

March 27, 2022 E-Newsletter

Message from the Alliance for Retired Americans Leaders

Senior GOP Sen. Grassley Tells Democrats to Pass Drug Price Legislation Now



Robert Roach, Jr.
 President, ARA

Sen. **Chuck Grassley** (R-Iowa) acknowledged during a **Senate Finance Committee hearing**

Wednesday that it would be difficult to pass legislation lowering drug prices if his own party regains control of Congress following the 2022 midterm elections. He then called on Democrats to pass it now.

Grassley made the admission while speaking to Committee Chair **Ron Wyden** (D-Ore.), saying, "I think you suggested the difficulty of passing something like this in a Republican Congress, so you got an opportunity to do it right now, when Democrats and Republicans can work together to accomplish this. If we want to reduce drug prices, then we need to do it now."

Democrats' most recent attempts to lower skyrocketing drug costs, including allowing Medicare to negotiate prices, stalled in December, leading to current attempts to try again.

"Seniors agree with Senator Grassley's conclusion that now is the time to pass legislation to lower drug prices," said **Robert Roach, Jr.**, President of the Alliance. "His statement is also a warning: if the GOP regains control of the House or Senate, older Americans will have to pay even more for the drugs they need to stay healthy."

As Medical Debt Stacks Up, Many People in Their Early 60s Count the Days Until They Are Eligible for Medicare



Joseph Peters, Jr.

As we age, we typically need more health care and often have higher medical costs. Unsurprisingly, middle-aged adults

are therefore more likely than young adults to have debt related to those health expenses. Fortunately, the percentage of adults with significant medical debt decreases when people reach Medicare age.

After analyzing data from the Survey of Income and Program Participation (SIPP), a nationally representative survey of U.S. households, the Peterson Center



on Healthcare and Kaiser Family Foundation have **found** that 12% of adults ages

50 to 64 report having significant medical debt, compared to 6% for those ages 65 to 79.

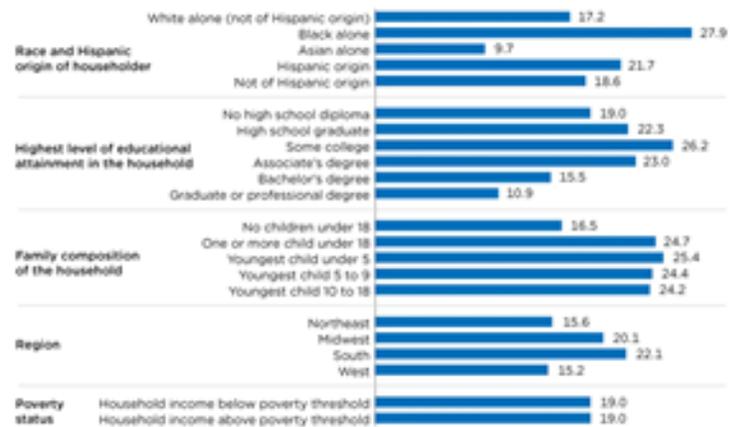
Most of the 23 million adults with significant medical debt owe over \$1,000, and about 3 million (13%) owe more than \$10,000.

People with disabilities, those in worse health, and poor or near-poor adults are more likely to have significant medical debt.

Black Americans and people living in the South or in Medicaid non-expansion states are also more likely to face this financial burden.

"Even for people with health insurance, a serious injury or illness or one major health event can cost thousands of dollars out-of-pocket due to denied claims, deductibles and other cost-sharing requirements," said **Joseph Peters, Jr.**, Secretary-Treasurer of the Alliance. "When Medicare kicks in at age 65, it often comes as a huge relief."

Figure 1.
 Share of U.S. Households With Medical Debt (in percent)



Source: U.S. Census Bureau, 2018 Survey of Income and Program Participation.

Earned income tax credit (EITC): What it is and who qualifies

Prices are soaring at the fastest rate many Americans have ever seen, making one of the most popular tax credits for lower-income workers all the more relevant: the earned income tax credit.

But while millions of taxpayers are eligible for the earned income credit, this particular tax break is among the trickiest. IRS Commissioner

Chuck Rettig told lawmakers in a March testimony that the credit has an error rate of 25 percent.

Here's how the earned income credit works, including what it is, who qualifies and how you can claim the money to ensure you don't leave any money on the table when you file.



Department of the Treasury
 Internal Revenue Service

What is the earned income tax credit (EITC)?

The earned income tax credit is one of the largest refundable tax credits for the country's lowest paid workers. Workers don't have to owe taxes to receive the credit, and many taxpayers **receive more money through the credit than they pay in federal income tax.**

according to the Internal Revenue Service (IRS). All of that means, the credit can either reduce the total taxes individuals owe - or give them money back in the form of a refund....**Read More**

Who qualifies for the earned income tax credit
How to claim the earned income tax credit

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New KFF Report Examines Beneficiary Exposure to Part B Drug Costs

A new **brief** from the Kaiser Family Foundation (KFF) examines the often extreme cost liability that **Part B covered drugs**—typically, those administered by physicians and other health care providers—can carry. The findings are clear: immediate action is needed to rein in drug prices, improve affordability, and better support people with Medicare.

As with most **Part B covered services**, people with traditional Medicare generally pay 20% coinsurance for Part B drugs, with no annual limit on their out-of-pocket (OOP) costs. Although many beneficiaries have supplemental coverage that helps with these expenses, such as a **Medigap** policy or **Medicaid**, nearly **6 million** people do not and must pay the full 20%.

Medicare Advantage (MA) enrollees also usually face high **cost-sharing** for Part B drugs. Plans can set coinsurance rates at no more than 20% for Part B drugs administered in-network, but there is no similar limitation out-of-network. And while MA plans do limit total enrollee OOP costs, the current

caps (\$7,550 for in-network and \$11,300 for in-network and out-of-network combined) are too high.

As a result, and as the report underscores, beneficiaries in both traditional Medicare and MA can face high costs for Part B drugs. Among KFF's key findings:

◆ **In 2019, 25% of the traditional Medicare enrollees who used Part B drugs experienced a cost-sharing liability of at least \$1,000.** Of the four million traditional Medicare enrollees who used Part B drugs in 2019, one in four—one million people—faced at least \$1,000 in cost-sharing. One in five faced \$2,000 or more, while 1 in 10 were on the hook for at least \$5,000.

◆ **More than half of all Part B drugs had an average annual cost-sharing liability of at least \$1,000 in 2019.** Of the 287 Part B drugs that KFF analyzed, 54% had average annual cost-sharing liability of at least \$1,000; 43% would cost enrollees at least \$2,000, while 13% carried a minimum



cost-sharing liability of \$10,000 for a year's access.

