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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Message from Alliance *for* Retired Americans Leaders

Biden-Harris 2024 Announces the Launch of Seniors for Biden-Harris

Robert Roach, Jr
President, ARA

Biden-Harris 2024 Announces the Launch of Seniors for Biden-Harris This week members of the Alliance participated as the Biden-Harris campaign launched its "Seniors for Biden-Harris" effort to engage senior voters for the 2024 reelection campaign with events in at least seven states. The campaign initiative seeks to engage senior voters through a variety of events, from postcard writing and phone banks to pickleball tournaments. See how Arizona Alliance members played in one of the **bingo nights**.

President Biden and Vice President Harris have a strong record on issues important to older Americans. The Biden Administration has taken on Big Pharma by requiring Medicare to negotiate lower prices for the highest priced prescription drugs, capped the price of insulin at $35 per month for Medicare beneficiaries and made all recommended adult vaccines free under Medicare.

In addition, the administration has demonstrated unwavering opposition to GOP cuts to Social Security and Medicare, instead offering ways to expand the programs.

On Wednesday, a "Seniors for Biden-Harris Grassroots Supporters Call" was led by DNC Chair Jaime Harrison. It featured Reps. John Larson (CT), Grace Napolitano (CA) and Jan Schakowsky (IL); Jon "Bowzer" Bauman, seniors activist and performer with the group Sha Na Na; and other speakers telling their personal stories. The call discussed the many ways that President Biden and the administration are fighting for older Americans and their families.

During the call Minnesota Alliance member Marianne Yernberg spoke powerfully about how she has benefited from the annual out-of-pocket cap on prescription drug costs. She paid more than $7,000 a year out of pocket for her medications in 2022 and 2023 but this year will pay no more than $3,200 thanks to the law passed by the Biden-Harris administration. Next year her out of pocket costs will decline to $2,000.

"The future of our Social Security and Medicare benefits depend on the outcome of this election," said Robert Roach, Jr., President of the Alliance. "President Biden has proven he fights for seniors, and the Biden-Harris administration will do even more if reelected."

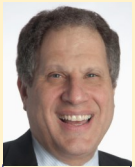
For a comparison of the Biden and Trump records on seniors issues, click **here**

Pennsylvania Alliance Files a Lawsuit Challenging Mail-in Ballot Rejections

The Pennsylvania Alliance has filed a **lawsuit** against the Lancaster County Board of Elections to challenge the rejection of mail-in and absentee ballots that are missing the last two digits of the year from the handwritten date on the outer return envelope.

Pennsylvania voters are required by law to record the date they sign their declaration. Late last year, the Pennsylvania Department of State (DOS) started pre-printing the first two digits of the year on the outer envelopes of mail-in and absentee ballots. This threatened voter access during this year's primary elections in April, as certain counties – including Lancaster County – chose to reject ballots with envelopes that included the day and month but not the last two digits of the year, even though the ballots were timely received in the county election office The Pennsylvania Alliance's lawsuit argues that this is not lawful because the current year is displayed on the ballots themselves and the year in which they are issued and cast is self-evident.

"The right to vote and choose our leaders is our most basic freedom, and it should never be infringed upon. Counties should not be permitted to throw out a ballot just because the voter neglected to fill in the last two digits of the year on the outside of the ballot envelope," said Mike Crossey, President of the Pennsylvania Alliance for Retired Americans. "The Pennsylvania Alliance is determined to fight to make sure that no county is allowed to disenfranchise voters over this minor technicality."



Rich Fiesta,
Executive
Director, ARA

"Older Pennsylvanians should not have to worry about nitpicky requirements when casting their ballots," added **Richard Fiesta, Executive Director of the Alliance**. "We will always fight to ensure that every American can exercise their right to vote without unnecessary restrictions."

Alliance Mourns the Death of Scott Watts

Founding President of the Nevada Alliance Scott Watts **passed away** on May 29. Scott served as President from the Alliance's inception in 2001 until 2014. In his role as President, he managed over 19,000 members and 28 chapters, and under his leadership, the Nevada Alliance grew into the largest progressive senior citizen organization in Nevada. Scott championed Social Security, Medicare, Medicaid, and the Affordable Care Act. He was a retired UAW member who served on its staff assisting other members during his work life. Scott and his wife Susan were a great team of senior activism.

"Scott will be remembered not only for his enduring leadership of the Nevada Alliance and the incredible impact he left, but also for his upstanding character and the many ways he improved the lives of those around him," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "He will be missed but we will always remember his kindness, thoughtfulness and dedication."

Joseph Peters, Jr.
Secretary
Treasurer ARA

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

The Nursing Home Workforce Standards Board Bill Passes the Rhode Island General Assembly After House and Senate Vote

Nursing home caregivers, family members and Community supporters call on Governor McKee to sign the bill

PROVIDENCE - Raise the Bar on Resident Care, a coalition of nursing home caregivers, community partners, nursing home residents, and family members working to end the staffing crisis in Rhode Island nursing homes, applauds today's historic passage of the Nursing Home Workforce Standards Board Bill (H-7733 | S-2621) (WSB) with the House and Senate vote.

"The Senior Agenda Coalition of RI has been a strong and consistent advocate for quality long term care including safe staffing requirements for nursing homes. We are pleased to see passage of the Workforce Standards Board. It is critical to bring all interested stakeholders to the table to ensure the highest quality care is being provided for our vulnerable nursing home residents which requires staff to be adequately trained and compensated," said Diane Santos, Senior Agenda Coalition Board Chair and member of Raise the Bar, "This is especially important as our older population is growing, the number of persons with neurodegenerative conditions such as Alzheimer's Disease is projected to increase and we have more residents with behavioral health issues being admitted to our nursing homes."

"Nursing home residents and caregivers have been through so much in the last three years and the Workforce Standards Board finally gives us hope for a way to end the care crisis," said Tenah Nimmo-Powell, CNA/Transport at Bannister Center, "We are grateful for the elected leaders, especially Senator Bridget Valverde and Representative Scott Slater, that never forgot us and pushed for better staffing and higher wages. Now we need Governor McKee to finish the job."

Rhode Island's nursing home crisis spurred passage of The Nursing Home Staffing and Quality Care Act, signed into law by Governor McKee in 2021. But lack of enforcement has allowed for-profit nursing homes, which form the majority in Rhode Island, to cut corners on staffing and investment in caregivers, all the while making millions in profit. **Rhode Island ranks 38th** in the nation for nursing home staffing levels and in the last three years, ranked **second in the nation for serious nursing home deficiencies**. At the same time, **47% of RI´s direct care nursing home staff rely on public assistance, and 38% live in or near poverty levels.**

The Nursing Workforce Standards Board will offer a holistic approach to stabilizing the nursing home system by doing the following:

- **Incorporates the perspectives of diverse healthcare professionals** to form a 13-member board including frontline staff, nursing home management representatives, state government (such as the DOH/EOHHS), and two community organizations working with Medicaid to ensure comprehensive and informed decision-making;
- **Sets training standards:** Ensures comprehensive training for nursing home staff to meet the diverse care needs of residents.
- **Promotes caregiver rights:** Advocates for better working conditions and fair wages for nursing home staff, aiming to attract and retain a skilled workforce.
- **Depoliticizes fund allocation:** Ensures that financial resources are allocated transparently and equitably, focusing on enhancing care quality rather than being influenced by political factors.
- **Financial oversight:** Implements financial audits and monitoring to assure funds are appropriately allocated to care and staffing, promoting transparency.

