

## May 21, 2023 E-Newsletter



### Message from Alliance for Retired Americans Leaders

#### A Possible Default on the National Debt Approaches as GOP Continues to Threaten Seniors' Programs



Robert Roach,  
President, ARA

Congressional leaders from both parties and President Biden left a Tuesday White House meeting without appearing to make progress toward a deal to address the debt ceiling. The country risks a default and economic catastrophe as soon as June 1 if Congress fails to hike the borrowing limit. Analysts increasingly say that an unprecedented federal government default would hurt almost every American, including seniors. **For example, July Social Security benefit payments** could be disrupted and Medicare and Medicaid, which pay for the health care of millions of Americans, would be **unable to pay health care providers**. The White House has **conveyed** to GOP congressional negotiators that one of President Biden's greatest legislative achievements, the **Inflation Reduction Act**, is off the table as a way to cut

spending. The administration is instead eyeing measures like expanding Medicare's ability to negotiate drug prices and clawing back unspent Covid relief funds to reach an agreement.

House Republicans have said for months that they will not agree to raising the debt ceiling unless it is accompanied by drastic federal budget cuts. This week a group of 43 Republicans in the U.S. Senate, led by Sen. Mike Lee (UT), **said in a letter** to Democratic Senate Majority Leader Chuck Schumer that they too oppose voting on a bill that only raises the U.S. debt ceiling without slashing spending.

"The members of the Alliance demand that Congress put the needs of seniors and the American people first and ensure that the Social Security benefits we've earned will be paid in full and on time," said **Robert Roach, Jr., President of the Alliance**. "We must not allow extremists to hold Americans hostage unless their unreasonable demands are met."

#### HELP Committee Passes Package of Bipartisan Drug Price Bills to Increase Competition, Transparency



Rich Fiesta,  
Executive Director, ARA

The Senate Health, Education, Labor and Pensions (HELP) Committee voted Thursday to advance a far-reaching package of bipartisan bills to lower the price of prescription drugs.

The legislation would lower drug prices by promoting transparency, competition, and accountability and also curb anti-competitive pharmaceutical corporations' and Pharmacy Benefit Managers' (PBMs) practices.

Full details on the legislation, including descriptions, links and bill numbers, are available **here**.

"High drug prices continue to hit older Americans hard, and it's encouraging that the Senate HELP Committee was able to work in a bipartisan action to address this crisis," said **Richard Fiesta, Executive Director of the Alliance**. "We call on Senate Majority Leader Schumer to bring these bills to the floor and for the House of Representatives to pass similar legislation without delay."

#### Missouri House Votes to

#### Eliminate State Income Tax on Social Security Benefits



Joseph Peters  
ARA  
Sec.-Trea.

The Missouri legislature has **passed** a bill that eliminates the state income tax on Social Security benefits and provides a property tax credit for senior citizens. The Senate passed the bill in April, 33-1. Because the House did not add onto the Senate bill before passing it, the legislation now goes to Gov. Mike Parson who is expected to sign it.

For the 2022 tax year, **11 states** taxed Social Security benefits: Colorado, Connecticut, Kansas, Minnesota, Missouri, Montana, Nebraska, New Mexico, Rhode Island, Utah and Vermont. Benefits are not taxed by the other 39 states and the District of Columbia.

"Congratulations to Missouri Alliance members who helped get this bill passed," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "Missouri seniors will be better off with this money back in their pockets."

### Homeless Veterans Will Receive Less Help as Pandemic Aid Dries Up

With the COVID-19 public health emergency now officially concluded, congressional Democrats are pushing to revive pandemic-related powers that allowed the **Department of Veterans Affairs** to expand support services for **homeless** veterans.

At a news conference Friday at

the Washington, D.C., chapter of a nonprofit that provides housing and employment assistance to veterans, Democrats on the House Veterans Affairs Committee and advocates for homeless veterans warned that fewer veterans will be able to find help now that emergency



authorities have ended and called on Republicans to move forward with a bill to renew the aid.

"The rate that we receive for servicing a homeless veteran went from, last night, \$164.67 to \$64.52," said Clifton Lewis, executive director of U.S. Vets D.C., where the press conference

was held. "How can you provide services to a veteran with just \$64.52? Housing, food, case management services -- all the things that we do to service homeless veterans."...**Read More**

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# Republicans Vow Not to Cut Veterans' Benefits. But the Legislation Suggests Otherwise

*Addressing the impact of the House GOP debt-ceiling bill on veterans' programs, "I'm dead serious that we're not cutting veterans, and I mean it."*



House Republicans have set themselves a tough, if not impossible, task in attempting to use a standoff over **the nation's debt limit** to cut federal spending to what it was in 2022.

Retrenching to those budget levels would **require cutting** 8% or 9% from the **discretionary program side of the ledger**, which excludes **entitlement programs such as Social Security and Medicare**. Spending on those programs is required by law. Other spending is dictated by congressional appropriations annually. The latter is up for debate here.

Nevertheless, House Republicans tried to thread the needle with the **Limit, Save, Grow Act**, which narrowly passed the House on April 26. Its backers say the measure would address the debt ceiling while implementing "commonsense spending reforms." The House GOP leadership promised to

spare programs that are popular with Republican voters, such as the defense budget and veterans' health services.

Democrats pounced on these possible cuts, especially those that would affect veterans. Their talking points appeared to infuriate Rep. Mike Bost (R-Ill.), chairman of the House Committee on Veterans' Affairs. On the House floor, he drew a line in the sand.

"I'm dead serious that we're not cutting veterans, and I mean it," Bost said. "The White House and Democrats know that we can get our fiscal house in order while ensuring our service members and veterans are taken care of, and yet, with no regard for the impact of their words, they continue to speak lies about how House Republicans are cutting veterans' benefits."

With such an unequivocal statement, we wondered whether Bost was correct. Can the GOP plan dramatically reduce federal spending without taking away funding for veterans' programs?

To understand this fully, two things need to be examined: the budget projections that suggest the GOP plan would result in trims to veterans' programs, and

what is spelled out in the legislation.

## Digging Into the Numbers

Democrats and agencies within the Biden administration, such as the Department of Veterans Affairs, looked at the GOP bill and did their own math to determine budgetary estimates.

Because the bill is mostly a list of general spending categories, the estimates reflect uniform cuts to discretionary spending. And, because there is no specific language in the House-passed measure to exempt support for veterans' programs, the VA assumed a full, 22% cut for fiscal year 2024 compared with 2023 funding and estimated reductions as high as \$29.7 billion.

That could translate to 13 million fewer health care appointments for veterans and significant cuts to benefit payments, staffing, and clinic construction, according to the agency.

Bost's communications director, Kathleen McCarthy, said, however, that Democrats are knowingly making a bogus assumption that cuts will be applied evenly, and pointed to public statements by Republican leaders who have insisted

veterans will be spared.

"We make sure that our veterans and our service members are taken care of," House Speaker Kevin McCarthy **said in a speech** at the New York Stock Exchange last month.

"We will provide for our national defense, take care of veterans, and secure our border — all while reducing overall spending," House Appropriations Committee Chairwoman Kay Granger (R-Texas) **said when Republicans unveiled** their plan.

