Rhode Island Alliance for Retired Americans®

RI ARA

Affiliated with the Rhode Island AFL-CIO
"Fighting for the future of our members."
"NOW, more than ever!!!"

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Friday Alert Message from the Alliance *for* Retired Americans Leaders

New Report Shows How Medicaid Cuts Will Increase Cost of Healthcare for All Americans

Robert Roach, Jr President, ARA

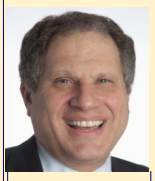
A new AFL-CIO report **finds** that Senate Republicans' budget reconciliation bill, which includes major Medicaid cuts, will increase healthcare costs — for everyone.

If the bill passes, 179 million workers with job-based insurance could see an increase in premiums by almost $500 a year for each covered individual. Sixteen million Americans could **lose** their healthcare coverage and over 600,000 front-line health care workers would be **fired**. More than 330 rural hospitals across the country would have to **close** as a result of this bill, eliminating those communities' access to care.

"This budget reconciliation bill makes it seem like cutting Medicaid is going to save taxpayers money when it's really going to cost all of us more—all to give tax breaks to the rich," **said** AFL-CIO President Liz Shuler. "We're not going to let the Republican-controlled Congress make our healthcare more expensive and less accessible for working people."

"This new report confirms what we already knew. The Senate budget plan is just as cruel and devastating as the House version. It will gut Medicare, Medicaid, and food assistance – and still increase the federal deficit – so Republicans can give more tax cuts to the wealthiest Americans," said **Robert Roach, Jr., President of the Alliance.** "We must send a loud and clear message that this cannot stand." **ACTION NEEDED: Click here to tell your senators to vote against the budget proposal when it comes to the floor.**

Report Shows Social Security is Strong and Solvent



Rich Fiesta, Executive Director, ARA

The following statement was issued by **Richard Fiesta, Executive Director of the Alliance for Retired Americans**, regarding the Trustees reports on the Social Security and Medicare Trust Funds **released** this week:

"Older American retirees can feel confident about their Social Security based on the Trustees' report released today.

Today's report reaffirms that the Social Security Trust Fund is able to pay full benefits and expenses until 2033 as is the Medicare Trust Fund. If Congress does not make any changes, the Social Security Trust Fund will then pay 77% of benefits to all current and future beneficiaries.

However, we cannot be complacent. Republicans in Congress have made clear they are eager to cut the benefits Americans have worked a lifetime to earn. Whether it's raising the retirement age beyond 67, privatizing Social Security, or continuing the DOGE agenda of dismantling the Social Security Administration to make it harder to claim benefits, the future of our guaranteed benefits is at risk.

There is a better way to strengthen Social Security for current and future generations. 94% of working Americans pay into Social Security with every paycheck. If the wealthiest 6% of Americans had to do the same, current and future generations of Americans would not only receive all the benefits they have earned, but we could increase benefits for those who need it the most.

We urge Congress and the Administration to strengthen Medicare's finances by reining in the high cost of prescription drugs and allowing Medicare to negotiate lower prices for more drugs. In addition, we urge HHS to hold Medicare Advantage insurance corporations accountable for delivering care at a reasonable cost and crack down on practices that increase corporate profits without improving patient care.

In just a few weeks Medicare will celebrate its 60th anniversary while Social Security will celebrate its 90th. There is no better time for all Americans to commit to strengthening these critical programs. Our children and grandchildren are counting on us."

Senate Republicans Release Long-Awaited Budget Bill Details in Lead Up to July 4 Deadline

The Senate Finance Committee **released** legislative text that will act as the foundation for the Senate Republican budget bill this week. The text **incorporates** many provisions from the House version, like repealing the minimum nursing home staffing rule and making the 2017 Trump tax cuts permanent.

But the new language also targets Medicaid more aggressively. It calls for reducing financial incentives for states that have expanded Medicaid and cutting federal funding for health care facilities that rely on Medicaid. It also reduces federal funding for rural hospitals.

Under the overall Senate budget proposal, certain Medicaid enrollees would have to pay higher copays and the deficit would increase by $5 trillion instead of the House version's projected $4 trillion.

Unlike the House bill, the Senate version does not crack down on Medicare Advantage insurers' questionable practice of "upcoding" to get higher payments from Medicare.

"Republicans are trying to destroy essential services and increase the financial burden on average Americans in order to pay for more tax breaks for the wealthiest in the country," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "We call on Congress to stop this bill from passing in the Senate and prevent millions from losing access to healthcare."

Joseph Peters, Jr. Secretary Treasurer ARA

KFF Health News: Nurse Practitioners Critical in Treating Older Adults as Ranks of Geriatricians Shrink

By Jariel Arvin

On Fridays, Stephanie Johnson has a busy schedule, driving her navy-blue Jeep from one patient's home to the next, seeing eight in all. Pregnant with her second child, she schleps a backpack instead of a traditional black bag to carry a laptop and essential medical supplies — stethoscope, blood pressure cuff, and pulse oximeter.

Forget a lunch break; she often eats a sandwich or some nuts as she heads to her next patient visit….**Click here to read more**

Whitehouse, Dingell Introduce Bill to Bolster Medicaid and CHIP, Extend Uninterrupted Coverage to All Enrollees

Washington, DC – As Republicans continue to negotiate their Big, Beautiful-for-Billionaires Bill behind closed doors to terminate health insurance for millions of Americans, U.S. Senator Sheldon Whitehouse (D-RI) and Representative Debbie Dingell (D-MI) introduced the Stabilize Medicaid and CHIP Coverage Act, legislation to help provide reliable access to care by guaranteeing a 12-month period of enrollment to all adult Medicaid beneficiaries

Last week, Whitehouse **joined** Finance Committee Ranking Member Ron Wyden (D-OR) and several other Senate Democrats in announcing a legislative package to strengthen and invest in Rhode Island's Medicaid program for children, seniors, Americans with disabilities, and working families, while boosting federal anti-fraud initiatives. Whitehouse included the Stabilize Medicaid and CHIP Coverage Act as part of this legislative package.

"Republicans' **Big, Beautiful-for-Billionaires Bill** will destabilize Rhode Island hospitals and entire health care systems with cruel and dangerous cuts to Medicaid, all so they can fund even more tax giveaways to big corporations and their billionaire donors," **said Senator Whitehouse, a senior member of the Senate Finance Committee, which has jurisdiction over Medicaid.** "I'm glad to join Congresswoman Dingell in introducing this bill to cut red tape and strengthen Medicaid for the Rhode Islanders who rely on it for childbirth, addiction treatment, nursing home care, and so much more."

"No one should lose access to health care because of bureaucratic delays," **said Congresswoman Dingell.** "Especially at a time when Medicaid is facing the biggest cuts in history, it's more important than ever that we prevent people from losing coverage and slipping through the cracks due to paperwork and red tape. This legislation will guarantee 12 months of continuous coverage for the most vulnerable Americans, improving access to consistent, quality healthcare that results in better health outcomes."