"In 2023, Minnesota passed its own Nursing Home Workforce Standards Board and just voted to raise wages for caregivers to over $23 an hour in 2027 while guaranteeing 11 paid holidays. Here in Rhode Island, the Workforce Standards Board is a critical step toward transforming nursing home jobs into sustainable careers that can support a family and provide quality resident care. Now we need Governor McKee to show his support and sign this bill into law," said Jesse Martin, Executive Vice President of SEIU 1199 New England, member of Raise the Bar on Resident Care.

Advocates from Raise the Bar on Resident Care launched the campaign to achieve safe staffing and quality resident care in nursing homes in July of 2019. *The Raise the Bar Coalition includes the following partners: Advocates for Better Care in Rhode Island, Senior Agenda Coalition of RI, District 1199 SEIU New England, RI Organizing Project, Sista Fire, RI Interfaith Coalition to Reduce Poverty, Women's Fund of Rhode Island, Newport Partnership for Families, Fuerza Laboral, Protect our Healthcare Coalition, R.A.M.P (Real Access Motivates Progress), Economic Progress Institute, RI AFL-CIO and* ***Rhode Island Alliance for Retired Americans***

Congress focuses on health care mergers and Medicare payments

As hospital systems and insurers continue to buy up medical practices and grow ever larger, the consequences for patients and the health care system writ large are serious. In Congress, the House Budget Committee is looking at how these mergers affect cost, access to care, and health outcomes. Republicans and Democrats agree that consolidation in the health care space must stop before health care costs escalate even more, reports Rebecca Pifer for **HealthCareDive**.

To bring down Medicare spending, Republicans and Democrats appear to support ensuring that Medicare payments are the same for the same services, whether they are performed at a physician's office or a hospital-owned outpatient facility. This fix would seem like low-hanging fruit for Congress, but Congress has failed to address this small issue for a very long time.

Health care prices keep going up overall. Republican Congressman Ron Estes, captured the sense of the members: "We just can't afford to have this continued increase in prices." Substantial evidence indicates that consolidation in the healthcare marketplace is driving up costs.

Equally substantial evidence shows that consolidation is not improving quality of care. In 2022, Rand studied the data and found hospital consolidations lead to price increases of as much as **65%** percent.

To be clear, consolidation in the health care market is not happening because physicians are asking for it. In fact, most physicians don't want it. Physicians usually have no choice but to sell their practices to private equity firms and insurers if they want to continue to treat patients.

The hospitals and health systems buying physician practices want more power to secure higher prices from insurance companies and Medicare. For their part, physicians need help handling all the bureaucratic obstacles insurers impose on them. Not surprisingly, between 2005 and 2022, 15 percent more community hospitals had joined a health system, up from 53 percent to 68 percent. In the 10 years between 2012 and 2022, 12 percent more physicians moved from independent practices to working at a hospital, from 29 percent to 41 percent.

Biden Administration Advances Plan To Remove Medical Debt From Credit Scores

Americans would no longer have to worry about medical debts dragging down their credit scores under federal regulations proposed Tuesday by the Consumer Financial Protection Bureau.

If enacted, the rules would dramatically expand protections for tens of millions of Americans burdened by medical bills they can't afford.

The regulations would also fulfill a pledge by the Biden administration to address the scourge of health care debt, a uniquely American problem that touches an **estimated 100 million people,** forcing many to make sacrifices such as limiting food, clothing, and other essentials.

"No one should be denied access to economic opportunity simply because they experienced a medical emergency," Vice President Kamala Harris said Tuesday.

The administration further called on states to expand efforts to restrict debt collection by hospitals and to make hospitals provide more charity care to low-income patients, a step that could prevent more Americans from ending up with medical debt.

And Harris urged state and local governments to continue to buy up medical debt and retire it, a strategy that has become increasingly popular nationwide.

Credit reporting, a threat traditionally used by medical providers and debt collectors to induce patients to pay their bills, is the most common collection tactic used by hospitals, **a KFF Health News analysis** has shown.

Although a single unpaid bill on a credit report may not hugely affect some people, the impact can be devastating for those with large health care debts.

There is growing evidence, for example, that credit scores depressed by medical debt can **threaten people's access to housing** and fuel homelessness. People with low credit scores can also have problems getting a loan or can be forced to borrow at higher interest rates.

"We've heard stories of individuals who couldn't get jobs because their medical debt was impacting their credit score and they had low credit," said Mona Shah, a senior director at Community Catalyst, a nonprofit that's pushed for expanded medical debt protections for patients.

Shah said the proposed regulations would have a major impact on patients' financial security and health. "This is a really big deal," she said.

Administration officials said they plan to review public comments about their proposal through the rest of this year and hope to issue a final rule early next year.

CFPB researchers **have found** that medical debt — unlike other kinds of debt — does not accurately predict a consumer's creditworthiness, calling into question how useful it is on a credit report.

The three largest credit agencies — Equifax, Experian, and TransUnion — said they would stop including some medical debt on credit reports as of last year. The excluded debts included paid-off bills and those less than $500.

Those moves have substantially reduced the number of people with medical debt on their credit reports, government data shows. But the agencies' voluntary actions left out many patients with bigger medical bills on their credit reports.

A **recent CFPB report** found that 15 million people still have such bills on their credit reports, despite the voluntary changes. Many of these people live in low-income communities in the South, according to the report.

The proposed rules would not only bar future medical bills from appearing on credit reports; they would also remove current medical debts, according to administration officials.

Officials said the banned debt would include not only medical bills but also dental bills, a major source of Americans' health care debt.

Even though the debts would not appear on credit scores, patients will still owe them. That means that hospitals, physicians, and other providers could still use other collection tactics to try to get patients to pay, including using the courts.

Patients who used credit cards to pay medical bills — including medical credit cards such as CareCredit — will also continue to see those debts on their credit scores as they would not be covered by the proposed regulation.

Hospital leaders and representatives of the debt collection industry have warned that restricting credit reporting may have unintended consequences, such as prompting more hospitals and physicians to require upfront payment before delivering care.

But consumer and patient advocates continue to call for more action. The National Consumer Law Center, Community Catalyst, and about 50 other groups last year sent letters to the CFPB and IRS urging stronger federal action to rein in hospital debt collection.