But delivering on that promise would necessitate even deeper cuts to other programs.

Of the \$1.7 trillion discretionary budget spent in 2022, a Congressional Budget Office **analysis released in March** found that \$113 billion went to certain veterans' benefits and \$751 billion covered defense.

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## Can You Collect Social Security and Be Eligible For Food Stamps?

More than 70 million Americans collect **Social Security**, Supplemental Security Income (SSI), or both, according to the Social Security Administration (SSA). The vast majority are people age 65 and older collecting Social Security retirement benefits alone.

The Supplemental Nutrition Assistance Program (**SNAP**) is the country's largest anti-hunger initiative. Formerly known as food stamps, the program supports nearly 42 million beneficiaries who rely on SNAP to buy groceries and other food.

Both programs help tens of millions of people avoid poverty and food insecurity, but are the two mutually exclusive? Can Social Security recipients also collect food stamp benefits?

Despite much misinformation and an unfortunate number of eligible people who do not, the answer is yes — **food stamps**

### can go to seniors and others on Social Security.

#### **SNAP Treats Social Security Like Any Other Income**

The USDA uses income limits based on household size to determine SNAP eligibility. Most applicants must meet the limits on both gross income — which is a household's total income before deductions — and net income, which is gross income minus deductions.

#### ◆ **The gross monthly income limit is 130% of**

**poverty:** Between \$1,396 for a household of one and \$4,839 for a household of eight, plus \$492 for each additional member.

◆ **The net monthly income limit is 100% of poverty:** Between \$1,074 for a household of one and \$3,722 for a household of eight, plus \$379 for each additional member.



In determining SNAP eligibility, the USDA counts income from all sources, including earned income before payroll taxes and unearned income like child support, cash assistance and Social Security.

Therefore, you can collect Social Security and SNAP benefits simultaneously, provided the payment from the former doesn't bump you over the income limits of the latter.

#### **What About SSI?**

Supplemental Security Income (SSI) is a branch of Social Security that serves the most vulnerable individuals who are both disabled and part of a low-income household. To qualify, you must earn \$1,350 per month or less — \$2,260 for the blind.

Here, too, receiving SSI does not disqualify you — but your benefits count as income when applying for SNAP. You're free

to collect food stamps as long as your SSI distributions don't put you over the USDA's SNAP income limits.

The SSA's site explicitly states, "If you receive SSI, you may be eligible to receive SNAP assistance to purchase food," and that the SSA provides SNAP applications at local offices and can even help eligible households fill them out. Even so, the SSA states, "Many people who are potentially eligible for SSI benefits do not know how receiving SSI affects their benefits or payments from other government and state programs." Millions of Eligible Seniors Aren't Collecting SNAP Benefits

According to a 2021 report from the National Council on Aging (NCOA), three out of five older adults who qualify for SNAP — about five million people — are missing out on their rightful benefits....**Read More**



# Advancing Health Equity Through The CMS Innovation Center, First Year Progress

In October 2021, the Centers for Medicare and Medicaid Services (CMS) Innovation Center released its new 2030 vision: “A health system that achieves equitable outcomes through high quality, affordable, and person-centered care.” To achieve this vision, the CMS Innovation Center outlined **five strategic objectives**, one of which is 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, or other factors that affect access to care and health outcomes.”

To meet this objective, the CMS Innovation Center **launched a new health equity initiative** in 2022, proposing to: 1) develop new models and revise existing models to promote and incentivize equitable care; 2) increase participation of safety-net providers; 3) increase collection and analysis of equity

data; and 4) monitor and evaluate models for health equity impact. The CMS Innovation Center has made meaningful progress in each of these areas, which we believe will help mitigate health inequities within CMS’s beneficiary populations. This article provides a one-year look back at what we have accomplished and describes additional areas of focus moving forward.

1) Develop New Models And Revise Existing Models To Promote And Incentivize Equitable Care

In the past year, three revised models and one new model have been announced, all of which have a prominent focus on addressing health equity. One revised model is the **Medicare Advantage (MA) Value-Based Insurance Design Model**, which builds upon the statutory authority permitting CMS to waive the uniformity requirements with respect to supplemental benefits provided to chronically ill enrollees. CMS is using this authority to permit MA plans to **target and provide supplemental benefits** to



beneficiaries with chronic illnesses and also allow plans to target beneficiaries with health-related social needs. Participating plans can provide targeted supplemental benefits such as **food, transportation, and housing assistance**; reduced copayments; and rewards and incentives in connection with participation in activities that focus on promoting improved health, preventing injuries and illness, and promoting efficient use of health care resources.

Beginning in July 2023, we will collect detailed information from participating plans about the supplemental benefits provided, so that we can assess their use and effectiveness in improving care and outcomes. In addition, model participants will be required to develop and submit health equity plans to ensure they understand the needs of their beneficiary populations, identify any disparities within these populations, and develop and implement interventions to remedy these disparities; and form networks of Medicare hospice providers who have a

history of serving underserved communities, have strong relationships with their local communities, actively collaborate with organizations that may help meet the health-related social needs of patients, and demonstrate cultural competency

The second revised model is the **ACO Realizing Equity, Access, and Community Health (ACO REACH) Model**, which is a revamped and renamed version of the former Global and Professional Direct Contracting Model. This model, which launched in January of this year, also requires development and submission of health equity plans, as well as sociodemographic data collection and screening of beneficiaries for health-related social needs. In addition, the ACO REACH Model is testing a novel “health equity benchmark adjustment,” to remove the disincentive for providers serving disproportionate numbers of underserved beneficiaries to participate in the model. ...**Read More**

## Senate Hearing Highlights Problems with Medicare Advantage Directories and Networks

On May 3, the Senate Finance Committee **held a hearing** on access to behavioral health care in Medicare Advantage (MA) and the problem of inaccurate provider directories. One area of focus in the hearing was “ghost networks”—MA provider networks that look more robust than they are because the underlying plan directories list providers who are not in the plan, no longer practicing, or not accepting new patients. Inaccurate MA provider directories are a **long-standing problem**. For example, in 2018, the Centers for Medicare & Medicaid Services (CMS) **found that 52% of provider locations listed in directories** were inaccurate. But the problem goes much deeper than location. Preparatory to the hearing, committee staff **conducted secret shopping** and demonstrated **how inaccurate provider directories could keep**

**enrollees from scheduling appointments**: “Staff reviewed directories from 12 different plans in a total of 6 states, calling 10 systematically selected providers from each plan, for a total of 120 calls. Of the total 120 provider listings contacted by phone, 33% were inaccurate, non-working numbers, or unreturned calls. Staff could only make appointments 18% of the time.”

If plan enrollees cannot access the care they need inside the network, they may experience harmful delays and extreme costs. Some may not be able to find an in-network provider in a timely manner or at all, while others may not be able to afford to go out of network. Those who do may not realize it comes with extra cost, and all may be forced to wrangle with their plan to cover their care. Such access barriers can lead to higher and



more expensive care needs, including hospitalizations and emergency room visits.

The risks are especially acute in behavioral health, which encompasses both mental health and substance use disorders.

