



May 22, 2022 E-Newsletter

Message from the Alliance *for* Retired Americans Leaders



Alliance Stands with Those Targeted in Mass Shooting in Buffalo



**Robert Roach, Jr
President, ARA**
Robert Roach, Jr., President of the Alliance, expressed his condolences this week to the victims and families of the tragic mass shooting last Saturday in Buffalo, New York at a Tops Friendly Markets grocery store. Ten people were killed, and three others were injured; 11 of the victims were black. Police said the 13 victims, including the wounded, ranged in age from 20 to 86. Authorities are calling the attack “racially motivated.” The suspect allegedly wrote a 180-page document filled with hateful rants about race that invoked the false “great replacement” conspiracy theory.

“The members of the Alliance join with all Americans who were hurt by the terrible violence last weekend in Buffalo in calling for an end to the bloodshed. Our thoughts are with the deceased, the injured and all of their loved ones. We send our deepest wishes for healing to everyone affected by this senseless attack.”

President Roach said that the rhetoric that has become all too familiar on television and social media has contributed to the violence in America.

“Regardless of what they may think they are saying, when cable television pundits, politicians and everyday Americans use harsh, hateful and inappropriate

language to communicate, it divides the nation and can have serious consequences.”

Health Insurance CEOs Raked in Record Compensation Last Year

The CEOs of America’s seven largest publicly traded health insurance and services companies together earned more than \$283 million in 2021 — the most of any year in the past decade by far.

Soaring stock prices made up the bulk of the executives’ fortunes, according to a Stat analysis of disclosures from UnitedHealth Group, CVS Health, Anthem, Cigna, Humana, Centene, and Molina Healthcare from 2012-2021.

Higher profits drove the companies’ stocks. With the coronavirus pandemic leading people to delay some of the care they would have otherwise sought, insurers retained premiums that would have been paid out as medical claims. Years of large acquisitions have also paid off as health insurance companies became conglomerates encompassing lucrative drug benefits

middlemen, physician groups, pharmacies, and other services.

Cigna CEO David Cordani took home more than \$91 million in 2021 and has received more than \$365 million since 2012, the most of the seven executives over the last ten years.

“The pandemic could have allowed insurers to do more to keep their prices in check,” said President Roach. “Instead, workers, taxpayers and employers have continued to watch health care premiums soar. Insurers have an incentive to let spending and premiums keep growing, because that increases their share of the profits.”

Please [click here](#) to RSVP for this free, one-hour online workshop.



Rich Fiesta,
Executive
Director, ARA

“Scammers frequently target older Americans,” said Richard Fiesta, Executive Director of the Alliance.

“This training is an opportunity to learn how to identify and stop the criminals trying to steal your hard-earned money.”

An email with a link to join the

session will be sent to those who sign up 24 hours before the session.

Questions? Email Maureen Dunn, Director of Field Mobilization for the Alliance, at mdunn@retiredamericans.org.

CMS Unveils Updated, More User-Friendly Medicare Website

On Wednesday the Centers for Medicare & Medicaid Services (CMS) unveiled several updates to the [Medicare.gov](https://www.medicare.gov) website, designed to make it easier to navigate and access information to compare health and drug coverage and find providers.

The updated website features timely messages on the homepage and highlights the information most often sought by Medicare beneficiaries, people nearing Medicare eligibility, and their families.

This week’s improvements also add more detailed pricing information about Medicare Supplement Insurance (Medigap). Policies that give individuals the information they need to compare Medigap plans, which supplement traditional Medicare benefits.

“We applaud all efforts to make it easier for people to understand their Medicare benefits and then make choices based on what they’ve learned,” said Joseph Peters, Jr., Secretary-Treasurer of the Alliance.



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

ADD
YOUR
NAME

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Kaiser Health News: Why Won't More Older Americans Get Their Covid Booster

Even as top U.S. health officials say it's time America **learns to live** with the coronavirus, a chorus of leading researchers say faulty messaging on booster shots has left millions of older people at serious risk.

Approximately 1 in 3 Americans 65 and older who completed their initial vaccination round still have not received a first booster shot, according to the Centers for Disease Control and Prevention. The numbers have dismayed researchers, who note this age group continues to be at the highest risk for serious illness and death from covid-19.

People 65 and older account for about 75% of U.S. covid deaths. And some risk persists, even for seniors who have completed an initial two-dose series of the Moderna or Pfizer vaccine or gotten one dose of the Johnson & Johnson vaccine. Among older people who died of covid in January, 31% had completed a first vaccination round but had not been boosted, according to a **KFF analysis** of CDC data.

