

June 25, 2023 E-Newsletter



Message from the Alliance for Retired Americans Leaders

New House Republican Budget Plan Raises Social Security Retirement Age, Privatizes Medicare



Robert Roach,
President, ARA

The Republican Study Committee (RSC) just released a new budget plan that includes devastating cuts and changes to

Social Security and Medicare. It also repeals the portions of the Inflation Reduction Act that lower drug prices, including requiring Medicare to negotiate with drug corporations.

The plan raises the Social Security retirement age — beginning in 2026, people 59 years of age would see an increase in the retirement age of 3 months per year, ultimately raising the full retirement age from 67 to 69 for people born in 1971 or later. Guaranteed Medicare benefits would be replaced with a "premium support" plan, meaning seniors would be given a coupon to put toward the cost of purchasing a private insurance plan. People who qualify for Social Security disability payments would have to wait five years, rather than two, to receive Medicare benefits.

The RSC budget's tax cut would make the individual tax cuts in the 2017 tax code overhaul, currently scheduled to expire after 2025, permanent. The Congressional Budget Office (CBO) estimates this would add \$2.5 trillion to the deficit over the next 10 years.

"We cannot allow this cruel budget to become a reality. It takes away the benefits we earned over a lifetime and gives massive handouts to wealthy corporations and the richest Americans," said **Robert Roach, Jr., President of the Alliance**. "Retirees must lead the fight against anyone who goes after our Social Security and Medicare benefits and wants drug prices to be even higher than they are today."

Study: Medicare Advantage Overpayments are Far Higher than Estimated



Rich Fiasta,
Executive
Director, ARA

More seniors are choosing private Medicare Advantage (MA) plans over traditional Medicare, but overpayments to the private insurance companies running those plans now exceed \$75 billion per year. Researchers with the USC Schaeffer Center for Health Policy & Economics found that the overpayments are due to the way patients' health conditions are coded by the insurers.

The report suggests overhauling the current payment formula that links private plan rates to average spending by traditional Medicare beneficiaries. Another option would be to institute competitive bidding by Medicare Advantage plans to determine what insurers are paid. "We simply cannot afford to let insurance corporations overcharge Medicare year in and year out," said **Richard Fiasta, Executive**

Director of the Alliance.

"We urge the U.S. Department of Health and Human Services (HHS) to hold these corporations accountable and return overpayments to the Medicare program."

Drug Corporations Must Pay Penalties for Hiking Prices on 43 Drugs Excessively



Joseph Peters
ARA
Sec.-Trea.

President Biden's Inflation Reduction Act includes a provision that penalizes drug makers for charging prices that rise faster than inflation for people on Medicare.

Now, drug corporations will pay finest to Medicare for hiking the price of 43 drugs.

Biden announced in March that his administration would subject 27 drugs to inflation fines for the second quarter of this year. The new list of 43 replaces that selection for the third quarter of 2023.

The list of drugs for the third quarter includes — for the second time — AbbVie's arthritis drug Humira and Seagen's targeted cancer therapy Padcev.

The Inflation Reduction Act's Medicare Prescription Drug Inflation Rebate Program is one of the many important tools Medicare now has to address rising drug costs. By reducing coinsurance for some people with Part B coverage and discouraging drug companies from increasing prices more briskly than inflation, HHS can lower out-of-pocket costs for some people with Medicare and reduce Medicare program

spending for costly drugs.

"People who take these drugs may save between \$1 and \$449 per average dose between July 1 and September 30 of this year, depending on their individual coverage," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "Each day more people are getting relief from high drug prices thanks to the Inflation Reduction Act."

Also, this week, the Biden-Harris Administration announced new tools to lower prescription drug costs for low-income people with Medicare through the Extra Help program.



Beginning January 1, 2024, eligible seniors and people with disabilities will benefit even more

through the expansion of the program. People with Extra Help who currently have partial benefits will be newly eligible for full benefits, meaning they will pay no deductible, no premium, and fixed, lower copayments for certain medications. This could save nearly \$300 per year, on average, according to estimates.

Up to 3 million seniors and people with disabilities could benefit from the Extra Help program now but aren't currently enrolled.

ADD
YOUR
NAME

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

Rhode Island Alliance for Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381

riarajap@hotmail.com • <http://www.facebook.com/groups/354516807278/>

Can You Drop Medicare Part A?

Peter contacted my company about his situation recently. He is 68 years old and still working. He enrolled in Part A two years ago because his company's group health plan was terrible. He was probably going to need surgery and the hospital deductible was outrageous (his words). He changed jobs recently and his new employer's policy is much better. He wants to set up a Health Savings Account (HSA). So how can he drop Part A?

This isn't the first time I've been asked this question. Let's start with some basics.

- ◆ Part A, hospital insurance, is premium-free for those who have worked and paid taxes for at least 10 years (40

credits) or have a spouse who has.

- ◆ Those who do not have 40 credits can purchase Part A and pay monthly premiums. Individuals who have earned at least 30 credits pay \$278 every month and those with fewer than 30 pay \$506.
- ◆ This part of Medicare covers four services: inpatient hospitalization, skilled nursing facility stays, home health care, and hospice care. In Peter's situation, Part A is the secondary payer to Medicare. It may provide additional coverage and help with costs up to the Part A limits.
- ◆ Once enrolled, an individual is



no longer eligible to contribute to an HSA, which is why Peter wants to disenroll from Part A.

- ◆ My answer to his question about dropping Part A was probably not one Peter wanted to hear. Unfortunately, there is nothing he can do. According to the Centers for Medicare and Medicaid Services (CMS), "Individuals entitled to premium-free Part A cannot voluntarily terminate their Part A coverage. This is not permitted by law." In other words, only those who pay a premium for Part A can disenroll.

When I shared this, Peter pushed back. The human resources director at his company gave him a form to complete. The form is titled, "[Request for Termination of Premium Part A, Part B, or Part B Immunosuppressive Drug Coverage.](#)" The instructions note:

- ◆ Who can use this form? People with *Medicare premium Part A* or B who would like to terminate their hospital or medical insurance coverage.
- ◆ Use this form: If *you have premium Part A* or Part B but wish to no longer be enrolled. Peter has premium-free Part A and, by law, he cannot terminate Part A....[Read More](#)

Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments

Rapid growth in Medicare Advantage (MA) has led to almost equal numbers of Medicare beneficiaries in 2023 receiving benefits from MA plans and from traditional fee-for-service (FFS). But MA rates paid to plans are based on spending by FFS beneficiaries, resulting in Medicare overpaying MA plans by 6% (\$27 billion) in 2023 alone, according to the Medicare Payment Advisory Commission (MedPAC). Overpayments were due primarily to "coding intensity" (\$23 billion) and Star Rating (quality) bonuses. Importantly, the MedPAC overpayment estimate does not include the effects of favorable selection into MA, but favorable selection likely generates a larger

magnitude of overpayment.