A **Government Accountability Office (GAO) report last year** examining access to these services emphasized the prevalence of narrow and ghost mental health networks across payers, from MA to private health coverage. These network issues, coupled with prior authorization barriers, can delay or derail access to behavioral health care for plan enrollees.

At Medicare Rights, our experience confirms these findings. Provider directories, especially for behavioral health care, are often inaccurate, leaving MA enrollees scrambling to find and afford care. We are deeply concerned that each year,

misleading or inaccurate plan directories may lock enrollees into a plan that does not cover the providers they need. We applaud the Senate Finance Committee for their important bipartisan work to shine a light on these issues.

Importantly, inaccurate directories and inadequate networks are not the only problems potential enrollees face when they are choosing an MA plan. In a **new fact sheet on simplifying MA enrollment**, we lay out additional options for improving the process.

We will continue to urge both Congress and the Biden-Harris administration to do more to conduct meaningful oversight, limit bad actors in the MA marketplace, improve decision-making, and increase transparency.

**Watch the Senate Finance Committee hearing.**

## Will there be Social Security payments in June 2023 if the debt ceiling is not raised?

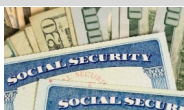
The economy of the United States could be facing a crisis very soon if the White House and Congress fail to agree on raising the debt ceiling.

The ceiling refers to the limit of money that the federal government can borrow. While the Biden administration seeks to increase funding, lawmakers—mostly Republicans—refuse to do so unless spending is cut. The last time the ceiling was raised was in December 2021, increasing the total budget to \$31.4 trillion.

According to Treasury

Secretary Janet Yellen, the country's government would no longer be able to pay its financial responsibilities as of June 1, and would therefore face a default. Such an occurrence would affect monthly checks for Social Security, Medicare, and payments to veterans and government workers including military personnel. Several non-essential government agencies would temporarily close, leaving millions of people unemployed.

Will there be Social Security



payments in June 2023 if the debt ceiling is not raised?

Considering the effects of the debt ceiling on insurance payments, many beneficiaries have begun to question whether they will receive their monthly check in relation to next June.

If the ceiling doesn't go up, the checks may be delayed, though the disruption will depend on how long it takes legislators to come to an agreement. However, considering that the Treasury sends insurance payments a

month late, it means that the check received in June actually covers May's benefits.

That said, *Forbes* analysts note that the payments to be sent to beneficiaries in June will most likely continue to come out; though if the ceiling hasn't been raised by the end of June, Treasury may not have the staff available to send payments for July.

## Insulin companies, PBMs pass the blame as they face bipartisan ire on pricing

Major stakeholders in the pharmaceutical industry on Wednesday testified in front of a key Senate panel to address questions over the affordability of insulin, with the assembled witnesses, as expected, passing the blame amongst each other.

Leaders from top insulin manufacturers Eli Lilly, Novo Nordisk and Sanofi joined with executives from top pharmacy benefit management (PBM) companies CVS Health, Express Scripts and OptumRx to face the grilling from lawmakers on the Senate Committee on Health, Education, Labor and Pensions (HELP).

In their opening statements, drug manufacturing leaders cited numerous causes of insulin's sky-

high price that exist outside their companies.

Eli Lilly CEO David Ricks pointed out his company had not raised the list price, the initial price for a drug that manufacturers set, for its insulin products since 2017. While heralding the recent consumer price caps his company announced, Ricks alluded to the role PBMs play in drug pricing.

"Last year, about 80 percent of our list prices went to pay ever-increasing fees and rebates to companies who don't invent, didn't develop nor manufacture the medicine," Ricks said. "With the remaining 20 percent, we cover the cost of making and distributing the product, which also supports about 4,000 high-



paying manufacturing jobs here in America with full benefits and pensions."

Paul Hudson, CEO of the French multinational drug company Sanofi, directly pointed a finger to "pharmacy benefit management, health insurance, specialty pharmacies and group purchasing organizations" in his opening remarks.

"This vertical integration gives these corporations near total control over the products the patients can access and the price they have to pay," said Hudson.

Earlier this year, the drug companies who spoke in front of the committee on Wednesday all announced they would be capping the out-of-pocket monthly prices for some of their

insulin products. While consumers will benefit from these policies, the list prices for these products are unchanged.

Representatives from the PBM industry subtly shot back at the drug company representatives, insisting that their companies have a key role in keeping costs down. "The PBM industry has helped clients hold increased spending to just four and a half percent and kept member cost growth to just 1.4 percent," said David Joyner, executive vice president and president of pharmacy services at CVS Health. Joyner pushed the blame for large drug costs on to high list prices and a lack of competition in the market. [Read More](#)

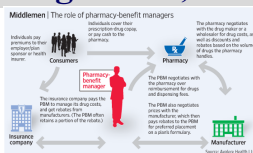
## PBMs, the Brokers Who Control Drug Prices, Finally Get Washington's Attention

For two decades, patients and physicians eagerly awaited a lower-cost version of the world's bestselling drug, Humira, while its maker, AbbVie, fought off potential competitors by building a wall of more than 250 patents around it. When the first Humira biosimilar — essentially a generic version — finally hit the market in January, it came with an unpleasant surprise. The biosimilar's maker, Amgen, launched two versions of the drug, which treats a host of conditions including rheumatoid arthritis. They were identical in every way but this: **One was priced** at about \$1,600 for a two-week supply, 55% off Humira's list price. But the other was priced at around \$3,300, only about 5% off. And OptumRx, one

of three powerhouse brokers that determine which drugs Americans get, **recommended option No. 2**; the more expensive version.

As Murdo Gordon, an Amgen executive vice president, explained **in an earnings call**, the higher price enabled his company to give bigger rebates, or post-sale discounts, to Optum and other intermediaries. Most of that money would be passed on to insurers, and patients, he said. Gordon did not mention that the higher-priced option would leave some patients paying much more out-of-pocket, undermining the whole rationale for generic drugs.

The Optum-Amgen announcements perfectly



elucidated why, after years of thundering against drugmakers, Congress and the administration

have now focused on regulating the deal-makers known as pharmacy benefit managers, or PBMs. Sen. Bernie Sanders' health committee **grilled a panel of PBM** and pharmaceutical executives Wednesday in preparation for a vote on PBM legislation, expected Thursday.

The three biggest PBMs — OptumRx, CVS Caremark, and Express Scripts — control about 80% of prescription drug sales in America and are the most profitable parts of the health

conglomerates in which they're nestled. CVS Health, the fourth-largest U.S. corporation by revenue **on Fortune's list**, owns CVS Caremark and the insurer Aetna; UnitedHealth Group, a close fifth, owns Optum; and Cigna, ranking 12th, owns Express Scripts. While serving as middlemen among drugmakers, insurers, and pharmacies, the three corporations also own the highest-grossing specialty drug and mail-order pharmacies

"John D. Rockefeller would be happy to be alive today," said David Balto, a former Federal Trade Commission attorney who represents clients suing PBMs. "He could own a PBM and monopolize economic power in ways he never imagined."....[Read More](#)



## Can I Switch My Social Security Benefit to a Spousal Benefit?

Social Security benefits can provide you with a stream of retirement income that is reliable. Deciding when to take benefits is an important question, especially if you're married and hope to qualify for spousal benefits. If you're already taking Social Security, you might be wondering if it's possible to switch to a spousal benefit later. The answer depends on whether your spouse is receiving Social Security benefits yet.