State leaders also have taken steps to expand consumer protections. In recent months, a growing number of states, led by Colorado and New York, have enacted legislation prohibiting medical debt from being included on residents' credit reports or factored into their credit scores. Other states, including California, are considering similar measures.

Many groups are also urging the federal government to bar tax-exempt hospitals from selling patient debt to debt-buying companies or denying medical care to people with past-due bills, practices that remain widespread across the U.S., KFF Health News found.

Medicare Addiction Parity Project

MEDICARE ADDICTION PARITY Project

Modernizing Medicare to Treat Substance Use Disorders Comprehensively and Equitably

LAC's Medicare Addiction Parity Project was established in 2021 to improve access to substance use disorder (SUD) care in Medicare, the federal program that provides health insurance coverage to individuals ages 65 and older as well as younger individuals with long-term disabilities.

Medicare's coverage of SUD treatment is strikingly limited and out of sync with evidence-based models and the current care delivery system. Medicare does not cover the full continuum of services recognized by the American Society of Addiction Medicine, or the range of providers and the settings needed for treatment. Medicare is also not subject to the Mental Health Parity and Addiction Equity Act, which protects people with SUD and mental health conditions from discrimination. As a result, many Medicare beneficiaries receive inadequate, if any, treatment until their conditions become acute enough to require hospitalization.

With our Learning Collaborative of over 30 national organizations with a range of expertise (see full list below), the Medicare Addiction Parity Project has developed a comprehensive set of legislative and regulatory policy recommendations to strengthen Medicare to treat substance use disorders. Modernizing Medicare will meet the needs of people with SUDs, eliminate discriminatory treatment practices, and save lives.

3 Big Social Security Changes Coming in 2025 May Surprise Many Americans

Social Security will undergo several changes next year, and a recent survey suggests many Americans will be surprised by those changes.

More than 50 million retired workers received a **Social Security benefit** in April 2024. Those monthly disbursements are often their largest source of income. Indeed, a recent survey from Gallup found that 88% of retirees depend on Social Security to some degree, and 60% said benefits were a "major source" of income.

The Social Security program undergoes certain changes annually to keep benefits aligned with inflation and general wage level. Given the important role benefits play in retirement, it is imperative that beneficiaries (and soon-to-be beneficiaries) stay informed. But a recent survey from Nationwide Retirement Institute shows that many Americans misunderstand basic aspects of the program.

Here are three Social Security changes coming in 2025 that may surprise many Americans.

1. Social Security benefits will get a cost-of-living adjustment (COLA) in 2025

Nationwide Retirement Institute recently reported that 70% of surveyed adults incorrectly agreed with this statement: "Social Security is not protected against inflation." That statement is false. Social Security payments get an annual **cost-of-living adjustment** (COLA) to protect the purchasing power of benefits.

The COLA applied to benefits in any given year is based on how a subset of the **Consumer Price Index** (CPI) changes in the third quarter of the previous year, meaning the three-month period between July and September. To that end, the Social Security Administration cannot determine the official 2025 COLA until CPI data from September is published in **mid-October**.

However, based on current consumer pricing trends, The Senior Citizen League estimates that benefits will increase **2.7% in 2025**. But the nonprofit senior advocacy group has already revised its forecast higher several times due to hotter-than-expected inflation in recent months, meaning the official 2025 COLA could be higher.

However, assuming Social Security benefits do indeed get a 2.7% COLA next year, the average monthly benefit for retired workers would increase by about $51, bringing the total to $1,967.

2. Some workers will have more Social Security taxes withheld from their paychecks in 2025

According to Nationwide, 74% of surveyed adults incorrectly agreed with the following statement: "Workers pay Social Security taxes on all of their income." That statement if false. Current law caps the income subject to Social Security payroll tax. The maximum taxable earnings limit is $168,600 in 2024, meaning any income above that amount is not subject to taxation by the Social Security program.

The maximum taxable earnings limit is adjusted annually based on changes in the national average wage index. The official limit for 2025 will be published in mid-October, but the Social Security Board of Trustees estimates that the taxable maximum will be $174,900 next year. In that scenario, workers will pay up to $391 more in Social Security taxes in 2025.

To elaborate, the tax rate is generally 6.2%, meaning a worker with income exceeding $174,900 will have $10,844 withheld from their paychecks next year. But that same worker will have $10,453 withheld from their paychecks this year. The difference is $391.

3. Some Social Security recipients will have benefits withheld in 2025

According to Nationwide, 46% of surveyed adults incorrectly disagreed with the following statement: "Some of your benefits may be withheld if you're still working before your **full retirement age**." That statement is true.

Workers that receive Social Security may indeed have some of their benefit temporarily withheld if they are (1) under full retirement age and (2) their earnings exceed thresholds known as the retirement earnings test exempt amounts. There is a lower limit that applies to beneficiaries below full retirement age for the full year, and an upper limit that applies to beneficiaries that will reach full retirement age during the year.

Currently, the lower limit is $22,320 and the upper limit is $59,520. That means beneficiaries under full retirement age in 2024 will have $1 in benefits withheld for every $2 in earnings that exceed the lower limit. Similarly, beneficiaries that will attain full retirement age in 2024 will have $1 in benefits withheld for every $3 in earnings that exceed the upper limit.

The official retirement earnings test exempt amounts for 2025 will be calculated based on changes in the national average wage index and published in mid-October. However, the Social Security Board of Trustees estimates that the lower limit will be $23,280 and the upper limit will be $61,800. Put differently, benefciaries under full retirement age will be able to earn more income before benefits are withheld next year.

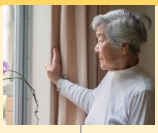
Importantly, the retirement earnings test amounts no longer matter once a Social Security beneficiary reaches full retirement age. Additionally, any benefits withheld before full retirement age are gradually repaid, such that retired workers typically recoup most or all of the money over a normal lifespan.

Does Medicare Cover the Cost of Medical Alert Systems?

Learn how to offset the cost of medical alert systems through programs and resources outside of Medicare and health insurance plans.

More than 27% of U.S. adults over age 60 live alone, according to research by the Pew Research Center. That estimate is expected to rise as more baby boomers reach retirement age.

"Many older adults are **aging in place** as technological innovations offer more vulnerable seniors the opportunity to live safely in their homes," says gerontologist Dr. Stephen Golant, an emeritus professor at the University of Florida in Gainesville, Florida.



While **independent living** offers numerous advantages, it can pose challenges during medical emergencies when quick assistance is needed. That's why medical alert systems have become so popular.

"Medical alert systems can address these risks with reliable services that can connect seniors with help, keeping them safely independent and giving family members one less thing to worry about," says Marcia Mantell, founder and owner of Mantell Retirement Consulting in Plymouth, Massachusetts.

What Are Medical Alert Systems?

