

### Message from the Alliance *for* Retired Americans Leaders



#### Help Build Momentum for Rep. Larson's Bill that Expands Social Security Benefits



Robert Roach, Jr.  
 President, ARA

H.R. 5723, Rep. John Larson's (CT) "Social Security 2100: A Sacred Trust," expands and strengthens Social Security, increasing benefits for all beneficiaries by requiring wealthy Americans to pay payroll taxes on wages above \$400,000. It will also restore earned Social Security benefits to more than 2 million public sector retirees by repealing the Windfall Elimination Provision and Government Pension Offset.

Rep. Larson, the House Ways and Means Social Security Subcommittee Chairman, introduced the legislation on October 26, 2021. His bill expands benefits across the board, with greater increases for the lowest-income and oldest beneficiaries. A vote on H.R. 5723, which currently has 201 co-sponsors in the House, could come as soon as this spring. Send a letter to your U.S. Representative here and help build the momentum to pass it quickly.

"An increase in Social Security benefits is critical to help seniors fight inflation," said Robert Roach, Jr., President of the

Alliance, who urged passage of the legislation in testimony before the subcommittee in December. "One in four Americans over age 65 relies on Social Security for 90% of their income."

#### Big Pharma's Lies on Drug Prices Debunked



Rich Fiesta,  
 Executive Director, ARA

This week, the Alliance joined the bipartisan patient coalition Patients for Affordable Drugs Now (P4ADN) as it implemented Debunking Big Pharma Week. Throughout the week, P4ADN highlighted five of Big Pharma's biggest lies to shed light on the truth behind important drug pricing reforms.

- ◆ Innovation: While Big Pharma claims that pricing reforms stifle innovation, we can still create innovative medicine at affordable prices.
- ◆ Access: Drug pricing reforms will increase patient access by lowering costs, regardless of what Big Pharma wants you to believe.
- ◆ COVID-19 Vaccines: Even though drug companies claim to have 'saved the day' by quickly producing vaccines for COVID-19, the truth is that the taxpayers saved

ourselves.

- ◆ Out-of-pocket costs: Don't listen when Big Pharma says that patients only care about lowering out-of-pocket costs. We can't lower out-of-pocket costs without lowering drug prices first.

With Congress so close to passing drug pricing reform for the first time in two decades, Big Pharma has ramped-up its disinformation campaign against any bills that threaten its unchecked power to dictate prices of brand-name drugs.

"Unless we combat the misinformation on lower drug price reforms, older Americans will keep paying exorbitant prices for the medicine they need," said Richard Fiesta, Executive Director of the Alliance. "We need to allow Medicare to negotiate lower drug prices even if the drug industry tries to trick members of Congress and Senators into maintaining their outrageous profits through inaction."

#### Workers Memorial Day is April 28 Find an Event Near You



Joseph Peters, Jr.

Workers Memorial Day, April 28, is next Thursday. This year, the labor movement will commemorate those we have lost on the job and will

organize to make the fundamental right of a safe job a reality for all workers. The theme is "Organize! Safe Jobs Now."

Trade unionists around the country and globe are organizing events to observe Workers Memorial Day. Please find an event near you, join the AFL-CIO and fellow Alliance members and honor the victims of workplace injury and illness by calling to organize safe jobs for all workers. Labor will highlight the toll of job injuries and deaths and demand that elected officials put workers' well-being above corporate interests. This year, and every year, the AFL-CIO will defend the right of every worker to a safe job and build collective power to make that right a reality.

"The best thing we can do to improve worker safety is urge senators to pass the PRO Act, H.R. 842, which makes it easier to join or form a union," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "That would mean not only improved worker safety, but also benefits such as health care, pensions and employer contributions to retirement plans. A safer working environment goes hand-in-hand with a more comfortable retirement."



## NATIONAL WEP/GPO REPEAL TASK FORCE DAY OF ACTION & RALLY IN WASHINGTON, DC MAY 18, 2022

Help us to help you. Sign up to attend on the next page.



ADD YOUR NAME

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



**Rhode Island  
Alliance  
for Retired  
Americans** ©



**NATIONAL WEP/GPO REPEAL TASK FORCE  
DAY OF ACTION & RALLY IN WASHINGTON, DC  
May 18, 2022. 8 AM - 5 PM.  
Rally from 11:30 AM - 1 PM**

The Rhode Island Alliance *for* Retired Americans will meet with:

**Senator Jack Reed at 2 p.m.**

**Senator Sheldon Whitehouse at 1:30 pm**

**Congressman James Langevin at 4 p.m.**

**Congressman David Cicilline at 10:30 a.m.**

**For more information and to register by May 18th, go to**

**[www.ri-ara.org](http://www.ri-ara.org)**

**or sign up at**

**[Sign up for the WEP/GPO Day of Action](#)**

**[Washington D.C.](#)**

## President Proposes New Rules for Medicare Enrollment

Last week, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to update Medicare enrollment and eligibility rules that would expand coverage for people with Medicare and advance health equity.

This proposed rule would provide Medicare coverage the month immediately after enrollment, thereby reducing the uninsured period and expand access through Medicare special enrollment periods.

It would also allow eligible beneficiaries to receive Medicare Part B coverage without a late enrollment penalty. This proposed rule would make it easier for people to enroll in Medicare and eliminate delays in coverage.

The proposed rule would also establish a new immunosuppressive drug program that would extend Medicare immunosuppressive drug coverage to certain individuals who have had a kidney transplant.

If finalized, the proposed rule would promote accessibility to vital life-saving drugs. This rule, if finalized, would become effective January 1, 2023.

\* \* \* \* \*

## Fight Over Alzheimer's Drug May Not be Over

We have previously reported on the decision of Medicare to

cover the cost of the very expensive and controversial Alzheimer's drug *Aduhelm* only in very limited circumstances. The decision was important because the unusually large increase in Medicare Part B premiums this year was due to the anticipated costs for covering the treatment of all Medicare-eligible Alzheimer's patients with the drug *Aduhelm*.