A **financial advisor** can help you figure out what you qualify for and when the best time is for you to start taking benefits as part of your full retirement plan.

Finding a **qualified financial advisor** doesn't have to be hard. **SmartAsset's free tool matches** you with up to 3 fiduciary financial advisors in your area in 5 minutes. Each advisor has been vetted by **SmartAsset** and is held to a fiduciary standard to act in your best interests.

**How Do Social Security Spousal Benefits Work? Calculating Social Security benefits** as a married couple is a

bit different than doing it as a single person. When someone files for Social Security benefits, their spouse may be able to claim a spousal benefit. The benefit is based on their spouse's contributions to Social Security and is capped at 50% of their benefit amount at full retirement age. For example, if they were to receive \$2,200 per month at full retirement age, their spousal benefit would max out at \$1,100 per month.

In order to receive spousal Social Security benefits, you must:

- ◆ Be at least 62, the earliest age at which you can receive Social Security benefits OR
- ◆ Be a caretaker for a child under age 16 or a child who's receiving **Social Security disability benefits**
- ◆ Be married for at least one year to someone who has filed for their retirement benefits

When you apply for spousal benefits, the Social Security Administration calculates your benefits based on your own work



and earnings record as well. If you're eligible to receive your retirement benefit as well as spousal benefits, then you'd get the higher of the two.

If your spouse hasn't filed for retirement yet, then you can't get spousal benefits. You can, however, file for your own retirement benefits if you're at least 62 years old.

**Taking Social Security at age 62** will reduce your benefit amount, below the amount you'd be entitled to if you had waited until you reached full retirement age. Delaying benefits until age 70, on the other hand, increases your benefit amount.

If you're claiming spousal benefits and filing before your full **retirement age**, then your benefit amount would be roughly 30% instead of 50%. The only exception is if you're claiming spousal benefits and you're a caretaker for a child under 16 or a child with disabilities.

**Can I Switch My Social Security Benefit to a Spousal Benefit?** Switching from your regular

retirement benefit to a spousal benefit is something you might be interested in if you're hoping to **maximize Social Security benefits**. Whether you can make this switch is determined by whether your spouse is already receiving benefits.

If your spouse is not receiving any retirement benefits yet, then you could technically take your regular Social Security benefit as early as age 62. When your spouse files for their benefit later you could switch to spousal benefits. That could potentially increase the total amount of benefits you receive as a couple if they're waiting until age 70 to start taking benefits.

What if your spouse is already receiving their Social Security benefits? In that situation, the deemed filing rule applies. That rule dictates that when someone applies for their regular retirement benefit, they're also approved for spousal benefits if they're entitled to receive them. So again, you'd get the higher amount of the two....**Read More**

## COVID-19 Public Health Emergency Expired May 11, 2023

The COVID-19 public health emergency (PHE) declaration in effect since early 2020 ended May 11. The PHE allowed the federal government to waive or modify certain Medicare rules to ease access to care during the pandemic. While some of these policies will remain in place, others expire immediately. As outlined below, these changes may impact what Medicare beneficiaries pay for certain COVID-related services.

### Medicare Coverage and Costs after the PHE

**At-home COVID-19 Tests**—The program that allowed Medicare to pay for up to eight over-the-counter COVID-19 tests per month ends on May 11. People with Medicare will now pay out-of-pocket for these tests. Some Medicare Advantage (MA) plans may elect to cover the tests but are not required to do so; enrollees should check with their plan for details.

**Clinical COVID-19 Tests**—Medicare Part B will continue to cover provider-ordered,

laboratory-based COVID-19 tests at no cost to the beneficiary. However, Original Medicare (OM) and MA enrollees may now face cost-sharing for testing-related services, such as the associated provider visit. Depending on their plan, MA enrollees may also pay cost-sharing for the test itself and face utilization management restrictions.

**COVID-19 Vaccines**—Medicare beneficiaries will continue to have access to COVID-19 vaccines, including boosters, at **no cost under Part B**. MA plans must cover the vaccinations in-network without cost-sharing.

**COVID-19 Oral Antiviral Treatments**—During the PHE, Medicare enrollees paid nothing for COVID-19 oral antiviral medications like Paxlovid. Post-PHE, treatments purchased by the federal government will remain available at no cost until the federal supply is exhausted. Part D plans will begin to cover



these drugs as they shift to the commercial market. Enrollees may face varying cost-sharing amounts, depending on their plan.

**Medicare Telehealth**—The PHE's expanded Medicare telehealth policies will largely remain in place. Congress **extended** most of them through December 2024.

**90-day Fills**—During the PHE, Medicare Part D plans were required to provide up to a 90-day supply of covered drugs when requested. This policy ends with the PHE.

**Three-day Inpatient Stays**—Though waived during the PHE, most OM enrollees will again require a 3-day inpatient hospital stay before Medicare will pay for needed skilled nursing facility care.

The PHE expiration will impact policies and coverage well beyond this list, including Medicaid services and other assistance. Importantly, it is distinct from the **unwinding** of

the Medicaid continuous eligibility requirement, also established to promote timely care during the COVID-19 pandemic. Nationally, those enrollment protections ended March 31, though **state implementation timelines** vary.

As these changes take effect, Medicare Rights will continue to work with policymakers and stakeholders to ensure access to affordable coverage and care.

◆ **Visit Medicare Interactive for the latest Medicare coverage details.**

◆ **Read more about what will change in Medicare at the end of the PHE.**

◆ **Read an FAQ from the Centers for Medicare & Medicaid Services.**

The Kaiser Family Foundation has several resources explaining the end of the PHE, including a **timeline**, details on what it means for **health coverage and access**, and an analysis of the implications of these **developments**.

## Science Reveals Key Driver of Alzheimer's, and How Newly Approved Drug May Fight It

Researchers have isolated for the first time a free-floating form of amyloid beta that appears to be a key driver of Alzheimer's disease.

Further, they argue that a newly approved Alzheimer's drug — lecanemab (Leqembi) — directly targets these small, complex chains of amyloid beta (A-beta) called fibrils. The U.S. Food and Drug Administration approved lecanemab in January.

The A-beta fibrils were found by soaking brain tissue samples from Alzheimer's patients in a saline solution, then spinning the liquid in a centrifuge, said senior researcher **Dr. Dennis Selkoe**, co-director of the Brigham and Women's Hospital Center for Neurologic Diseases, in Boston.

Such fibrils had been found stuck together in the amyloid plaques that are a hallmark of Alzheimer's, but they'd never before been found floating freely

in brain tissue fluid, Selkoe said.

"The tiny, diffusible fibrils were identical to the fibrils that make up the myriad amyloid plaques in the patients' brains," Selkoe said. "These tiny fibrils bind to the outside of nerve cells, and they also can clump together to make amyloid plaques."