This paper analyzes the degree of biased selection associated with beneficiaries choosing to switch from FFS to an MA plan by studying MA enrollees in 2020 who switched from FFS during annual open-enrollment periods (which come late in the year) in 2006-2019 and comparing them with those who remained in FFS. Applying the CMS risk adjustment model to the differing diagnoses and demographics of the 402 million FFS beneficiary years in 2006-2019, we found that switchers had substantially lower risk-score-adjusted expenditures in the year that they made the election to



switch than beneficiaries who remained in FFS. For each of the 14 years, the odds of switching to MA were consistently higher for FFS beneficiaries with

lower risk-score-adjusted expenditures, with the likelihood of switching diminishing as expenditures increase.

The persistent migration of FFS beneficiaries with below-average, risk-score-adjusted expenditures to MA generates overpayments because the capitation amounts paid to MA plans assume these FFS beneficiaries have average expenditures. Focusing on those who switched from FFS to MA plans from 2015 through 2019, we estimate that these distortions in payment rates led to

overpayments on the order of 14.4%, with sensitivity analysis suggesting the estimate remains relatively stable under alternative assumptions. This favorable selection into MA makes the current approach of basing MA payments on FFS increasingly problematic and costly to the government, increasing annual overpayments in 2023 from the \$27 billion estimated by MedPAC to \$75 billion or more. Reform options can attempt to substantially improve the relationship between FFS expenditures and MA payments or delink MA payments from FFS spending, potentially through competitive bidding limited to MA....[Read More](#)

Can we fix our broken health care system without reining in costs?

Aaron Carroll writes for the [New York Times](#) about how to fix our broken health care system. Notwithstanding all the ways the Covid-19 pandemic exposed fissures in our health care system, along with more than one million deaths, Congress is doing precious little to address uninsurance and underinsurance and their consequences for our health and well-being. Carroll studied health systems in five other countries to appreciate differences, and suggests universal health care is a solution, whatever it looks like, but he

doesn't see health care costs in the US as a stumbling block.

We spend more per person on health care than any other country, and health outcomes are generally significantly worse, including life expectancy. So, what does the United Kingdom, France, Australia and New Zealand do differently? They all guarantee health care coverage to their citizens. Carroll says that in every other significant way they each do things differently.



Carroll fails to recognize that these countries not only share guaranteed universal coverage, but a system that sets prices for

most health care goods and services. It's that combination, along with significant restrictions on insurance company profits, that makes health care affordable for their citizens.

Australia, New Zealand and Canada all offer government-provided coverage, sometimes called single-payer. Australia and New Zealand's single-payer systems allow people to buy

private insurance to improve their access to care. Canada does not allow that. Australia's system requires people to contribute significantly to the cost of their care.

Carroll says France's system is not quite single-payer because people get their coverage through different systems. But, it is primarily with government funding either through their jobs or some other means. France requires people to pay upfront for their outpatient care and then reimburses them for the cost....[Read More](#)

Bernie Sanders blasts drug manufacturers for the “unconscionable” price of Alzheimer’s drug

CNBC.com **reports** that Senate HELP committee chair, Bernie Sanders, is blasting drug manufacturers Eisai and Biogen for setting the price of its Alzheimer’s drug at a level that will prevent people with Medicare from being able to get it. He wants the US Department of Health and Human Services to lower the price of Leqembi down from its “unconscionable” current price of \$26,500 a year.

Like Aduhelm, Leqembi is a prescription drug administered by a physician and therefore covered under Medicare Part B. Medicare covers 80 percent of the cost, and individuals must pay 20 percent coinsurance. People’s annual out-of-pocket costs for Leqembi alone would be more than \$5,000, unless they have Medicare supplemental coverage.

Right now, the price of Leqembi will drive up Medicare Part B premiums significantly. It will also contribute to the erosion of the Medicare Trust Fund. Medicare will be spending more than it spent on the three most costliest Part B drugs in 2021. And, though the government has the right to negotiate drug prices for the Part B and D drugs it spends the most on, it could not negotiate the price of Leqembi for 13 years,

given restrictions on drug price negotiation in the Inflation Reduction Act.

As I **wrote earlier this year** when the FDA approved Leqembi, “Keep in mind that after the FDA approved Aduhelm, the government adjusted the Medicare Part B premium up \$11 a month! Its list price was \$56,000 a year, and the government assumed hundreds of thousands of people would take it. Thankfully, Medicare did not end up covering it. And, this year, the standard Part B monthly premium is down \$5.20 because the government adjusted it to account for the fact that Medicare is not covering Aduhelm.”

Sanders wants manufacturers to voluntarily reduce Leqembi’s price. If not, he wants the US Department of Health and Human Services to use its authority to break the drug’s patent in order to drive competition in the market. Sanders also suggests that the Centers for Medicare and Medicaid Services (CMS) has the authority to pay less for Leqembi. It is possible, though not likely, that a similar Eli Lilly drug, **donanemab**, that has not yet gone to market will help drive down Leqembi’s price.



How many people with Medicare would get Leqembi? We don’t yet know how many people with Medicare will take it. Leqembi. Medicare is covering it for “patients with mild cognitive impairment or mild dementia with confirmed amyloid plaques,” which could be a large cohort of the 6.7 million people with Alzheimer’s disease. The **Kaiser Family Foundation** estimates that if one in 20 people with Medicare take it, it would cost the Medicare Part B Trust Fund \$8.9 billion annually.

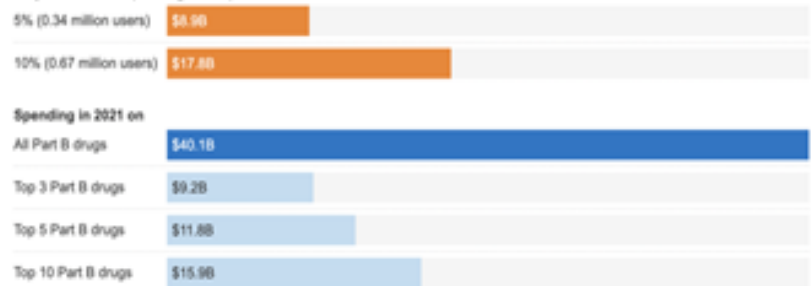
About half of people with Medicare have an annual income

under \$30,000. They would be hard-pressed to afford coinsurance of more than \$5,000. Even if they have supplemental coverage which would pick up the coinsurance, the cost of their supplemental coverage is likely to rise significantly, given the cost of this drug and the number of people with Medicare who might take it.

What is the fair price for Leqembi? The Institute for Clinical and Economic Review suggests that the fair price for Leqembi could be as low as \$8,900 a year. Even at that price, it would mean nearly \$1,800 a year in out-of-pocket costs for people taking it.

