatitis at some point.

The U.S. National Center for Health Statistics further reveals that about 25% of men who seek medical attention for urological problems exhibit symptoms of prostatitis. Here, experts give the

rundown on prostatitis, including its various types, causes, common symptoms and available treatments.

What is prostatitis?

Prostatitis, a condition characterized by the inflammation of the prostate gland, is known for its frequent and often debilitating pain. According to the **Cleveland Clinic**, it is a complex condition that can lead to various symptoms, including infection, inflammation and pain.

Two types of prostatitis are associated with urinary tract infections (UTIs), while the remaining types may not have an infectious origin. Regardless of the type, prostatitis is commonly recognized for the intense pain its sufferers feel, which can significantly impact a man's quality of life.

Types of prostatitis
According to the U.S. National



Institute of Diabetes and Digestive and Kidney Diseases, there are **four distinct types of**

prostatitis, each with its own characteristics:

- ◆ Chronic prostatitis or chronic pelvic pain syndrome: This prostatitis is characterized by **symptoms that start gradually and linger over a couple of weeks**. It may also involve urinary symptoms such as frequent urination, urgency and difficulty emptying the bladder.
- ◆ Acute bacterial prostatitis: Acute bacterial prostatitis is caused by a bacterial infection in the prostate gland. It starts suddenly with severe pain in the pelvic region, fever, chills and difficulty urinating. StatPearls indicates that **acute bacterial prostatitis is rare; when it occurs, it is often associated with bladder obstruction or an**

immunocompromised state.

- ◆ Chronic bacterial prostatitis: Unlike the acute form, chronic bacterial prostatitis is a persistent infection that may recur over an extended period. It shares symptoms with acute bacterial prostatitis, but is characterized by milder pain and discomfort. Harvard Health states that **chronic bacterial infection accounts for a small percentage of cases of chronic prostatitis.**
- ◆ Asymptomatic inflammatory prostatitis: As the name suggests, men with this prostatitis **do not experience any symptoms**. It is often diagnosed incidentally during tests for other urinary or reproductive tract disorders. Fortunately, asymptomatic inflammatory prostatitis does not lead to complications and typically does not require treatment....**Read More**

Need a Prostate Exam? Here's What to Expect

You're due for a prostate exam, but you don't know what to expect.

So, what is this exam like?

Regular check-ups are essential for maintaining your health, and a prostate exam is crucial to preventive care for men. Not only is it a screening test for early signs of prostate cancer, but it also helps detect other potential health issues.

Here, experts walk you through what a prostate exam entails, when to consider scheduling one, how to prepare, and what the results might mean for you. So, dive in and learn more about this medical examination that every man should get at some point in

his life.

What is a prostate exam?

Per the Cleveland Clinic, a prostate exam is a **screening method to detect early signs of prostate cancer**. Typically, the exam involves two main components: a prostate-specific antigen (PSA) blood test, and a digital rectal exam.

The PSA blood test measures the levels of PSA in the bloodstream. According to the **U.S. Centers for Disease Control and Prevention**, PSA is a substance produced by the prostate gland, and higher levels can indicate the presence of prostate cancer. However, it's



important to note that elevated PSA levels can also be caused by other prostate-related conditions and factors such as age and race.

Medical procedures, medications, an enlarged prostate or a prostate infection can all influence PSA levels. Therefore, it is crucial to consult with your doctor to accurately interpret PSA test results. If the PSA test shows abnormal results, your doctor may recommend a biopsy to determine if prostate cancer is present.

The other test that is often conducted during a prostate exam is the digital rectal exam, or

DRE. The prostate gland is located just in front of the rectum. The **Prostate Cancer Foundation** says that during this part of your prostate exam, your doctor will gently insert a lubricated, gloved finger into the rectum to assess the size, shape and texture of the prostate for any irregularities. Although the test is brief, it may cause some discomfort, but it should not be painful.

By combining the PSA blood test results and the digital rectal exam, health care providers can gather vital information to evaluate the health of your prostate....**Read More**

Loneliness Can Cut Survival After a Cancer Diagnosis: Study

There's a "loneliness epidemic" in the United States, and feelings of isolation have been linked to heart disease, stroke and other health conditions.

Now, new research suggests that cancer survivors who feel lonely may be more likely to die than survivors who have more social support.

"Loneliness may be linked to worse survival following a cancer diagnosis through multiple

mechanisms, such as the increased risk of experiencing negative emotions such as hostility, stress and anxiety, increased unhealthy behaviors including smoking, alcohol abuse and less physical activity, or through physiological pathways such as immune system disorders," explained study author **Jingxuan Zhao**. She is a senior associate scientist at the



American Cancer Society. "It is also possible that cancer survivors who feel lonelier might not receive the practical and emotional support they need for their symptoms," Zhao added.

For the study, Zhao and her colleagues looked at data on nearly 3,450 cancer survivors aged 50 and older who were part of the 2008-2018 Health and Retirement Study. These folks

were followed through the end of 2020.

The researchers assessed loneliness every four years and grouped folks into four categories: low/no loneliness; mild loneliness; moderate loneliness; and high loneliness....**Read More**

Is a Liver Dialysis Device on the Horizon?

A new liver dialysis device might soon be able to save patients on the edge of death from liver failure, early clinical trial results show.

The DIALIVE device safely improved organ function and alleviated symptoms in patients with acute-on-chronic liver failure, compared with others receiving standard care, the researchers reported.