Amyloid beta is a naturally occurring substance in human brains, but it's typically thought to be entirely soluble. "That is, it's like putting sugar in a cup of coffee," Selkoe said. "It would just dissolve."

This research shows that "the smallest toxic form of the amyloid protein is a tiny fibril, rather than an entirely soluble molecule," Selkoe said.

Further testing showed that the Alzheimer's drug lecanemab specifically works to clear these fibrils from the brain, Selkoe



said.

Lecanemab is a monoclonal antibody that attaches to these A-beta fibrils, Selkoe said. When it binds to a fibril, the antibody attracts the attention of brain immune cells called microglia.

"It causes them to phagocytose — to engulf the fibers and clear them — but they only do it when an antibody to the fibrils is attached," Selkoe said. "We know that people with Alzheimer's just keep on getting worse and worse over months and years, and it seems that their microglia are not able to digest and clear amyloid fibrils or amyloid plaques by themselves."

The new study represents "a novel way to understand these beta amyloid states, and whether they exist only as part of plaques or also in the surrounding environment of the brain," said **Heather Snyder**, vice

president of medical and scientific relations for the Alzheimer's Association.

"The researchers suggest that amyloid beta exists, or can exist, in both, and that the newly FDA-approved drug, lecanemab, may bind to both," Snyder said. "This multiple binding ability may help inform how lecanemab acts in the brain, even if the outcome measure used in the clinical trials was specific only for the plaques."

The FDA approved lecanemab under an accelerated process, and is expected to consider the drug for full approval this summer, Selkoe said.

However, the U.S. Centers for Medicare and Medicaid has resisted covering drugs like lecanemab and its predecessor, aducanumab (Aduhelm)...[Read More](#)

## COPD: Causes, Symptoms & Treatments

Finding out that you or a loved one has chronic obstructive pulmonary disease (COPD) can be alarming and may leave you with a lot of questions.

Though **COPD** has no cure, it's a condition that can be managed with the right treatments and medications, according to the **American Lung Association** (ALA).

Here's what you need to know about COPD, including what it is, its causes, symptoms, stages and risk factors, plus the many treatment options available to those living with the condition. **What is COPD?**

COPD is a group of progressive, chronic diseases that constrict airflow in and out of the lungs so that less oxygen moves through the body.

"It's three different illnesses, all of which create the same fundamental problem, which is you can't blow out as fast as you should," explained **Dr. Scott Eisman**, a pulmonary disease and critical care medicine specialist at Scripps Memorial Hospital Encinitas in California.

"And those three illnesses are **asthma and chronic bronchitis**

and emphysema -- and they're all different," he noted.

### Causes and risk factors

According to the **U.S. Centers for Disease Control and Prevention**, the cause of most cases of COPD is smoking. However, as many as 25% of people in the United States with the disease have never smoked cigarettes.

"If you talk about chronic bronchitis and emphysema, the most common cause is cigarette smoking," Eisman said. However, he explained that asthma-related COPD could have various causes, such as environmental toxins or certain preexisting conditions such as gastroesophageal reflux disease.

**Scripps Health** states that chronic lung infections that damage lung tissues and some cases of chronic asthma where lung tissues fail to relax after an asthma attack can also cause COPD.

The risk factors for developing COPD outlined by the **ALA** include:

- ◆ Secondhand smoke exposure,



including smoke from a coal or wood-burning stove

- ◆ Aging, which leads to

declining lung function, particularly for those over 40

- ◆ Childhood respiratory infections
- ◆ A history of asthma
- ◆ Underdeveloped lungs.

### COPD stages

The Global Initiative for Chronic Obstructive Lung Disease (**GOLD**) takes into account your lung test assessments, symptoms and COPD exacerbations (flare-ups) when assessing your COPD stage, according to the **COPD Foundation**.

**It mostly focuses on two lung function readings:**

- ◆ How much air you can exhale in one second, known as FEV1 (forced expiratory volume in the first second)
- ◆ How much air you can exhale in one total breath, known as FVC (forced vital capacity).

If your ratio of FEV1 to FVC is less than 0.7, you may be diagnosed with one of four stages

of COPD:

- ◆ GOLD stage I: FEV1 is greater than or equal to 80%, indicating mild airflow limitations
- ◆ GOLD stage 2: FEV1 is 50% to 79%, indicating moderate airflow limitations
- ◆ GOLD stage 3: FEV1 is 30% to 49%, indicating severe airflow limitations
- ◆ GOLD stage 4: FEV1 is less than 30%, indicating very severe airflow limitations.

### COPD symptoms

Different people may experience different symptoms, depending on the type and severity of COPD they have. The **ALA** notes that common symptoms of COPD include:

- ◆ Coughing up mucus
- ◆ Fatigue
- ◆ Shortness of breath during daily activities
- ◆ Wheezing
- ◆ Tightness in the chest
- ◆ Coughing continuously
- ◆ An inability to breathe deeply....[Read More](#)



## Anaphylactic Shock: What It Is, Causes, Symptoms & Treatments

If you or someone you know experiences allergies, you've probably heard of the life-threatening reaction called anaphylactic shock.

To help you better understand exactly what this condition is and how to manage it, experts offer a guide on what anaphylactic shock is, its symptoms, causes, risk factors and treatments.

What is anaphylactic shock?

Anaphylactic shock is a consequence of anaphylaxis, which is a severe immune reaction to something you're allergic to, such as peanuts or bee stings. According to the [Mayo](#)

[Clinic](#), what sets anaphylaxis apart from other allergic reactions is that it involves several systems in your body.

During anaphylactic shock, chemicals released during anaphylaxis cause your blood pressure to drop rapidly and your airways to narrow, inhibiting your ability to breathe.

Anaphylactic shock symptoms  
Identifying the signs of anaphylactic shock can help ensure you seek medical attention as quickly as possible, since the condition can be fatal if not



treated immediately. The Mayo Clinic says that the main anaphylaxis and anaphylactic shock

symptoms are:

**Swelling, especially in the throat • Low blood pressure • Trouble breathing • Difficulty swallowing • Passing out or feeling dizzy • Wheezing and chest tightness • Turning red or going pale • Vomiting, stomach cramps or diarrhea**

Rash, including hives or welts.

These symptoms typically happen within a few minutes of the body coming into contact

with the substance, although it may take half an hour or longer.

If you think you or a loved one are experiencing anaphylactic shock, immunologist [Dr. Anuja Kapil](#) recommended reaching out for help immediately.

"Calling 911 is better than driving to the emergency department. Emergency medical technicians in an ambulance have protocols and access to treatments specifically for severe allergic reactions," she advised in a Cleveland Clinic [article](#).

Anaphylactic shock causes and risk factors...[Read More](#)

## Surgery Beats Targeted Radiation for Patients Battling Early Stage Lung Cancer

More patients are choosing radiation therapy over surgery to treat their early-stage lung cancer, but a new study argues they might be making a mistake.

People who are good surgical candidates for lung cancer appear to have a five-year survival rate that's 15 percentage points lower if they opt to have radiation treatment instead, according to [findings](#) presented Monday at a meeting of the American Association for Thoracic Surgery, in Los Angeles.