With the decision to limit the coverage, it was announced that the Center for Medicare and Medicaid Services (CMS) is looking at lowering the Part B premium increase.

However, the maker of the Alzheimer's drug and patient advocates are increasing their lobbying presence as they press Medicare to reverse its decision.

It is unclear if this increased lobbying effort will affect Medicare's decision on lowering Part B premiums, but it is unfortunate that this has become a political issue rather than strictly a medical-scientific issue.

If the medical evidence was convincing on the effectiveness of *Aduhelm* in treating Alzheimer's, it would be very different, but the results are not clear, which is why Medicare made the decision to pay for it only certain approved clinical trials.

We are watching for the CMS decision about lowering Part B premiums and we will report on



it when it is made.

\* \* \* \* \*

## Who Will Pay Costs for Improving Nursing Home Staffing?

The Biden administration is pushing for increasing federal nursing home staffing requirements. That effort has entered the important rule making phase, which will determine what the staffing requirements will be.

But now these crucial questions are being asked: How much will it cost, and who is going to pay for it?

As is well known, Covid hit elderly populations the hardest with more than 154,000 deaths among U.S. nursing home residents and staff.

As a result, the Biden administration issued a proposal for mandatory minimum staffing levels, which would fulfill a decades-long quest to shore up the quality and uniformity of care in the nation's 15,000-plus nursing homes.

However, some industry critics say the facilities should pay the entire cost for any needed staff additions.

As reported by Bloomberg Government News, industry officials, citing low Medicaid reimbursement rates, say staffing requirements are unworkable and unrealistic, especially during a time of staffing shortages, rising labor costs, depressed occupancy, and costly infection-control measures. They say

higher Medicaid payments, or some other federal funding is needed.

Better staffing in nursing homes, especially among registered nurses, has been linked to improved quality of care and infection control. A 2020 study of Connecticut's 215 nursing homes found that in facilities with at least one confirmed case of Covid-19, every 20-minute increase in RN staffing—per resident, per day—was associated with 22% fewer infections and 26% fewer Covid deaths.

In 2001, the Center for Medicare and Medicaid Services (CMS) recommended a minimum standard of 4.1 nursing hours per resident each day to prevent harm and ensure the safety of long-term residents. That broke down to 2.8 hours from certified nursing assistants; 0.75 hours from registered nurses, and 0.55 hours from licensed practical nurses.

Only 25% of nursing homes, however, report providing that recommended level of 4.1 hours per resident per day.

The CMS will conduct a study to determine the appropriate level of mandatory care and how to finance it before announcing its plan next year. In the meantime, it has asked those affected by the pending decision to share their thoughts on the proposal.

## Members of Congress urge administration to end overpayments in Medicare Advantage

If you have traditional Medicare, you are paying higher Part B premiums to cover higher costs in Medicare Advantage. The Centers for Medicare and Medicaid Services is paying Medicare Advantage plans substantially more than it is spending in traditional Medicare. Congresswomen Katie Porter, Rosa DeLauro and Jan Schakowsky, along with Senator Elizabeth Warren, are leading an effort to end these overpayments in Medicare Advantage.

In total, 19 members of Congress signed onto a letter to Administrator Chiquita Brooks-

LaSure, urging her to end overpayments in Medicare Advantage, which are bolstering insurer profits at significant cost to the integrity of the Medicare program, taxpayers, and people with Medicare. The letter recommends that payments to Medicare Advantage be on a par with payments in traditional Medicare. And, it calls on CMS to increase transparency in Medicare Advantage.

Overpayments in Medicare Advantage not only drive up costs for people in traditional



Medicare, but threaten the Part A Hospital Insurance Trust Fund. Even though Medicare Advantage plans spend significantly less on enrollees' care than traditional Medicare, they are allowed to pocket huge profits at great cost to the Medicare Trust Fund as well as taxpayers. The Congressional letter explains that "Unless CMS addresses overpayments, public funds will continue to finance private profits at the expense of taxpayers, as well as older adults and disabled individuals on Medicare."

Traditional Medicare remains more cost-effective than Medicare Advantage. When launched, Medicare Advantage plans were expected to cost no more than 95 percent of traditional Medicare. "But Medicare Advantage has failed to achieve savings in any year since its inception," the letter goes on to say.

The members of Congress seek to work with CMS to achieve greater savings, transparency and value in Medicare Advantage....[Read More](#)

## KFF Report Highlights State Differences in Access to Medicare's Low-Income Programs

Medicare provides vital health coverage, but the program's high premiums, deductibles, and other cost-sharing requirements can put care out of reach, particularly for people with limited incomes. Some who need help paying for coverage and prescription drugs may qualify for Medicare's low-income assistance programs. This includes the **Medicare Savings Programs** (MSPs), which can cover Part A and Part B premiums and cost sharing. The

MSPs also help by automatically enrolling beneficiaries in the Part D Low Income Subsidy (LIS, or "**Extra Help**"), which pays some to most of an enrollee's Part D prescription drug costs.

A new Kaiser Family Foundation (KFF) **report** examines these assistance programs and their reach, including differences across states.



While MSPs are administered at the state level, the minimum financial **eligibility standards** are set federally at 135% of poverty. Troublingly, these limits are extremely low. In 2022, to qualify for help with premiums and cost-sharing, an individual must have an annual income of \$18,347 or less and assets below \$8,400. States are allowed to ease these limits, but few have.

The LIS eligibility rules are slightly different. They allow people with incomes and assets up to 150% of poverty (\$20,385 in annual income, \$14,010 in assets for an individual in 2022) to receive varying levels of assistance. Unlike the MSPs, LIS is a fully federal program so states cannot set higher income or asset thresholds...**Read More: [The KFF data captures the programmatic and state differences, key findings:](#)**

## Administration Outlines Goals and Steps Toward Health Equity

This week, the Centers for Medicare & Medicaid Services (CMS) **outlined an action plan** to drive health equity. CMS's vision focuses on changing both the agency itself and encouraging health leaders to make their own commitments to advance health equity.

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes."