◆ **In 2022, most MA enrollees pay 20% coinsurance for Part B drugs provided in-network, but many—more than 21 million—may face higher cost sharing out-of-network.** Among the 8.3 million MA enrollees in plans with out-of-network coverage, close to half (44% or 3.7 million people) would be charged more than 20%—as high as 50%—for Part B drugs administered by an out-of-network provider. Another 31% (2.5 million people) may face coinsurance higher than 20% depending on the type of drug and/or where it is administered. In addition, nearly 15 million enrollees are in plans with no out-of-network coverage; they typically must pay 100% of the cost for Part B drugs administered out-of-network unless they receive prior approval from their plan.

Due to the lack of an OOP limit in traditional Medicare, Part B drug costs can be a

significant burden for people with no or inadequate supplemental coverage. Similarly, MA's OOP cap does not maximize enrollee affordability, and out-of-network cost sharing arrangements can also have substantial cost implications. These structural challenges leave beneficiaries far too exposed. Policymakers must address these flaws, as well as the underlying issue of high and rising drug prices. As KFF notes, the Build Back Better reconciliation bill includes proposals that would begin to do so. Specifically, that “allowing the federal government to **negotiate prices** for some drugs covered under Part B and Part D and by **requiring inflation rebates** for Medicare-covered drugs to limit annual increases in drug prices could help to address the spending burden that Medicare beneficiaries could face if they need high-cost drugs, whether covered under Part B or Part D.”

Medicare Rights continues to strongly urge lawmakers to pass these reforms, without delay.

MedPAC Demonstrates Medicare Advantage Overpayment and Inadequate Quality Metrics

This week, the Medicare Payment Advisory Commission (MedPAC) delivered its **annual report to Congress** that examines Medicare's payment policies, including Medicare Advantage (MA). In this year's report, MedPAC **reiterated** its position that Medicare pays more for MA enrollees than it does for similar beneficiaries enrolled in traditional Medicare and added that it is impossible to judge the quality of MA plans, including plans specifically designed for those who are dually eligible for Medicare and Medicaid.

By MedPAC's estimates, Medicare pays four percent more for beneficiaries who are enrolled in MA than it would if those beneficiaries were covered by traditional Medicare. These overpayments are a result of many complex policy choices. MedPAC notes

that MA plan payments include adjustments “to account for differences in expected beneficiary medical costs. The purpose of risk adjustment is to ensure that plans are adequately and fairly compensated for treating all categories of enrollees—those with high medical costs as well as those with less health care utilization.” But risk adjustment can be gamed by plans who claim enrollees are sicker than they truly are, driving up payments per enrollee with no benefit to the patient or Medicare.

MedPAC is not alone in identifying this MA practice, called “upcoding” or “uncorrected coding intensity,” as a significant issue. For example, the U.S. Department of Health and Human Services



Office of the Inspector General **flagged billions of dollars of payments** to MA

plans based on diagnoses that were found only on medical records and that did not lead to any treatment. Researchers have found similar results, **showing that hundreds of billions of dollars may be at stake due to upcoding.** And insurers have faced **significant federal lawsuits** for the practice as well.

MedPAC highlights this excess funding for several reasons: It is worsening Medicare's long-term fiscal sustainability; people in traditional Medicare are paying extra to fund MA plans; and more beneficiaries are attracted to MA's extra benefits which are funded by rebates from upcoding, leading to

exponential increases in costs and an unbalanced playing field.

In addition, MedPAC flags important gaps in quality information for MA plans, stating, “The current state of quality reporting is such that the Commission's yearly updates can no longer provide an accurate description of the quality of care in MA.” The lack of reliable information on quality may put MA enrollees at risk. This problem is exacerbated in MA plans designed for those who are dually eligible for Medicare and Medicaid—D-SNPs. MedPAC is newly required to report on D-SNP quality, but it notes that “the performance data that MA plans report . . . provide limited insight on the relative performance of D-SNPs.”...**Read More**

Pressure Mounts for Presidential Actions on Drug Prices

When it comes to seniors' issues, the main focus of Congress continues to be on the high cost of prescription drugs. The Republicans in the Senate continue to unanimously refuse to support the broad legislation put forth by Democrats that includes provisions to reduce drug prices, and Senator Joe Manchin (D-W.Va.) still has not agreed to the bill, meaning there are not enough Democratic votes to pass it.

Democratic leaders in the Senate are negotiating with Manchin to see if they can make the changes he seeks so they can pass the bill this year but so far, there has been no breakthrough.

Because of the impasse, there is a group of nearly 100 liberal Democratic members in the House who are urging President Biden to issue executive orders insofar as he can, to lower drug prices. While that is one way to overcome Congressional deadlock, it may be only temporary.

That's because executive orders by one President can easily be overturned by another, or by the courts.

President Obama signed 276 executive orders and hundreds of presidential memoranda during

his eight years in office, while President Trump issued 220 executive orders during his single term.

President Biden has issued 84 executive orders so far and in his first days in office he overturned many Trump-era policies.

Democrats prefer to pass legislation that would make the drug-price reductions permanent, but if negotiations with Senator Manchin continue to prove fruitless, it becomes more likely that the President will issue some sort of executive orders.

* * * *

Senate Vote on Insulin Legislation Expected Soon

Because legislation on over-all drug pricing is stalled, new legislation has been offered by Senator Sen. Raphael Warnock (D-Ga.) to specifically lower the price of insulin.

Last week he said he's hoping to get his bill through committee and onto the Senate floor by Easter, which falls on April 17 this year.

Warnock's bill (S. 3700) would cap consumers' out-of-pocket insulin costs at \$35 per month without changing the price drug makers charge for insulin. It would apply only to those who have insurance.

The bill currently has 29 co-sponsors, all Democrats or senators who caucus with



Democrats. Although Warnock has said he thinks the idea ought to garner bipartisan support, so far no Republicans have signaled they will support it, even though a few of them have expressed concern about insulin prices in the past. However, this is an election year and it appears Republicans have no intention of supporting legislation that would give Democrats a legislative victory no matter how much it is supported by the public.

* * * *

Insurance Companies Sue Walgreens for Overcharging for Drugs

A number of health insurance companies, including Blue Cross and Blue Shield units are suing Walgreens, alleging that the company has been engaged in a fraudulent scheme to overcharge for prescription drugs by submitting claims for payment at inflated prices and made false statements to conceal the scheme.

Walgreens has overcharged the plaintiffs hundreds of millions of dollars, the plaintiffs said in a Tuesday complaint filed in the U.S. District Court for the Northern District of Illinois.

According to the suit, Walgreens created a program under which it submitted usual and customary prices to the insurance companies that were "five, ten, or twenty times

higher" than what cash customers paid.

Walgreens knowingly and wrongfully overcharged the insurance companies by submitting false and inflated usual and customary prices to the plaintiffs, the complaint says.