Medical alert systems have been around since the 1980s when the TV commercial for Life Alert became famous with the memorable slogan: "I've fallen, and I can't get up." Since then, several newer systems are now available, including Lifeline, Medical Guardian, Mobile Help and Medical Alert.

Medical alert systems are personal emergency response devices designed to protect seniors in a home health emergency. The alert systems immediately notify emergency services and connect them with a trained operator if the person presses a help button.

Common features of medical alert systems include:

- **Fall detection.** Some devices have fall detection sensors that automatically alert emergency services or family members and caregivers **when a loved one falls**….**Read More**

The Medicare Advantage Paradox: How private insurers cost taxpayers billions

Medicare Advantage (MA) has recently reached a milestone with enrollment surpassing 30 million. The health insurance industry's trade group claims MA is beneficial for both members and taxpayers. However, recent studies and reports from the Medicare Payment Advisory Commission (MedPAC) reveal that MA overpayments have significantly burdened taxpayers.

MedPAC **estimated** that MA over payments added $82 billion to taxpayer costs in 2023 and $612 billion between 2007 and 2024. These over payments are driven by two main strategies: Diagnosis up-coding and avoiding enrollees who require costly care.

MA plans are paid based on a risk-adjustment formula incorporating diagnoses reported by insurers. This allows insurers to inflate the number and severity of diagnoses to boost revenues. Up-coding has resulted in a net over payment of 13 percent last year, despite a 5.9 percent automatic deflator applied by CMS to account for this practice.

Before risk adjustment, MA plans cherry-picked healthier enrollees and managed to drop those needing expensive care. Despite refinements in risk adjustments, MA plans continue to enroll beneficiaries who are less costly for their risk scores, shifting from any healthy older adults to those who are inexpensive for their risk scores.

MA insurers tailor networks to exclude clinicians and centers needed by high-cost patients, encouraging them to avoid MA. Expensive drugs are placed in high co-payment tiers to repel potentially unprofitable enrollees. Prior authorization requirements constrain the use of expensive care and hassle patients needing it most.

MA plans incur significant overhead costs for advertisements, network management, benefit design, executive salaries, utilization review, and shareholder profits. These costs drive their overhead up to 14%, compared to 2% for traditional Medicare. Most of the over payments go towards administrative costs and profits rather than improving patient care.

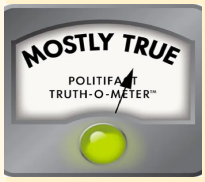
MA's managed-care techniques reduce both high-value and low-value services, potentially harming vulnerable patients. MA enrollees requiring complex surgeries are less likely to be treated at specialized centers, experiencing longer delays and higher mortality rates.

Despite efforts to control MA gaming and over payments, past reforms have largely failed. The study suggests abolishing MA and redeploying the $88 billion saved from over payments to upgrade benefits for all Medicare beneficiaries.

Dr. Adam Gaffney, assistant professor of medicine at Harvard Medical School, emphasized that "Medicare Advantage is a bad deal for taxpayers. Money that could be used to eliminate all co-payments or shore up Medicare's Trust Fund is instead lining insurers' pockets."

Wendell Potter, a former insurance executive turned critic of Medicare Advantage, advocates for its elimination, noting the program's high administrative costs and the excessive payments insurers receive. He acknowledges that while eliminating MA may be challenging due to political influence, reforming MA to address over payments and prior authorization abuses is crucial….**Read More**

Biden's on Target About What Repealing ACA Would Mean for Preexisting Condition Protections



If the Affordable Care Act were terminated, "that would mean over a hundred million Americans will lose protections for preexisting conditions."

President Joe Biden's reelection campaign wants voters to contrast his record on health care policy with his predecessor's. In May, Biden's campaign began airing a monthlong, $14 million ad campaign targeting swing-state voters and minority groups with spots on TV, digital, and radio.

In the ad, titled "**Terminate**," Biden assails former President Donald Trump for his past promises to overturn the Affordable Care Act, also known as Obamacare. Biden also warns of the potential effect if Trump is returned to office and again pursues repeal.

"That would mean over a hundred million Americans will lose protections for preexisting conditions," Biden said in the ad.

Less than six months from Election Day, **polls show** Trump narrowly leading Biden in a head-to-head race in most swing states. And voters trust Trump to better handle issues such as inflation, crime, and the economy by significant margins.

An **ABC News/Ipsos poll** of about 2,200 adults, released in early May, shows the only major policy issues on which Biden received higher marks than Trump were health care and abortion access. It's no surprise, then, that the campaign is making **those topics central** to Biden's pitch to voters.

As such, we dug into the facts surrounding Biden's claim.

Preexisting Condition Calculations

The idea that 100 million Americans are living with one or more preexisting conditions is not new. It was the subject of a back-and-forth between then-candidate Biden and then-President Trump during their previous race, in 2020. After Biden cited that statistic in a **presidential debate**, Trump responded, "There aren't a hundred million people with preexisting conditions."

A KFF Health News/ PolitiFact **HealthCheck** at the time rated Biden's claim to be "mostly true," finding a fairly large range of estimates — from 54 million to 135 million — of the number of Americans with preexisting conditions. Estimates on the lower end tend to consider "preexisting conditions" to be more severe chronic conditions such as cancer or cystic fibrosis. Estimates at the spectrum's higher end include people with more common health problems such as asthma and obesity, and behavioral health disorders such as substance use disorder or depression.

Biden's May ad focuses on how many people would be vulnerable if protections for people with preexisting conditions were lost. This is a matter of some debate. To understand it, we need to break down the protections put in place by the ACA, and those that exist separately.

Before the ACA's preexisting condition protections took effect in 2014, insurers in **the individual market** — people buying coverage for themselves or their families — could charge higher premiums to people with particular conditions, restrict coverage of specific procedures or medications, set annual and lifetime coverage limits on benefits, or deny people coverage.

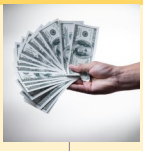
"There were a number of practices used by insurance companies to essentially protect themselves from the costs associated with people who have preexisting conditions," said **Sabrina Corlette**, a co-director of the Center on Health Insurance Reforms at Georgetown University and an expert on the health insurance marketplace.

Insurers providing coverage to large employers could impose long waiting periods before employees' benefits kicked in. And though employer-sponsored plans couldn't discriminate against individual employees based on their health conditions, small-group plans for businesses with fewer than 50 employees could raise costs across the board if large numbers of employees in a given company had such conditions. That could prompt some employers to stop offering coverage.….**Read More**

Humana and CVS will raise costs for Medicare Advantage enrollees in 2025

Humana and CVS intend to raise premiums and reduce benefits on their MA plans in 2025, reports Rebecca Pifer for **Health Care Dive**. They want to increase their profits further, even though the government already overpays them billions of dollars a year.