Despite Medicare's progress in **reducing disparities** in insurance coverage, **challenges persist**. The **COVID-19 pandemic** has **exacerbated** many underlying structural problems,

often leaving racial and ethnic minorities with worse outcomes, poorer health, more chronic conditions, higher rates of COVID infection, and higher death rates. Reducing sexual orientation and gender discrimination in health care is also urgent. Many LGBTQ+ individuals have **significant challenges finding able and willing providers**, and LGBTQ+ individuals who are over age 50 are especially likely to experience **pronounced health disparities**.

CMS's new strategy includes several agency-wide goals to help address this, such as closing the gaps in health care access, quality, and outcomes for underserved populations; promoting culturally and linguistically appropriate services; increasing enrollment outreach; and expanding and standardizing the collection and



use of data, including on race, ethnicity, preferred language, sexual orientation, gender identity, disability, income, and geography.

In addition, CMS highlighted goals and strategies for its various subagencies. For example, the Office of Minority Health will continue to play a significant role, by providing technical assistance, training materials, and outreach to improve services and access to care.

For its part, the Center for Medicare's outlined equity work includes proposals to require information in multiple languages and to give beneficiaries more information so that they can assess Medicare Advantage and Part D plans on their performance on health equity measures.

The Medicare-Medicaid Coordination Office—the office

that works to ensure those who are dually eligible for both Medicare and Medicaid have access to appropriate care—flags potential improvements in coordination between the two programs and in outreach on **Medicare Savings Programs**, which help those with lower incomes better afford their coverage and care.

Other divisions of CMS, including Medicaid, the Innovation Center, and the office that oversees Affordable Care Act plans, also include their specific goals and actions.

At Medicare Rights, we are encouraged by this focus on equity and ensuring all people have access to the coverage and care they need to improve their well-being, their health, and their financial security. We applaud these steps and urge CMS to continue this important work.

## CMS proposes to expand access to Medicare benefits

As anyone who has spent time trying to navigate Medicare knows, the rules are too often complicated and whacky. The Centers for Medicare and Medicaid Services (CMS) plans to fix some of the whackier rules and expand access to Medicare benefits. The proposed **new rules** would eliminate many of the waiting periods people must endure in order to have Medicare coverage.

If finalized, the proposed rules would improve Medicare enrollment and eligibility, expanding coverage to older and disabled Americans. Right now,

people who sign up for Medicare during the three months after they turn 65, must wait two or three months before their coverage begins. And, everyone who enrolls in Medicare during the annual General Enrollment Period between January and March must wait until July 1 for their coverage to begin.

Under the proposed rules, everyone who enrolled in the three months after their 65th birthday month, during the Initial Enrollment Period, would be covered the month after they enrolled. And, everyone who



signed up for Medicare during the General Enrollment

Period—every January through March—would also be covered the month after they enrolled. In addition, CMS is **proposing special enrollment periods** to protect people who delay enrolling because of a natural disaster or because their employer or health plan misled them about the Medicare enrollment rules. Special enrollment periods would also extend to people losing Medicaid coverage and to others on a case-by-case basis because of

exceptional circumstances beyond their control.

The rules would reduce the number of people eligible for Medicare who are uninsured awaiting coverage. The rules would also protect more people from having to pay a penalty for failing to enroll in Medicare Part B when they are first eligible. Right now, people who do not sign up when they are first eligible pay a **10 percent Part B premium penalty** for every year they delay enrolling...**Read More**

## US Rep. Gaetz's Diagnosis of What's Driving Insulin Costs Misses the Root Cause

**"The price of insulin increases as waistlines increase."**



At the end of March, after the House **passed a bill** that would cap the cost of insulin at \$35 per month for insured consumers, **Rep. Matt Gaetz** (R-Fla.) **tweeted** about why he voted against the legislation

"Insulin price increases have more to do with increased consumer demand than the bad behavior of Big Pharma, which I am quick to condemn," Gaetz wrote.

He continued, in a 10-part Twitter thread, to offer weight loss as a potential solution to insulin costs rather than capping prices: "90-95% of people with diabetes have type 2 diabetes, which 'can be prevented or

delayed with healthy lifestyle changes, such as losing weight, eating healthy food, and being active.' Arbitrary price controls are no substitute for individual weight control. Since 2000, the number of diabetes cases in the U.S. has nearly doubled. The demand for insulin has increased and the requisite price increase has followed suit. In other words, the price of insulin increases as waistlines increase."

The tweet picked up attention on social media and from **news outlets**, but we wondered whether there was any connection between demand for insulin and the rising cost of the drug. One economic principle states that, for some products, if demand increases, prices will follow.

Does that hold true for insulin,



a drug that millions of Americans need to survive?

We reached out to Gaetz's office to ask for the evidence to back up his claim but received no response.

So we asked the experts to explain what's going on with insulin prices.

### Types of Diabetes and Treatment

Insulin was first discovered in 1921 and patented two years later. The hormone is essential for people with **Type 1 diabetes** because their pancreas no longer makes natural insulin, needed to regulate blood sugar. An extremely high blood sugar level can be deadly. These patients make up about a tenth of the total number of people with diabetes in the country.

Some patients need to inject

insulin often, at least twice a day.

The majority of people with diabetes, however, have **Type 2**, which has been linked to obesity. Excess weight may interfere with the body's ability to effectively use insulin, leading to high blood sugar levels.

"As obesity increases, diabetes increases as well," said **Dr. Paresh Dandona**, a professor at the University at Buffalo's medical school who studies diabetes.

But many of these patients are not prescribed insulin as a treatment. Around 30% of people with Type 2 diabetes use insulin when other drug options are not successful in treating the disease, Dandona said. For some Type 2 patients, exercising and a healthier diet "may help reduce the insulin dose, but it doesn't eliminate its use."...**Read More**

## What is the 4% rule for retirement withdrawals?

Within the vast topic of retirement, the concept of "the 4% rule" hits right at the core of most people's concerns: how much money is enough money to have in your savings when you finally reach retirement?