"It seems like surgical patients get a real benefit in long-term survival, and you see a real separation in the survival curve after two years," said lead

researcher [Dr. Brooks Udelsman](#), a

cardiothoracic surgeon with Yale School of Medicine. "If you have a patient who is expected to live more than two years, they're probably going to benefit from the surgery."

For the study, researchers analyzed data from the National Cancer Database on more than 30,000 non-small-cell lung cancer patients who were diagnosed and treated between 2012 and 2018.

The data included about 24,700 patients whose tumors were surgically removed and nearly 6,000 who underwent targeted



stereotactic body radiation therapy (SBRT). SBRT targets small tumors with large radiation doses without damaging healthy tissue and organs nearby.

The percentage of early-stage lung cancer patients who receive targeted radiation therapy instead of surgery amounted to 26% in 2018, up from 16% in 2012, Udelsman said.

It's not surprising that some would choose radiation over surgery, because it's an easier option, he said.

SBRT for early-stage lung cancer usually involves three to five treatments over the course of

a week, while a person could be laid up in the hospital for days and in pain for weeks after surgery, Udelsman said.

"Surgery requires some time in the hospital, and there's some pain associated with it," Udelsman said. "The radiotherapy is a little bit more convenient. You don't have to be hospitalized. There's almost no pain associated with it." Cleveland Clinic radiation oncologist [Dr. Gregory Videtic](#) agreed that the comparative ease of radiation therapy prompts more patients to choose SBRT over surgery....[Read More](#)

## Head-to-Head Study Finds Which Diabetes Meds Are Best for the Heart

There are many medications for type 2 diabetes, but one class may stand out for protecting the heart, a new study suggests.

The study, of thousands of U.S. veterans with diabetes, found that those who added drugs called GLP-1 receptor agonists to their usual regimen were somewhat less likely to suffer a first-time heart attack or stroke in coming years.

That was in comparison to vets who added either of two other types of diabetes drug.

GLP-1 receptor agonists are a newer class of drug for type 2 diabetes and include medications like dulaglutide (Trulicity), liraglutide (Victoza) and semaglutide (Ozempic). They are usually taken by injection.

The drugs are already

recommended options for people with type 2 diabetes who either have heart disease or are at high risk of it -- due to additional conditions like high blood pressure or obesity.

Experts said the new findings -- published May 9 in the [Annals of Internal Medicine](#) -- do not mean that all diabetes patients with heart risk factors should be on a GLP-1 drug.

For one, the study was not a clinical trial that tested which type of diabetes medication is best for preventing first-time heart trouble.

But the findings do show that GLP-1 drugs are associated with a better cardiovascular outlook than other medications are, according to senior



researcher [Dr. Christianne Roumie](#).

"I think these findings are important for the care of patients with diabetes," said Roumie, a professor of medicine at Vanderbilt University Medical Center in Nashville, Tenn.

She said the results may encourage more doctors to consider GLP-1 drugs as an "add-on" treatment to help prevent heart disease.

More than 37 million Americans have diabetes, and the vast majority have the type 2 form, according to government figures.

Type 2 diabetes arises when the body can no longer properly use the hormone insulin, which regulates blood sugar. Over time, chronically high blood sugar can

damage the blood vessels and contribute to complications like heart and kidney disease.

For years, the first-line therapy for type 2 diabetes has been metformin -- an inexpensive oral drug that lowers blood sugar.

But in recent years, new options have emerged. Besides GLP-1 drugs, there is a class of medications called SGLT2 inhibitors, which include oral medications like canagliflozin (Invokana), dapagliflozin (Farxiga) and empagliflozin (Jardiance).

The latest guidelines from the American Diabetes Association and other groups now recommend both of those drug classes as options for people at high risk of heart disease....[Read More](#)

## Vaccine Slows Return of Pancreatic Cancer in Early Trial

A gene-targeted personalized vaccine may delay the return of pancreatic cancer according to a small, but promising, trial.

The mRNA vaccine, which was tailored to the genetic makeup of each patient's tumor, worked in half of those who received it during 18 months of follow-up, researchers reported May 10 in the journal *Nature*.

Scientists at BioNTech (known for developing a COVID vaccine with Pfizer during the pandemic) and Genentech created the novel vaccine.

Experts reacted to the news with cautious hope.

"It's relatively early days," **Dr. Patrick Ott**, of the Dana-Farber Cancer Institute in Boston, told the *New York Times*.

"This is the first demonstrable success — and I will call it a success, despite the preliminary

nature of the study — of an mRNA vaccine in pancreatic cancer," **Dr. Anirban Maitra**, a

specialist in the disease at the University of Texas MD Anderson Cancer Center in Houston, told the *Times*. "By that standard, it's a milestone."

The idea for the study came together at a meeting of cancer scientists in Mainz, Germany, several years ago. They tested the vaccine in a type of pancreatic cancer that often returns, even in patients whose tumors are removed, the *Times* reported.

The vaccine worked in about half of the 16 patients, triggering an immune response that may explain why these patients did not relapse during the study period.

In the study, BioNTech scientists used the tumors' genetic data to create personalized



vaccines. The goal of the vaccine was to teach the patients' immune systems to attack the

tumors.

Patients in the study were still treated with chemotherapy and a medication to keep the immune system on track, so it's possible the vaccine was not the only reason the tumors didn't return, the *Times* reported.

Patients received their vaccines about nine weeks after their tumors were removed. That is now possible after only six weeks, with the goal of providing future patients with the vaccine in four weeks, BioNTech CEO **Dr. Ugur Sahin** told the *Times*.

Still, the vaccine is costly at \$100,000 a dose, the *Times* reported.

"Cost is a major barrier for these types of vaccines to be

more broadly utilized," **Dr. Neeha Zaidi**, a pancreatic cancer specialist at the Johns Hopkins University School of Medicine in Baltimore, told the *Times*. Also, the vaccine was not effective in about half of patients, who experienced a relapse after 13 months.

But by creating vaccines that targeted mutated proteins found only on cancer cells, researchers may have realized a breakthrough.

"Just establishing the proof of concept that vaccines in cancer can actually do something after, I don't know, thirty years of failure, is probably not a bad thing," **Dr. Ira Mellman**, vice president of cancer immunology at Genentech, told the *Times*. "We'll start with that."

## Cancer drugs among top 5 most affected by shortages in the US

As the US faces a near-record number of drug shortages, cancer treatments are among the hardest hit.

There is an active shortage of about two dozen chemotherapy drugs, the fifth most of any drug category, according to **data** from the end of March from the University of Utah Drug Information Service.

"The fact that we have this many chemo drugs in shortage is really concerning," said Michael Ganio, senior director of pharmacy practice and quality at the American Society of Health-System Pharmacists.

Unlike some other drugs that also rank among the top five

categories for shortages, such as antimicrobials, there aren't often alternatives for chemotherapy

drugs, he said. And the shortages are affecting treatment for a broad range of cancers.

"One of the key predictors of how well a patient will respond to treatment is getting a full dose on the right schedule," Ganio said. "So when we can't give the drug because we just can't get the drug, that's heartbreaking."