Nearly 80 million Americans – including nearly 310,000 Rhode Islanders or more than 25 percent of the state's population – are enrolled in Medicaid or the Children's Health Insurance Program (CHIP). Medicaid is the largest public health insurance program in the United States. Medicaid provides funding to states for services at nursing homes, doctors' offices, and hospitals for low-income elderly adults, children, pregnant women, veterans, and people with disabilities. Medicaid also provides critical home health and school-based services as well as addiction and mental health services.

The Stabilize Medicaid and CHIP Coverage Act extends twelve months of guaranteed coverage to all individuals enrolled in Medicaid and CHIP. The legislation would ensure that once enrolled in Medicaid or CHIP, an individual retains their eligibility for 12 months regardless of fluctuations in income. Without this provision, beneficiaries can lose their eligibility for Medicaid because of short-term changes in income (e.g. a seasonal position) when income may briefly exceed 138% of the federal poverty level ($1,800/month for a single person). Guaranteeing a 12-month enrollment period smooths this cliff, ensuring beneficiaries do not lose their coverage until they are reevaluated at the next renewal.

Whitehouse introduced the bill as congressional Republicans continue to try to jam their reconciliation bill through the House and Senate. Republicans falsely claim the bill addresses waste, fraud and abuse in the health care system but it actually **rips away affordable health care from millions of Americans** without doing anything meaningful on health care fraud. The nonpartisan Congressional Budget Office (CBO) **has found** that virtually all of the health care cuts in the legislation would actually come from families that count on Medicaid losing their coverage or benefits. If the Big, Beautiful-for-Billionaires Bill passes, it would be the largest cut to American health care in history – all to fund tax breaks that would further enrich the country's richest people.

The full text of the Stabilize Medicaid and CHIP Coverage Act is available here

Medicare and Social Security go-broke dates pushed up due to rising health care costs, new SSA law

The go-broke dates for **Medicare** and **Social Security** 's trust funds have moved up as rising health care costs and new legislation affecting Social Security benefits have contributed to earlier projected depletion dates, according to an annual report released Wednesday.

The go-broke date — or the date at which the programs will no longer have enough funds to pay full benefits — was pushed up to 2033 for Medicare's hospital insurance trust fund, according to the new report from the programs' trustees. Last year's report put the go-broke date at 2036.

Meanwhile, Social Security's trust funds — which cover old age and disability recipients — will be unable to pay full benefits beginning in 2034, instead of last year's estimate of 2035. After that point, Social Security would only be able to pay 81% of benefits.

The trustees say the latest findings show the urgency of needed changes to the programs, which have faced dire financial projections for decades. But making changes to the programs has long been politically unpopular, and lawmakers have repeatedly kicked Social Security and Medicare's troubling math to the next generation.

President Donald Trump and other Republicans have vowed not to make any cuts to Medicare or Social Security, even as they seek to shrink the federal government's expenditures.

Social Security Administration Commissioner Frank Bisignano, sworn into his role in May, said in a statement that "the financial status of the trust funds remains a top priority for the Trump Administration." A common misconception is that Social Security would be completely unable to pay benefits once it reaches its go-broke date.

"Current-law projections indicate that Medicare still faces a substantial financial shortfall that needs to be addressed with further legislation. Such legislation should be enacted sooner rather than later to minimize the impact on beneficiaries, providers, and taxpayers," the trustees state in the report.

The trustees are made up of six people — the Treasury Secretary serves as managing trustee, alongside the secretaries of Labor, Health and Human Services, and the commissioner of Social Security. Two other presidentially-appointed and Senate-confirmed trustees serve as public representatives, however those roles have been vacant since July 2015.

About 68 million people are enrolled in Medicare, the federal government's health insurance that covers those 65 and older, as well as people with severe disabilities or illnesses.

Wednesday's report shows a worsening situation for the Medicare hospital insurance trust fund compared to last year. But the forecasted go-broke date of 2033 is still later than the dates of **2031, 2028 and 2026** predicted just a few years ago…..**Read More**

‘Not Accountable to Anyone’: As Insurers Issue Denials, Some Patients Run Out of Options

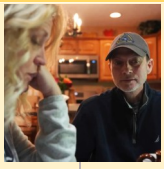
By the time Eric Tennant was diagnosed in 2023 with a rare cancer of the bile ducts, the disease had spread to his bones. He weighed 97 pounds and wasn’t expected to survive a year with stage 4 cancer.

Two years later, grueling rounds of chemotherapy have slowed the cancer’s progress, even as it has continued to spread. But chemotherapy has also ravaged Tennant’s body and his quality of life.

Recently, however, the 58-year -old had reason to hope things would improve. Last fall, his wife, Rebecca, learned of a relatively new, noninvasive procedure called histotripsy, which uses targeted ultrasound waves to destroy tumors in the liver. The treatment could extend his life and buy him more downtime between rounds of chemotherapy.

Early this year, Tennant’s oncologist agreed he was a good candidate since the largest tumor in his body is in his liver. But that’s when his family began fighting another adversary: their health insurer, which decided the treatment was “not medically necessary,” according to insurance paperwork.

Health insurers issue millions of denials every year. And like the Tennants, many patients find themselves stuck in a convoluted appeals process marked by long wait times, frustrating customer service encounters, and decisions by medical professionals they’ve never met who may lack relevant training.



Recent federal and state efforts, as well as changes undertaken by insurance companies themselves, have attempted to improve a 50-year-old system that disproportionately burdens some of the sickest patients at the worst times. And yet many doctors complain that insurance denials are worse than ever as the use of prior authorization has ramped up in recent years, reporting by KFF Health News and NBC News found.

When the Tennant family was told histotripsy would cost $50,000 and insurance wouldn’t cover it, they appealed the denial four times.

“It’s a big mess,” said Rebecca Tennant, who described feeling like a pingpong ball, bouncing between the insurer and various health care companies involved in the appeals process.

“There’s literally nothing we can do to get them to change,” she said in an April interview with KFF Health News. “They’re, like, not accountable to anyone.”

While **the killing of UnitedHealthcare chief executive** Brian Thompson in December incited a fresh wave of public fury about denials, there is almost no hope of meaningful change on the horizon, said Jay Pickern, an assistant professor of health services administration at Auburn University.

“You would think the murder of a major health insurance CEO on the streets of New York in broad daylight would be a major watershed moment,” Pickern said. Yet, once the news cycle died down, “everything went back to the status quo.”

An Unintended Consequence of Health Reform?

Prior authorization varies by plan but often requires patients or their providers to get permission (also called precertification, preauthorization, or preapproval) before filling prescriptions, scheduling imaging, surgery, or an inpatient hospital stay, among other expenses.

The practice isn’t new. Insurers have used prior authorization for decades to limit fraud, prevent patient harm, and control costs. In some cases, it is used to intentionally generate profits for health insurers, according to a **2024 U.S. Senate report.** By denying costly care, companies pay less for health care expenses while still collecting premiums.

“At the end of the day, they’re a business and they exist to make money,” said Pickern, who **wrote about the negative impacts of prior authorization** on patient care for The American Journal of Managed Care.