Depending on Take-up, Projected Annual Medicare Spending on Leqembi Could Roughly Equal or Exceed Spending on the Top 3, Top 5, or Top 10 Part B Drugs in 2021

Projected annual spending on Leqembi based on*



NOTE: \$ is billion. *Projected annual spending on Leqembi is based on the annual list price of \$26,500 and an estimated 6.7 million people ages 65 and older with Alzheimer’s disease. Spending on total and top 3/5/10 Part B drugs is based on actual Medicare spending in 2021. SOURCE: KFF estimates of projected Leqembi spending and analysis of Centers for Medicare & Medicaid Services 2021 Medicare Part B Spending by Drug. • PNG

KFF

2023: Medicare data and trends

The Kaiser Family Foundation has **new Medicare data**: Who’s enrolled, costs, trends and more. In short, Medicare spending represents a large share of total government spending (13 percent of the federal budget in 2021), and spending will rise over the next few decades as older adults represent a larger share of the population.

Today, more than 65 million Americans benefit from Medicare, about 20 percent of Americans. By 2060, more than 93 million Americans are projected to benefit from Medicare.

In 2020, about 17 percent of the US population were people over 65—56 million. By 2060, that percentage will grow to 25 percent. And, one third of people over 65 will be over 80.

Medicare per person and overall spending have grown

enormously in the last 20 years as health care costs have increased. Per person spending is up to \$15,700 from \$5,800 in 2000. Overall spending is now at \$744 billion a year, up from \$200 billion in 2000. And, spending is projected to rise to more than double that, \$1.7 trillion, by 2033.

A lot of Medicare’s increased cost can be attributed to Medicare Advantage. Payments to these health plans has tripled in the last decade, from \$137 billion to \$403 billion. And, the government overpays these plans—as much as 20 percent more than Traditional Medicare, according to a **new study out of USC**. The percentage of people enrolled in Medicare Advantage plans has doubled from 25 percent to 50 percent.

People with Medicare are using more services, and costs of

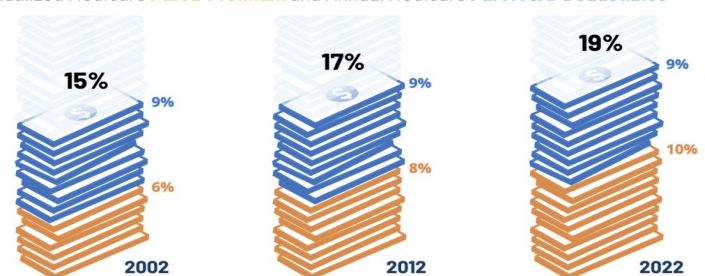
services are rising significantly. Costs are also up significantly since 2000 because Medicare began covering prescription drugs in 2004. That said, Medicare pays significantly less for most services than private insurers because it negotiates provider rates.

Not surprisingly, people with Medicare now pay a lot more for their care. Medicare Part B

premiums consume 10 percent of the typical Social Security benefit, up from 6 percent. If you include Parts A and B deductibles, 19 percent of a typical Social Security check goes to Medicare costs, up from 15 percent. And, then there’s the cost of long-term care at home or a nursing home, dental, hearing and vision care and prescription drug coverage and copays.

Selected Out-of-Pocket Costs as a Share of the Average Social Security Benefit

Annualized Medicare **Part B Premium** and Annual Medicare **Part A & B Deductibles**



Why doesn't Medicare cover Ozempic and other weight-loss drugs?

While Medicare covers certain services to treat obesity, Medicare is not allowed to cover Ozempic and other weight-loss drugs under the law establishing Medicare Part D prescription drug coverage. Still, the pressure is on to get Medicare to cover them, Rylee Wilson reports for **Becker's**.

To treat obesity, Medicare covers **obesity screening, behavioral counseling, and bariatric surgery**. But, it is prohibited from covering weight-loss drugs and a range of other drugs, such as drugs that treat erectile dysfunction. That could change

for weight-loss drugs, given the efficacy of new weight-loss drugs and the public pressure to cover them.

GLP-1 drugs, such as Ozempic, are more effective for weight loss than the older drugs. Putting aside these drugs, which come with an enormous price tag, Medicare can't even cover older weight-loss drugs that cost less. Even when they cost less, spending for all these weight-loss drugs are over the long-term. People generally need to take these drugs indefinitely to sustain their weight loss.



One **New England Journal of Medicine** study found that covering new weight-loss drugs

would increase Medicare spending by more than \$25 billion a year. In addition, one of the study's authors said that these drugs are not cost-effective; they are not so much better than the older generation drugs to justify their huge price tags.

Today, people must pay more than \$10,000 out of pocket for GLP-1 drugs. If Medicare decides to cover these drugs, it will mean higher Part D premiums for everyone with Medicare. Given the drug price

monopoly that US drug manufacturers still have—without negotiated drug prices—there's no end to drug company price gouging.

The good news is that Medicare Part D drug coverage will have a \$2,000 out-of-pocket cap beginning in 2025. But, \$2,000 is still unaffordable for a large cohort of people with Medicare. And, as Part D premiums rise, more and more people with Medicare will struggle to afford the premiums for their prescription drug coverage.

Medicare now covers power seat lifts for wheelchairs in some cases

Medicare is required by law to cover all medically reasonable and necessary health care services with certain exceptions, such as vision, hearing, dental and long-term services and supports. Of course, when it's not black and white, our government decides which services are medically reasonable and necessary and should be covered. The Centers for Medicare and Medicaid Services (CMS), which oversees Medicare, has **decided that power seat lifts should be covered**.

Of course, every time Medicare covers a product or service that makes people's lives easier and improves their health and well-being, it's a huge benefit. Yet, as Medicare covers more costly items, Part B premiums rise and out of pocket

costs for people with Medicare become increasingly unaffordable. To keep costs down, Congress needs to step in and negotiate better prices for many products Medicare covers, including prescription drugs, as well as **eliminate overpayments to Medicare Advantage plans**.

Medicare has always covered wheelchairs and, in certain cases, power wheelchairs, for people who are unable to get around their homes without one. But, Medicare had not covered the power seat lift that allows people in a wheelchair to sit at a counter or access items they could not otherwise access in their homes. The government's argument back in 2006 was that the power seat



elevation system was not primarily medical in nature.

The industry making the seat-lift device, along with the disability community, lobbied hard for its coverage. They argued that from a health equity perspective, lower income people can experience worse health outcomes than people with more income are not because they can afford to pay for the seat lift themselves. "Allowing beneficiaries with a permanent disability to access technology to stand, reach, and function in their home and community, is not a luxury, nor is it an item of convenience, but a necessity."

The health equity argument is compelling. On those grounds, however, Medicare should be

spending as much on people in Traditional Medicare as it does on people in Medicare Advantage, giving traditional Medicare an out-of-pocket spending limit, among other things. Instead, most people with Medicare cannot afford to enroll in Traditional Medicare and are forced into Medicare Advantage plans. They do not have the meaningful choice between Traditional Medicare and Medicare Advantage, which is available to people with higher incomes.

Of note, Medicare still does not cover the power standing device that would allow wheelchair-bound people to stretch their legs and bear weight, which also has significant health benefits, according to some experts.