Overall, data from the University of Utah shows that there were more than 300 drugs



with an active shortage in the US at the end of March, including nearly 50 new shortages that accumulated in the first

three months of the year. The last time active drug shortages — including both newly reported and ongoing — were this high was in 2014, the data shows.

"Shortages are still happening, and they're not resolving, or they're not resolving as quickly as new shortages are starting," Ganio said.

On Thursday, the US House of Representatives' Energy and Commerce Subcommittee on Oversight and Investigations

held a hearing exploring the root causes of these shortages.

Increased demand is part of it. But experts say that some high-profile shortages — such as amoxicillin during the most recent respiratory virus season and Adderall for ADHD — are the exception.

"They don't really tell the story of drug shortages," Ganio said.

Instead, the hearing was more heavily focused on manufacturing issues and the broader structure of the drug market in the US....**Read More**

## Think You Need an Opioid? Here Are Questions to Ask Your Doctor

It's important to ask questions when your doctor or dentist writes you a new prescription.

This is especially true for opioid pain medications, such as hydrocodone, oxycodone or morphine.

While these drugs are approved by the U.S. Food and Drug Administration for acute and chronic pain, they can have serious side effects, including addiction and even death.

Misuse of opioids have led to the current drug overdose crisis in the United States. The majority of overdose deaths in

this country involve opioids, according to the **U.S. Centers for Disease Control and Prevention**.

The FDA offers some tips for using these medications safely. Start by asking your doctor how long your pain is likely to last and what medication is being prescribed.

If the drug is an opioid, ask if there are non-opioid alternatives.

If your doctor decides an opioid is best, ask how long you should take the medication. Find out when and how to stop using



it. Ask for the lowest dose possible for the shortest time needed and in the smallest quantity, the FDA advised. Also

ask about a follow-up appointment.

While prescription opioids can be safe and effective, using them in a way that differs from what was prescribed or for non-medical reasons can lead to dependence, addiction and even death, the FDA cautioned.

Side effects from opioid use include dizziness, drowsiness, weakness, nausea and

constipation. Familiarize yourself with the side effects so that you and your family know when to call a doctor, go to the hospital or call 911.

Ask your pharmacist for a Medication Guide handout to learn more about your prescription.

Reduce the chances for serious side effects by taking the drug exactly as prescribed. If you still feel pain, call a doctor -- don't take an extra dose....**Read More**



## FDA Approves First Drug Meant to Ease Alzheimer's-Linked Agitation

A medication to treat agitation in Alzheimer's patients now has approval from the U.S. Food and Drug Administration.

The FDA gave supplemental approval to Otsuka Pharmaceutical Company Ltd., and Lundbeck Inc. for Rexulti (brexpiprazole) oral tablets on Thursday. Rexulti is the first FDA-approved treatment for these symptoms.

"Agitation is one of the most common and challenging aspects of care among patients with dementia due to Alzheimer's disease. 'Agitation' can include symptoms ranging from pacing or restlessness to verbal and physical aggression," said **Dr. Tiffany Farchione**, director of the division of psychiatry in the FDA's Center for Drug Evaluation and Research.

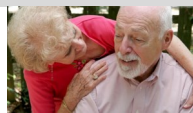
"These symptoms are leading

causes of assisted living or nursing home placement and have been associated with accelerated disease progression," she added in an agency news release.

The approval followed two 12-week studies. Participants were between 51 and 90 years of age, and had a probable diagnosis of Alzheimer's dementia, along with the type, frequency and severity of agitation behaviors that require medication.

Patients in the first study received either 1 or 2 milligrams (mg) of Rexulti. In the second study, they received 2 or 3 mg of Rexulti.

Over the 12 weeks, researchers looked for a change from baseline in a patient's Cohen-Mansfield Agitation Inventory (CMAI) score. The inventory is a



tool that uses caregivers' input to rate the frequency of agitation on a scale from one to

seven.

Patients who received 2 mg or 3 mg of Rexulti had statistically significant and clinically meaningful improvements in total CMAI scores compared to patients taking a placebo.

Alzheimer's disease is the most common form of dementia, a debilitating neurological condition with progressive decline. Many people with the condition require permanent at-home or residential care. More than 6.5 million Americans have Alzheimer's disease. Agitation is a symptom that's complex and stressful. The approval for Rexulti was made under the FDA's Fast Track designation, which speeds the

review of drugs to treat serious conditions and satisfy an unmet medical need.

Recommendations call for new patients to take 0.5 mg once daily on days one to seven. They should step up to 1 mg daily on days eight through 14, and then to 2 mg daily starting on day 15. The recommended target dose is 2 mg once daily.

Possible side effects include headache, colds, dizziness, urinary tract infection and sleep disturbances.

Rexulti will continue to carry a Boxed Warning designation for medications in this class. Elderly patients with dementia-related psychosis who are being treated with antipsychotic drugs are at an increased risk of death.

## Rate of Fatal Falls Among U.S. Seniors Doubled in 20 Years

Older Americans are dying of falls at more than double the rate of 20 years ago -- with women, men and all racial groups showing increases, according to a new study.

In 2020, the study found, just over 36,500 Americans age 65 and up died of a fall-related injury. That was up from roughly 10,100 deaths in 1999.

Adjusted for age, those numbers translated into a more

than twofold increase in the rate of fall-related deaths among older Americans: from 29 per 100,000 in 1999, to 69 per 100,000 in 2020.

It's well known that falls are the leading cause of injury death among older Americans, and that the problem is growing.

The new findings underscore that, and show that no demographic is unaffected,



according to researcher **Alexis Santos-Lozada**, an assistant professor of human development and family studies at Pennsylvania State University.

He found that fall-related death rates more than doubled among both women and men. Among racial and ethnic groups, white older adults had the highest death rate from falls, and the biggest

increase -- reaching 78 deaths per 100,000 in 2020.

But death rates also rose among Black seniors, Hispanic seniors, Asian seniors and Native American seniors alike.

"For every group, it's going in the same direction," Santos-Lozada said. "That's concerning."

Yet, he added, "fall prevention is not something we talk about a lot." ....[Read More](#)

## Am I Depressed? The Most Common Symptoms to Look Out For

Think you might be struggling with depression? It's not always easy to recognize, but identifying the symptoms is the first step toward getting the help you need.

Depression is a common mental health condition that affects millions of people worldwide. In the United States alone, **an estimated 21 million adults had at least one major bout of depression in 2020**, representing about 8.4% of the adult population, according to the U.S. National Institute of Mental Health (NIMH). Symptoms of depression vary from person to person, but some are more commonly experienced than others.

Exploring the most common symptoms will help you know what to look for if you suspect

that you or someone you know may be struggling with depression.

**What are symptoms of depression?**

**Craig Sawchuk**, a clinical psychologist at the Mayo Clinic in Rochester, Minn., said "**understanding the basics of depression can help you take the next step.**" In a Mayo Clinic video, he noted: "Depression is a mood disorder that causes feelings of sadness that won't go away ... and people who experience depression can't just snap out of it."

Depression can show up in many ways and can affect each person differently. But some common symptoms are associated with this condition. They can range from feeling



persistently sad or hopeless to losing interest in activities you once enjoyed. Other symptoms

may include changes in appetite, sleep disturbances and difficulty concentrating.