For most patients, though, the process works seamlessly. Prior authorization mostly happens behind the scenes, almost always electronically, and nearly all requests are quickly, or even instantly, approved.

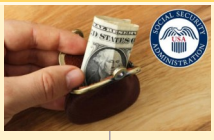
But the use of prior authorization has also increased in recent years. That’s partly due to the growth of enrollment in Medicare Advantage plans, which rely heavily on prior authorization compared with original Medicare. Some health policy experts also point to the passage of the Affordable Care Act in 2010, which prohibited health insurers from denying coverage to patients with preexisting conditions, prompting companies to find other ways to control costs

“But we can’t really prove this,” said Kaye Pestaina, director of the Program on Patient and Consumer Protection at KFF, a health information nonprofit that includes KFF Health News. Health insurers haven’t been historically transparent about which services require prior authorization, she said, making it difficult to draw comparisons before and after the passage of the Affordable Care Act….**Read More**

Where do the government's resources for Social Security benefits come from?

The **Social Security** program is a cornerstone of financial support for millions of Americans, with approximately 68 million beneficiaries each year. Of these, around 75% are retired workers who rely on these monthly payments. To comprehend how these benefits are sustained, it's vital to explore the origins of the funds allocated by the government to this program.

Primarily, **Social Security** is funded through a payroll tax. Both employees and employers contribute to this fund, each paying 6.2% of wages. This results in a total of 12.4% in Social Security payroll taxes. However, not all income is subject to this tax; the program sets a cap on taxable earnings, known as the "wage base limit." For instance, in 2025, this limit has increased to $176,100, up from $168,600 in 2024.



This adjustment is significant for higher earners, as they may pay more in Social Security payroll taxes than in previous years. To qualify for the maximum Social Security benefit, one must have earned at least the wage base limit for 35 years. This highlights the importance of understanding how income levels impact contributions and eventual benefits.

In addition to payroll taxes, about 4% of the program's funds come from the taxation of Social Security benefits themselves. All these revenues are credited to two federal trust funds, which are used to pay current and future Social Security benefits. This dual funding mechanism is crucial for maintaining the program's financial health.

However, the system faces a significant challenge. The population is aging, raising concerns that these funds may be depleting. Projections suggest that within a decade, millions of Americans could see their Social Security benefits reduced if Congress does not take action to strengthen the program.

The last major reform of Social Security occurred in 1983, when the federal government gradually increased the eligibility age from 65 to 67. This change was implemented at a time when Social Security insolvency was imminent. This historical context underscores the importance of understanding how the program is funded and the challenges it faces to ensure its long-term sustainability.

House Reconciliation Bill's Health Care and SNAP Cuts Put Older Adults at Risk

A **new analysis** from the Center for Budget and Policy Priorities (CBPP) finds the House Republicans' budget reconciliation bill would directly harm older adults by eroding their access to affordable health care and critical food assistance.

Health Care

More than seven million older adults and nearly five million people with disabilities receive health coverage through Medicaid and Medicare. Medicaid covers over **3 in 5 nursing home** residents and pays for community-based long-term services and supports that Medicare does not. It also helps pay premiums, deductibles, and cost sharing for some Medicare beneficiaries.

The House reconciliation bill would make the largest Medicaid cuts in the program's history, but that would not reduce anyone's need for care. It would simply shift the full cost of that care onto states, a burden that would ultimately fall on the shoulders of older adults and people with disabilities: Unable to fill the federal Medicaid funding gap, states would be forced to make cuts that would leave Medicare-Medicaid enrollees with higher costs, **less health care**, and worse outcomes. At the same time, the bill's changes to Medicare eligibility and expiring Affordable Care Act (ACA) cost assistance would further erode coverage and care. CBPP notes those harms could come in the following ways.

Increasing Medicare Costs

The bill **would block** recent **final rules** that streamline access to the **Medicare Savings Programs** (MSPs). The MSPs are Medicaid benefits that help people with Medicare who have **limited income and savings** afford their Part B premiums (**$185.00 per month in 2025**). These Medicare-Medicaid enrollees automatically get the **Part D Low Income Subsidy (LIS)/Extra Help**, which helps pay their out-of-pocket prescription drug costs, saving them an average of **$6,200 per year.** Combined, these programs make health care costs more manageable, allowing enrollees to maintain Medicare coverage, afford medications, and better meet daily living expenses like food and housing. According to the nonpartisan **Congressional Budget Office** (CBO), roughly 1.4 million people would no longer receive this cost-sharing assistance under the House bill and would therefore face increased out-of-pocket costs that could put Medicare coverage—and with it, health and financial security—out of reach.

… 1.4 million people would no longer receive this cost-sharing assistance under the House bill and would therefore face increased out-of-pocket costs that could put Medicare coverage—and with it, health and financial security—out of reach.

Threatening Home- And Community-Based Care

The House bill would create new restrictions on how states can finance their share of Medicaid. States unable to work within those new parameters would face a funding shortfall. To cover those losses, they may reduce **Medicaid services they aren't required to provide,** such as home- and community-based care for older adults and people with disabilities.

Imposing Harmful Work Requirements

The House bill's Medicaid work requirement would create a job loss penalty that would apply to individuals up to the age of 64. CBO finds **5.2 million adults** would lose Medicaid as a result, including many who are working or should have an exemption, but who would nevertheless get tripped up by the requirement's red tape. This provision would likely have a disproportionate impact on **older adults**, who face **outsized barriers** to steady employment as well as obstacles to compliance reporting.

Cutting Medicare and ACA eligibility

On top of the Medicaid cuts, the bill would terminate Medicare coverage for many **individuals with lawful immigration status** who have worked and paid taxes in the US for decades. This is a significant departure from current, longstanding policy, which recognizes eligibility for everyone who has paid sufficient Social Security and Medicare taxes. Further, Medicare already prohibits payment for care for anyone who is undocumented; withholding or revoking Medicare eligibility from legally present older adults and people with disabilities who have paid in, and continuing to collect Medicare taxes on their wages, would be a dangerous precedent and ominous programmatic shift. Many would have nowhere to turn for coverage. The bill would also cut off their access to ACA tax credits and federal law already restricts Medicaid eligibility for people with lawful status who do not have a green card.… withholding or revoking Medicare eligibility from legally present older adults and people with disabilities who have paid in, and continuing to collect Medicare taxes on their wages, would be a dangerous precedent and ominous programmatic shift….**Read More**

Dear Marci: How does retiree insurance work with Medicare?