It also intentionally concealed from the companies the actual cash prices offered to members of the general public by making false statements and omitting material facts, the complaint says.

We want to stress that, like anyone who is sued in court, those who are suing have to prove their case and the fact that there is a lawsuit doesn't mean the things they are charging are true.

But with so many Americans struggling to pay for the drugs they need, and with legislation to lower drug prices held up in Congress, it is troubling to hear about this. Like so many cases involving large corporations, this case is likely to go on for a very long time and could eventually be settled out of court.

However, it reinforces our belief that Congress needs to act to lower drug prices, and reinforces our determination to fight as hard as we can to make that happen.

High deductible health plans are a barrier to care for working people

Corporate health insurers can use a range of tactics to make it seem that they are offering you more at less cost. One such tactic relies on high deductibles to keep premiums down so that the health plan looks more affordable. A recent EBRI report on employers who offer high deductible plans to their workers confirms that high deductibles can be a huge barrier to care.

EBRI looked at the effect on access to care for people with mental health disorders of a switch from a preferred provider organization to a high deductible health plan. EBRI observed that people with major depressive disorders and anxiety were less likely to get care in high deductible health plans.

EBRI further found that

working people with mental health disorders in high deductible health plans used fewer health services of many types. They used fewer office visits, they filled their prescriptions less frequently, they spent fewer days in the hospital and they used emergency rooms less often. Moreover, working people in high deductible health plans also used fewer preventive services, including fewer cancer screenings and vaccinations.

In sum, working people in high deductible health plans saved their employers a lot of money on health care. Workers made the choice to forgo health care services and spend less on health care in a variety of instances. It would therefore stand to reason



that the higher the deductible, the greater the barrier to care for people with Medicare, who tend to live on far lower incomes than working people.

EBRI's findings are in sync with a range of other findings showing that, overall, cost is a barrier to care for people with health insurance. Tens of millions of Americans with insurance are underinsured and live on small fixed incomes. Once out-of-pocket health care costs come into play, they are forced to decide between their health and their rent or mortgage or heat or supper. These are choices that no one should have to make.

A recent **NBER study** found that more than 20 percent of

people with Medicare drop all their prescriptions—including life-saving medicines—when they face a copay increase of as little as \$10.40. As a result, thousands die. So, it's not surprising that high-deductible health plans, with deductibles in the thousands of dollars, lead lots of people to forgo care. Some of these people likely die needlessly as a result.

Congress continues to sit back and let people opt against getting needed health care because of the cost rather than regulating health care prices and guaranteeing access to health care to anyone and everyone who needs it, regardless of ability to pay. Talk about a Darwinian approach that will lead to countless needless deaths and disabilities.

Medical debt on the rise

New research from the Peterson Center on Health Care and the Kaiser Family Foundation finds that Americans are now holding at least \$195 billion in medical debt. Nine in ten of them have health insurance. **Emergency care, COVID-19 care and mental health** care are the three biggest causes.

Three million Americans owe more than \$10,000 in medical debt, and 16 million Americans owe more than \$1,000. Not surprisingly, the most vulnerable Americans face the greatest debt. Researchers say that "Medical debt can happen to almost anyone in the United States, but this debt is most pronounced among people who are already struggling with poor health, financial insecurity, or both,"

In a separate survey of 1,250 people, more than half (55 percent) say they have some medical debt. And, almost half of these people report not being able to purchase a home or put money aside for retirement as a result.

Nearly seven in 10 people (69 percent) who purchase their own health insurance have medical debt and just over six in ten (61 percent) who have employer coverage have medical debt. Just under six in ten (59 percent) without health insurance report having medical debt.

People with health insurance appear to have the same rate of medical debt as people without health insurance. But having health insurance limits the amount of debt people have.



Health insurance deductibles have skyrocketed over the last several years, presenting a barrier to care for many Americans. They are also a driver of medical debt.

Employer plan deductibles average \$1,669 in 2022 for people who work for large employers. People working in companies with fewer than 200 workers face even higher average deductibles, **\$2,379**. And, individuals with state health insurance exchange plans and no subsidies faced average deductibles of \$4,364 in 2020.

Total average out-of-pocket costs for health care are now \$12,530. That includes premiums, deductibles and copays. And, it represents about 20 percent of the typical person's

annual income, \$67,521 in 2020. People not yet eligible for Medicare, with incomes between 100 and 400 percent of the federal poverty level, are entitled to subsidies that can bring down their health care costs significantly. People with Medicare with low incomes are also eligible for government assistance paying premiums, deductibles and coinsurance, through **Medicaid** and **Medicare Savings Programs**

To minimize your costs, plan ahead. If you have Medicare, to save money, make sure you have the number of the local ambulance that takes Medicare on your phone and your refrigerator. If you're in a Medicare Advantage plan, have the number of an in-network ambulance.

Major Credit Agencies Will Drop Most Medical Debt From Reports

Most medical debt will be dropped from Americans' credit reports as of this summer, the top three credit reporting agencies said Friday.

The announcement by Equifax, Experian and TransUnion comes as **medical bills** have become the largest source of personal debt in the United States, *CBS News* reported.

Credit reports are used by lenders to determine whether a person is a good loan risk, and having a poor credit score makes

it more difficult to get financial products such as a mortgage or car loan, rent an apartment or even get a job.

The three companies said they will make a number of changes in how they handle medical debt. They include dropping paid medical debt and medical collection debt under \$500 from credit reports, and increasing the time period from six months to one year before unpaid medical debts in collections will appear



on a credit report, *CBS News* reported.

About 1 in 5 U.S. households have health care-related debt,

according to the Consumer Financial Protection Bureau (CFPB), which supervises the credit agencies.

Errors related to medical debt are common on credit reports, and consumers often have difficulty getting the problems cleared up, according to the agency, *CBS News* said.

In a March 1 **report**, the bureau said it planned to "hold credit reporting agencies accountable" for inaccurate medical debt on consumer reports and also to decide whether medical debt should be included in credit reports.

CFPB said Equifax, Experian and TransUnion accounted for more than 6 in 10 complaints received by the agency in 2021, which is more than any other topic, *CBS News* reported.

1 Social Security Surprise That Could Cost You in Retirement

Social Security benefits can make retirement far more affordable, especially if your retirement savings are falling short. The average retiree collects over \$1,600 per month in benefits, according to the Social Security Administration, which can go a long way in retirement.

However, there's one sneaky expense that could take a bite out of your benefits. And if you're not prepared for it, it could throw off your budget in retirement.

How taxes affect your Social Security

Unfortunately, even in retirement, you may not be able to get away from taxes. Your Social Security benefits may be subject to both state and federal

income taxes, and it's wise to prepare for them now so they don't take you by surprise down the road.

State taxes will depend on where you live, as each state has different regulations as to whether

benefits are taxed.