International Rights Group Calls Out US for Allowing Hospitals to Push Millions Into Debt

Human Rights Watch, the nonprofit that for decades has called attention to the victims of war, famine, and political repression around the world, is taking aim at U.S. hospitals for pushing millions of American patients into debt.

In a **new report**, published June 15, the group calls for stronger government action to protect Americans from aggressive billing and debt collection by nonprofit hospitals, which Human Rights Watch said are systematically undermining patients' human rights.

"Given the high prevalence of

hospital-related medical debt in the US, this system is clearly not working," concludes the report, which draws extensively on an **ongoing investigation** of medical debt by KFF Health News and NPR.

The report continues: "The US model of subsidizing privately operated hospitals with tax exemptions in the hope that they will increase the accessibility of hospital care for un- and underinsured patients allows for abusive medical billing and debt collection practices and undermines human rights,



including the right to health." Nationwide, about 100 million people — or 41% of adults — have some form of health care debt, a KFF survey conducted for the KFF Health News-NPR project found. And while patient debt is being driven by a range of medical and dental bills, polls and studies suggest hospitals are a major contributor.

About a third of U.S. adults with health care debt owed money for hospitalization, KFF's polling found. Close to half of those owed at least \$5,000. About

a quarter owed \$10,000 or more.

The scale of this crisis — which is unparalleled among wealthy nations — compelled Human Rights Watch to release the new report, said researcher Matt McConnell, its author. "Historically, Human Rights Watch has been an organization that has focused on international human rights issues," he said. "But on medical debt, the U.S. is a real outlier. What you see is a system that privileges a few but creates large barriers to people accessing basic health rights..." **Read More**

Biden Admin Implores States to Slow Medicaid Cuts After More Than 1M Enrollees Dropped

Too many Americans are losing Medicaid coverage because of red tape, and states should do more to make sure eligible people keep their health insurance, the Biden administration said Monday.

More than a million Americans have lost coverage through the program for low-income and disabled Americans in the past several weeks, following the end of pandemic protections on April 1, according to the latest Medicaid renewal data from more than 20 states.

After a three-year pause, most states have now resumed checking **which Medicaid recipients remain eligible** and dropping those who no longer qualify or don't complete

required paperwork. About 4 in 5 people dropped so far either **never returned the paperwork** or omitted required documents, federal and state data show.

Xavier Becerra, secretary of the Department of Health and Human Services, decried those numbers **in a letter** sent to state governors on June 12.

"I am deeply concerned with the number of people unnecessarily losing coverage, especially those who appear to have lost coverage for avoidable reasons that State Medicaid offices have the power to prevent or mitigate," he wrote.

The Biden administration outlined several optional steps



states can take to ensure everyone who still qualifies for the safety-net health insurance program

stays covered. For instance, states can pause the cancellations to allow more time to reach people who haven't responded. Health insurance companies that manage Medicaid plans can help their enrollees fill out the paperwork.

Some states were already choosing to take extra time. Though Wyoming began renewals in May, the state is being "deliberately cautious" and won't drop people for incomplete paperwork until July or August, state Health Department spokesperson Kim Deti said. Oregon won't start those cancellations **until October**.

Officials in other states have demonstrated no eagerness to slow the cuts.

About 10 percent of Arkansas' Medicaid and Children's Health Insurance Program enrollees have already been dropped, nearly all because they didn't complete paperwork. Arkansas is speeding through the redeterminations in just six months, while most other states are taking about a year, as HHS recommended. Despite outcry from some **federal lawmakers and advocates**, Medicaid officials in the state wrote on June 8 that they would **continue to "swiftly disenroll"** people who no longer qualify.

Most Americans Face Hassles With Their Insurance Plans, and It's Harming Care: Poll

A majority of insured Americans have struggled with a wide array of stumbling blocks when trying to get coverage for their health care needs, a new national survey shows.

All told, the **KFF report** uncovered numerous obstacles to coverage with all types of health insurance, including an inability to find a covered in-network provider; delays in getting needed care; unexpected out-of-pocket costs; problems meeting pre-authorization requirements; and outright denial of claims.

"We found that most people — about 60% — experience problems when they try to use their coverage," noted survey lead **Karen Pollitz**, a senior fellow for health reform and

private insurance at KFF and co-director of KFF's program on patient and consumer protections.

"We also found consumers can only fix their health insurance problems about half of the time, while about 30% of those with problems don't try at all or give up," she added.

Other main findings included that most consumers (51%) have difficulty understanding their coverage and how it works; that most (60%) are unaware that they have legal rights to appeal a denied claim; and that most (76%) don't know what government agency to call when they have problems with their insurance.

And while some coverage issues "may just end up being a



pain in the neck," Pollitz stressed that "for some consumers, the consequences can be serious."

For instance, among those who experienced coverage problems in the last year, roughly 1 in 6 said the result was delayed care or no care at all. And one-quarter said that when they did get care, it cost more out-of-pocket than they had been expecting.

David Allen, director of communications and public affairs for America's Health Insurance Plans (AHIP, an advocacy and trade association of health insurance companies), countered the new KFF findings by citing positive patient feedback from AHIP's own surveys.

For instance, he pointed to AHIP data suggesting that about 6 in 10 of adults with employer-based insurance are both satisfied with their coverage and rate the quality of their plan as high.

As for Medicaid patients, Allen said AHIP's research suggests that 84% are able to gain regular access to needed care.

"Every American deserves access to affordable, comprehensive, high-quality care and health coverage," Allen said. "When people have an experience that isn't the best it can be, health insurance providers take that feedback, learn from it, build on what works, and fix what doesn't," he added.**Read More**

Opioid Settlement Payouts to Localities Made Public for First Time

Thousands of local governments nationwide are receiving settlement money from companies that made, sold, or distributed opioid painkillers, like Johnson & Johnson, AmerisourceBergen, and Walmart. The companies are shelling out more than \$50 billion total in settlements from national lawsuits. But finding out the precise amount each city or county is receiving has been nearly impossible because the firm administering the settlement hasn't made the information

public.

Until now. After more than a month of communications with state attorneys general, private lawyers working on the settlement, and the settlement administrators, KFF Health News has obtained documents showing the exact dollar amounts — down to the cent — that local governments were allocated for 2022 and 2023. More than 200 spreadsheets detail the amounts paid by four of the companies involved in national settlements.



(Several other opioid-related companies will start making payments later this year.)

For example, Jefferson County, Kentucky — home to Louisville — received \$860,657.73 from three pharmaceutical distributors this year, while Knox County, a rural Kentucky county in Appalachia — the region many consider ground zero of the crisis — received \$45,395.33.

In California, Los Angeles County was allocated \$6.3

million from Janssen, the pharmaceutical subsidiary of Johnson & Johnson, this year. Mendocino County, which has one of the **highest opioid overdose death rates** in the state, was allocated about \$185,000....**Read More**

Find Out How Much Opioid Settlement Cash Your Locality Received....Click Here

Social Security Changes Are Coming - Elizabeth Warren Confirms Tax Increase Is Inevitable

Lawmakers have a mere 12 years to fix the Social Security program before it can no longer pay full benefits, according to the most recent Social Security trustees' report.