Dear Marci

Dear Marci,

I'm trying to understand how my retiree insurance will work with Medicare. What kind of coverage can I expect if I have Medicare with retiree insurance? – Yan (Dover, OH)

Dear Yan,

When you have both retiree insurance and Medicare, your coverage will depend on the type of retiree insurance plan you have. Below are a few common types of retiree plans and how they might work with Medicare:

- **Fee-for-service (FFS) plans:** These plans pay for care from any doctor or hospital. They cover Medicare cost-sharing and work like supplemental insurance.
- **Managed care (HMO or PPO) plans:** These plans require you to see in-network providers and facilities. Your costs are typically lowest when you see providers who take both Medicare and your retiree insurance. If you see Medicare providers who don't take your retiree insurance, you will pay regular Medicare cost-sharing amounts, and your retiree insurance might not pay at all.
- **Employer-sponsored Medicare Advantage Plans:** These plans offer both Medicare and retiree health benefits. Some employers require that you join their Medicare Advantage Plan to continue getting retiree health benefits after becoming Medicare-eligible. You can choose not to take your employer's coverage and sign up for Original Medicare or a different Medicare Advantage Plan. Keep in mind, though, that you might not be able to get your retiree benefits back later.
- **Employer-sponsored Medigap policies:** These plans offer supplemental insurance for Medicare-eligible individuals. You need to have Original Medicare to enroll in a Medigap plan. Remember, you can always choose not to take your employer's coverage and sign up for a Medicare Advantage Plan or a different Medigap. You might not be able to get your retiree coverage back later, though.

Retiree insurance is almost always secondary to Medicare. This means it **pays after Medicare.** Retiree insurance might provide coverage for Medicare cost-sharing, like deductibles, copayments, and coinsurance. It might also pay for care or other items and services that Medicare doesn't cover. Examples include vision care, dental care, and off-formulary or over-the-counter prescription drugs.

For more information on your retiree insurance plan, contact your benefits administrator or your employer's human resources department.

Hope this answers your question!

-Marci

Polling Shows Most People Are Worried About Significant Cuts to Medicaid Spending

Recent **KFF polling** tracks public opinion regarding the latest **budget reconciliation bill**, examining the views of the general public, as well as those who could be most directly impacted by the legislation. The bill includes devastating cuts to Medicaid and the Affordable Care Act (ACA), among other health care provisions. **The Congressional Budget Office estimates** that the bill would cut federal Medicaid spending by more than $700 billion and terminate Medicaid coverage for more than 10 million people.

Medicaid- and ACA-Covered Republicans, MAGA Supporters Concerned Over Cuts

The polling shows that people who get their coverage from Medicaid and from the ACA marketplaces represent a range of political identities, including people who identify as supporters of the "Make America Great Again" (MAGA) movement. KFF found that most of the public is worried about the consequences of the significant reductions in federal Medicaid spending. Notably, though the bill is solely supported by Republican members of congress, those concerned about the effects include two-thirds or more of Republicans enrolled in Medicaid or with lower incomes who report worry "that Medicaid spending reductions would hurt their families and their communities."

Most of the public is worried about the consequences of the significant reductions.

Rural Residents Largely Worried About Their Communities

The poll also finds that a large majority of rural residents, particularly those with lower incomes, worry about cuts leading to more children and adults losing health care coverage, harm to providers in their communities, and more difficulty accessing or affording health care. KFF notes that "rural healthcare providers, which often rely heavily on Medicaid funding, may be especially vulnerable to the Medicaid cuts in the reconciliation bill."

Partisan Divide Over Administration's Policies Generally

Views on the administration's policies more broadly, and how those policies will impact the country's health care programs, were "largely partisan," with most of the public saying the policies will "weaken Medicare and Medicaid, including most Democrats and independents, while most Republicans expect the administration's policies to strengthen or have no impact on these programs." Among Republican Medicaid enrollees, however, views are more mixed with similar shares saying the policies will "strengthen, weaken, or have no impact on the program [s] they rely on."

Medicare Rights Opposes Cuts to Health Care Programs

Medicare Rights opposes cuts to Medicaid, the ACA, and Medicare. We know that terminating health coverage for millions will lead to **damaging ripple effects** across the entire economy and result in older adults, people with disabilities, caregivers, and working families losing the support they need to protect their health, financial security, access to food, and even their homes.

Funding cuts put community health centers at risk

Thousands of federally-funded **community health centers** throughout the country deliver free and low-cost outpatient services to tens of millions of uninsured and lower-income Americans each year. Historically, Democrats and Republicans in Congress have supported these centers. But, now, the Commonwealth Fund **reports** that Congress has put these centers on the chopping block and many might not survive.

Community health centers (CHCs) provide a range of health care services, including primary care, chronic care management, behavioral care, maternal care, and dental health care to more than 31 million Americans every year. CHCs are there for people who cannot afford to pay privately for their basic health care needs and people who live in rural communities without private health care providers. They offer cost-effective care to people who cannot pay high health care costs.

CHCs provide high-value care, which is what the Trump administration says it wants in our health care system. A Congressional Budget Office **analysis** last year found that additional government investments in CHCs could save Medicare and Medicaid billions of dollars.

Unfortunately, recently, both the Trump administration and Congress have been cutting CHC funding. Grant funds to CHCs have been frozen, forcing some CHCs to close and others to fire staff. In addition, Congress reduced CHC funding to $4.26 billion from $4.4 billion, even though there are more CHCs and more patients using them.

Moreover, if Congress cuts Medicaid, as appears to be the desire of the majority of Republicans, CHC revenues will take a big hit. Medicaid dollars represent more than 40 percent of CHC revenue.

Even before the administration and Congress began cutting funding to CHCs, many experts projected that CHCs would not have the resources needed to meet community needs. CHCs have been seeing more people who are uninsured or who are unable to pay for their care.

Attention mounts on Medicare Advantage fraud and abuse

More Democrats and Republicans in Congress are speaking out and raising alarms about Medicare Advantage. If Republicans need to find savings to pay for their tax cuts, they need look no further than the $1 trillion in Medicare Advantage overpayments.

A growing number of Republicans are speaking out against these massive government overpayments to Medicare Advantage insurers. At a recent Senate Finance Committee hearing, Senator Roger Marshall (KA-Rep) said: "Like Dr. Oz, I thought Medicare Advantage was a good thing when it came out. But, unfortunately, it's been manipulated. They found loopholes to manipulate and now we're spending probably $83 billion more a year on Medicare Advantage patients as opposed to if they had been on traditional Medicare…I hope that there's an opportunity to fix that very broken system that friends across the aisle who speak so boldly about Medicare Advantage that they will vote for reforming it as well whenever we have that opportunity."

Senator Chuck Grassley (Rep-IO) has expressed similar concerns about Medicare Advantage, as have Senators **Bill Cassidy** (Rep-LO) and **James Lankford** (Rep-OK), who recognizes **inappropriate denials** in Medicare Advantage, which are keeping some hospitals in his state from contracting with MA insurers.

Indeed, increasingly, hospital systems, including some of the best hospital systems in the country are **dropping Medicare Advantage contracts.** Seventy-eight Democrats in the House of Representatives wrote HHS Secretary Kennedy and Acting CMS Administrator Carlton to express their **concerns about Medicare Advantage overpayments and more**."If Republicans were serious about combating waste, fraud and abuse, they would be focused on Medicare (dis)Advantage plans," says Representative Pramila Jayapal (CA-Dem) on **MSNBC**.

Eight Democrats in the Senate sent **a similar letter**.