The good news is that 38 states do not tax Social Security at all. The 12 that do include Colorado, Connecticut,



Kansas, Minnesota, Missouri, Montana, Nebraska, New Mexico, Rhode Island, Utah, Vermont, and West Virginia. (North Dakota formerly taxed benefits as well, but as of 2021 has excluded Social Security

from taxation.)

Whether you owe federal taxes will depend on a factor called your "combined income." This is your adjusted gross income (such as **401(k)** withdrawals) plus half of your annual Social Security benefit amount....**Read More**

Percentage of Your Benefits Subject to Federal Taxes	Combined Income for Individuals	Combined Income for Married Couples Filing Jointly
0%	Less than \$25,000 per year	Less than \$32,000 per year
Up to 50%	\$25,000 to \$34,000 per year	\$32,000 to \$44,000 per year
Up to 85%	More than \$34,000 per year	More than \$44,000 per year

How to Avoid Surprise Bills — And the Pitfalls in the New Law

Patients are no longer required to pay for out-of-network care given without their consent when they receive treatment at hospitals covered by their health insurance since a federal law took effect at the start of this year.

But the law's protections against the infuriating, expensive scourge of surprise medical bills may be only as good as a patient's knowledge — and ability to make sure those protections are enforced.

Here's what you need to know.

Meet the No Surprises Act.

Studies have shown that about 1 in 5 emergency room visits **result in a surprise bill**.

Surprise bills frequently come from emergency room doctors and anesthesiologists, among others — specialists who are often outside a patient's insurance network and not chosen by the patient.

Before the law took effect, the problem went something like this: Say you needed surgery. You picked an in-network hospital — that is, one that accepts your health plan and has negotiated prices with your

insurer.

But one of the doctors who treated you didn't take your insurance. SURPRISE! You got a big bill, separate from the bills from the hospital and other doctors. Your insurer didn't cover much of it, if it didn't deny the claim outright. You were expected to pay the balance.

The new law, known as the **No Surprises Act**, stipulates, in broad terms, that patients who seek care from an in-network hospital cannot be billed more than the negotiated, in-network rate for any out-of-network services they receive the

Instead of leaving the patient with an unexpected bill that insurance will not cover, the law says, the insurance company and the health care provider must work out how the bill gets paid.

But the law builds in wiggle room for providers who wish to try end runs around the protections.

Caution: The law leaves out plenty of medical care.

The changes come with a lot of caveats.

Although the law's protections



apply to hospitals, they do not apply at many other places, like doctors' offices, birthing centers, or most

urgent care clinics. Air ambulances, often a source of exorbitant out-of-network bills, are covered by the law. But ground ambulances are not.

Patients need to keep their heads up to avoid the pitfalls that remain, said Patricia Kelmar, health care campaigns director for the nonprofit Public Interest Research Group, which lobbied for the law.

Say you go for your annual checkup, and your doctor wants to run tests. Conveniently, there's a lab right down the hall.

But the lab may be out of network — despite sharing office space with your in-network doctor. Even with the new law in effect, that lab doesn't have to warn you it is out of network.

Beware the "Surprise Billing Protection Form."

Out-of-network providers may present patients with a form addressing their protections from unexpected bills, labeled

"Surprise Billing Protection Form."

Signing it waives those protections and instead consents to treatment at out-of-network rates.

"The form title should be something like the *I'm Giving Away All of My Surprise Billing Protections When I Sign This Form*, because that's really what it is," Kelmar said.

Your consent must be given at least 72 hours before receiving care — or, if the service is scheduled on the same day, at least three hours in advance. If you've waited weeks to book a procedure with a specialist, 72 hours may not feel like sufficient advance warning to allow you to cancel the procedure.

Among other things, the form should include a "good faith estimate" of what you'll be charged. For nonemergency care, the form should include the names of in-network providers you could see instead.

It should also inform you of an unfortunate catch-22: The provider can refuse to treat you if you refuse to waive your protections. ... **Read More**

To Families' Dismay, Biden Nursing Home Reform Doesn't View Them as Essential

Relatives who often provide vital caregiving for nursing home residents say the lockdowns during the COVID pandemic showed the need for family members to visit in person with their loved ones.

When the Biden administration announced a set of **proposed nursing home reforms** last month, consumer advocates were both pleased and puzzled.

The reforms call for minimum staffing requirements, stronger regulatory oversight, and better public information about nursing home quality — measures advocates have promoted for years. Yet they don't address residents' rights to have contact with informal caregivers — family members and friends who provide both emotional support and practical assistance.

That's been a painful concern during the pandemic as nursing homes have locked down, caregivers have been unable to visit loved ones, and a significant

number of residents have become isolated, discouraged, or depressed. Thousands of residents died alone, leaving a trail of grief for those who couldn't be by their side.

Altogether, **more than 200,000 residents and staffers** in long-term care facilities perished of COVID-19 in the first two years of the pandemic, according to an analysis by KFF. "What we learned is that family members' support is absolutely essential to the well-being of residents," said **Maired Painter**, Connecticut's long-term care ombudsman.

(**Ombudsmen** are official advocates for nursing home residents.) "We need to make sure that the far-reaching restrictions put in place never happen again."

Although nursing home residents **have a right to have visitors** under federal law, this protection was "degraded"



during the pandemic, said Tony Chicotel, a staff attorney for California Advocates for Nursing Home Reform. "I worry that facilities and public health departments will feel emboldened to cut visitation off at their discretion, whenever there's an infectious disease outbreak," he explained.

What's needed now, Chicotel suggested, is legislation stating that "even in a public health emergency, residents have a core right to support from [informal] caregivers that cannot be waived."

A new "essential caregivers" bill in California (**AB-2546**) would allow residents to designate two such informal caregivers, one of which would have access to a facility around-the-clock without advance scheduling. Caregivers would need to comply with the same safety and infection control protocols that apply to staffers. Laws with a similar intent have

passed in 11 states, according to the **Essential Caregivers Coalition**, an advocacy group formed during the pandemic.

Nationally, the **Essential Caregivers Act of 2021**, another measure along these lines, is languishing in the House Ways and Means health subcommittee. Competing priorities, pandemic-related fatigue, and a sense that the covid emergency "is behind us" are contributing to inaction, said Maitely Weismann, a co-founder of the Essential Caregivers Coalition.

If sweeping nursing home changes don't address the harm to residents when they are cut off from families, "we're only halfway where we need to be," she cautioned. The White House did not respond to requests for comment about whether it planned to address the issue. ... **Read More**

Medicare Advantage Plans Send Pals to Seniors' Homes for Companionship — And Profits

Widowed and usually living alone, Gloria Bailey walks with a cane after two knee replacement surgeries and needs help with housekeeping. So she was thrilled last summer when her Medicare Advantage plan, SummaCare, began sending a worker to her house in Akron, Ohio, to mop floors, clean dishes, and help with computer problems. Some days, they would spend the two-hour weekly visit just chatting at her kitchen table. "I love it," she said of the free benefit.