There's no shortage of advice about how much you should save for retirement, but there's a lot less clarity around how much money you'll ultimately need when the time comes. This is what the 4% rule addresses.

What is the 4% rule?

The 4% rule is a rule of thumb that suggests retirees can safely withdraw the amount equal to 4 percent of their savings during the year they retire and then

adjust for inflation each subsequent year for 30 years.

The 4% rule is a simple rule of thumb as opposed to a hard and fast rule for retirement income. Many factors influence the safe withdrawal rate such as **risk tolerance**, tax rates, the tax status of your portfolio (i.e., the ratio of tax-deferred assets to taxable assets to tax-free assets) and inflation, among others.

The upside to this go-to rule is its simplicity. Having a guideline from retirement spending that's this clean and simple makes planning much easier. The downsides are that it's a number that might become outdated by



the time you reach retirement, and that any flat number doesn't adjust for market conditions, which surely will change year to year.

Let's dig into the 4% rule a bit more - and unpack whether or not it might be a helpful guiding rule for **your own retirement planning** or whether it's ill-equipped for the dynamic set of factors that rule over long-term savings and future spending.

History of the 4% rule

In 1994, using historical data on stock and bond returns over a 50-year period - 1926 to 1976 - financial advisor William Bengen challenged the previous go-to

thinking that withdrawing 5 percent yearly in retirement was a safe bet.

Based on a **deep dive into the half century of market data**, Bengen concluded that essentially any conceivable economic scenario (even the more tumultuous ones) would allow for a 4 percent withdrawal during the year they retire and then they'd adjust for inflation each subsequent year for 30 years.

Bengen used a 60/40 portfolio model (60 percent equities, 40 percent bonds) and was conducted during a period of higher bond returns (higher interest rates) compared with current rates....**Read More**

## Data Shows Susceptible Seniors Living Alone

Nearly ninety percent of the senior citizens across the U.S. prefer to age in place and grow old at home. Professionals believe that's the place where people can afford to live over other costly places like nursing homes. But even staying home raises concerns, like the ones that block healthy aging. The most significant are lack of transportation, affordable housing, and isolation.

When adults have little access to shopping and social activity,

isolation becomes a high risk factor that plays havoc on their health. Here's what few seniors from my Facebook group says about aging at home with little support and connection — the comments illustrate the challenges.

"Budget, transportation, and health are the main causes of my isolation. I had to give up driving because of severe glaucoma.

Also, having a rare autoimmune disease makes me exhausted most



of the time."

"Loneliness and isolation are a real problem. Our culture is different than most Asian and Latin cultures where no older person has to worry about being alone."

What's troubling when studying the U.S. Census, is the high numbers of older residents living alone. Across America, close to 30 percent of the 65 and over, live at home without support, totaling over 11 million,

and of these, 71% are female.

That's a lot of older adults at risk for isolation, a factor of chronic illness. Research examining loneliness says the effects negatively relates to physical activity, mental, and motor function. Strong social connections are central to physical and mental well-being. But it's a complex issue. When vulnerable older adults have setbacks, they become disconnected and isolated....**Read More**

## Dear Marci: How do I file a quality-of-care complaint?

**Dear Marci,**  
**My mother recently received a misdiagnosis, resulting in unnecessary and painful treatment. We are so upset about her situation but are not sure what to do about it. Is there anything Medicare beneficiaries can do when they receive poor quality of care?**  
**-Vincent (Abbeville, SC)**

Dear Vincent,  
 I am so sorry to hear about your mother's situation. If you have a concern about the quality of care she received from a Medicare provider, your concern can be directed to the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) for your area. The BFCC-QIOs are made up of practicing doctors and other health care experts. Their role is to monitor and

improve the care given to Medicare enrollees. BFCC-QIOs review complaints about the quality of care provided by physicians, hospitals, skilled nursing facilities, home health agencies, and ambulatory surgery centers. Examples of situations about which you might wish to file a quality-of-care complaint include:

- ◆ A medication mistake
  - ◆ Developing an infection during a stay in a facility
  - ◆ Receiving the wrong care or treatment
  - ◆ Running into barriers to receiving care
- You can file a quality-of-care complaint by calling your QIO or submitting a written complaint. When the BFCC-QIO gets your complaint:



Dear Marci

◆ They should call you to ask clarifying questions about your complaint and to get the contact information for your provider.

- ◆ A physician of matching specialty will review the medical record to determine whether the care provided met the medical standard of care, or whether the standard of care was not met.
- ◆ You and your doctor will be notified by phone and in writing when the review is over (the review process can take up to a few months).

Livanta and KEPRO are currently the two BFCC-QIOs that serve the entire country. To find out which BFCC-QIO serves your state or territory and how to contact them, visit [www.qioprogram.org/locate-your-bfcc-qio](http://www.qioprogram.org/locate-your-bfcc-qio) or call 1-800-

MEDICARE.

**If you have a Medicare Advantage Plan**, you can choose to make complaints about the quality of care you receive through your plan's [grievance process](#), through the BFCC-QIO, or both.

**Your state may have other ways for you to file a complaint** about a provider or facility. You may be able to file a complaint through the consumer or patient protection sections within your state's office of the Attorney General. You can also consider filing a complaint through the state licensing boards that oversee providers, for example, the Board of Medicine or the Nursing Board.

I hope your mother is doing better and that this information is helpful to you all.  
 -Marci

## CMS proposes 5 Medicare special enrollment periods

Medicare beneficiaries experiencing specific illnesses or circumstances could soon get Part B coverage outside the normal open enrollment periods under a proposed rule released Friday.

Individuals who are impacted by an emergency or disaster, formerly incarcerated people and those subject to a health plan or employer error that prevented them from enrolling in Medicare on time could get coverage during special enrollment periods under the Centers for Medicare and Medicaid Services proposal.

The agency additionally proposed extending the privileges to people who need to

enroll after their Medicaid eligibility is terminated and others who are experiencing "exceptional conditions." The latter would be decided on a case-by-case basis.