The failure to boost more of this group has resulted in the loss of tens of thousands of lives, said Dr. Eric Topol, founder and

director of the Scripps Research Translational Institute. "The booster program has been botched from day one," Topol said. "This is one of the most important issues for the American pandemic, and it has been mismanaged."

"If the CDC would say, 'This could save your life,'" he added, "that would help a lot."

Although the initial one- or two-dose vaccination course is effective at preventing hospitalization and death, **immunity fades** over time. Boosters, which renew that protection, are especially important for older people now that covid cases are rising again, more transmissible omicron subvariants are proliferating, and Americans are dropping their masks, Topol said.

Some older people, who were prioritized for initial vaccination in January 2021, are now more than a year from their last shot. Adding to the confusion: The CDC defines "fully vaccinated" as people who have completed an initial one- or two-dose course even though a first booster is considered crucial to extending covid immunity.

Numerous studies have confirmed that the first booster

shot is a critical weapon against covid. A **study of older veterans** published in April found that those who received a third dose of an mRNA vaccine were as much as 79% less likely to die from covid than those who received only two shots.

A central question for scientists championing boosters is why rates have stalled among people 65 and older. Surveys have found politics and misinformation play a role in vaccine hesitancy in the population at large, but that's not been the case among older people, who have the highest initial

vaccination rate of any age group. **More than 90%** of

older Americans had completed an initial one- or two-dose course as of May 8.

By contrast, 69% of those vaccinated older Americans have gotten their first booster shot.

Overall, fewer than half of eligible

Americans **of all ages** have received a booster.

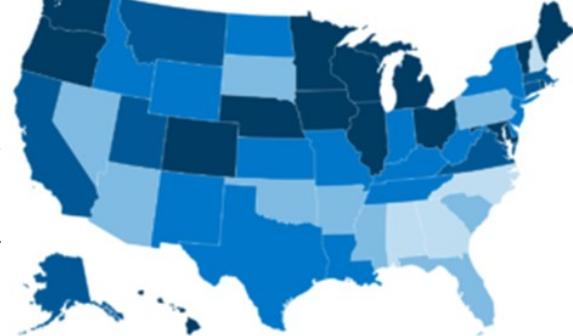
The discrepancy for seniors is likely due to changes in the way the federal government has distributed vaccines, said David Grabowski, a professor of health care policy at Harvard Medical School. Although the Biden administration coordinated vaccine delivery to nursing homes, football stadiums, and other targeted venues early last year, the federal government has played a far less central role in delivering boosters, Grabowski noted....[Read More](#)

Southeastern US Lags in Covid Boosters for Adults 65+

The share of people 65 and older who completed their initial vaccination course but have yet to receive their first booster shot ranges widely by state.

Share of Vaccinated Adults 65+ With At Least One Booster Dose as of May 8, 2022

39.5%-59.9% 60%-64.9% 65%-69.9% 70%-74.9% 75%+



Note: North Carolina officials say the state's booster rates are higher than Centers for Disease Control and Prevention data indicates because of data-sharing problems.
Source: U.S. Centers for Disease Control and Prevention
Credit: Philip Renz for KHN

KHN

Expect high out-of-pocket costs if you're hospitalized, with insurance—and fight them

Michael Levenson reports for the **New York Times** on a woman who had to go to court to avoid paying hundreds of thousands of out-of-pocket health care costs that her insurer wouldn't cover. The woman, Lisa Melody French, went to her local hospital for back surgery. The hospital told her to expect about \$1,300 in out-of-pocket costs given her health insurance; but, because the hospital "misread" her insurance, it charged her \$229,000.

If you're hospitalized and have commercial health insurance, including Medicare Advantage, you could be faced with higher out-of-pocket costs than you expected. You have little control over the doctors who see you and are at high risk of out-of-network doctors providing your care. With Medicare, they generally

can't charge above Medicare's rate, but that can still be a lot. That said, depending on your income, you could qualify for **charity care** if you are in a non-profit hospital.

Ms. French challenged her hospital charges in Colorado state court. Fortunately, the Colorado Supreme Court ruled in her favor. She was liable for only \$766.74. It took eight years for her to get that decision.