Eileen Appelbaum, health economist at the Center for Economic and Policy Research, explains the Medicare Advantage rip-off **here**:

13 Ways to Save Money on Your Health Care

Among our top advice: Question your doctors, comparison shop and consider a health savings or flexible spending account.

You probably don't need to be told that health care costs are going up. You likely see it on your bank statement or pay stub.

But if you like data with your financial pain**, according to the American Medical Association**, in 2023, the most recent numbers they have, health spending in the United States increased by 7.5%, the highest growth rate observed since 2003 (8.5%), if you don't count 2020 (when COVID-19 hit), which saw health care costs climb 10.4%.

In other words, this might be a good time to start thinking hard about what you're spending on medical care.

For instance, do you automatically opt for the plan you had the previous year **each fall during open enrollment**? Change can be hard. If your doctor writes you a prescription, do you buy it without asking if there are **less expensive and equally effective options**? Do you agree to whatever tests your doctor recommends, without asking if you really need the exam or whether a less pricey option would be just as good?

Here are 13 strategies for getting the most from your health care coverage without breaking the bank

How to Save Money on Medical Expenses

- **Consider starting a health savings account**
- **Invest in a flexible spending account**
- **Let your doctors know about your financial situation**
- **Avoid the hospital when possible**
- **Comparison shop**
- **Use health care decision tools**
- **Check your bills**
- **Think about long-term health issues and end-of-life care**
- **Consider telehealth options**
- **Take advantage of wellness programs**
- **Explore government assistance programs**
- **Consider long-term care insurance**
- **Get routine screenings and preventative care**

Consider Starting a Health Savings Account

"One of the most effective tools for saving money on health care costs is a **health savings account**, which can be used in combination with a qualifying high-deductible health plan," says Lorna Sabbia, a Boston-based managing director and head of workplace benefits for Bank of America.

Sabbia says that you can use a health savings account (HSA) to cover current health care costs, from medication to co-pays.

The Internal Revenue Service defines a high-deductible health plan as any plan with an annual deductible of at least $1,600 for an individual or $3,200 for a family. Only people enrolled in high deductible health plans (HDHP) are eligible to open HSAs…..**Read More**

Trump's executive order on prescription drugs does not reduce drug prices for Americans

A new **Arnold Ventures poll** finds that nearly nine out of 10 voters believe the government should have the power to negotiate prescription drug prices. And, more than 75 percent say that it is very important for the government to reduce drug prices, including seven in 10 Trump supporters. Unfortunately, President Trump's recent Executive Order on prescription drug prices and tariffs are likely to raise drug prices for Americans.

More specifically, the vast majority of Americans support capping drug price increases to the rate of inflation and Medicare negotiating drug prices for all drugs. Indeed, 86 percent say that they do not want people with Medicare to pay more for their drugs than people in other wealthy nations. But, Trump's executive order undermines Medicare's limited efforts to negotiate drug prices, much less expand Medicare's authority to negotiate drug prices.

Bottom line: Your prescription drug costs are probably not coming down any time soon. President Trump's tariffs on China could lead to higher drug costs for all Americans, as pharmaceutical manufacturers import ingredients from China. Meanwhile, Trump's new **Executive Order on prescription drug prices** appears to favor the pharmaceutical industry's interests, allowing drug companies to continue to set prices sky high and calling for changes to the Inflation Reduction Act that would drive up drug prices for people with Medicare.

Here are some of the key provisions of the Executive Order.

On a positive note, with caveats:

- It aims to reduce the cost of insulin and injectable epinephrine at community health centers for uninsured and some low-income individuals. It's not clear by how much.
- It asks the FDA to make it easier for states to import drugs. But, it's not at all clear that this provision will help Americans at the pharmacy. Today, the FDA has only granted permission to Florida to import drugs from Canada, and **Florida appears not to have begun importing drugs**. Moreover, Florida's program is not designed to help its residents. It would only help lower the state's costs a small amount for Medicaid recipients and for the state's health and corrections departments.
- It calls for more generics and biosimilars–lower-cost alternatives to brand name drugs. But, the Trump administration has cut FDA staffing drastically. It eliminated the office that was tasked with speeding up generic drug approvals, slowing down drug approvals. Moreover, the administration has also cut NIH funding, which supports virtually all new drug development. So, while the president's goal is laudable, it does not seem doable.

On a negative note:

- It is projected to drive up Medicare drug costs by $6 billion and force people with Medicare to pay $1.5 billion more for their drugs. How? The Executive Order buys into a pharmaceutical industry claim that the Inflation Reduction Act discriminates against pills. Discriminates? Well, let's just say that the law gives license to pharmaceutical companies to charge high prices for injectable drugs for a longer period of time than for pills. The IRA permits drug price negotiation over pills on the market for nine years and injectable drugs on the market after 13 years. The Executive Order asks Congress to allow pharmaceutical companies the same 13 years of protection for pills as for injectables. If the Republican majority complies, more than half the drugs for which the Centers for Medicare and Medicaid Services is negotiating lower prices would no longer have lower negotiated prices.
- It calls for better transparency around the fees drug middlemen receive from pharmaceutical companies, which does not bring down drug prices for Americans.
- The Trump administration also ended a Biden initiative that would have permitted people with Medicare to buy generic drugs for $2. And, it is denying Medicare coverage of anti-obesity drugs, as the Biden administration had proposed.

RI ARA HealthLink Wellness News

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

HealthLink Wellness "Taking Control"

New COVID Variant, NB.1.8.1, May Now Make Up 1 in 3 U.S. Cases

The variant, known as NB.1.8.1, has been spreading fast. The U.S. Centers for Disease Control and Prevention (CDC) estimates that it accounted for nearly half of the cases found in travelers coming into the country during the last week of May.

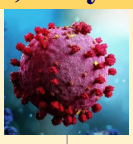
The agency's airport surveillance program detected the variant in travelers from several countries, *CBS News* said in a new report.

In that **program,** international travelers arriving at designated airports volunteer to contribute nasal swab samples and complete a survey, according to the CDC. The samples are then analyzed in a lab to look for variants or mutations important to public health.

Still, the CDC said these new estimates have a wide margin of error and may change as more data come in. But the increase suggests that the variant is spreading — and spreading fast.

"Data indicates that NB.1.8.1 does not lead to more severe illness compared to previous variants, although it appears to have a growth advantage, suggesting it may spread more easily. In other words, it is more transmissible," **Subhash Verma,** a professor of microbiology and immunology at the University of Nevada, Reno, told *CBS News*.

The symptoms of NB.1.8.1 are similar to those of earlier COVID variants. People may experience:



- ♦Cough
- ♦Sore throat
- ♦Fever
- ♦Tiredness

As the virus continues to evolve, access to vaccines may change for some groups.

In May, the U.S. Food and Drug Administration (FDA) **announced** that it will still approve updated vaccines for people at higher risk, like seniors and those with health conditions such as pregnancy or diabetes.

But vaccine makers will have to run large new trials before updated shots can be approved for everyone else. This could mean that many healthy adults and children won't have access to a new vaccine this fall, *CBS News* reported.