As many as 700,000 CVS and Humana MA enrollees could switch to other plans, and CVS and Humana don't seem to care. UnitedHealth is likely to grow its business in the process,



depending upon whether it decides to cut benefits and/or raise premiums. The insurers offering Medicare Advantage are unlikely to increase their out-of-pocket caps and their deductibles, which people with Medicare apparently care most about.

We won't know what these insurers will decide to do until October. To be clear, CVS and Humana, like all of the big insurers, are first and foremost in the Medicare Advantage business to generate profits for their shareholders. Enrollee needs are secondary. They will exit markets where they don't see good profits.

CVS, Humana and UnitedHealth all own medical provider groups. So, they are likely to continue their MA businesses in counties in which those groups have clinics and they can generate better profits.

Insurers are most likely to raise copays for specialty care, which people can't really wrap their heads around before enrolling and needing specialty care. Insurers also could cut supplemental benefits, such as money for home improvements and pet care.

The insurers have a lot of discretion, but they can't change anything they want. The government limits their ability to change "total beneficiary cost," which is limited to $40 per enrollee each month.

Scan Health plan wins suit against CMS on Medicare Advantage star ratings

If you're shopping for a Medicare Advantage plan, you might look at the number of stars the government has given it. Any Medicare Advantage plan with fewer than four stars should be avoided. But, **a plan with four or five stars might also not meet your needs**.

The government awards four and five stars to Medicare Advantage plans with high denial rates and high mortality rates. Plans with excessive rates of prior authorization requirements can also get four or five stars. And, of course, you want to avoid those plans.

Because the Medicare Advantage star ratings are terribly misleading, the star-rating program needs an overhaul. But, the insurers have so much power that it might never happen. The Centers for Medicare and Medicaid Services (CMS) tried to adjust star ratings to better capture quality, and Scan Health Plan sued, claiming that it did so inappropriately. Emily Olsen reports for **Healthcare Dive** on Scan's recent legal victory, preventing the government from giving it a 3.5 star-rating and reducing payments to Scan by $250 million.

Currently, CMS awards star-ratings based on enrollee complaint rates and hospital readmission rates, among other factors. Those plans with a four or five-star rating get tens of millions of dollars in additional funding from CMS. Moreover, even if an insurers' score drops a lot, CMS can't change the rating significantly from one year to the next.

Scan is not the only insurer to sue CMS over the star-rating calculations. Elevance also brought a lawsuit that a judge has yet to rule on. CMS has no comment.

The best thing about the star-rating system is that it requires CMS to drop contracts with plans that have a star rating of three stars or less for three years running. It's a non-discretionary penalty. Politics can't get in the way.

But, unless CMS can change the star-rating program significantly and include important data in the metrics, which it currently excludes, the star-rating program is of little value. In fact, it's terribly misleading. People mistakenly believe that if they enroll in a Medicare Advantage plan with a four or five-star rating, they will get the care they need.

Thousands of Disabled Workers Removed From Social Security Benefits

The number of disabled workers who received Social Security benefits fell by about 20,000 in May compared to the prior month, data from the Social Security Administration revealed.

There were 7.25 million disabled workers who were beneficiaries of Social Security benefits in April. In May, that number ticked down slightly to about 7.23 million. In percentage terms, it was unchanged between the months with both May and April having about 11 percent of recipients being disabled workers. Those workers received on average about $1,540 a month in support from the government.

It was not immediately clear why the number of disabled workers who are recipients of benefits from the agency fell in May.

Newsweek contacted the Social Security Administration for comment via email on Friday.

"I don't know for certain, but I would imagine it's a combination of people being moved from disability to retirement benefits, people passing away, or people no longer qualifying for benefits," Burt Williamson, a retirement specialist with PlanPrep, told *Newsweek*. "The latter of the three is probably the least likely."

In the past, those who received benefits as disabled workers had their benefits terminated typically if they fit into any four categories set out by the agency.

Conversion to the retirement program (that is, attainment of full retirement age), death, medical recovery, and work recovery. In addition, benefits to disabled widow(er)s and disabled adult children can be terminated for marriage or for entitlement to a larger benefit," the agency noted.

Meanwhile, there could be different ways of judging whether benefits were terminated in the Supplemental Security Income (SSI).

"For blind and disabled adults in the SSI program, there is no conversion to the aged category at age 65; the disability designation continues although medical recovery is no longer an issue after the age of 65. There is no termination for substantial gainful activity in the SSI program," the SSA has said.

The agency added: "SSI disabled children are subject to a redetermination at the age of 18, during which an assessment is made as to whether they meet adult disability standards. Nearly one in three SSI children is terminated at the age of 18 for not meeting the adult standards."

Looking at the overall data from the agency, May saw more people come into the benefits program, with the increase seemingly coming from those who receive retirement benefits.

There was a total of 72.35 million beneficiaries of support from the agency in May, an uptick from April's 72.23 million. Social Security benefits alone made up about 65 million recipients last month, with about 4.9 million who got Supplemental Security Income. Those that got both came to 2.5 million.

The prior month, the beneficiaries of Social Security were at 64.8 million, SSI recipients were at 4.92 million and both came out to 2.5 million.

RI ARA HealthLink Wellness News

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

HealthLink Wellness "Taking Control"

Another Study Finds Lung Cancer Screening Saves Lives

Lung cancer patients who underwent screening were more apt to be diagnosed at earlier stages and have better outcomes than patients who were not screened, new research shows.

The findings — from a **study** of close to 58,000 patients diagnosed through the U.S. Veterans Health Administration — underscore the importance of early detection through screening.

Lung cancer is the No. 1 cancer killer worldwide.

Current recommendations urge annual screening for 50- to 80-year-olds with a history of smoking a pack a day or more for the last 20 years or two packs a day for the last 10.

Clinical trials have shown screening with computed tomography (CT) scans to be beneficial, but real-world data have been scarce.

This study of U.S. veterans gauged the impact of screening prior to a lung cancer diagnosis. Researchers found that patients who were screened had higher rates of early stage cancer diagnoses than those who were not screened — 52% versus 27%.

Over five years, they also had lower rates of premature death from any cause (49.8% versus 72.1%) as well as death from cancer (41% versus 70.3%).

"It is incredible to witness how dedicated national efforts to increase lung cancer screening from the Lung Precision Oncology Program can lead to substantial improvements in lung cancer outcomes," said co-author **Dr. Michael Green** of the University of Michigan and the Veterans Affairs Ann Arbor Healthcare System.

The findings were published June 10 in the journal ***Cancer***.

Depression Could Take Toll on Memory With Age

Depression and memory declines may be closely linked in older people, new research suggests.

"Our study shows that the relationship between depression and poor memory cuts both ways, with depressive symptoms preceding memory decline and memory decline linked to subsequent depressive symptoms," said senior study author **Dr. Dorina Cadar**, of University College London.

The study suggests that effective **depression** treatment could help preserve memory function with age, she added in a university news release.