Bailey, 72, is one of thousands of seniors around the country being visited each week by employees of Papa Inc. Known as "Papa pals," their primary aim is to provide companionship to seniors along with helping with errands and light housework duties. Since 2020, more than 65 Medicare Advantage plans nationwide have signed up with Papa, a Miami-based company, to address members' loneliness — a problem exacerbated by the pandemic.

"It's the best thing ever" to

counteract social isolation, said **Anne Armao**, a vice president at SummaCare. More than 12% of the company's 23,000 Ohio Medicare members used the Papa benefit last year.

But SummaCare and other health plans also stand to benefit by sending Papa pals into members' homes. The workers can help the plans collect more money from Medicare by persuading members to get **annual wellness exams**, fill out personal health risk assessments, and undergo covered health screenings.

Accomplishing these steps helps plans in two ways:

By gleaning more information, plans may discover members have health issues that may earn higher reimbursement rates from Medicare.

Plans can boost their star ratings, which are based on more than 40 performance measures, including cancer, diabetes, and blood pressure screenings; outcome measures such as controlling



hypertension; and overall satisfaction with the plan. Plans that score at least four stars on a five-star scale receive bonuses from Medicare.

Bonus payments from the star ratings make up an increasing share of federal payments to these private Medicare Advantage plans, which are an alternative to traditional Medicare. In 2021, Medicare paid plans \$11.6 billion in bonus pay, double the amount in 2017.

The federal government's base pay for the plans is a monthly fee for each member, but it increases that amount based on the members' health risks. So plans also get billions of dollars a year in extra payments by pinpointing members' health problems through a variety of measures, including the health risk assessments.

Yet federal investigators have found these diagnoses do not always result in **additional treatment or follow-up care to beneficiaries**. As a result, the federal government is probably

overpaying the Medicare health plans and wasting billions in taxpayer dollars, according to the Medicare Payment Advisory Commission that advises Congress.

In a report last September, the Health and Human Services inspector general found 20 Medicare Advantage companies generated **\$5 billion in extra payments** from the federal government for diagnoses identified through health risk assessments and chart reviews without documentation that the patients were treated for these issues.

Nearly half of Medicare enrollees get their coverage through Medicare Advantage.

David Lipschutz, associate director of the Center for Medicare Advocacy, said Papa pals provide an important benefit to seniors by helping them with chores, reducing their loneliness, and getting them to medical appointments. But the benefit can also help the insurers' bottom lines...[Read More](#)

Here comes the sun: Senate agrees on permanent daylight saving time

It's unclear whether the House will act to end America's fall-back, spring-forward clock-moving. But for the moment, senators basked in their agreement.

A bipartisan group of senators has tried and failed, for Congress after Congress, to keep America on daylight saving time permanently. Until Tuesday, when their bright idea finally cleared the chamber.

Just two days after the nation's latest stressful "spring forward" to the later sunsets of daylight

saving time, the Senate **unanimously and surprisingly passed** Sen. Marco Rubio's (R-Fla.) bill to lock the clocks. The quick and consequential move happened so fast that several senators said afterward they were unaware of what had just happened.

Shortly after the Senate came back from a recess for a GOP lunch and a Democratic visit to the White House, Rubio took to the floor and passed a bill with a



name befitting his state, the Sunshine Protection Act.

"If we can get this passed, we don't have to keep doing this stupidity anymore," Rubio said. "Why we would enshrine this in our laws and keep it for so long is beyond me."

As he made his request, Sen. Kyrsten Sinema (D-Ariz.), presiding over the Senate, appeared to exclaim: "Oh, I love it." (Sinema's state does not observe daylight saving time.)

Though some senators had offered objections to the proposal in recent days, all of them melted away in the end, said Sen. Sheldon Whitehouse (D-R.I.), one of Rubio's partners on the bill. He said the bill's backers intentionally waited until the nation was reeling from yet another time change, which occurred on Sunday: "We did try and get it done once the clocks had just changed. Because it made it more timely..."[Read More](#)

Free COVID Tests, Treatments for Uninsured Americans Cut for Lack of Funding

Uninsured Americans will no longer be covered for free COVID-19 tests and treatments because of the budget impasse in Congress, a Biden administration official said Tuesday.

The program was to stop accepting claims at midnight Tuesday, according to Martin Kramer, a spokesman for the Health Resources and Services Administration, the *Associated Press* reported.

"The lack of funding for COVID-19 needs is having real consequences," Kramer said in a statement. "We have begun an orderly shutdown of the program."

After April 5, the program will have to stop accepting claims for vaccination-related costs, Kramer warned.

The program, which reimburses hospitals, clinics,



doctors and other service providers for COVID care for uninsured people, is a victim of the budget battle over Biden's request for an additional \$22.5 billion for an ongoing COVID response, the *AP* reported.

A **fact sheet** from the White House details further potential fallout from the lack of funding. It says the government will not have enough money to

provide **boosters** or vaccines targeting specific variants to all Americans, while the supply of **monoclonal antibody treatments** will be gone by late May. Additionally, certain treatments needed by patients with immune system problems could soon be hard to get, and continuing a robust **COVID testing** will be again become a challenge....[Read More](#)

Pfizer asks FDA to authorize 2nd Covid booster for people 65 and older

Pfizer and BioNTech announced Tuesday that they asked U.S. regulators to authorize a second Covid-19 vaccine booster for people 65 and older.

If the Food and Drug Administration grants authorization, the additional shot would go to a group of people who are among those with the highest risk of serious illness and death from Covid.

Pfizer cited data from Israel that showed Covid infections were 2 times lower and rates of severe illness were 4 times lower among individuals who received a second booster dose of the vaccine, compared to those who received only one booster shot.

The second booster was administered at least four months after the initial booster,

Pfizer said.

The company also included data from Israel on health care workers who had been vaccinated and boosted with the vaccine.

That data showed participants saw neutralizing antibody titers increase sevenfold to eightfold a few weeks after the additional booster dose.

The FDA has authorized booster shots for everyone 12 and older on an emergency use basis.

Multiple studies have shown that the protection from the initial booster dose begins to wane after several months, particularly against the omicron variant of the coronavirus.

Pfizer CEO Albert Bourla said Friday that the company was close to submitting data to the



FDA on a fourth dose of its vaccine after its scientists found that the protection from the first booster began to wane after three or four months.

The Centers for Disease Control and Prevention recommends everyone ages 12 and up receive a booster five months after their second shot of either the Pfizer or the Moderna vaccine or two months after receiving the single-dose Johnson & Johnson vaccine.