According to the NIMH, these are **common symptoms of depression**:

- ◆ Persistent feelings of sadness, anxiety or emptiness that do not go away
- ◆ A constant sense of hopelessness or negativity
- ◆ Unexplained irritability, frustration or restlessness
- ◆ Overwhelming feelings of guilt, worthlessness or helplessness
- ◆ Loss of interest or enjoyment in activities that used to be

pleasurable

- ◆ Persistent feelings of exhaustion, fatigue or being slowed down
- ◆ Difficulty concentrating, remembering things or making decisions
- ◆ Changes in sleep patterns, such as difficulty falling asleep, waking up early or sleeping too much
- ◆ Unplanned changes in appetite that lead to weight gain or loss
- ◆ Unexplained physical symptoms, such as cramps, digestive issues or headaches that don't respond to typical treatment
- ◆ Thoughts of suicide or death, or attempting suicide....[Read More](#)

## Toxins From Grilling, Smoking & Car Exhaust Could Raise Odds for Rheumatoid Arthritis

Toxic chemicals that develop from car exhaust, smoking and backyard grilling might increase your risk of developing the autoimmune disease rheumatoid arthritis, a new study suggests.

These chemicals are called polycyclic aromatic hydrocarbons (PAHs). They form as coal, oil,

gas, wood or tobacco burn. Flame grilling of meat and other foods also contribute to PAH formation, the researchers said.

"While more studies are needed, the findings suggest that polyaromatic hydrocarbons may be a significant contributor to



rheumatoid arthritis," said lead researcher **Chris D'Adamo**, director of the Center for Integrative Medicine at the University of Maryland School of Medicine. "People at risk of rheumatoid arthritis should be cautious of

polyaromatic hydrocarbons and consider minimizing modifiable sources of exposure."

Blood and urine samples from nearly 22,000 adults revealed those with the highest PAH levels had the highest risk of rheumatoid arthritis....[Read More](#)

## Former Marine Opens Up About Struggles and Feelings of Hopelessness After Stroke

One hot day last June, Elmar Uy and his girlfriend, LJ Jennings, were gardening outside their home in Hudson, New Hampshire, when something strange happened. Everywhere Uy looked, he saw crescent-shaped spots.

Jennings thought Uy might be dehydrated. She got him some water.

Over the next few days, Uy's eyes became sensitive to light. He had headaches. He thought it might be an ocular migraine. He took to staying in dark rooms at home to avoid bright light.

Uy saw a neurologist who specializes in headaches. The doctor ordered several tests. Uy was still waiting for some results when July Fourth weekend rolled around.

He happily gathered with his sons, Junior and Brandon, and

their kids at the family's holiday home in the Berkshires in western Massachusetts. Jennings was working and stayed in New Hampshire. After unpacking, the family caught up over chicken wings. At the kitchen sink, Elmar washed a glass for a drink. His eldest son, Junior, was by his side, ready to pour.

Elmar wanted to move his feet. When he looked down, they were moving but he couldn't feel them. He sat on a bench in the kitchen and told Junior to call 911. When the ambulance got there, Elmar was able to walk outside. In the ER, with both eyes open, Elmar's right eye vision shifted eight inches. He saw double. He pushed the panic button.

Doctors gave him medicine and his vision improved. They moved him to a critical care



coronary unit, where years earlier his mother had worked as a charge nurse. Elmar passed a

series of neurological tests including following the doctor's finger and closing his eyes and touching his nose. He felt fine.

Over four days, he had blood work, an ultrasound of his heart and a brain scan. The results of the scan showed a handful of white dots. Dead spots, the doctor told him. From his hospital bed he listened to the Fourth of July fireworks.

Elmar had experienced an ischemic stroke, which happens when a blood vessel that supplies the brain gets blocked. It happened in the back of his brain in an area in charge of mobility and vision. But doctors couldn't pinpoint an exact cause for the stroke.

At the same time, the neurologist Elmar saw in June finally called with results of the imaging recently done. It, too, spotted the blockage.

Elmar started medication to lower his cholesterol and help prevent another stroke. During the three-hour drive home, he was petrified he might have another stroke.

Elmar, a 57-year-old former Marine, had led an active lifestyle, doing cardio boxing twice a week. After the stroke, he began his recovery by walking. A mile took him 40 minutes and left him tired.

"Maybe in the back of my mind I didn't want to push my heart," he said. "I was more traumatized than anything the stroke did to me."....[Read More](#)

## Are Heart Rate and Blood Pressure the Same? No, and It's Important to Understand Why.

Lower your blood pressure. Get your heart rate up. Know your numbers.

When it comes to heart health, understanding all the numbers involved – and which should be up or down and when – can be confusing. But experts say it's important to learn at least some of the basics to help maintain good cardiovascular health.

The measurements taken most often are heart rate and blood pressure, which are two different things.

"Blood pressure is the force of the blood moving through your vessels," said Scott Collier, director of the Vascular Biology and Autonomic Studies Laboratories and a professor at Appalachian State University in Boone, North Carolina. "Heart rate is the number of times in one minute that your heart beats." Both measurements signal how well the heart gets blood flowing to the rest of the body, he said.

### Heart rate

"You can tell what kind of shape you're in by looking at your heart rate," Collier said. "If your heart is in really good shape, it does not have to beat as many times to get the blood flowing."

A normal resting heart rate for most adults is between 60 and 100 beats per minute. But people who exercise may have lower heart rates, with some athletes showing resting rates as low as 40 beats per minute.

However, during exercise, heart rate goes up – as it should, he said. A person's target heart rate during exercise varies by age, but should be 50%-70% of their maximum rate during moderate exercise and 70%-85% during vigorous activity. For example, a person in their 20s would aim for a heart rate of 100-170 beats per minute while exercising, whereas a person in their 50s should aim for 85-145



beats per minute.

Many exercise machines help people monitor their heart rate during a workout. So do smartwatches.

Measuring heart rate before, during and after exercise can help a person make sure they are working hard enough and also monitor their overall fitness level, Collier said.

Dr. John Flack, professor and chair of the department of internal medicine at Southern Illinois University in Springfield, said it's important to know if a person's heart rate – also commonly referred to as pulse rate – is consistently outside the normal range when they're not exercising or if heartbeats are irregular. Such issues can signal problems such as atrial fibrillation, or AFib, a serious condition that if left untreated can lead to blood clots, stroke, heart failure and other complications.

"We're entering an era of

smartwatches and other wearable devices that tell you when your pulse rate is abnormal and pick up on AFib," Flack said. "Having an irregular pulse rate is something people need an awareness of. If it's not regular, if it's racing or slowing down, if they're getting funny readings, they need to get it checked."

### Blood pressure

Blood pressure is the force of the blood pushing against blood vessel walls as it moves through them. If there's too much pressure on them – if blood pressure is high – over time the force will damage them, causing small tears where plaque can build up, narrowing the space left for blood to flow. This makes the heart work harder and less efficiently. It can ultimately lead to irregular heartbeats, heart attacks or strokes....[Read More](#)