How did Ms. French end up with more than \$200,000 in out-of-pocket costs? Centura Health, which runs the hospital that provided the surgery, said that her providers were out of network. And, Ms. French signed two agreements to pay all hospital charges after the hospital told her that her estimated out-of-pocket costs would be \$1,300.



Out-of-network rates can be ridiculously inflated: The out-of-network charges were the hospital's full rates—the amounts listed on its "chargemaster." The court rule in Ms. French's favor because she did not know there was a chargemaster and had never agreed to pay its rates. The hospital did not tell her anything about the chargemaster nor would it disclose the chargemaster during the litigation, claiming that the chargemaster was proprietary, a trade secret.

Hospitals should not be able to charge any rate they please for out-of-network care: Chargemasters "have no basis in reality," according to Gerard Anderson, a Johns Hopkins professor. They are not

tied to the actual cost of a given treatment or procedure. Likely for this reason, hospitals tend to keep them confidential. President Trump ordered that **hospitals make this information public**, but they have never done so in a way that anyone can understand.

Patients have no way to comparison shop for hospital care: Since patients have no clue what procedures providers will undertake and no control over them, they have no way to comparison shop for their care.

What if you're in a Medicare Advantage plan? As with insurance for working people, with Medicare Advantage plans, corporate health plans that cover Medicare benefits, your costs can be insanely high, especially if you're in an HMO. There is no limit on your out-of-pocket costs.

Beginning at age 72, you must withdraw money from your retirement accounts

If you have money in an individual retirement account, once you turn 72, the **Internal Revenue Service** requires that you withdraw money from this account every year, even if you still work. (Note: The Secure Act of 2019 made changes to this rule. "If you reached the age of 70½ in 2019 the prior rule applies, and you must take your first Required Minimum Distribution by April 1, 2020. If you reach age 70 ½ in 2020 or later you must take your first Required Minimum Distribution by April 1 of the year after you reach 72.")

In effect, once you turn 72, the IRS requires you to stop saving all your money in your individual retirement account "IRA" or most other employer-based retirement accounts, such as 401(k), 403(b) and 457(b) plans. You must withdraw it over time. Unfortunately, when you withdraw the money, the government gets to tax it. Remember that any money that

you put into these accounts went in tax-free, before taxes. And, any money in an IRA can appreciate without any taxes on the appreciation until you withdraw the money.

How much must you withdraw from your retirement account? The amount you are required to withdraw before the end of each year depends upon the amount in your IRA and your life expectancy. It is called the RMD or required minimum distribution. The total distribution can come out of one or more of your IRA accounts, if you have more than one. It does not have to come out of each one of them. But, the 401(k) and 457(b) distributions must come out of those accounts.

Can you withdraw more than the required minimum distribution amount? Yes. You will be taxed on whatever amount you withdraw that was deposited pre-tax; it will be counted as part of your taxable



income and taxed at your income tax rate. It will not count towards your RMD for the following year.

♦ Are there any retirement accounts not subject to the RMD?

Any retirement accounts you have with after-tax contributions are not subject to the RMD and you are not required to withdraw money from them. This would include a Roth IRA, unless you inherited it.

When must you take your first distribution? You are permitted to take your first distribution in the April of the calendar year following the year you turn 72. Put differently, you do not need to take a distribution in the calendar year you turn 72. But, you must then take another distribution by the end of that calendar year.

What if you forget to take a distribution? If for any reason you forget to take a distribution

when you are required to, do so as soon as possible and complete an **IRS form** explaining **why you forgot**. Unless the IRS accepts your explanation, you may have to pay a big penalty if you do not take a distribution when you are required to. That penalty can be as much as half of the amount you should have withdrawn.

Must you spend the money you withdraw from your retirement account? You are not required to spend the money from your IRA after you withdraw it. You can reinvest it in a different taxable account if you do not need it, but not into a tax-deferred account. And, if you want to give the money in the IRA to a charity, you may distribute up to \$100,000 from the IRA to the charity without paying any taxes on it.

(Note: This article was updated to reflect the new withdrawal age of 72. It used to be 70.5)

Stimulus Update: The Truth About Social Security Recipients and a Fourth Stimulus Check

Despite inflation, the U.S. economy has managed to survive one of the worst global pandemics in history. But with an unemployment rate lingering at 3.6%, there's little chance that Congress will approve another stimulus check for the majority of Americans.