If the device proves out in a larger trial, it could provide patients with liver failure a lifeline at a time of immediate danger, said senior researcher **Dr. Rajiv Jalan**, a professor of hepatology at University College London (UCL), in the United

Kingdom.

"Liver failure is potentially reversible as the liver has enormous capacity for regeneration," Jalan said. "Therefore, the aim of a liver dialysis machine is to try and create a conducive environment for regeneration to occur and keep the patient alive until this is achieved. In case of overwhelming liver failure, liver dialysis would bridge the patient to a liver transplant."

A larger trial is also needed to prove the device can actually save lives, noted **Dr. Meena Bansal**, a gastroenterologist and professor of liver disease with the Icahn School of Medicine at



Mount Sinai, in New York City.

Although DIALIVE did improve liver function in this small pilot group of 32 patients, the device did not provide any survival benefit over standard care, said Bansal, who was not involved with the study.

"Equal numbers of patients died at the end of four weeks in either arm," Bansal said. "If your blood markers look better, that's wonderful, but if you still die it's really not that great. That doesn't mean it's not promising. It just means that the study was too small to really show a potential survival benefit."

Acute-on-chronic liver failure

occurs in people with cirrhosis. Liver function suddenly declines, liver cells begin to die, and the gut begins to leak bacteria into the bloodstream, the researchers said.

"It's this overwhelming inflammatory storm," Bansal said, adding that patients can suffer multiple organ failures and die within a month after developing acute-on-chronic liver failure.

About 100 million people around the world live with cirrhosis of the liver, and 3 million go on to develop acute-on-chronic liver failure, the study authors said in background notes.... [Read More](#)

1 in 6 Unvaccinated People Struggle With Symptoms 2 Years After Getting COVID

People unvaccinated for COVID-19 have significant odds of lingering illness if they get the virus, with one in six still suffering symptoms two years later, new research shows.

A study from Switzerland found that 17% of that group did not return to their previously normal health, and 18% reported COVID symptoms such as shortness of breath 24 months after their infection was gone. "Persisting health issues create significant challenges for affected individuals and pose an important burden on population health and health care services," lead researcher **Tala Ballouz** and

colleagues wrote in the May 31 issue of the **BMJ**.

Ballouz, from the Epidemiology, Biostatistics and Prevention Institute at the University of Zurich, and her team called for clinical trials "to establish effective interventions to reduce the burden of post-COVID-19 condition."

While most people who contract COVID-19 recover, others continue to have health issues that can affect quality of life and ability to work. This is termed long COVID.

Researchers have been unable to make firm conclusions about long-term treatment and support



for these patients because previous studies have varied in their estimates of patient numbers and duration of symptoms.

For this study, the investigators looked at patterns of recovery and symptom persistence over two years in adults from the Zurich SARS-CoV-2 Cohort, an ongoing study of COVID-19 patients.

The study used data from more than 1,100 unvaccinated adults, average age 50, who had their infections confirmed between Aug. 6, 2020, and Jan. 19, 2021. Also included were 628 adults, average age 65, randomly

selected from the general population who had not had the virus.

The study participants provided information on 23 potential long COVID symptoms at six, 12, 18 and 24 months after infection. The researchers also considered their age, sex, education, employment and pre-existing health problems.

More than half (55%) of participants reported returning to their normal health status less than a month after infection. Another 18% reported recovering within one to three months.... [Read More](#)

Worried About Cataracts? Here's What You Need to Know

Cataracts are the leading cause of blindness around the world, but surgery can restore vision.

"Unlike many of the other major eye diseases, such as glaucoma or diabetes-related eye disease, cataracts can be easily and painlessly treated by surgery to remove and replace the eye's lens, restoring sight for most patients," said **Jeff Todd**, president and CEO of the nonprofit organization Prevent Blindness.

"We urge patients to work with their eye doctor to understand their diagnosis and the best available treatment options," Todd said in a news release from the organization.

Here what else you should know about the common

condition:

More than half of all Americans will have a cataract, a clouding of the eye's lens that blocks or changes the passage of light into the eye, by the time they reach age 80, according to the organization.

Some patients have no early symptoms. The U.S. National Eye Institute says that people developing cataracts may notice cloudy or blurry vision, colors that look faded and difficulty seeing at night.

They may also see a halo around lights, have frequent changes to their eyeglass prescription or find that lamps, sunlight or headlights appear too bright.



Some may also see double, an issue that can go away as the cataract becomes larger.

About 4 million cataract surgeries take place each year in the United States, according to the American Academy of Ophthalmology. More information on this treatment is available at PreventBlindness.org/ataract-surgery, and its printable "Guide to Cataract Surgery" fact sheet.

In a cataract surgery, the eye surgeon may remove the lens with the cataract and replace it with an intraocular lens (IOL). The eye surgeon implants the new lens in about the same place as the natural lens, according to Prevent Blindness. This results in

the most natural vision.

Different types of lenses are available:

- ◆ A monofocal IOL, which is most commonly used, corrects for distance vision. Patients will likely still use glasses for close vision.
- ◆ Another option is a multifocal IOL, which provides both distance and near correction at the same time.
- ◆ An accommodative IOL can move or change shape inside the eye, allowing correct vision at different distances.
- ◆ A toric IOL corrects vision for people who have astigmatism.