More than 66 percent of Americans ages 65 and older who are eligible for a booster have received one, according to data from the CDC.

If the additional Pfizer booster is authorized, it's unclear if every eligible person who wants a

second booster will be able to get one — the U.S. government currently only has enough doses for immunocompromised people to seek a fourth shot, a senior administration official said Tuesday.

Health experts have said that additional shots will likely be needed, though it is still unclear when and how often.

Experts also still don't know if every person will need an additional dose, but it makes sense for the elderly to get their shots first, said Dr. Anna Durbin, a vaccine researcher at Johns Hopkins University.

"Because we know already that their immune systems don't work quite as well and that they are at higher risk for severe disease," she said.

Knee Replacement in Folks Over 80: Less Risky Than You Think

Knee replacement surgery is increasingly common among people over 80 sidelined with knee pain, and the procedure isn't as hazardous for them as often assumed.

That's the main message from a new study of more than 1.7 million seniors who underwent knee replacement surgery.

The findings come as no surprise to Dr. Thomas Fleeter, whose oldest knee replacement patient was 96.

Age is just a number when it comes to knee replacement surgery, said Fleeter, an

orthopedic surgeon with offices in Reston and Centreville, Va. He was not involved with the new study.

"Nobody wants to live in pain, and one of the greatest fears of elderly people is being dependent," he said. These folks want to go to the grocery store, see their grandchildren, travel, garden and live their lives to the fullest, he added.

For many of them, knee replacement surgery can help meet these goals.



Octogenarians do have longer hospital stays after knee replacement surgery and are also more likely to be readmitted to the hospital within 90 days than patients aged 65 to 79, but the two age groups tend to have similar risks for other complications, the study team found.

"We are seeing an increase in life expectancy, and more people want to sustain a good quality of life and activity, so patients older and older are considering knee replacement as a way to

overcome chronic knee pain," said study author Priscilla Varghese, a medical student at SUNY Downstate in New York City.

Varghese conducted the study at Maimonides Medical Center, in Brooklyn, during a summer research program. "Knee replacement surgery carries a very low risk for people aged 80 and older, and they will likely have a substantial, if not complete, reduction of pain after surgery," Varghese said... Read More

More Than Half of Cancer Patients End Up With Medical Debts

More than half of individuals who are diagnosed with cancer end up in some form of medical debt, and 53% of those individuals have a debt that ends up in collection, according to data that was released yesterday by the American Cancer Society. Three-quarters of those who are diagnosed said that they were unprepared for the financial toll that having the disease would place on the and their families.

The ACS conducted a poll of

1,200 cancer patients last month to collect its research and found that 35% currently have unpaid medical bills and only 32% were able to pay their bills without incurring any debt. Only 16% have paid off debts that were incurred as a result of being treated for cancer.

For those who incurred medical debt, more than 50% had at least \$5,000 and 22% had more than \$10,000, according to the survey. More than 25% of



the respondents were in debt for at least three years and 46% said that their credit scores had dropped because of unpaid medical bills.

Accumulating medical debts after being diagnosed with cancer has led many to delay other important financial decisions or make changes to their situations while also avoiding being treated for other illnesses. Nearly two-thirds of the respondents said they have

delayed medical care for minor issues and 45% have done so for serious issues. Many have been forced to put off vacations or other major purchases, and to cut back on food, clothing, and other basic household expenses.

Ultimately, 16% of cancer patients said that they have suffered negative setbacks, such as a delayed diagnosis or longer recovery times or recurrences of the disease as a result of the financial toll that the diagnosis and treatment has taken.

A Routine Checkup Led Him to Fix a Leaky Heart Valve Before It Became a Problem

When Randy Fritz went to his primary care physician for a checkup, he hadn't been to see his doctor in more than a decade, but he wasn't concerned. Why would he be? He played tennis and racquetball regularly with nary a problem. He ate healthy foods. He felt fine.

So, he was shocked by what his doctor told him: He had a heart murmur and needed to see a cardiologist.

"The cardiologist said I had a leaky mitral valve," said Fritz, who lives near Austin, Texas. "I jokingly said, 'So I guess I'll need surgery?'"

"Yes," his doctor said.

"I was being sarcastic!" Fritz replied.

"Sarcastic or not," his doctor said, "you're going to need it."

Then the cardiologist emphasized two points. Even if Fritz felt fine, a leaky mitral valve would eventually degrade

his quality of life. It wasn't a question of if but when. And he would be better off repairing the valve while he was healthy.

"Valves in the heart are designed to let blood flow in one direction only," said Dr. Stephen J. Dewan, the cardiothoracic surgeon who performed Fritz's procedure. "Randy's valve was defective and allowed blood to go backwards inappropriately. To compensate, the heart tends to pump more blood."

Left untreated, he said, patients can develop shortness of breath and atrial fibrillation, which need even more intervention.

"We want to interrupt this before the chambers of the heart get too big," Dewan said, "before patients develop symptoms."

Studies show, he added, "that folks who are operated on while they are healthy and



asymptomatic tend to do better further down the road" than those who have surgery once they've developed atrial fibrillation.

"That was one of the main things I was told: If I waited too long and got an oversized ventricle, it would not be repairable," Fritz said.

Still, he had no symptoms, which was why his wife and their three grown children struggled to reconcile that this seemingly healthy guy needed heart surgery.

Fritz decided to have an echocardiogram every six months. If it showed his situation was worsening, he'd have surgery.

Everything looked fine until mid-2019. "My cardiologist wanted me to have the surgery in 2020, but the pandemic hit, and elective procedures were being shut down. I didn't want to be in

the hospital during that time anyway."

Fritz began going in for tests every quarter. After his echocardiogram in January 2021, almost four years after this cardiac waiting game began, his cardiologist told him, "You can't wait."

So Fritz, who still felt fine, resigned himself to the surgery. He went online to research his condition and the surgery.

"It would have been better if I'd never looked," he said. "You don't want to know all the things they're going to do to you and all the things that can go haywire. That's input you don't need. Nothing positive can come out of that."

He took a deep breath and put his trust in his surgeon, who completely understood Fritz's curiosity...[Read More](#)

Mammograms Can Also Highlight Heart Risks

Your annual screening mammogram may do more than spot breast cancer early — it may give you a heads up on your heart disease risk, too.

[Digital breast X-rays](#) can also detect a build-up of calcium in the arteries of your breasts, an early sign of heart disease. These white areas — known as breast [arterial calcification](#), or BAC — are markers of hardening in the arteries and tend to go along with advancing age, type 2 diabetes, high blood

pressure and inflammation. (It is not the same as calcification of the inner layer of the arteries that is often found in smokers or people with high cholesterol.)

"A single test that is universally accepted can address the two leading causes of death in women," said study author Dr. Carlos Iribarren. He is a research scientist at the Kaiser Permanente Northern California Division of Research, in Oakland.