U.S. Health and Human Services Secretary **Robert F. Kennedy Jr**. also said last month that he would remove the CDC's recommendation for healthy pregnant women and children to be vaccinated against COVID-19.

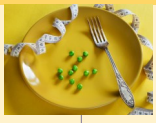
The CDC later said that kids without health problems may still get the vaccine if their parents and doctor agree it's the right choice.

"Where the parent presents with a desire for their child to be vaccinated, children 6 months and older may receive COVID-19 vaccination, informed by the clinical judgment of a healthcare provider and personal preference and circumstances," the CDC stated.

Daily GLP-1 pill could work as well as Ozempic

Rebecca Robbins and Gina Kolata report for the **New York Times** that a new pill to be taken each day could do as much to lower blood sugar and help with weight loss as Ozempic and Mounjaro, injectable weight-loss medicines. The FDA has not yet approved the pill for sale and is not likely to do so before next year.

What's the value of Eli Lilly's orforglipron pill? The pill conceivably could be cheaper than the current GLP-1 drugs because it costs less to manufacture a pill than an injectable drug. And, unlike an injectable, the pill does not need to be refrigerated or injected. The market for a GLP-1 pill is significant because many people do not want to inject themselves.



Lilly reports that, in a clinical trial, two-thirds of the 559 people who took the pill saw their blood sugar levels fall to the normal range. Lilly further reports that people who took the highest pill dose lost an average of 16 pounds.

But, it's not yet clear whether the clinical trial data supports Lilly's claims about the efficacy of its new pill. Side effects, such as diarrhea and nausea could be worse than claimed, and benefits could be smaller than claimed. Independent experts are not expected to analyze Lily's data until June.

Axios reports that Lilly's Zepbound, an injectable GLP-1 drug, delivered a greater amount of weight loss over 18 weeks for people without diabetes than people who took the pill. People had between 15.3 percent and 36.2 percent weight loss,, according to the data.

Today, one in eight Americans have taken a GLP-1. But, about four in ten Americans are obese. So, there's a huge market for GLP-1 drugs.

N.B.: Medicare currently only covers **weight-loss medicines** for people with diabetes and heart disease. It does not cover these medicines for people who simply want to lose weight.

An ER Doctor's Guide to Staying Safe in Summer Heat

As summer temperatures rise, a Houston emergency room doctor is sharing important tips to help folks stay safe while outdoors.

Dr. Neil Gandhi, an emergency medicine physician with Houston Methodist, says a mix of heat, humidity and extreme weather makes it especially important to be prepared.

"Don't jump directly into the frying pan; take some time to acclimatize during outdoor activities," Gandhi said.

He recommends easing into outdoor time by starting with short periods outside, then slowly increasing the time to allow your body to adjust to the high temps.

Water is the best way to stay hydrated in the heat, Gandhi added.

"Individuals will also need to remain vigilant about hydration to counteract increased sweating caused by high heat and humidity," he said.

He added that sparkling water and water-rich fruits such as watermelon can help, too. But it's best to avoid sugary drinks and alcohol, which can make dehydration worse.

Breathable fabrics such as cotton and linen are ideal for hot weather, Gandhi said.

Spending time outside has many benefits, Gandhi said, including better physical and mental health. But take care.

"Sunburn can develop slowly and go unnoticed until it's severe," he said. "In addition to sunscreen, clothing with ultraviolet protective factor (UPF) can be another layer of protection."

It's also important to recognize when your body is getting overheated, Gandhi said.

He pointed out that people who work outside or attend summer festivals and sporting events are at greater risk for heat-related illness. So are young children and older adults.

Watch for early warning signs such as dizziness, confusion, muscle cramps and a lot of sweating, he advised.

"If you notice these symptoms in someone or experience them yourself, move to a cool place immediately, hydrate and seek medical attention, if severe," Gandhi said.

Appendix Cancer Cases Surge in Millennials and Gen X

When Chris Williams started feeling sharp stomach pain one night in 2021, he went straight to the emergency room. The next morning, he had surgery to remove his appendix.

But that wasn't the end of his health scare. A few days later, doctors gave Williams unexpected news: They found a tumor on his appendix. Tests showed it was cancer — and it had already reached **stage 3**.

"Had it stayed in me for a while longer, it would have been stage 4," said Williams, who is cancer-free after treatment, told *CNN*. "It was actually a blessing."

Williams, who was 48 at the time, is part of a growing group of younger adults being diagnosed with appendix cancer.

A new study shows that rates of appendix cancer are rising quickly among millennials and Generation X, especially compared to people born in earlier decades.

The research — published June 10 in the ***Annals of Internal Medicine*** — looked at data on nearly 5,000 appendix cancer patients from 1975 to 2019.

Compared to those born in the 1940s, patients born between 1976 and 1984 had cancer rates more than three times higher. Rates were four times higher among those born between 1981 and 1989.

"The rates and trends which we observed were alarming and worrisome," said lead author Dr. **Andreana Holowatyj**, a cancer expert at Vanderbilt University Medical Center.

"We're seeing some of these generational effects for cancers of the colon, the rectum, the stomach, and so that's one of the reasons why we were curious to explore this in rare appendix cancers," she said.

Appendix cancer is still rare — affecting 1 or 2 people per million each year in the U.S. — but the increase in younger adults is concerning, *CNN* reported.

"There are no standardized screening techniques for appendiceal cancers. Many of them are incidentally found after presentation of something like acute appendicitis," Holowatyj added.

That's what happened to Williams. When his appendix removed during emergency surgery, doctors discovered the tumor.

The appendix is a small pouch on the lower right side of the belly, connected to the large intestine, and is thought to help with immune function.

Appendix cancer often causes no symptoms until it ruptures, and when it does, signs can include: abdominal or pelvic pain, bloating, nausea and vomiting.

These symptoms are also common with appendicitis.

Researchers don't yet know why appendix cancer is increasing in younger generations.

It's not likely due to better screenings, they said, since there is no standard way to screen for the disease. Instead, the rise could be linked to "environmental exposures that may increase risk for generations now entering mid-adulthood," researchers wrote.

What's more, some experts suspect obesity, stress or diet may play a role.

"It's probably some type of combination, something multifactorial, but we have not yet identified it. There is thankfully now a lot of work, a lot of research going into this," **Dr. Andrea Cercek** of Memorial Sloan Kettering Cancer Center in New York City, who treated Williams but was not involved in the study, told *CNN*.

"It is very rare, even though it's rising," she added. "However, it is an important part of this overarching story of the rise in cancer in young adults."..**Read More**

Alcohol-Linked Liver Deaths Rising in Women and Young Adults

Alcohol-related liver disease deaths are increasing — and they're rising faster in some groups, including women, young adults and Indigenous people, new research shows.

Between 2018 and 2022, deaths from alcohol-associated liver disease (ALD) rose nearly 9% a year, compared to 3.5% annually between 2006 and 2018, according to a study published June 11 in ***JAMA Network Open***. Experts say the rise likely owes to higher drinking during the COVID-19 pandemic — as well as other long-term health problems like obesity and **high blood pressure**.