After 2034, the report "What the 2021 Trustees' Report Shows

About Social Security" notes, the \$2.9 trillion trust fund will be depleted, and with no legislative action, Social Security would have to rely solely on current tax income to pay benefits. This income would result in an ability to pay out only about three-quarters of the scheduled benefits.

However, there is good news. There are several proposed policy changes to address the Social Security funding gap that voters on both sides of the aisle overwhelmingly support.

Recent Survey Shows
Americans in Agreement on
Social Security Fixes

The University of Maryland's
Program for Public Consultation
(PPC) surveyed over 2,500
registered voters through an

online 'policymaking simulation' process. Respondents were briefed on the state of the Social Security program and then asked their opinion on arguments for and against various proposals to address the budget shortfall.

Surprisingly, a large majority of Republicans and Democrats favored various proposals to increase revenue, trim benefits, and even increase benefits for low-income earners. According to PPC researchers, these measures would eliminate 78-95% of the shortfall over the next 75 years, depending on the implemented policies.

Here are seven proposals that Americans agreed they were willing to make.

1. Raising the Payroll Tax Cap

Overall Support: 81%
(Republicans 79%, Democrats 78%)

Currently, only the first \$147,000 of income is subject to the payroll tax. A proposal to raise the payroll tax cap to



\$400,000 would go a long way to closing the budget gap. Researchers estimate this fix alone would eliminate 61% of the shortfall. An overwhelming majority of both Republicans and Democrats in the survey supported this proposal, which may embolden policymakers to put forward legislation that would sign this into law.

There has already been some movement in Congress, with one proposal by Bernie Sanders and Elizabeth Warren to increase the payroll tax on all income over \$250,000, including capital gains. Another proposal called **Social Security 2100: A Sacred Trust** would increase the payroll tax cap to \$400,000 on earned wages.

2. Reducing Benefits for High Earners

Overall Support: 81%
(Republicans 78%, Democrats 86%)

Those beneficiaries who earned a higher salary during their working years are also the

ones who most likely have other ways of funding their retirements, such as through pensions, 401(k) accounts, and other savings.

One proposal that received a large majority of bipartisan support would reduce benefits for the top 20% of earners and eliminate 11% of the shortfall. While workers who make more money would still get a larger benefit than others, it would be less than in the current program.

3. Raising the Retirement Age

Overall Support: 75%
(Republicans 75%, Democrats 76%)

One of the first changes to the original Social Security program enacted in 1983 was slowly increasing the full retirement age from 65 to 67. With people living and working longer on average, one proposal would seek to raise the retirement age slightly to 68. This change would reduce the budget shortfall by 14%.

Spousal Social Security Benefits: 3 Vital Things All Married Couples Should Know.



The great thing about being married in retirement is having someone to share that period of life with. It can be lonely and isolating to go from working full-time to not having a job or the structure that goes with it. Having a life partner to help occupy your free time and support you during that transition is crucial.

Being married could also work to your advantage when it comes to **Social Security**. If you're entitled to a monthly benefit of your own, based on your personal earnings history, you can coordinate with your spouse to establish a savvy filing strategy. And if you're not entitled to Social Security because you never worked or you didn't work enough, you may be eligible for a spousal benefit by virtue of being married.

Even if you're divorced, you

may be eligible for spousal benefits from Social Security if your ex is entitled to benefits of their own. But either way, it's important to know how spousal benefits work. Here are some rules to keep in mind.

1) There's no point in delaying spousal benefits
If you're claiming Social Security on your own earnings record, you're entitled to your full monthly benefit at **full retirement age**, or FRA, which is 67 for anyone born in 1960 or later. You can also boost your benefit by 8% a year by delaying your filing past FRA. This incentive runs out once you turn 70. But there's no such thing as a delayed spousal benefit. If you're claiming a spousal benefit, you may as well sign up once you reach FRA. Filing for a spousal benefit at age 70 will leave you with the same monthly payday you'd get by filing at FRA.



2) You can't claim a spousal benefit when married until your partner files for Social Security

If you're divorced, you don't necessarily need to wait for your ex-spouse to claim Social Security to file for spousal benefits on their record. But if you're married, you can't sign up for spousal benefits until your spouse claims Social Security.

That's why it's important to sync up on that decision. Your spouse may want to delay their filing to snag a higher monthly benefit. By doing so, however, your spouse might prevent you from claiming benefits when you want to.

3) You can't collect a spousal benefit on top of your own
It may be the case that you worked for many years and are entitled to Social Security based on your own earnings. But if your spouse was a much higher earner, claiming spousal

benefits could leave you with a higher monthly paycheck.

As long as you wait until your own FRA to claim a spousal benefit, you'll get 50% of what your spouse is collecting. Social Security will pay you the higher of either your personal benefit or 50% of your spouse's benefit. But it won't pay both.

In other words, let's say that based on your earnings history, you're eligible for \$1,300 a month from Social Security. If your spouse's monthly benefit amounts to \$3,000, you're better off with a spousal benefit, which, in this case, is worth \$1,500. But in that case, you'd only get \$1,500 a month from Social Security -- not \$2,800.

Spousal benefits are something you may be eager to claim. Just make sure you're clear on the rules before moving forward.

Alzheimer's Stages: Mild, Moderate & Severe

When a loved one is diagnosed with Alzheimer's disease, it can be a challenging and emotional journey for the individual and their family.

Understanding the progression of the disease and recognizing the changes in symptoms and behavior accompanying each stage becomes crucial in providing the necessary care and support.

In this comprehensive guide, experts will navigate through the different stages of Alzheimer's, shedding light on the mild, moderate and severe phases.

Alzheimer's stages

When it comes to understanding the progression and stages of Alzheimer's, it's essential to know that there is no universally accepted staging system. However, two widely recognized frameworks outline the progression of this debilitating condition. First, there is the commonly used breakdown of mild, moderate and severe stages outlined by the U.S.

National Institute on Aging (NIA).

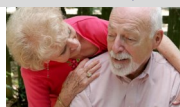
Then, we will explore Dr. Barry Reisberg's **7 stages model**, which offers a more detailed understanding of the cognitive decline experienced by individuals with Alzheimer's. By combining these perspectives, it becomes easier to assess the changes in symptoms and behavior that occur as this illness progresses.

Mild Alzheimer's

In the early stages of Alzheimer's disease, commonly called mild Alzheimer's, individuals may experience subtle but noticeable changes in their thinking. Recognizing these signs and understanding how they manifest is crucial to provide appropriate support and care.

Moderate Alzheimer's

In the moderate stage of Alzheimer's disease, the NIA states that significant damage occurs in brain areas responsible for language, reasoning, conscious thought and sensory



processing. This leads to a progressive decline in memory and thinking abilities, making it increasingly challenging for individuals to recognize their loved ones and carry out everyday tasks.