Still, that reality has not slowed rumors regarding a fourth stimulus payment to Social Security recipients. Social Security, paid to retirees and those who cannot work due to disability, may arrive reliably but it does not keep up with inflation. And that is one of the primary reasons Rick Delaney, chairman of The Senior Citizens League (TSCL), sent a letter to Congress asking for a one-time \$1,400 stimulus payment for those on Social Security.

Perspective

To put this in perspective, Delaney sent his letter in October 2021. That's seven months ago. In those seven months, coverage of the letter has made the rounds of talk radio, newspapers, and online publications (including The Ascent). The possibility of a

fourth check has been covered so often that it's easy to understand how people might be confused. Here's where we're at:

Congress has not addressed the issue of another payment to Social Security recipients. Regardless of rumors to the contrary, the IRS has not been ordered to issue a fourth payment to any American.

Congress has not outright rejected the proposal, so the issue is not quite dead and buried. However, no one should count on another round of stimulus payments from the federal government.

What to do instead

If you're a Social Security recipient who finds yourself struggling to make ends meet, these organizations are designed with you in mind.

Help with housing Homeowners

If you're on Social Security and concerned that you may not be able to make your mortgage payments, there may be relief options available through your state or mortgage



lender. If you choose to work with a housing counselor, that person will help you tailor a plan of action, at no cost to you.

You can locate a housing counselor through the Consumer Financial Protection Bureau website.

Renters

Although the CDC eviction moratorium ended last summer, help is still available to renters who may have trouble paying their rent or utilities. Visit this page for the contact information you'll need.

Lost your housing

If you're without a home, this web page spells out where you can find safe temporary housing, pay bills, and even protect your credit score.

Food

If you're having trouble coming up with the money to buy groceries, do not go hungry. There are hundreds of organizations across the country that exist solely to provide you with the food you need.

Food pantries

To find a food pantry near you,

check out the FoodFinder website. All you need to do is type in your zip code.

FoodFinding instantly shows a map of your area, with red indicators showing where each pantry is located. Click on any of the indicators and you'll find the name of the organization sponsoring the food bank, as well as the address.

If you don't drive or have transportation, call one of the organizations near you to learn if they deliver.

SNAP

Finally, if you're eligible, apply for the Supplemental Nutrition Assistance Program (SNAP) in your state. And while you're at it, visit the USDA website to find several other innovative food programs for people over 60.

As time passes, the odds of Congress approving another stimulus check lessen. Still, there are community programs, churches, and government programs that want to help.

New Study Finds that Private Plans Pay Hospitals More Than Medicare for Inpatient and Outpatient Services

By Lindsey Copeland

A new [RAND study](#) found that in 2020, employers and private health insurance plans paid hospitals 224% more than Medicare for inpatient and outpatient services, with wide variation in prices among states.

According to the report, hospital services accounted for 37% of total health spending for the privately insured in 2019 and hospital price increases are key drivers of growth in per capita spending among the privately insured. Yet, much about those prices remains opaque.

The researchers explain that while recent price transparency tools have made price information about certain procedures more available to patients, employers (who provide most private insurance) typically do not have usable information about the prices negotiated with hospitals on their behalf. Their study is intended to help fill this knowledge gap.

To that end, they examined medical claims data from employers and state databases from 2018 to 2020 covering 4,102 hospitals and 4,091 ambulatory surgical centers that account for \$78.8 billion of spending. They present “private insurance prices relative to Medicare as a way to compare private insurance prices to a

common payer and as a way to apply a publicly available approach to fairly compare private insurance prices among different hospitals.”

Among the key findings:

- ◆ The Medicare payment ratios remained relatively stable over the study period. Private insurers paid 222% of Medicare prices in 2018 and 235% in 2019. In 2020, relative prices for hospital facility-only services averaged 224%, while associated professional services, such as physician fees, averaged 163% of what Medicare would have paid for the same services
- ◆ In 2020, COVID-19 inpatient hospitalizations averaged 241% of Medicare, which is similar to the relative price for all inpatient procedures.
- ◆ There was significant variation across states. Some states (Hawaii, Arkansas, and Washington) had relative prices below 175% of Medicare, while others (Florida, West Virginia, and South Carolina) had relative prices that were at or above 310% of Medicare levels.
- ◆ Very little pricing variation is explained by each



hospital's share of patients covered by Medicare or Medicaid; a

larger portion is attributable to hospital market power. This finding challenges industry claims that Medicare and Medicaid payment rates drive up costs for privately insured people and matches [previous studies](#) that show hospitals in concentrated markets focus on raising prices to private insurers, while hospitals in competitive markets focus on cutting costs.