For the study, his team reviewed health records of more than 5,000

women, aged 60 to 79, who underwent one or more [screening mammograms](#). None of these women had a history of heart disease or breast cancer when the study began. They were followed for about 6.5 years.

Those whose mammogram showed breast arterial calcifications were 51% more likely to develop heart disease or

have a stroke compared with women without calcium build-up in their arteries, the study found.

In addition, women with calcium build-up were 23% more likely to develop any type of heart or vascular disorder, including heart disease, stroke, heart failure and related diseases, the study showed.

"BAC provides additional information and is not intended to replace any current risk factors for heart disease," Iribarren said...[Read More](#)

CPR 'Heroes' Need More Support, Report Says

When she arrived at her neighbor's house and found him unconscious and turning blue, Brianna Colquitt knew what to do.

While someone called 911, Colquitt, then a high school senior in Carrollton, Georgia, started CPR. She kept it up until emergency responders arrived. Her training, which she'd received in a high school health class the year before, had prepared her to act, she said. "Everything just clicked."

But it didn't prepare her for everything that followed. First came the news that her neighbor

didn't make it. Then came the wondering: Had she done all she could? Even now, more than three years later,

"the memories are very vivid, because it was a traumatic experience," Colquitt said.

The need to understand such experiences is part of what inspired a new report from the American Heart Association about lay responders and CPR.

"We've trained people for decades to do bystander CPR, but we've never actually gone back and paid attention to supporting them after we call



them to action," said Katie Dainty, who led the writing committee for the scientific statement published Monday in the AHA journal *Circulation*.

Lay people who perform CPR are "amazing heroes," said Dainty, a research chair in patient-centered outcomes at Toronto's North York General Hospital. The new statement aims to serve those people better by summarizing the latest research on their experience, which could improve training, remove barriers to people taking action and, ultimately, save

lives.

An estimated 347,322 adults in the U.S. have a cardiac arrest each year, AHA statistics show. CPR approximately doubles the odds of someone surviving a cardiac arrest, yet bystanders in North America initiate CPR only 39% to 44% of the time, according to the new report.

There are big challenges to improving that rate that go beyond more training, said Dainty, who also is an associate professor at the Institute of Health Policy, Management and Evaluation at the University of Toronto....[Read More](#)

Palliative Care Crucial After Severe Stroke, But Many Patients Miss Out

Landing in the hospital with a serious illness such as stroke can be one of the worst experiences of a person's life.

Why, then, do so few take advantage of a medical specialty aimed at easing pain and suffering during their hospital stay?

Palliative care professionals focus on improving a patient's quality of life by emphasizing pain management and symptom relief during medical treatment. They also help the sick person and their loved ones deal with stress and grief and guide them through important decision-making.

But only 1 in 5 people

hospitalized with a severe stroke during a recent three-year period received a palliative care consultation, according to a recent study in the *[Journal of Pain and Symptom Management](#)*.

"I don't think that every patient who has a severe stroke necessarily needs a palliative care consult, but I have a feeling it should be more than 20%," said senior author Dr. Alexia Torke, a research scientist at the Regenstrief Institute in Indianapolis.

"Such a life-changing event really needs a lot of support for the patient and family, and one



aspect of support both coping with a life-threatening illness and making decisions is palliative care," she added.

Palliative care is a relatively new field. It is sometimes mistaken for hospice care, which "is specifically focused on the very end of life and those who are dying," said Dr. R. Sean Morrison, chairman of the Brookdale Department of Geriatrics and Palliative Medicine at Mount Sinai in New York City. He was not part of the study.

But palliative care is meant to ease the suffering of all patients, regardless of their prognosis,

Morrison and Torke said. "Palliative care is team-based care that's focused on improving quality of life for people living with serious illness of all ages, and can and should be provided at the same time as all other appropriate treatments, including those to prolong life," Morrison said.

"When palliative care is provided at the same time, people have reduction in pain and other symptoms, their families feel better cared for and supported, and in cancer, for example, they live longer," he added....[Read More](#)

Lots of Napping Could Raise a Senior's Odds for Alzheimer's

Taking longer or more frequent naps during the day may sound enticing, but it may be a harbinger of Alzheimer's disease.

Older adults who nap throughout the day may be more likely to develop [Alzheimer's](#), while napping may also be a consequence of advancing Alzheimer's, a new study suggests.

"Daytime napping and Alzheimer's disease seem to be driving each other's changes in a bi-directional way," said study author Dr. Yue Leng. She is an assistant professor of psychiatry at the University of California, San Francisco.

The bottom line? "Older adults, and especially those with Alzheimer's disease, should pay more attention to their daytime napping behaviors," Leng said.

There are several potential ways that [daytime napping](#) and Alzheimer's may be linked.

"It could be a reflection of underlying Alzheimer's pathology at the preclinical stage that affects the wake-promoting network and contributes to increased daytime sleepiness," she said. "Excessive daytime napping might also impact and interact with nighttime sleep, resulting in



altered 24-hour [circadian rhythms](#), which has also been linked to an increased risk of Alzheimer's."

For the study, more than 1,400 older Americans, average age 81, wore a watch-like activity monitor for two weeks every year. Any prolonged period of no activity from 9 a.m. to 7 p.m. was considered a nap. Participants also underwent a battery of neurological tests each year.

When the study started, more than three-quarters of participants showed no signs of any cognitive impairment, 19.5% had mild cognitive

impairment, and slightly more than 4% had Alzheimer's disease.

Daily napping increased by about 11 minutes per year among folks who didn't develop cognitive impairment during roughly 14 years of follow-up. The greater the increase in naps, the more quickly memory and thinking skills declined, the findings showed.

The rate of increase in naps doubled after a diagnosis of mild cognitive impairment and nearly tripled after a diagnosis of Alzheimer's disease, according to the report published March 17 in the journal *[Alzheimer's & Dementia](#)*....[Read More](#)

Triglycerides a Stroke Danger, Even With Statin Treatment

Stroke survivors may be watching their "bad" cholesterol, but a new study suggests another type of blood fat could put them at risk of a repeat stroke within the next year.

Researchers found that stroke survivors with [high triglycerides](#) suffered repeat strokes at about twice the rate of survivors with normal triglyceride levels. Their risk of heart attack and severe chest pain were similarly raised — even if they were taking cholesterol-lowering statin drugs.

However, experts said it's not clear that high triglycerides, per

se, were to blame.

They may simply be a marker of something else that's going on, said Dr. Leah Dickstein, a clinical assistant professor of neurology at NYU Langone Health in New York City.