Medicare special enrollment periods for exceptional conditions have never been offered before, according to CMS. Congress gave the agency the authority to establish these special enrollment periods in 2021. Medicare Advantage beneficiaries can also use special enrollment periods to make changes to their coverage, though rules about when changes can be made differ with each



enrollment period.

"These proposals highlight CMS' efforts to advance

health equity and improve access to Medicare," Dr. Meena Seshamani, deputy administrator of CMS and director of the Center for Medicare, said in a statement. "Reducing gaps in coverage, allowing for special enrollment periods for individuals in exceptional circumstances, spending money in a smarter way on kidney transplant patients — these are meaningful changes that put people at the center of their care and improve the Medicare program."

CMS proposed updating regulations governing state payments of Medicare Part A and B premiums for low-income individuals as well, including limiting states' retroactive liability for paying Part B premiums to 36 months for dually-eligible beneficiaries.

The agency also wants to extend Medicare immunosuppressive drug coverage to kidney transplant patients who don't have other health insurance coverage. Congress authorized the program last year.

## Alliance Draws Attention to Dangers of Sen. Scott's "Rescue America Plan"

Pennsylvania Alliance member Mary Wills, President of the Capitol Area Retired Pennsylvania State Education Association, spoke out at a Pennsylvania Democratic Party event on Thursday on the state capitol steps in Harrisburg.

The event came during the week that Americans' federal taxes were due to the IRS. In their remarks, Ms. Wills and

others reacted to Sen. Rick's Scott's (FL) so-called 11-point Rescue America Plan, which would raise taxes on nearly half of all Americans, including seniors.

His plan also calls for "sunsetting" Social Security and Medicare within five years, meaning they would be automatically terminated unless



renewed by legislative action.

Scott is the chairman of the National Republican Senatorial Committee, which is in charge of developing Republican strategy and recruiting Republican candidates for the U.S. Senate.

"The wealthiest member of Congress, with a net worth of more than \$200 million, actually

had the nerve to tell workers and retirees that they're not paying their fair share," said Ms. Wills of the proposed tax changes.

"Workers pay into Social Security over a lifetime," she added regarding the provision that would sunset Social Security. "It is NOT the government's money. How dare Sen. Scott do this!"

## CDC advisers mull what's next for Covid-19 boosters

Vaccine advisers to the US Centers for Disease Control and Prevention continue to mull over what the future of Covid-19 booster shots might look like -- and they acknowledge that entirely different vaccine formulations could be needed.

At their meeting Wednesday, the members of the CDC's **Advisory Committee on Immunization**

**Practices** discussed their next steps around recommending additional booster doses of Covid-19 vaccines for the general public.

Currently, **additional**

**booster** doses are recommended only for certain people with weakened immune systems and adults 50 and older.

"Policy around future doses require continued evaluation of Covid-19 epidemiology and vaccine effectiveness, including the impact of both time and variants, and the ability of doses to improve this protection," the CDC's Dr. Sara Oliver, an epidemic intelligence service officer with the Division of Viral Diseases, said at the meeting.

Before recommending future doses of Covid-19 vaccines,



Oliver said, the committee members would need to assess the nation's recent case counts, hospitalization rates, vaccine effectiveness -- including whether it's waning over time -- and the impacts of circulating coronavirus variants.

As the virus continues to evolve, the "evolution of the Covid vaccines will be important," including the vaccine platforms, Oliver said.

The Covid-19 vaccinations that people get in the future could be completely different formulations from what's being

given now, which is based on the original version of the virus that emerged in late 2019.

### **The next booster might be a new vaccine**

Some companies, including Pfizer/BioNTech and Moderna, are developing variant-specific vaccines that could target whatever strain of the coronavirus is circulating when that booster might be needed. Pfizer and Moderna are working on vaccines that would specifically protect against the Omicron variant, even though it's not clear whether one is needed... **Read More**

## Coronavirus: A new pill treats the virus

A new pill, Paxlovid, treats the novel coronavirus after you become infected. The Food and Drug Administration (FDA) has approved it for emergency use. Three infectious disease experts at **Yale Medicine** explain that Paxlovid is an antiviral pill that can prevent older people and immunocompromised people from being hospitalized and dying as a result of COVID-19.

**How do you get Paxlovid?** Your doctor must prescribe it for you and can do so if you test positive for COVID-19. Anyone over 18 who weighs at least 88 pounds can get a prescription if they are at "high risk" of getting a severe case of COVID-19, either because of age or a serious underlying medical condition, such as diabetes or cancer.

**How quickly must I take**

**Paxlovid for it to work?** You must take Paxlovid within five days of getting COVID-19 symptoms. If you wait longer, there is a high likelihood that COVID will have already affected your system, and Paxlovid will not be able to erase its effects.

**How well does Paxlovid work?** You take a three-pill dose two times each day for five days. Nearly nine in ten fewer people who took Paxlovid in a clinical trial were hospitalized than those who did not.

**How much does Paxlovid cost?** It's free so long as the COVID-19 public health emergency continues. As of now, the public health emergency will last at least until July.

**Is Paxlovid the only drug that treats COVID-**



**19? Molnupiravir (Lagevrio) also treats COVID-19, but its efficacy in terms of preventing hospitalization is not nearly as good as Paxlovid. Paxlovid is also far easier to take than remdesivir, which is administered through an IV.**

**Does Paxlovid have side effects?** It's too early to know all the side effects of Paxlovid. The FDA has a **fact sheet** of known side effects. As a general rule, you should not have serious side effects. But, your taste buds might change slightly or you could get diarrhea. In addition, your blood pressure might increase and you could develop muscle aches.

**Can I take Paxlovid if I am taking other medicines?** It depends. There are interactions if you are a transplant patient

taking organ anti-rejection drugs, or if you are taking certain drugs for heart arrhythmias, or if you are taking blood thinners and cholesterol-lowering medicines.

**If I cannot take Paxlovid, are there other drugs I can take to reduce my risk of hospitalization?** If it is too risky for you to take Paxlovid, you might be able to take sotrovimab (a single IV injection) and remdesivir (a three-day IV injection,) or molnupiravir, another oral medicine.