- ◆ Prices for services performed in ambulatory surgery centers (ASCs) averaged 162% of Medicare. Since Medicare payment rates for ASCs are below those for hospital outpatient departments (HOPDs), the ratio would have been lower (117%) if ASCs were paid the same way.
- ◆ Among a set of five procedures commonly performed in both ASCs and HOPDs, the average HOPD price was 2.1 times higher and commercial payments were 2.6 times larger. If the same providers were paid Medicare rates for the same services, employers and private plans would have

saved \$49.9 billion.

An Axios [article](#) puts the report in context:

“Annual per-person spending growth for workplace health coverage has exceeded spending growth for government programs in nine of the past 13 years...[t]he divergence in pricing has been linked to mergers and acquisitions, affiliation agreements and other consolidation that increases hospitals’ leverage. In 2021, the average premium cost of an employer-sponsored family plan was more than \$22,000, an increase of 47% from 2011, [according to the Kaiser Family Foundation.](#)”

The study is part of a RAND [initiative](#) on health care price transparency, and the fourth in a [series](#) designed to demystify hospital pricing. The researchers suggest it could help employers and others become better-informed purchasers of health services and benefits as well as contribute to policy discussions on strategies to curb health care spending.

Medicare Rights agrees with the need for greater pricing transparency to help guide policy decisions. We urge policymakers to use such data to identify and advance systemic reforms that will meaningfully lower costs for individuals and programs.

Issue Brief Explores Ways to Reduce Medicaid Churn

By Julie Carter

A new [issue brief](#) from the Integrated Care Resource Center (ICRC) examines strategies to reduce churn, the unnecessary loss of Medicaid coverage, for the 12 million people who are dually eligible for Medicaid and Medicare. Churn causes [significant health](#) and financial burdens for beneficiaries, providers, insurance plans, and states.

Despite these harms, many states have erected overly burdensome administrative barriers that increase churn. For example, they may require people with Medicaid to resubmit their income and asset

information multiple times a year to stay eligible. Since such compliance can be difficult, people may lose their coverage despite still being eligible.

ICRC’s brief suggests states should move in the opposite direction and reduce or lessen the effects of churn by changing state policies and practices. This includes lengthening enrollment periods, using pre-populated forms, and using state resources, rather than beneficiary-submitted paperwork, to prove income eligibility.

The brief also outlines ways that states can work with Dual



Eligible Special Needs Plans (D-SNPs), Medicare Advantage plans that specifically serve

people who are covered by both Medicare and Medicaid. These plans can help states reach people with Medicaid, reminding them of upcoming administrative deadlines, assisting with paperwork, and enlisting providers to help spread the word.

In addition, states can work with D-SNPs by requiring or allowing plans to offer “deeming periods”—continued enrollment for individuals who lose Medicaid eligibility but are

expected to regain Medicaid coverage within six months. At Medicare Rights, we know that the cyclical pattern of churn causes stress, financial instability, and gaps in coverage for people with Medicaid. We urge states to take up ICRC’s suggestions and to go further by [increasing income and asset limits](#) for people to qualify for Medicaid. In 2019, the median [income limit was only 74% of the federal poverty level](#), a number that leaves far too many people without access to care and coverage.

The Average Social Security Beneficiary Has Lost Nearly \$6,500 in Annual Purchasing Power

Regardless of whether you're currently retired or just entering the workforce, there's a good chance America's most successful social program, Social Security, is going to play a key role in your financial well-being.

According to surveys conducted by national pollster Gallup in April 2021, 85% of nonretirees expect to rely on their Social Security income to some degree to make ends meet during retirement. This compares somewhat similarly to the 89% of polled retirees who were already leaning on Social Security as a "major" or "minor" source of income.

Because of the critical role Social Security will play/is playing for most workers during retirement, arguably no announcement from the Social Security Administration is more closely monitored than the annual cost-of-living adjustment (COLA).

What is Social Security's cost-of-living adjustment and how is it calculated?

In simple terms, COLA is the "raise" that beneficiaries receive

most years to account for **inflation**. If the price for goods and services increases from the previous year, beneficiaries should receive a commensurate benefit hike so they can still afford the same amount of goods and services.

You'll also note I've put "raise" in quotation marks to represent that this isn't a raise in the true sense of the word. Rather, COLA is simply designed to true-up benefits to match the prevailing inflation rate (not help beneficiaries get ahead).