"It puts numbers to what we're seeing in the hospital, in the clinic," Dr. Brian Lee, a liver specialist at Keck Medicine of USC in Los Angeles, said in a *STAT News* report. He was not part of the study.

The study used death certificates from across the U.S. to track deaths from alcohol-associated hepatitis and cirrhosis, two very serious liver conditions.

While men still had the highest number of deaths — 17 per 100,000 people — women's death rates grew faster. In 2022, 8 of every 100,000 women died from ALD, up from 3 per 100,000 over the study period. Women's death rates rose by about 4.3% each year, nearly twice the rate of men.

Indigenous communities were hardest hit. Among American Indian and Alaska Native adults, cirrhosis deaths reached 33 per 100,000 people in 2022, the highest of all racial and ethnic groups studied.

Hepatitis deaths more than doubled in those groups from 2010 to 2022, *STAT News* reported.

"The pandemic itself came under control, but the disparities that came with it continued and lingered," said **Dr. Nasim Maleki,** a psychiatry professor at Harvard Medical School who reviewed the findings.

People between ages 25 and 44 had the biggest yearly increase in deaths from alcohol-associated hepatitis between 1999 and 2022. This condition can come on quickly and lead to symptoms like fatigue, jaundice (yellowing of the skin or eyes) and liver pain — even in folks who haven't been drinking very long, *STAT News* said.

Experts worry the full effects of pandemic drinking may not be seen for many years.

"Alcohol-related cirrhosis takes time to develop. So we may not see the true extent of the consequences until five, probably 10, years from now, which is very concerning," **Dr. Robert Wong**, a liver specialist at Stanford University, said.

One reason women may be affected more is because of how the body processes alcohol.

Biologically, cisgender women are less able to break down alcohol than cisgender men. That means even a little drinking can have a bigger impact on their organs over time.

That's why current federal guidelines suggest that women have no more than one drink a day, while men may have up to two.

"You'd be surprised by how shocked people are when they hear that drinking more than two drinks per day, for example, is considered heavy drinking by federal definitions," Lee explained.

In 2021, more than 12,000 deaths from "unspecified liver cirrhosis" were caused by heavy drinking, though that may not have been obvious from death certificates, said **Marissa Esser**, who led the alcohol program at U.S. Centers for Disease Control and Prevention (CDC) until it was shut down earlier by the Trump administration this year.

The American Medical Association recently came out in support of new efforts to educate people on how alcohol raises the risk of breast cancer.

The group is also calling for better labeling on alcohol containers to make the risks clearer, *STAT News* said.

Some studies suggest alcohol use dropped slightly after peaking in 2020, as conversations about drinking increased. Still, it's unclear if that drop will lead to less deaths in the future.

ALD remains the leading reason for liver transplants in the U.S., and alcohol-associated hepatitis is the fastest-growing reason people need one.

CT Scans Outperform DNA Stool Tests In Colon Cancer Screening, Study Says

CT scans might be able to prevent more **colon cancers** than stool DNA tests, a new study says.

CT colonography performed every three to five years could ward off more cases of cancer than DNA testing of stool to look for evidence of colon cancer, researchers reported June 10 in the **journal *Radiology***.

"Among the safe, minimally invasive colorectal cancer screening options, CT colonography is more effective at preventing and detecting cancer — and is also more cost-effective — than stool DNA testing," lead researcher **Dr. Perry Pickhardt** said in a news release. He's a professor of radiology and medical physics at the University of Wisconsin School of Medicine and Public Health.

Colonoscopy remains the dominant form of colon cancer screening, Pickhardt noted. The procedure, while invasive, remains the gold standard for screening because pre-cancerous polyps can be removed during the exam.

However, many patients opt for either stool tests or CT scans because they are uncomfortable with a colonoscopy, which requires a person to be sedated while a thin, flexible tube is inserted into their colon through the anus.

Medicare now covers both DNA stool testing and CT colonography, so researchers decided to perform a head-to-head comparison of the two less invasive screening methods.

DNA stool tests search for genetic evidence of colon cancer in samples taken from patients, while CT colonography uses CT scans to examine the colon and rectum.

For the study, researchers created a model to simulate the progression of colon cancer, and how the different screening methods might detect and prevent cancers. The model was based on 2017 data from the U.S. Centers for Disease Control and Prevention (CDC).

Screening of the simulated population began at 45 years old and ended at 75, researchers said.

Without any screening, researchers estimated that just under 8% of people would develop colon cancer and 3% would die from it each year.

Results show that colon cancer cases would decline by an estimated 59% with stool DNA tests performed every three years.

But two different approaches of CT colonography would prevent even more cancer cases, researchers estimate:

- A 70% reduction with CT scans performed every three years and follow-up colonoscopy performed to remove polyps 10 millimeters or larger.
- A 75% reduction with CT scans every five years and follow-up removal of polyps 6 millimeters or larger.

These results indicate that CT colonography can join conventional colonoscopy and stool testing "as a legitimate frontline screening option," researchers concluded.

"In particular, CT colonography may represent a highly favorable screening strategy for younger patients" in their 40s, researchers noted.

Both CT scan strategies were also more cost-effective than stool DNA testing, researchers said.

However, the five-year CT strategy was not as cost-effective as the three-year strategy, the study says.

People who undergo CT colonography still have to perform bowel prep, using powerful laxatives to empty their colon prior to the exam.

But Prickhardt noted that a CT colonography can be used to also check for other problems like osteoporosis or hardening of the arteries.

Researchers noted that their simulation is in line with previous results, but that as a simulation it can't prove a direct cause-and-effect link between the screening methods and reduced rates of colon cancer. **More**

Drinking Coffee May Help You Live Longer — But Skip the Extra Sugar

Drinking a cup or two of coffee every day may help you live longer — but only if you skip the heavy cream and sugar, new research suggests.

The research, published recently in ***The Journal of Nutrition***, found that black coffee or coffee with just a little sugar and saturated fat was tied to a lower risk of premature death. But when people drank coffee with lots of sweeteners or cream, the health benefits disappeared.

"Coffee is among the most-consumed beverages in the world, and with nearly half of American adults reporting drinking at least one cup per day, it's important for us to know what it might mean for health," senior author **Fang Fang Zhang** of Tufts University said in a news release.

Researchers looked at data from more than 46,000 U.S. adults who took part in national health surveys between 1999 and 2018. They analyzed what kind of coffee people drank — caffeinated or decaf — and how much sugar and saturated fat they added.

They compared that data to deaths from any cause, as well as heart disease and cancer.

The results?

- Drinking at least one cup of caffeinated coffee per day was linked to a 16% lower risk of premature death from any cause.
- Drinking two to three cups a day was linked to a 17% lower risk.
- No clear association was found between coffee and cancer deaths.

Researchers said people who drank black coffee or added coffee with low amounts of added sugar and saturated fat seemed to benefit the most.**Read More**

Zicam and Orajel Swabs Recalled for Possible Fungal Contamination

Some nasal and baby teething swabs from **Zicam** and **Orajel** are being recalled across the country because they may be contaminated with fungus, U.S. health officials said.