**Why should I get vaccinated and get booster shots if I can get Paxlovid?** As efficacious as Paxlovid is, you are still at risk of hospitalization if you get the coronavirus. Getting the vaccine and booster shots reduce those risks.

## U.S. Task Force Rejects Daily Aspirin for Heart Health in People Over 60

It seemed a simple prospect -- take a low-dose baby aspirin tablet once a day and reduce your risk of ever suffering a heart attack or stroke.

But new science has shown it's not that simple.

Noting the drug's risk of dangerous bleeding, the nation's leading panel of preventive health experts has reversed course and **now recommends** that most people

not start taking daily low-dose aspirin to prevent their first heart attack or stroke.

The U.S. Preventive Services Task Force (**USPSTF**) updated its guidelines Tuesday to recommend against initiating daily low-dose aspirin in people 60 and older.

The choice for people between 40 and 59 would be between themselves and their doctor, but



the task force warns that the "net benefit of aspirin use in this group is small."

The guidelines' change is mainly based on data from three large clinical trials published in 2018, all of which showed that the benefits of aspirin were minimal and definitely outweighed by the increased risk of gastrointestinal and brain bleeding.

"Those trials really showed

essentially no benefit in reducing cardiovascular events but showed increased rates of bleeding," said Dr. Eugene Yang, chair of the American College of Cardiology's Prevention Section Leadership Council. "I think what we have really learned is that the benefit is really not apparent, and the harm has been consistently demonstrated in terms of increased major bleeding."... **Read More**

## Scientists Pinpoint Five Bacteria Linked to Aggressive Prostate Cancer

Researchers have identified five types of bacteria associated with aggressive prostate cancer, and they say their findings could lead to new treatments for the disease.

The five types of bacteria were common in urine and tissue samples from men with aggressive prostate cancer, according to the team at the University of East Anglia (UEA) in the United Kingdom.

All of the bacteria are **anaerobic**, meaning they can grow without oxygen present, the researchers reported.

For the study, the investigators analyzed urine or tissue samples from more than 600 patients with or without prostate cancer.

"We already know of some strong associations between infections and cancer. For example, the presence of *Helicobacter pylori* bacteria in the digestive tract can lead to stomach ulcers and is associated with stomach cancer, and some types of the HPV virus can cause cervical cancer," project leader Colin Cooper, a professor



at UEA's Norwich Medical School, said in a university news release.

"We wanted to find out whether bacteria could be linked to the way **prostate cancer** grows and spreads," Cooper explained.

Prostate cancer is more commonly a disease men die with rather than from, according to co-author Jeremy Clark, of Norwich Medical School.

"And little is known about what causes some prostate cancers to become more aggressive than others. We now

have evidence that certain bacteria are involved in this and are part of the puzzle," Clark added.

Along with pinpointing the five types of bacteria, the researchers also identified potential biological mechanisms of how these bacteria may be linked to cancer.

The report was published April 20 in the journal ***European Urology Oncology***.

## Is a Drug for Sleep Apnea on the Horizon?

The most common treatments for sleep apnea are mechanical - CPAP machines, mouthguards and the like.

But researchers think they've found a drug that might ease sleep apnea in some.

The drug sulthiame, normally used to treat epilepsy, appeared to reduce breathing pauses by more than 20 events an hour, on average, in **obstructive sleep apnea** patients, according to early clinical trial results.

Those results are some of the strongest ever reported in a drug trial for sleep apnea, researchers said.

"For just over a third of patients in the study, only half of their breathing pauses were left, and in 1 in 5 the number fell by at least 60%," said lead researcher Dr. Jan Hedner, a

professor of pulmonary medicine at the University of Gothenburg in Sweden.

Sulthiame inhibits an enzyme that serves to maintain the balance of carbon dioxide in the body.

Some people suffer from what doctors call a "high loop gain," an elevated sensitivity to blood levels of oxygen and carbon dioxide, said Dr. Kannan Ramar, a sleep medicine expert with the Mayo Clinic in Rochester, Minn.

High loop gain is believed to contribute to sleep apnea in about a third of patients with obstructive sleep apnea, Ramar said.

These patients are more apt to experience a pause in breathing while asleep due to changes in



their oxygen or carbon dioxide levels.

"High loop gain makes the system very unstable," Ramar said. "The medication blunts that response. It makes the system more stable, so it doesn't respond as dramatically to changes in carbon dioxide or oxygen levels. The breathing pauses then subsequently stop."

In the United States, the Sleep Foundation estimates that between 2% and 9% of adults have **obstructive sleep apnea**. The sleep disorder contributes to daytime drowsiness and to heart disease, high blood pressure and stroke.

This early clinical trial was designed to test mainly for safety, and involved about 60 people with moderate or severe sleep apnea. Patients were

randomly assigned to one of three groups -- one receiving a high dose of the drug, another receiving a lower dose, and a third receiving a placebo.

After four weeks, researchers found that sulthiame reduced the number of breathing pauses during the night and promoted oxygenation of patients' blood.

Sulthiame also proved relatively safe, with headache and a pins-and-needles sensation on the skin reported as the most common side effects. Some high-dose patients also reported shortness of breath. No severe adverse events occurred, but six patients from the high-dose group dropped out due to their side effects.

"We have decent effects with very few side effects," Hedner said... **Read More**

## In Long Run, Antidepressants Don't Improve Quality of Life: Study

Millions of Americans take antidepressants to combat low moods. But a large, new study suggests that these medications over time may do little to improve overall quality of life.

"We found the change in health-related quality of life to be comparable or similar between patients that used antidepressant medications and those who did not use them," said study lead author Omar Almohammed, an assistant professor of clinical pharmacy at King Saud University in Saudi Arabia.

The researchers were "surprised by the results," he admitted.

However, "we are not saying that [antidepressants] are not helpful at all," Almohammed noted. Quality of life, he emphasized, is only one of many measures intended to assess health outcomes.

The research suggests patients and their doctors probably should not rely on antidepressants alone.