"For many, this stage brings noticeable changes, and it will become harder to blame age. It's common to be diagnosed in this stage because this is when a person's daily routine becomes more disrupted," **Dr. David Wolk**, co-director of the Penn Memory Center in Philadelphia, said in a recent Penn Medicine **article**.

Common difficulties in this stage go beyond forgetting names and misplacing objects. Symptoms such as hallucinations, delusions, paranoia and impulsive behavior may also emerge in this stage.

Severe Alzheimer's

As Alzheimer's disease progresses to its final stage, the symptoms of dementia become

incredibly severe. The Alzheimer's Association states that **patients reach a point where they lose the ability to interact with their environment**, engage in conversations and eventually, even control their own movements. Although they may still utter words or phrases, expressing pain or specific needs becomes increasingly challenging.

Significant personality changes can occur with the ongoing deterioration of memory and thinking abilities, necessitating comprehensive and extensive care for these individuals.

Dr. Barry Reisberg's 7 Stages of Alzheimer's

Dr. Barry Reisberg, a renowned researcher and clinician, has developed a **widely recognized staging system** that helps professionals and caregivers identify and understand the different stages of Alzheimer's disease....**Read the complete article**

How Do You Get Hepatitis C? Here's What to Know

Hepatitis C is a viral infection of the liver no one wants to catch, so knowing how that can happen can be critical.

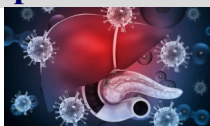
The **American Liver Foundation** estimates that it affects about 2.7 million people in the United States today.

To help you protect yourself against this virus, liver experts describe how you get hepatitis C, if it's curable and how contagious it is. They will also explain if there's a hepatitis C vaccine, and what medications are used to treat this viral infection.

How do you get hepatitis C?

According to the **U.S. Centers for Disease Control and Prevention**, hepatitis C transmission occurs when you come into contact with the blood of someone who is infected. This can happen through:

- ◆ Tattoos and piercings, especially from unlicensed and unregulated establishments
 - ◆ Sex with someone infected with the virus, which is reported more among men who have sex with other men
 - ◆ Sharing medical and other items, such as glucose monitors and razors that have infected blood on them
 - ◆ Health care worker exposure to blood-borne infections
 - ◆ Organ transplants and blood transfusions
- "Before 1993, a blood transfusion was a common way to get hepatitis C, but now blood transfusion is safe because we check the blood," explained **Dr. Melissa Jenkins**, chief of the division of infectious diseases at MetroHealth, in Cleveland, Ohio. A research article published recently in the journal **Pathogens** noted that the



opioid epidemic and less access to health care have also fueled new hepatitis C cases.

Incidents of hepatitis C infections increased by 15% between 2019 and 2020 for acute cases, according to the **CDC**.

Is hepatitis C contagious?

The **New York State Department of Health** says that hepatitis C is typically contagious for at least a week or more before symptoms appear, and remains so "indefinitely" afterward for people with chronic hepatitis. Anyone who tests positive for the virus is considered contagious. **Dr. Nancy Reau**, hepatology section chief at Rush University Medical Center in Chicago, explained in an **American Liver Foundation video** that "everyday contact to someone with hepatitis C very, very rarely will lead to infection. So, you should not be afraid of your relatives or loved ones who have hepatitis C."

But, Reau added, "Just be careful with anything that might

have been exposed to someone else's blood or body products."

Is hepatitis C curable?

The CDC says the cure rate is over 90% for anyone who is treated for hepatitis C with antiviral medications.

"For people who are treated, we check a hepatitis C level 12 weeks or more after the last dose of medicine," Jenkins explained. "If the hepatitis C virus level [viral load] is negative, also known as undetectable, then the patient has a sustained virologic response [SVR]. This is considered a cure."

She added that "people who have cirrhosis prior to treatment still need to see a liver doctor because they are still at risk for liver cancer or complications of cirrhosis, but the risk is much lower after the hepatitis C is gone."

There is no hepatitis C vaccine?

Most Women With Early Breast Cancer Will Become Long-Term Survivors, New Study Shows

Most women diagnosed with early breast cancer will become long-term survivors, according to new research that finds a substantial reduction in the risk of death since the 1990s.

This news should reassure both patients and their doctors, researchers report June 13 in the *BMJ*.

"Our study is good news for the great majority of women diagnosed with early breast cancer today because their prognosis has improved so much," said the authors, who included **Dr. Carolyn Taylor**, a professor of oncology at the

University of Oxford in England.

"Most of them can expect to become long-term cancer survivors," they added in a journal news release.

While in the 1990s, the average risk of dying from breast cancer within five years of diagnosis was 14%, it's now 5%. More than 60% of women diagnosed during 2010 to 2015 had a five-year risk of 3% or less.

In addition to offering reassurance, the findings can also help identify those who still have substantial risk, according to the



study.

Researchers used National Cancer Registration and Analysis Service data for more than 512,000 women who were diagnosed in England with early breast cancer between January 1993 and December 2015.

Early breast cancer is that which is confined to the breast or spreads only to the axillary lymph nodes. More than 2 million women are diagnosed with early breast cancer worldwide each year.

The team estimated annual breast cancer death rates and

cumulative five-year risks, considering time since diagnosis, calendar period of diagnosis and women's characteristics such as age. They also looked at whether the cancer was detected by screening, involvement of lymph nodes, tumor size and tumor grade. They followed all the women until December 2020. For women with a diagnosis made within each of the calendar periods 1993 to 1999, 2000 to 2004, 2005 to 2009, and 2010 to 2015, the annual death rate from breast cancer was highest within the five years after diagnosis. It then declined....[Read More](#)

What's Causing Your Indigestion — And How to Treat It

Indigestion, or dyspepsia, is a common ailment that can bring about a range of uncomfortable symptoms, leaving one feeling full and experiencing stomach pain.

It's a condition that affects many individuals and can significantly impact their quality of life. In this article, experts delve into the intricacies of indigestion, exploring its causes, symptoms and treatment options.

Additionally, they shed light on the distinction between indigestion and heartburn, offering clarity on these often-confused terms.

What is dyspepsia (indigestion)?

Dyspepsia, commonly known

as indigestion, is a collective term encompassing a range of gastrointestinal symptoms. According to the U.S. National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), these symptoms typically manifest as **pain, a burning sensation or general discomfort in the upper abdomen**.

Heartburn vs. indigestion: What's the difference?

Heartburn and indigestion are often used interchangeably to describe digestive discomfort, but they are distinct conditions with different underlying causes and symptoms. It's important to understand the difference



between the two to address and manage the discomfort properly.

While a burning sensation in the chest characterizes heartburn, indigestion refers to a broader set of gastrointestinal symptoms, including pain, bloating and a feeling of fullness. "Acid reflux is a disorder of the lower esophageal sphincter that can cause various symptoms when it occurs," **Dr. F.P. "Tripp" Buckley III**, surgical director of Digestive Health, a clinical partnership between UT Health Austin and Ascension Seton, said in a recent [article](#). "Symptoms of acid reflux include a burning in your chest, known as heartburn,

regurgitation, excessive belching and sour taste when acid and bile flow back up the esophagus and into your throat or mouth."