The recall was announced by the U.S. Food and Drug Administration (FDA) after the manufacturer, **Church & Dwight Co., Inc.**, found the problem during testing, *CBS News* reported.

The issue was linked to the cotton components in the products, which may contain fungi, the company said.

The recall includes:

- All lots of Zicam® Cold Remedy Nasal Swabs (UPC **732216301205**)
- All lots of Zicam® Nasal AllClear Swabs (UPC **732216301656**)
- All lots of Orajel™ Baby Teething Swabs (UPC **310310400002**)

The FDA said other Zicam and Orajel products are not part of the recall and are still safe to use.

Anyone who has these recalled products should stop using them immediately, the FDA advised.

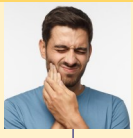
Swabs that are contaminated with fungi can lead to serious infections, especially in children, people with weakened immune systems or those with other medical conditions.

The FDA said the contamination could even cause life-threatening blood infections in rare cases.

So far, no illnesses or serious injuries have been reported, *CBS News* said.

Consumers can request a full refund at **www.churchdwightrecall.com** or call the company at (800) 981-4710.

2020 to 2022 Saw Nearly 2 Million Annual Emergency Room Visits for Dental Issues



Largest percentage of emergency department tooth disorder visits accounted for by adults ages 25 to 34 years, White non-Hispanics

Tooth disorders accounted for an annual average of 1,944,000 emergency department visits during 2020 to 2022, according to a June data brief published by the National Center for Health Statistics.

Susan M. Schappert and Loredana Santo, M.D., M.P.H., used data from the National Hospital Ambulatory Medical Care Survey to examine emergency department visits with a reason for visit or diagnosis of tooth disorder in 2020 to 2022.

The researchers found that during 2020 to 2022, tooth disorders accounted for an annual average of 1,944,000 emergency department visits (59.4 visits per 10,000 people). Adults ages 25 to 34 years had the largest percentage of emergency department visits for tooth disorders (29.2 percent). The largest percentage of emergency department tooth disorder visits was accounted for by White non-Hispanic people, followed by Black non-Hispanics and Hispanics. Medicaid was the primary expected source of payment for the majority of visits. There was a reduction seen in opioids as the sole pain relief drug given or prescribed at emergency department tooth disorder visits, from 38.1 percent in 2014 to 2016 to 16.5 percent in 2020 to 2022.

"During 2020 to 2022, tooth disorders, as a reason for visit or a diagnosis, accounted for about 1.9 million emergency department visits per year, or about 1.4 percent of all emergency department visits, with a rate of 59.4 visits per 10,000 people," the authors write. "The percent distribution of emergency department visits for tooth disorders varied by patient age and by patient race and ethnicity, but not by patient sex."

COVID Vaccine Protects Against Kidney Damage During Infection

Kidney damage is common during a severe case of **COVID-19,** but vaccination appears to protect people against this life-threatening side effect, a new study says.

Unvaccinated COVID patients with kidney damage severe enough to require dialysis are nearly three times as likely to die in the hospital compared with those vaccinated against the coronavirus, according to findings published in the June issue of the journal ***Kidney Medicine*.**

Unvaccinated patients given dialysis also are more than twice as likely to die following their discharge from a hospital or to require dialysis after going home, results show.

"The COVID-19 vaccine is an important intervention that can decrease the chances of developing complications from the COVID-19 infection in patients hospitalized with acute kidney injuries," said lead researcher **Dr. Niloofar Nobakht**, health sciences clinical associate professor of medicine in the Division of Nephrology at David Geffen School of Medicine at UCLA.

"It is important for individuals to discuss the benefits of getting vaccinated for COVID-19 with their doctors as it can decrease the chances of needing dialysis, which can severely affect the quality of life of patients and lead to further complications including death," she said in a news release.

As many as 46% of people hospitalized for COVID suffer acute kidney injury, with some requiring dialysis as their kidneys recover from infection-related damage, researchers said in background notes.

For the new study, researchers tracked about 3,500 patients hospitalized with COVID between March 2020 and March 2022.

About 48% of fully vaccinated COVID patients suffered kidney damage during their infection, compared with 42% unvaccinated patients.

But nearly 16% of unvaccinated patients had kidney damage so severe they required dialysis, compared with 11% of vaccinated patients.

Overall, unvaccinated patients requiring dialysis were:

- 2.8 times more likely to die in the hospital.
- 2.4 times more likely to die following their discharge.
- 2.6 times more likely to remain on dialysis after going home.

After accounting for other factors, unvaccinated patients overall were 5.5 times more likely to die in the hospital and 4.8 times more likely to die during long-term follow-up, results show.

"This study also emphasizes the importance of the need for continued research in understanding how COVID-19 infections affect the kidney and how we should manage and monitor kidney complications from COVID-19 infections to improve patient outcomes," Nobakht said.

Rheumatoid Arthritis On The Rise Worldwide, AI-Powered Study Estimates

Rheumatoid arthritis (RA) has steadily increased around the world during the past three decades, a new AI-powered study reports.

The autoimmune disease affected 17.9 million people worldwide in 2021, a 13% increase from 1990, researchers reported today in the ***Annals of the Rheumatic Diseases*.**

Results indicate that the global burden of RA has been vastly underestimated, researchers concluded.

Further, the research team projects that rheumatoid arthritis will continue to increase unless steps are taken to prevent it or treat existing cases.

"Our long-term forecasts predict a continued rise in RA incidence, emphasizing the need for dietary adjustments, accessible medical policies, and innovative treatments such as cell therapy," concluded the research ream led by **Queran Lin,** a clinical research fellow in epidemiology at Imperial College London in the U.K.

For the study, researchers analyzed rheumatoid arthritis data from 953 locations around the world between 1980 and 2021, using an AI program to calculate the number of years people suffer from disability or lose to early death because of the disease.

Rheumatoid arthritis occurs when the immune system attacks the tissue lining a person's joints, causing pain, swelling and stiffness.

Results show that the death rate for RA has declined significantly, falling 32% between 1980 and 2021.

But disability-adjusted life years (DALYs) nearly doubled between 1990 to 2021. That's a measure of the number of years people lose to early death or wind up living with disability due to RA, researchers found.

Higher case rates of rheumatoid arthritis were seen in Western Europe and North America, and lower rates in Africa, the study says.

West Berkshire in the U.K. had the highest rate of RA, while people in Zacatecas, Mexico, had the highest levels of disability-adjusted life years, results show.

Only Japan showed declining RA trends, exemplified by a 22% drop in Tokyo's rate of disability-adjusted life years since 1990, researchers found.

"Japan's sustained decline in DALYs despite a high sociodemographic index proves that socioeconomic status alone doesn't dictate outcomes," co-lead author **Boazhen Huang** of the City University of Hong Kong said in a news release. "Proactive healthcare policies such as early diagnosis programs can reverse trends."...**Read More**