"We still recommend that patients continue using their antidepressant medications," Almohammed said. "But they



may also want to ask their health care providers to provide them with other

nontherapeutic interventions, as this may have additional impact on their quality of life."

Almohammed's team focused on a large pool of adult patients who participated in an annual health survey conducted by the U.S. National Center for Health Statistics at some point from 2005 to 2015.

In each of those years, about 17.5 million U.S. men and women respondents were newly diagnosed with **depression**, at

an average age of 48. Nearly 58% were prescribed an antidepressant.

The study authors did not specify which antidepressants were used by which patients. Nor did they distinguish between types of depression or differing levels of severity.

Nearly 9 out of 10 patients in the study were white, most (63%) were middle-class or wealthy, and two-thirds were women. Women were more likely to be prescribed antidepressants than men (60% versus nearly 52%), the researchers said... **Read More**

## Intermittent Fasting: Is It Better Than Typical Weight-Loss Diets?

"Time-restricted" eating has become a popular weight-loss tactic, but a new clinical trial finds no benefits in adding it to old-fashioned calorie-cutting.

Time-restricted eating is a form of **intermittent fasting**, in which people limit themselves to eating within a certain time window each day. Outside that window, they swear off everything other than water or other calorie-free drinks.

Time restriction has become a popular **weight-loss strategy**, largely because it's simple. Instead of laboriously counting calories, people only have to watch the clock. And small studies have shown that limited eating windows -- six hours being a popular one -- can help people shed some pounds.

In the new trial, researchers tested whether adding time restriction to traditional calorie-counting had any extra weight-loss benefits.

The verdict was "no," according to findings published April 21 in the *New England Journal of Medicine*.

Researchers in China found that when they had a group of obese adults cut back on calories, with or without adding time-restricted eating, those in the fasting group showed no greater weight loss.

The good news was, both groups were successful -- shedding an average of about 14 to 17 pounds over one year. They also lost body fat and trimmed a few inches from their



waistlines, whether they used time restriction or not.

But experts said the findings do not actually say much about the effectiveness of time-restricted eating, per se.

They pointed out that both study groups were instructed to cut their daily calories by 25%, with the support of an intensive program that involved health coaches and keeping daily food logs.

So it's hard to show an added benefit from layering time-restricted eating onto that, according to Dr. Blandine Laferrère, an endocrinologist and professor of medicine at Columbia University Irving Medical Center in New York City.

Laferrère, who co-wrote an accompanying **editorial**, said the study demonstrates the power of calorie-cutting.

"Calorie restriction works for weight loss," she said.

But the extent to which the results apply to people in the real world is debatable, according to Laferrère.

Another U.S. researcher who studies intermittent fasting agreed.

"This trial is not really testing time-restricted eating," said Krista Varady, a professor of nutrition at the University of Illinois, in Chicago.

People turn to time restriction for a simpler way to achieve the goal of calorie reduction, not as an add-on to calorie-counting, Varady explained....[Read More](#)

## AHA News: Air Pollution Exposure May Cause Heart Attack Within an Hour

Exposure to air pollutants -- even at levels below World Health Organization air quality guidelines -- may trigger a heart attack within the hour, according to a new study from China that found the risks were highest among older people and when the weather was colder.

The study found exposure to any level of four common air pollutants could quickly trigger the onset of acute coronary syndrome. ACS is an umbrella term describing any situation in which blood supplied to the heart muscle is blocked, such as in a heart attack or unstable angina, chest pain caused by

blood clots that temporarily block an artery. The strongest risk occurred within the first hour of exposure and diminished over the course of the day.

"The adverse cardiovascular effects of air pollution have been well documented. But we were still surprised at the very prompt effects," said Haidong Kan, a professor in the School of Public Health at Fudan University in Shanghai. He led the study published Friday in the American Heart Association's journal *Circulation*.

"Another surprise was the non



-threshold effects of air pollution," he said. "In other words, any concentrations of air pollutants (such as fine

particulate matter, nitrogen dioxide, sulfur dioxide and carbon monoxide) recorded in the present study may have the potential to trigger the onset of a heart attack."

Exposure to fine particulate matter -- microscopic solids or liquid droplets that come from automobile emissions, power plants, construction sites and other sources of pollution -- has been unequivocally linked to heart disease, stroke and other

health issues, as well as 4.2 million premature deaths worldwide. These particles can be so small that when inhaled, they may go deep into the lungs or even the bloodstream.

In the new study, researchers analyzed medical data for nearly 1.3 million people treated for heart attacks and unstable angina at 2,239 hospitals in 318 Chinese cities between 2015 and 2020. They compared hourly onset times of heart events with concentrations of fine particulate matter, coarse particulate matter, nitrogen dioxide, sulfur dioxide, carbon monoxide and ozone....[Read More](#)

## New Combo Immunotherapy Prolongs Survival in Patients With Advanced Kidney Cancer

The use of immunotherapy and/or targeted drugs revolutionized the treatment of many cancers, but some people grow resistant to immunotherapy drugs and relapse as a result.

For cases of advanced **kidney cancer**, a new drug in combination with an existing therapy appears to extend survival, according to a new study.

People with advanced kidney cancer were less likely to relapse when they received nivolumab (Opdivo), a PD-1 checkpoint

inhibitor already approved to treat this cancer, and an investigational pill called sitravatinib, early research indicates.

Sitravatinib is part of a class of targeted therapies called tyrosine kinase inhibitors or TKIs.

"This phase 1-2 trial established that the new drug sitravatinib can be safely and efficiently combined with the standard of care immunotherapy drug nivolumab to improve anti-cancer immune responses in



patients with clear cell kidney cancer," said study author Dr. Pavlos

Msaouel, an assistant professor at the University of Texas-MD Anderson Cancer Center in Houston. (Clear cell kidney cancer starts in the lining of small tubes in the kidney.)

"If validated in the ongoing larger studies, the combination of sitravatinib with **immunotherapy** regimens can become a new arrow in our quiver for the treatment of cancer," Msaouel said. Given by injection, nivolumab

shuts down key proteins on immune cells which, when turned on, can give cancer a free pass to spread. TKIs like sitravatinib starve cancer by cutting off its blood supply. Several TKIs are already approved to treat kidney cancer, but sitravatinib may have an advantage over these, Msaouel said.