Since 1975, the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) has been the program's inflationary tether. **To determine Social Security's COLA for the upcoming year**, only CPI-W readings from the third quarter (July through September) are used. The other nine months can be helpful in identifying trends, but they won't factor into Social Security's COLA calculation.

If the average CPI-W reading from the third quarter of the current year is higher than the



average CPI-W reading from the third quarter of the previous year, beneficiaries are in line for a "raise." The amount of the raise is the year-over-year percentage increase in the average Q3 CPI-W reading, rounded to the nearest tenth of a percent.

Social Security beneficiaries have lost 40% of their purchasing power since 2000

Despite there being a clear formula to pass along inflationary benefit hikes, Social Security's **COLA has done a poor job** of keeping up with the inflation that the average Social Security beneficiary has contended with since the beginning of the century.

According to a **new report** issued by nonpartisan senior advocacy group The Senior Citizens League (TSCL), the purchasing power of Social Security dollars has declined by a whopping 40% since 2000, as of March 2022.

For added context, the 10-percentage-point loss of purchasing power over the most recent 12-month period (March

2021 to March 2022) is the largest ever recorded by Mary Johnson, a Social Security policy analyst for TSCL. Johnson highlighted a number of rapidly rising costs over the past year that've led to this purchasing power loss, including a 79% increase in home heating oil expenses, as well as certain Medicare premiums and out-of-pocket healthcare costs that aren't part of Social Security's COLA calculation.

Since 2000, the aggregate increase in monthly benefits via COLAs is 64%. This means the average monthly benefit has increased from \$816 in 2000 to \$1,336.90 by 2022. However, Johnson's study found that a 130% increase in payouts was needed simply to keep up with typical senior expenses. A 130% COLA since 2000 works out to a \$1,876.70 monthly benefit. This \$539.80 monthly shortfall equates to nearly \$6,500 in lost annual purchasing power for the average beneficiary in 22 years....[Read More](#)

Dear Marci: What is improper billing?

Dear Marci,

I recently applied to the Medicare Savings Program and was enrolled in the QMB program. Can you explain improper billing and how it will affect me now?

-Henrik (Billings, MT)

Dear Henrik,
Congratulations on successfully enrolling in the QMB program. I am so glad you applied and will receive help paying your Medicare costs.

In Medicare, the term **improper billing** refers to a provider inappropriately billing a beneficiary for Medicare cost-sharing. Cost-sharing can include deductibles, coinsurance, and copayments. Federal law prohibits Medicare providers from billing people enrolled in the **Qualified Medicare Beneficiary (QMB)** program for any Medicare cost-sharing. This means that if you have QMB, Medicare providers should not

bill you for Medicare copays or deductibles for any Medicare-covered services. *

If you have QMB and are enrolled in Original Medicare, you should not be billed for Medicare cost-sharing when receiving a Medicare-covered service from either:

- ◆ A **participating provider** (one who takes assignment)
- ◆ A non-participating provider If you have QMB and are enrolled in a Medicare Advantage Plan, you should not be billed for Medicare cost-sharing when receiving a plan-covered service from **in-network** providers, as long as you meet your plan's coverage rules, such as getting prior authorization to see certain specialists.

To protect yourself from improper billing, be aware that:

Dear Marci

Original Medicare and Medicare Advantage providers who do not accept Medicaid must still comply with improper billing protections and cannot bill you for Medicare cost-sharing.

- ◆ You keep your improper billing protections even when receiving care from Medicare providers in other states (Note: You can be billed if you are enrolled in a Medicare Advantage Plan and see an out-of-network provider, or if you have Original Medicare and see an opt-out provider).
- ◆ You cannot choose to waive these protections and pay Medicare-cost sharing, and a provider cannot ask you to do this.

Remember that if you have QMB, the Medicare providers

you see **must accept Medicare payment and any OMB payment as the full payment** for any Medicare-covered services you received. Providers who violate improper billing protections may be subject to penalties. If you are having issues with a provider who continually attempts to bill you, or if you have unpaid cost-sharing bills that have been sent to collection agencies, call 1-800-MEDICARE or contact your Medicare Advantage Plan.

*Note: Some states may impose Medicaid copays for certain Medicare-covered services. Medicare and Medicaid should pay the majority of the cost, leaving you a smaller copay. Contact your local Medicaid office to learn more about Medicaid copays in your state.