The new findings come from an analysis of data from the ongoing English Longitudinal Study of Ageing, where people are tracked by questionnaires every two years.

In this sample, 16 years of data were collected from nearly 8,300 adults averaging 64 years of age.

In contrast to the finding that memory and depression were closely intertwined, the research did not show a strong relationship between depression and another marker of brain health, verbal fluency.

Cadar, who is a research fellow in dementia at UCL, said it's not surprising that battles with depression could affect memory over time.

"Depression can cause changes in brain structures, such as the hippocampus, which is critical for memory formation and retrieval," she explained. "Chronic stress and high levels of [the stress hormone] cortisol associated with depression can damage neurons in these areas."

The researchers also believe that depression upsets the balance of serotonin and dopamine in the brain, and disrupts the brain's ability to repair and reorganize vital connections.

Memory troubles might also be linked to the tendency in depression to ruminate -- repeatedly thinking about certain things or dwelling on negative feelings.

On the flip side, a life spent dealing with memory lapses could trigger insecurity, frustration and other feelings that can be triggers for depressive episodes, Cadar's group reasoned. Memory troubles might also lead one to more social isolation.

"These findings underscore the importance of monitoring memory changes in older adults with increasing depressive symptoms, to identify memory loss early and prevent further worsening of depressive function," said study lead author **Jiamin Yin,** who has since graduated from UCL and is now a doctoral student at the University of Rochester in New York.

So, if and when depressive symptoms arise, it is "critical" to treat them to prevent folks "from developing depression and memory dysfunction," Yin said.

FDA Tells Vaccine Makers to Target New COVID Variant for Fall

COVID vaccine makers will be advised to update their shots to target the KP.2 variant, an offshoot of the JN.1 variant that spread widely last winter, the U.S. Food and Drug Administration announced Thursday.

It's a turnaround for the agency: The **new recommendation** follows an FDA advisory panel vote last week that unanimously recommended COVID vaccines target the older JN.1 variant this fall.

Following that vote, panel members and **Dr. Peter Marks**, the agency's top vaccine regulator, differed on which variant the agency should choose to target. Most panel members chose JN.1, while Marks preferred selecting a newer strain, such as KP.2.

"We are paying an incredibly high premium for mRNA vaccines to be able to have the freshest vaccines," Marks said at the time.

Although the FDA said it first advised vaccine makers to target JN.1, the most current data, along with a recent rise in COVID cases, suggests the preferred variant for the updated vaccines to target is now the KP.2 strain, the FDA said.

"[The] FDA has communicated this change to the manufacturers of the licensed and authorized COVID-19 vaccines," the agency added. "The agency does not anticipate that a change to KP.2 will delay the availability of the vaccines for the United States."

JN.1 has largely fallen out of circulation in the United States, according to the **U.S. Centers for Disease Control and Prevention**. KP.2 now accounts for 22.5% of new COVID cases in this country while KP.3, a sister variant, is fueling 25% of new cases.

Three drugmakers produce COVID vaccines: Pfizer, Moderna and Novavax. Pfizer's and Moderna's vaccines are mRNA-based, while Novavax's is protein-based. Because protein-based vaccines take much longer to manufacture, Novavax has indicated it won't be able to make a KP.2 vaccine in time for the fall, *NBC News* reported. Instead, it plans to distribute a JN.1 vaccine, which it had already been producing….**Read More**

Moving Off the Couch Brings Healthy Aging: Study Finds Benefit

It's tempting to binge-watch TV, but yet another study finds that when it comes to healthy aging, the less time on your sofa, the better.

The study looked at 20 years of data on more than 45,000 people taking part in the Nurses' Health Study. All were at least age 50 in 1992 and free of chronic disease when they entered the study.

Researchers tracked lifestyle habits like time sitting at work, home and watching television, as well as their hours at home or work spent standing or walking at home. All that data was compared to information on how healthily (or not) they had aged over time.

What defined "healthy aging"? According to the team from Harvard's T.H. Chan School of Public Health, it meant living to be 70 plus having no major chronic diseases, no impaired memory, and overall good physical and mental health.

One activity -- watching TV while sitting -- seemed particularly unhealthy, the researchers found.

"Replacing television time with light physical activity, moderate to vigorous physical activity, or sleep [in participants with inadequate sleep] were associated with better odds of healthy aging," wrote a team led by Dr. Molin Wang, an associate professor of medicine in the department of epidemiology at Harvard.

More specifically, every hour per day where sedentary TV watching was replaced by even "light" physical activity in the home (for example, routine housework) upped a person's odds of living to a healthy 70 or beyond by 8%.

If that hour of TV watching was replaced by "moderately vigorous" physical activity (for example, a workout), the odds of healthy aging rose by 28%, the study found.

Even folks who got less than the recommended seven hours of **sleep** per night gained a benefit in healthy aging if they got an extra hour of sleep each day instead of an hour spent watching TV from their sofa.

The findings were published June 11 in the journal ***JAMA Network Open***.

Speaking with *CNN*, **Dr. Andrew Freeman**, director of cardiovascular prevention and wellness at National Jewish Health in Denver, said TV watching appears to be a particularly unhealthy pursuit -- and not just because you're not moving around.

"When people sit in front of TV, it usually brings all these other co-morbid activities, like eating junk food, TV dinners, failing to connect with others, and it even can interrupt sleep," Freeman noted. He wasn't involved in the new study.

And exercise -- any way you can get it and for any length of time -- can turn all that around. It's "truly an unbelievable way to reduce cardiovascular risk and blood pressure," Freeman said.

"My very strong suggestion is you should consider at work getting a standing desk if you can, or even a treadmill desk if you're able and you have the space," Freeman said. "If you're sitting down for more than 30 minutes at a time, in my book, that's probably too long, and you really want to try to move a little bit

Medicare Advantage insurers increasingly use step therapy for cancer drugs, delaying care

A study by Avalere reveals that health insurers are increasingly delaying and denying drugs to cancer patients through the use of step therapy, reports Noah Tong for **Fierce Healthcare**.

The American Cancer Society Cancer Action Network (ACSCAN) released **a paper** that demonstrates Medicare Advantage insurers are weaving step therapy into their prior authorization requirements. Sometimes, enrollees don't even realize it.

Some say that requiring prior authorization for cancer drugs helps ensure safety. Prior authorization can also save patients money. But, what the Medicare Advantage insurers are doing is troubling. Patients and doctors are too often unaware of what the insurers are requiring. In particular, delays in treatment are concerning.

Kisqali and Verzenio are two breast cancer drugs for which Medicare Advantage insurers often require step therapy. One concern is "embedded step therapy," which could hide an insurer's use of step therapy. It might not be included in an insurer's Part D list of covered drugs.