On the other hand, indigestion "is a broad term that involves a variety of symptoms, and sometimes those symptoms may be related to other conditions," **Stephanie Doggett**, a licensed physician assistant at Digestive Health, **added**. "If you are experiencing persistent indigestion, it is recommended that you speak with your doctor, providing a precise description of the discomfort you are experiencing so they can try to rule out any underlying conditions that may be causing your symptoms." ...[Read More](#)

Does an Irrevocable Trust Protect Assets from Nursing Homes?

Paying for a nursing home can seriously deplete your retirement savings. The government-funded **Medicaid** program can pay some or all nursing home costs, but it's restricted to people of very limited financial means. You may be able to qualify for government assistance with nursing home costs, even if you control substantial wealth if you transfer nearly all your assets into an irrevocable trust. An irrevocable trust can protect your money from nursing home costs, but they have costs and drawbacks of their own, including permanently losing direct control of your assets. Talk to a **financial advisor** to learn about options for paying for long

-term care.

A **trust** is a legal entity many people create as part of an **estate plan**. The trust acts as a container for assets transferred into it by the **grantor**. A trustee is appointed to manage the assets in the trust for the benefit of one or more beneficiaries.

A trust can be **revocable or irrevocable**. You can make changes to a revocable trust after establishing it, including removing assets from the trust. Irrevocable trusts, however, cannot be changed after establishment. That means transferring assets to the trust is a one-way process. Once in, assets



cannot be removed from an irrevocable trust.

Irrevocable Medicaid Trusts

Irrevocable trusts come in several varieties and can help with many different estate planning and other personal finance tasks. **Medicaid trusts** are the kind used to help reduce the impact of nursing home costs.

More specifically, Medicaid trusts are designed to help people qualify for Medicaid, the government health insurance program. Unlike Medicare, which is not means-tested, Medicaid is only available to people of limited financial means.

The program is administered by states, which determine their own **Medicaid eligibility requirements** in a variety of ways. In most, the annual income limit is \$29,160 or less. This cap includes Social Security and pension benefits as well as wages and investment income. Financial resources such as bank accounts, investments, revocable trusts and real estate typically can't total more than \$2,000. People who have more income and more assets may have to spend their own assets to pay for nursing home care until their assets have declined to the point they meet the Medicaid caps....[Read More](#)

Inflammatory Bowel Disease Tied to Higher Odds for Stroke

Having inflammatory bowel disease, or IBD, could mean having a higher long-term risk of stroke, according to a new study.

People with IBD are 13% more likely to have a stroke up to 25 years after their diagnosis than those without the condition, the researchers found. Their report was published June 14 in the journal *Neurology*.

"These results show that people with inflammatory bowel disease and their doctors should be aware of this long-term increased risk," said study co-author **Jiangwei Sun**, of the Karolinska Institute in Stockholm, Sweden.

"Screening and management of stroke risk factors may be more urgent in people with IBD," Sun added in a journal news release.

The findings don't prove that IBD causes this serious outcome,

only that there is an association.

Types of IBD include Crohn's disease, ulcerative colitis and unclassified inflammatory bowel disease, causing chronic inflammation of the intestines.

The study included more than 85,000 people who had their IBD confirmed by biopsy. Each was matched with up to five people of the same age, sex and county of residence who did not have IBD. There were nearly 407,000 people in the control group.

Among the study participants, 3,720 of those with IBD had a stroke during the average follow-up of 12 years. That was compared to 15,599 of those without IBD who had a stroke and were from the much larger group.



The stroke rate was 32.6 per 10,000 person-years for those with IBD compared to 27.7 for those without IBD.

Person-years represent both the number of people in the study and the amount of time each person spends in the study.

The increased risk was mainly in ischemic stroke, the most common type, which is caused by a blockage of blood flow to the brain. Hemorrhagic stroke is caused by bleeding in the brain.

Both IBD and stroke have some genetic components predisposing people to the disease, the study authors noted. For this reason, the study also included full siblings of the people with IBD. The more than 101,000 siblings had no history of IBD or stroke when the study

began.

Those with IBD still had a higher risk of stroke than their siblings without IBD. Their overall risk was 11% higher.

"The elevated risk for people with IBD remained even 25 years after they were first diagnosed, corresponding to one additional stroke case for every 93 people with IBD until that point," Sun said.

The criteria for diagnosing IBD and stroke has changed over the years, which could affect the results, the authors cautioned. Also, the data did not include complete information on all factors that could affect stroke risk, such as diet, smoking and alcohol consumption, which was a study limitation.

Crohn's Disease: What Is It, and How Can It Be Treated?

Crohn's disease can turn your life into a gastrointestinal nightmare, but there is hope.

According to the **National Institute of Diabetes and Digestive and Kidney**

Diseases (NIDDK), more than half a million Americans have Crohn's disease, which has become more common in the United States in recent years. While there is no cure for the condition, there are treatments that can help ease its symptoms.

Here, experts will discuss those symptoms, how Crohn's disease develops and its different therapies. They'll also talk about the best Crohn's disease diet, and which foods to avoid.

What is Crohn's disease?

"Crohn's disease is an inflammatory bowel disease that causes chronic inflammation of the GI tract," Mayo Clinic gastroenterologist **Dr. Bill Faubion** explained recently in a **video**.

According to the NIDDK, the condition may affect any part of your digestive tract, including your mouth, esophagus, small intestine, large intestine and rectum.

What causes Crohn's disease?

While the exact causes of Crohn's disease are unknown, the NIDDK notes that several factors may lead to its development, including:

An autoimmune reaction caused



by digestive tract bacteria. Genetics, particularly if you have a sibling or parent with the condition. A history of smoking,

which may double your risk. A high-fat diet. Taking nonsteroidal anti-inflammatory drugs (NSAIDs). **Crohn's disease symptoms** Even though both men and women experience the **common symptoms** of Crohn's disease — like diarrhea, stomach pain, weight loss and blood in the stool — **Temple Health** notes that certain symptoms can show up more in one sex than the other. **Crohn's disease symptoms in females include:**

- ◆ Anemia
- ◆ Osteoporosis and bone loss
- ◆ Menstrual pain
- ◆ Potential increase in pregnancy complications

Crohn's disease symptoms in males include:

- ◆ Decrease in sexual desire
- ◆ Erectile dysfunction
- ◆ Higher risk for colorectal cancer
- ◆ Higher risk for primary **sclerosing cholangitis**, a rare liver disease....**[Read More](#)**

Testosterone Therapy Safe for Low-T Men at Risk of Heart Trouble

Testosterone replacement therapy is safe for most men with heart problems who also have been diagnosed with a low testosterone disorder, a new clinical trial has concluded.

The trial found that testosterone replacement did not raise these patients' incidence of heart attack, stroke or heart-related death in a group of men with both heart problems and hypogonadism -- a condition in which low testosterone levels have led to specific health problems.