People can grow resistant to the effects of immunotherapy drugs due to the accumulation of immune-suppressing myeloid cells. Sitravatinib, however, may counteract this....[Read More](#)

## Online Program Helps Stroke Survivors Recover

(Health Day) A healthier lifestyle is recommended for stroke survivors, but that's often easier said than done. Now, online programs are coming to the rescue, according to a new study.

"Online platforms are a viable and impactful model to address the health information needs and behavior change challenges of stroke survivors," said study author Ashleigh Guillaumier of the University of Newcastle in Australia. The study was published April 19 in [\*PLOS Medicine\*](#) and Guillaumier spoke

in a journal news release.

The researchers noted that most of the patients in the study had little to no disability, so the study findings may not be apply to all stroke survivors.

Stroke survivors can face significant challenges due to physical and mental disabilities caused by their **stroke**.

Lifestyle changes, such as reducing or **eliminating tobacco** and alcohol use, getting more physical activity, eating a healthy diet, and treating depression and anxiety, can



significantly improve stroke survivors' quality of life.

This study included nearly 400 adult stroke survivors who completed a phone survey and then received a list of websites with generic health information (control group) or were given 12 weeks of access to an online program called "**Prevent 2nd Stroke**" (P2S), which encourages users to set goals and monitor their progress across a number of health behaviors.

Those in the P2S group also

received text messages encouraging the use of the program.

After six months, 356 of the study participants completed a follow-up survey. It showed that those in the P2S group had higher health-related quality of life scores than those in the control group.

Compared to those in the control group, significantly higher proportions of people in the P2S group said they had no problems with personal care and could participate in their usual daily activities.

## Inappropriate Antibiotic Prescribing in U.S.

The majority of antibiotic prescriptions for U.S. seniors and Black and Hispanic Americans are inappropriate, a new report reveals.

For the study, researchers analyzed federal government data on more than 7 billion outpatient visits to doctors' offices, hospital clinics and emergency departments nationwide between 2009 and 2016.

Nearly 8 million visits (11%) led to antibiotic prescriptions, the researchers reported Thursday at a meeting of the European Congress of Clinical Microbiology & Infectious Diseases in Lisbon, Portugal. Research presented at meetings

should be considered preliminary until published in a peer-reviewed journal.

"Our results suggest that Black and Hispanic patients may not be properly treated and are receiving **antibiotic** prescriptions even when not indicated," said study leader Dr. Eric Young, of the University of Texas Health Science Center in San Antonio.

"We know that physicians typically send patients home with antibiotics if they suspect their symptoms may lead to an infection," Young explained in a meeting news release. "This practice becomes more common



when patients are unlikely to return for a follow-up visit (i.e., no established care within a

clinic or hospital system), which more frequently happens in minority populations."

Antibiotic prescribing rates were highest in Black and Hispanic patients (122 and 139 prescriptions per 1,000 visits, respectively), **the study** found. They were also high in patients under age 18 and females (114 and 170 prescriptions per 1,000 visits, respectively).

In all, 64% of antibiotic prescriptions for Black patients, 58% of those for Hispanic

patients, 74% of those for people aged 65 and older, and 58% of those for males were inappropriate, the researchers reported.

Inappropriate prescriptions were most often written for conditions not caused by a **bacterial infection**, such as non-bacterial skin conditions, viral respiratory tract infections and bronchitis, the study found.

The findings raise questions about the effectiveness of efforts to reduce inappropriate antibiotic prescribing and underscore the need to redouble efforts to cut down on that in primary care, the study authors said. ... [\*\*Read More\*\*](#)

## Despite Hopes, Vitamin K2 Supplements Fail to Slow Calcium Buildup in Heart Valve

The progressive narrowing of the aortic heart valve in a group of older men could not be slowed during a recent clinical trial using vitamin K2 supplements, dampening hopes of finding a medical treatment for this common but serious condition.

The research, published Monday in the American Heart Association journal *Circulation*, built upon earlier studies suggesting vitamin K2 supplements could slow the progression of aortic stenosis, a narrowing of the valve that controls blood flow from the heart to the rest of the body. But this randomized, double-blind, placebo-controlled trial – considered the gold standard of epidemiological studies – found vitamin K2 and vitamin D

supplements did not slow the progression of calcium deposits on the aortic valves of older men once the process had begun.

"As previous animal studies, epidemiological studies and an open-label study did suggest a beneficial effect, we hoped for a positive trial," said lead study author Dr. Axel Diederichsen, a professor in the department of cardiology at Odense University Hospital in Denmark. "Thus, we were surely disappointed."

Aortic stenosis is the most common heart valve disease in high-income countries, according to the study, which estimates it affects about 2% to 5% of people older than 65. The number of people in the United States and Europe with aortic stenosis is



expected to more than double by the year 2050, according to American Heart Association statistics that estimate 12.4% of

people over 75 have the condition.

Symptoms may include chest pain, a fluttering heartbeat, trouble breathing, lightheadedness, fatigue, swollen ankles or feet and difficulty sleeping. There are no treatments when detected early, other than trying to control risk factors such as high blood pressure, high cholesterol, obesity, diabetes and gum disease. In the later stages, it is treated by replacing the heart valve. If not treated, aortic stenosis can progress and lead to heart failure and death.

"We haven't had any medical

therapies that slow the progression of stenosis," said Dr. Brian Lindman, medical director of the Structural Heart and Valve Center and an associate professor of medicine at Vanderbilt University Medical Center in Nashville, Tennessee. "We anticipate when we see it in the earlier stages that it will eventually become severe, and you'll have to have your valve replaced."

Lindman, who was not involved in the research, said he was disappointed by the results because prior research suggested "this might be an effective intervention. I very much want to identify an effective medical therapy for these patients, so there's an emotional component to it." ... [\*\*Read More\*\*](#)