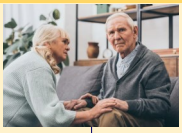
In the year between 2023 and 2024, overall, Medicare Advantage insurers used step therapy more often for breast cancer drugs and hepatocellular carcinoma, according to the **American Cancer Society**. Medicare Advantage insurers required step therapy as much as 95 percent of the time. They did not appear to require it for biosimilar drugs Kanjinti and Trazimera.

The bigger insurers tend to require step therapy more of the time than the smaller insurers. If the issue is truly safety, they should be using step therapy with the same frequency.

To date, the Centers for Medicare and Medicaid Services, CMS, which oversees the Medicare Advantage plans, has allowed insurers to decide for themselves when to use prior authorization. Some use it a lot more than others, at times **delaying and denying urgently needed care inappropriately**.

Prior authorization determinations should be standardized across all Medicare Advantage plans. Without standardization, people cannot meaningfully distinguish among MA plans. Moreover, MA plans can wrongly deny or delay care with little if any accountability.

Inherited Alzheimer's: Whether It's From Mom or Dad Could Matter



Genetics can play a role in a person's odds for **Alzheimer's disease,** and new research suggests differences in that risk are based on which parent had the illness.

In a study of 4,400 people still "cognitively unimpaired," there was higher buildup of amyloid protein plaques in the brain (a hallmark of Alzheimer's) if either the person's mother, or both parents, had Alzheimer's, compared to folks where Alzheimer's had only struck the father.

People with an Alzheimer's-affected mother may therefore be at special risk, said a team from Mass General Brigham, in Boston.

"Maternal inheritance of Alzheimer's disease may be an important factor in identifying asymptomatic individuals for ongoing and future prevention trials," said study co-author **Dr Reisa Sperling**, a neurologist at Mass General.

The findings were published June 17 in the journal ***JAMA Neurology***.

The study was based on data from a clinical trial focused on Alzheimer's prevention. People in the study were asked about whether or not either of their parents had ever been diagnosed with Alzheimer's disease, and when their parent's memory began to fail. Sperling and colleagues then compared those answers to levels of amyloid in people's brains.

Having had a father who developed Alzheimer's symptoms relatively late in life did not seem to be related to levels of amyloid in people's brains, the research showed.

However, there was a correlation between the accumulation of brain plaques and having had a mother whose Alzheimer's symptoms began at any age, or having a father whose symptoms began relatively early, the team reported….**Read More**

There's Another 'Magic' Mushroom Being Sold in Gummies -- But It Can Kill

Growing public fascination with "magic" psilocybin mushrooms as a trendy treatment for depression had led to increased interest in another type of psychedelic mushroom, a new study reports.

Unfortunately, this second sort of shroom -- known as *Amanita muscaria* -- can be more toxic than fentanyl, cocaine and PCP, researchers say.

Marketing the two types of mushrooms as essentially the same is not only wrong, but potentially dangerous, said senior researcher **Eric Leas**, an assistant professor in the University of California, San Diego's Herbert Wertheim School of Public Health and Human Longevity Science.

"Companies who are making these products are pushing the limits of our regulations. They are getting away with making a buck until someone tells them they can't," Leas said in a university news release.

"Given the substantial risks associated with using *Amanita muscaria* products, it is a buyer-beware marketplace where consumers are at risk and are not accurately informed," Leas added. "The time for a public health first response is now."

Google searches for *Amanita muscaria* mushrooms skyrocketed 114% between 2022 and 2023, researchers reported June 10 in the ***American Journal of Preventive Medicine***.

Gummies and chocolates containing compounds derived from *Amanita muscaria* mushrooms -- muscimol and ibotenic acid -- are being marketed as aids to reduce anxiety, depression and other conditions, researchers say.

Amanita muscaria mushrooms have psychedelic effects similar to psilocybin mushrooms, producing feelings of weightlessness, hypersensitivity to sights and sounds, distortions of space, unawareness of time and colored hallucinations.

But *Amanita muscaria* mushrooms act upon the brain and body in ways that are very different than psilocybin, researchers said.

Psilocybin is an antidepressant that works on serotonin receptors in the brain, activating pathways that mediate happiness and optimism.

On the other hand, *Amanita muscaria* is a depressant that suppresses the central nervous system, similar to alcohol and benzodiazepines, researchers said.

Ingestion of raw *Amanita muscaria* mushrooms has been known to cause dizziness, muscle spasms, loss of coordination, agitation, seizures, coma, and, in rare cases, death, researchers said.

Last year, a 44-year-old man died after ingesting four dried Amanita muscaria mushroom caps, researchers noted in their paper….**Read More**

AMA, lawmakers aim renewed prior authorization crackdown on insurers

The American Medical Association (AMA) and a bipartisan group of Congressional leaders are looking to stop unfair prior authorization practices from health plans.

Introduced by Rep. Suzan DelBene (D-Washington), the **Improving Seniors' Timely Access to Care Act** (PDF) is intended to modernize prior authorization in Medicare Advantage (MA). It is sponsored by 130 members from the House and 42 Senators.

"We've made important incremental headway in helping seniors get the medical care they deserve with the administration's prior authorization regulations," said DelBene in a statement. "However, we must go further and enshrine these advancements into law."

She said prior authorization burdens physicians and patients with long delays and unfair denials.

The bill, which unanimously passed the House in September 2022, would standardize the prior auth process for MA plans, mandate improved transparency and codify deadlines on prior auth decisions.

The new legislation obtained approval from the AMA and other industry groups such as Premier, MGMA, the Better Medicare Alliance and the American Academy of Family Physicians (AAFP). More than 370 organizations support the legislation, a list shared by DelBene shows.

"Modernizing prior authorization for Medicare Advantage patients is vital to reducing the delayed care, harm and costs, which are the legacy of an antiquated process requiring faxes and phone calls in time-sensitive clinical situations," said Soumi Saha, senior vice president of government affairs for Premier, in a statement.

"The average physician spends two business days completing prior authorizations," explained AAFP President Steven Furr, M.D. "The impacts on patient care are jarring, with nearly 97% of physicians reporting that their patients experienced delays or denials for medically necessary care due to prior authorization requirements."

"We think this is the year to get this bill over the finish line," said AMA President Bruce Scott, M.D.

Insurers, however, say prior auth policies are important tools in reducing costs and ensuring care is both medically necessary and safe, but plans increasingly face backlash for restrictive requirements.

Some payers support the proposal, including Humana.

"We are encouraged that the bill promotes expediting approvals of care through greater adoption of electronic prior authorization, which has been demonstrated to improve health outcomes and reduce costs for patients," said Humana Chief Medical Officer Kate Goodrich, M.D., in a statement shared with Fierce Healthcare…. **Read More**

There May Be 6 Types of Depression, and Brain Scans Can Sort Them Out

Depression can be sorted into six distinct types using brain scans, a revelation that could improve treatment for many suffering the debilitating mood disorder.

Researchers analyzed brain scans to identify six different biological types of **depression**, based on differences in patterns of brain activity, according to results published June 17 in the journal *Nature Medicine*.