"We don't know that treating high triglycerides will lower these risks," said Dickstein, who was not involved in the study. The good news, she added, is that many of the things [routinely recommended to stroke survivors](#) will help manage their triglycerides. Those include a diet low in saturated fat and [processed](#)



[carbohydrates](#), regular physical activity, and avoiding alcohol. LDL ("bad")

cholesterol gets most of the attention, but triglycerides are another blood fat that can soar when people are overweight, eat too many calories (especially from foods high in sugar or saturated fat) and drink excessively. High triglycerides also tend to go hand-in-hand with conditions like obesity, type 2 diabetes, kidney disease and high blood pressure.

However, it's been unclear whether high triglycerides predict a poorer prognosis for

stroke survivors.

For the new study, Dr. Takao Hoshino and colleagues at Tokyo Women's Medical University followed 870 patients at their hospital. All had recently suffered a stroke or "mini-stroke." At the outset, one-quarter had high triglycerides, defined as 150 mg/dL or higher.

Over the next year, those patients suffered major "cardiovascular events" at higher rates than stroke survivors with normal triglyceride levels....[Read More](#)

Medicare hospice benefit has become a luxury

For many years, Medicare has covered palliative or non-curative care at the end of life through its **hospice benefit**. The benefit is intended to allow people, with six months or less to live, to opt for palliative care and to die in their homes. But, as Alexis Drutchas et al. describe in **Health Affairs**, the Medicare hospice benefit has become a luxury because Medicare is not willing to spend more than a small amount on hospice care.

A large portion of older adults and people with disabilities cannot afford to take advantage of the Medicare hospice benefit and are forced to die in hospital or in a nursing home. They do not have friends or family to care for them and they cannot afford to pay for the in-home caregiving they need in order to take advantage of the Medicare hospice benefit. Without family or friends to supplement the care that

Medicare covers or the resources to pay for caregivers, Medicare hospice providers generally will not step in.

Medicare pays hospice providers about \$203 a day to provide limited routine care to people at the end of life. And, it caps spending on hospice care to \$31,297 a person. For this money, people can only receive a small amount of care from nurses and home-health aides. Hospice providers do not want to take on patients who are at risk living on their own at home.

Talk to your doctor about your health care wishes at the end of life and, specifically, about the Medicare hospice benefit during your annual wellness visit, which Medicare covers. If you might be interested in hospice, find out whether there's a hospice in your community that you would want to use. Keep in mind that **one in**



five hospices suffer from severe deficiencies.

Be aware that for-profit hospice agencies might be very different from non-profit agencies. Two in three hospice agencies are now **for-profit, owned by private equity and public companies.** They might step in to provide hospice, such as addressing pain or helping with activities of daily living, but **not to deliver the rich array of at-home benefits** people need at the end of life. And, data on hours agencies spent delivering care, on average, are not easily accessible.

Hospice patients often get just 30 minutes of care each day or three and a half hours a week. Thirty minutes a day is not enough to help people with even the simplest of needs, such as help taking medicines, going to the bathroom and bathing,

Medicare is now spending an average of \$80,000 on individuals

in the last year of life. It spends whatever amount necessary for curative treatments and treatments for people with chronic conditions, even if there is no hope of a person's survival. But, it limits spending for palliative care at home for people at the end of life.

To serve the needs of people with disabilities and older adults, Medicare should not put tight constraints on what it spends for hospice care at home. And, it must insist on collecting data on the amount of time hospice agencies spend with patients and how, more broadly, they spend the money Medicare pays them.

When choosing a hospice, people should know how many hours of care a particular agency provides from nurses and home health aides. Hospice Compare does not provide this information

Breakthroughs for Chronic Disease, Cancer, and the Common Flu

The **billions of dollars** invested in covid vaccines and covid-19 research so far are expected to yield medical and scientific dividends for decades, helping doctors battle influenza, cancer, cystic fibrosis, and far more diseases "This is just the start," said **Dr. Judith James**, vice president of clinical affairs for the Oklahoma Medical Research Foundation. "We won't see these dividends in their full glory for years."

Building on the success of mRNA vaccines for covid,

scientists hope to create mRNA-based vaccines against a host of pathogens, including **influenza, Zika, rabies, HIV, and respiratory syncytial virus, or RSV,** which hospitalizes 3 million children under age 5 each year worldwide.

Researchers see promise in mRNA to treat **cancer, cystic fibrosis,** and rare, **inherited metabolic disorders,** although potential therapies are still many years away.

Pfizer and Moderna worked on **mRNA vaccines for**



cancer long before they developed covid shots.

Researchers are now **running dozens of clinical trials** of therapeutic mRNA vaccines for pancreatic cancer, colorectal cancer, and melanoma, which frequently responds well to immunotherapy.

Companies looking to use mRNA to treat cystic fibrosis include **ReCode Therapeutics, Arcturus Therapeutics,** and **Moderna and Vertex Pharmaceuticals,** which are collaborating. The companies'

goal is to correct a fundamental defect in cystic fibrosis, a mutated protein.

Rather than replace the protein itself, scientists plan to deliver mRNA that would instruct the body to make the normal, healthy version of the protein, said David Lockhart, ReCode's president and chief science officer.

None of these drugs is in clinical trials yet. That leaves patients such as Nicholas Kelly waiting for better treatment options....**Read More**

Sleep Apnea Speeds Aging, But CPAP Can Help

Add this to the ever-growing list of health problems tied to sleep apnea: New data shows it ages you.

But the same **new small study** also found that using a **CPAP** (continuous positive airway pressure) machine for at least four hours a night for a year could slow or possibly reverse that trend.

"This highlights the need for both detection of the sleep apnea and for the efficient treatment of the sleep apnea," said study author Rene Cortese, an assistant professor at the University of Missouri.

"Even people that are being treated, sometimes CPAP is not the most comfortable treatment and people don't adhere to the treatment that they're supposed to, but this highlights the need for an efficient treatment," he said.

Obstructive sleep apnea is a condition in which the upper airway is blocked during sleep, causing breathing problems and repeated awakenings. It can be caused by a person's physical structure or other health conditions and can affect oxygen levels in the blood.

The standard treatment is using



a CPAP machine. Through a mask covering the nose and mouth, a patient's airways are kept open to receive a steady flow of oxygen so he or she can breathe normally.

The new study looked at **apnea** along with a phenomenon known as **epigenetic age acceleration.** Simply put, it means that a person's biological age is older than their age in years. It's linked to chronic diseases and early death.

The researchers recruited 24 nonsmokers between 28 and 58

years of age -- 16 who had been diagnosed with sleep apnea and eight who had not. All underwent a sleep study. Their blood and DNA was analyzed using a computer algorithm to measure their biological age. Individuals were then retested after a year of CPAP use.

Cortese said sleep apnea speeds up the aging process through oxidative stress and chronic inflammation. While prior sleep disruptions and lower oxygen levels had accelerated apnea patients' biological aging, regular CPAP treatment had paid off...**Read More**