"For men with heart disease or

at risk for heart disease, taking testosterone -- when given in appropriate doses and carefully monitored -- did not increase the risk of heart-related events like heart attack, stroke or death from heart-related causes," said senior researcher **Dr. Steve Nissen**, chair of cardiovascular medicine with the Cleveland Clinic.

However, researchers warn the results are not a green light for "Low-T Centers" to tout testosterone replacement for any healthy man, including those whose levels of the male



hormone are declining naturally with age. "My nightmare really is that we'll see ads on television that say, 'Cleveland Clinic says that testosterone is safe. Now, come on in and we'll give you your testosterone.' That's not a good outcome from this study," Nissen said.

The trial also identified certain health risks with testosterone replacement therapy that should be taken into account before prescribing the treatment, Nissen added.

"There are some people I

would not give it to," Nissen said. "Men that have had a history of atrial arrhythmias [heart rhythm problems] or any kind of clotting problems probably shouldn't get it."

The trial was prompted by the U.S. Food and Drug Administration's response to the proliferation of "Low-T Centers" throughout the nation. The results were published June 16 in the ***New England Journal of Medicine***....**[Read More](#)**

Black Patients Face Greater Risks From Leg Artery Blockages

A new study has unearthed significant racial disparities in both treatment and outcomes for peripheral artery disease (PAD).

Black patients with this condition, where plaque builds up in the arteries of the legs, were more likely to have a stroke, heart attack or amputation than white patients, according to researchers from Keck Medicine at the University of Southern California in Los Angeles.

Black patients were also 50% less likely than white patients to get vascular interventions that could make a big difference in outcomes.

"We discovered that Black patients are nearly 50% less likely to receive vascular interventions to potentially

restore the blood flow than white patients, and consequently are at a disproportionately higher risk of a stroke, heart attack or amputation," said study author **Dr. David Armstrong**, a podiatric surgeon specializing in limb preservation with Keck Medicine.

"Additionally, Black patients tend to have more advanced PAD and are sicker at the time of diagnosis, indicating they may not be getting as timely medical attention as their white counterparts," he added in a university news release.

PAD affects about 8 to 12 million Americans. It's associated with nearly half of 150,000 amputations in the United States



each year.

While symptoms usually begin with something mild, such as leg cramps or muscle pain, once it is detected through a blood test the condition is typically treated with medication and lifestyle changes.

The next step can be to have a procedure known as revascularization, which improves blood flow to the arteries with a balloon or stent to open them or reroutes the blood to a healthier artery.

Black patients were more likely to only receive medication and lifestyle change recommendations, the researchers found.

"Our findings suggest Black patients are missing out on

potentially limb- and lifesaving treatments," Armstrong said. "And because Black patients tend to be sicker at the time of diagnosis than white patients, they may actually be in more need of a revascularization than other patients."

Data for the study came from a national database. The researchers compared rates of diagnostic testing, treatment patterns and outcomes after diagnosis of PAD among commercially insured patients for the years 2016 to 2021. The team considered demographics, markers of disease severity, health care costs, patterns of medical management and rates of amputation and cardiovascular events...[Read More](#)

This Summer, Could You Spot the Signs of Heat Illness?

Heat illness can be deadly, so it's essential to recognize the warning signs and know what to do as the summer season gets into gear.

"Heat illness tends to happen when the body is unable to regulate its temperature due to overexertion or extended periods of time in high temperatures," said **Dr. Maria Carmenza Mejia**, an associate professor at Baylor College of Medicine in Houston.

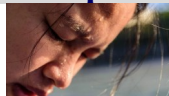
"Conditions can range from mild discomfort to life threatening," she said in a college

news release.

Mejia offered some information about heat illness and tips for avoiding or treating it.

The first sign of heat illness tends to be cramps and spasms due to dehydration or an electrolyte imbalance. This can progress to heat exhaustion, in which a person experiences fever, heavy sweating, weakness, dizziness, headache or nausea.

It is also possible to experience heat syncope, an episode of fainting or dizziness. This can be triggered by a decreased blood



flow to the brain due to standing for long periods in high heat or from quickly rising from the sitting or lying position when it's hot.

Heat exhaustion can progress to life-threatening heat stroke, if the body is no longer able to cool down. Body temperature rises rapidly above 104 degrees F, and a person with heat stroke may have seizures or lose consciousness and quickly experience damage to the brain, heart, kidneys and muscles.

Heat stroke requires immediate emergency intervention.

To keep heat illness from progressing all the way to heat stroke, Mejia said it is important to stop any physical activity as soon as you experience the initial heat cramps.

Move to a cool place inside and with air conditioning, if possible.

Fan the skin to cool it down and begin to hydrate.

If you suspect someone is experiencing heat exhaustion, move them to a cool place and try to bring the body temperature down, Mejia recommends...[Read More](#)

Hot Weather Can Bring on Kidney Stones. Here's How to Cut Your Risk

Kidney stones are something most folks want to avoid at all costs, but few may know that the chances of developing this excruciating condition rise during the hot months of summer.

Luckily, it is possible to take steps to prevent stones from forming, primarily by increasing water intake and making small changes to your diet.

An expert from the Department of Urology at UT Southwestern Medical Center in Dallas offers some tips for avoiding kidney stones and the searing pain they can cause.

"Once you've had one stone, you have up to a 50% chance of having another within the next 10 years," physician assistant **Megan Bollner** said in a

UT Southwestern news release. "But many risk factors for recurring kidney stones are within your control, and changing your eating habits can make a big difference."

Kidney stones are more likely to develop in urine that is highly concentrated, appearing dark yellow instead of clear or light-colored. These stones are formed by crystals and can block the flow of urine as it leaves the kidneys through the tubes that carry urine to the bladder.

Calcium oxalate and other minerals can form stones, which often start out the size of a grain of sand but can grow to fill the inside of a kidney.

They become more difficult to pass as they grow, sending more



than a half million people to U.S. emergency rooms for treatment each year, according to the National Kidney Foundation.

About 1 in 10 people will develop a kidney stone during their lifetime, with men having a slightly higher risk.

Contributors to recurrence include family history, underlying kidney disease, obesity, diabetes, dietary choices, chronic dehydration and inflammatory bowel disease.

Symptoms include severe one-sided lower back pain, nausea, vomiting, fever, chills and bloody urine. Some, however, have no symptoms.

How do you steer clear of this?

◆ Bollner recommends:

- ◆ Drinking more fluids to stay hydrated to dilute your urine, at least 8 cups of water a day if you have had a previous kidney stone. Twelve cups is even better.
- ◆ Drinking extra water if it's hot outside and you're sweating.
- ◆ Adding lemon or lime juice to your water because citrates bind to calcium to help block stone formation.
- ◆ Limiting sodium intake. Eating a high-sodium diet increases the amount of calcium in urine. Federal guidelines recommend limiting sodium to 2,300 milligrams daily -- equal to about 1 teaspoon...[Read More](#)