These differences allowed researchers to single out the potentially best treatments for three of the depression types, results show.

"To our knowledge, this is the first time we've been able to demonstrate that depression can be explained by different disruptions to the functioning of the brain," said senior researcher **Leanne Williams**, director of Stanford Medicine's Center for Precision Mental Health and Wellness.

"In essence, it's a demonstration of a personalized medicine approach for mental health based on objective measures of brain function," Williams said in a Stanford news release.

If these findings hold, people diagnosed with depression could one day undergo a brain scan to reveal the treatment that would best work for them.

About 30% of people with depression don't respond at all to either medication or talk therapy, and as many as two-thirds find that treatment isn't able to fully quell their depression.

That's in part because up to now there's been no good way to know which antidepressant or type of therapy would most benefit any particular patient, researchers said.

Drugs are prescribed through a trial-and-error method, so it can take months or years to land on one that works. In the meantime, the grinding process can make a person's depression even worse….**Read More**

Kidney Trouble Could Mean Tooth Loss for Older Women

Older women with chronic kidney disease might wind up losing so many teeth they aren't able to chew and talk effectively, a new study warns.

Postmenopausal women with kidney disease are about 40% more likely to have fewer than 20 teeth, the minimum number needed to adequately chew and speak, researchers reported June 12 in the journal ***Menopause***.

This sort of tooth loss is also associated with an increased risk of stroke and other systemic illnesses like diabetes, thyroid disease and osteoporosis, researchers noted.

"Our findings suggest that preventing and managing mineral and bone metabolism disorders in postmenopausal women with chronic kidney disease are crucial to prevent tooth loss," concluded the research team led by **Dr. Ki-Ho Chung**, an associate professor with Chonnam National University School of Dentistry in South Korea.

The kidneys play a critical role in health by filtering waste products and toxins from the blood, researchers explained in background notes.

Kidney function tends to decrease after menopause, and is associated with declining levels of female hormones in women who've gone through menopause.

For this study, researchers analyzed health records for nearly 65,000 South Korean women ages 40 to 79.

They found that the ability of the kidneys to effectively filter blood is associated with the number of teeth a woman has in her mouth.

Adults have 32 permanent teeth, but women with poorly functioning kidneys were at increased risk of having fewer than 20, results show. This was particularly true in women ages 66 to 79.

Researchers noted that chronic kidney disease can significantly affect bone health and mineral metabolism, both of which can contribute to tooth loss.

Inflammation and decreased salivation caused by kidney disease also could promote tooth loss, they added. Salivation is important to **dental** health, while inflammation plays a role in gum disease and bone health.

"This study highlights the known link between chronic kidney disease and bone metabolism," said **Dr. Stephanie Faubion**, medical director for The Menopause Society.

"Increased attention to oral and bone health is warranted in postmenopausal women with chronic kidney disease, in addition to meticulous efforts aimed at preserving kidney function. Conversely, oral health is a window to overall health, and good oral hygiene is important for women of all ages," Faubion added in a society news release.

Protect Your Eyes From Summer's Dangers

Summertime is primetime for the great outdoors, but that can mean new hazards for your eyes, one expert warned.

Simple steps can help cut the risk, said ophthalmologist Dr. Masih Ahmed, an assistant professor of ophthalmology at the Baylor College of Medicine in Houston.

Out in the sun

This one has an easy fix: Sunglasses. According to Ahmed, strong sunlight can lead to what's known as pterygium, growths within the eye and UV (ultraviolet) light has been linked to upped risks for early cataracts, worsened **macular degeneration** and even cancer of the eyelid.

In a Baylor news release, he said that "when choosing the right sunglasses, make sure the lenses are 100% UV blocking, ideally wrapping around the face to avoid light protruding from the sides. UV-blocking sunglasses with full coverage over the eyes is key."

Polarized lenses can also help, since they help cut down on glare -- especially useful when you're out on the water.

Sunscreen and your eyes

The **American Cancer Society** currently recommends a broad-spectrum sunscreen with SPF 30 or higher, reapplied at least every 2 hours. Wearing hats and long-sleeved shirts can also help, and seek out shade if possible.

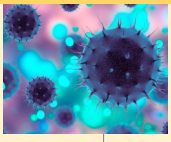
"In warm temperatures where sweating is inevitable, find a sunscreen that does not run when you sweat to avoid getting it into the eyes," according to Ahmed. "If sunscreen gets in your eye, rinse it out with sterile saline or fresh water to irrigate it. The irrigation process might be uncomfortable, but it will help wash out the sunscreen."

Swimming dangers

A jump in a pool, a lake or the ocean is so welcome on a hot day. But bacterial, fungal and other infection dangers can lurk in the water.

According to Ahmed, your eyes' best defense are swim goggles….**Read More**

'Dual Mutant' Seasonal Flu Virus Could Make Some Treatments Ineffective



Two human cases of "dual mutant" strains of H1N1 flu have been reported by U.S. health officials.

Unfortunately, the genetic changes appear to render the leading flu antiviral, **Tamiflu**, less effective, researchers from the U.S. Centers for Disease Control and Prevention noted.

The new analysis, published Wednesday in the agency's ***Emerging Infectious Diseases*** journal, describes these two concerning mutations -- which scientists have dubbed I223V and S247N.

The latest finding follows a report published last March in the *Lancet* journal by Hong Kong scientists that found the two mutations seemed to raise resistance to the flu treatment oseltamivir (Tamiflu).

Lab tests found the mutated flu viruses were up to 16 times less sensitive to the antiviral, a smaller drop-off than in some previous worrying mutations, reported researchers led by **Mira Patel**, a senior scientist at the CDC.

Still, the agency isn't hitting the panic button at this point.

"These mutated viruses retained sensitivity to other anti-influenza medications, including a newer one, **baloxavir marboxil**. There are no immediate implications to change decisions for clinical care," a CDC spokesperson told *CBS News,* and vaccination still offers protection against mutated viruses.

Despite the "rapid spread of dual mutants to countries on different continents," the CDC report added that these new flu strains are still rare for now.

Since they were first spotted in a case sampled from the Canadian province of British Columbia in May 2023, 101 sequences have been submitted to the global virus database GISAID from Africa, Asia, Europe, North America and Oceania, *CBS News* reported.

The two U.S. cases were detected by labs at the Connecticut Department of Health and University of Michigan this past fall and winter.

"It is unknown how widely these mutated viruses will circulate in the upcoming season. It is important to continue monitoring the spread of these viruses and the evolution of these viruses," the CDC spokesperson said.

Tamiflu is the most commonly prescribed flu treatment, according to the CDC. A study published in the journal ***Pediatrics*** last year found the drug made up 99.8% of flu antivirals prescribed to kids.

Doctors have also turned to Tamiflu to treat humans infected during an ongoing outbreak of **bird flu in dairy farms** this year, *CBS News* reported.