-Marci

'Full investigation' pledged of vast fines imposed by Social Security

The acting Social Security commissioner will launch a "full investigation" on Monday of Inspector General Gail Ennis's oversight of an anti-fraud program that imposed extensive penalties on disabled and elderly people, a senior agency official said Saturday.

The action follows a Washington Post [report](#) that revealed how attorneys in charge of a little-known program run by Social Security's watchdog division issued unprecedented fines beginning in the Trump administration.

More than 100 people who received disability benefits to which they were not entitled were hit with penalties as high as hundreds of thousands of dollars. Those fines were imposed on poor, disabled and elderly people, many of whom had no hope of ever being able to pay.

The acting commissioner "has very serious concerns about the issues raised by The Washington Post about the inspector general's oversight of this program," Scott Frey, chief of staff to Kilolo Kijakazi, said in



an interview. Kijakazi has scheduled a meeting with her senior staff on Monday "to discuss how to proceed," Frey said.

Top House Democrats with oversight of the Social Security Administration and its watchdog also called on President Biden to investigate, calling the penalties an "apparent abuse of authority."

"We are outraged by this stunning report," Ways and Means Committee Chairman Richard E. Neal (Mass.), Social Security subcommittee Chairman John B. Larson

(Conn.) and worker and family support subcommittee Chairman Danny K. Davis (Ill.) wrote in a statement late Friday.

The lawmakers called on the president and Kijakazi to "swiftly investigate this apparent abuse of authority, to put in place safeguards to prevent future abuse, and to provide relief to any individuals wrongfully victimized."

A White House official said in an email, "We are aware of the reporting but have no further comment at this time."

Woman Charged \$303,709 for \$1,337 Surgery Wins Court Battle Against Bill

A woman who was billed \$303,709 for surgery that she was expecting to pay \$1,337 for back in 2014 has taken a significant step towards having that debt wiped after the Colorado [Supreme Court](#) ruled in her favor.

According to the *Denver Post*, St. Anthony North Health Campus [hospital](#) had represented to French that a pair of back surgeries she needed would cost her \$1,337 out of pocket, with her health insurer picking up the remainder of the bill.

However, according to the report, a hospital employee misread French's insurance card,

with [their estimate for the bill](#) based on the proviso that her insurance provider was "in-network" with the hospital. This was incorrect

The term "in network" refers to hospitals and health care facilities that are part of a health insurance firm's network of providers, who offer care at a negotiated discount rate. Patients tend to pay less under a contract that requires the healthcare provider to accept the insurer's payment as payment in full.

In the event [a patient's insurance](#) is not in-network, then they can often be left with a bill for the balance not covered by the



insurer. This bill essentially amounts to the difference between the healthcare provider's full charge and their insurance company's approved amount of cover.

Situations of this kind have led many to call for the introduction of a [single national government program](#) for health insurance coverage. In 2020, a survey from the Pew Research Center found that 36 percent of Americans were in favor of a single program compared with 30 percent a year earlier, while 26 percent called for a mix of private and government programs.

In the case of French,

the *Post* said that she was required to pay the hospital's "chargemaster" price rates, a selection of the hospital's sticker prices for various procedures, which were never revealed to her. That left French facing a hospital bill of \$303,709. Though her insurance company covered \$74,000 of the bill, she was still left facing a remaining balance of \$228,000. She decided to take [legal action](#), claiming the additional chargemaster costs had not been disclosed before she signed the contracts for her [surgery](#)....[Read More](#)

Should retirees ever file for bankruptcy?

Filing for bankruptcy protection is a big decision for anyone, but for older people, it also raises some unique concerns. Many older adults have a lot of equity in their homes, something worth protecting, but that could be threatened in certain Chapter 7 bankruptcies.

If you're an older adult, it's important to consider all your options and know what's at risk before filing for bankruptcy.

Is bankruptcy possible?

"When someone comes to me asking about bankruptcy, I would ask 'What's driving you? What's the pressure point? What are your vulnerabilities and what are your goals?' says bankruptcy attorney Robert Haupt.

This is especially important to ask for seniors, because their

situations are usually different than younger adults. If they own their homes, they likely have a lot more equity in their home. Which means they could have more to lose in the case of a Chapter 7 bankruptcy if their equity isn't protected.

One scenario that would make the value of filing for bankruptcy protection questionable for seniors is if there's simply nothing for a creditor to take. If you're retired and don't have much income, this might apply to you. It could mean you are "judgment-proof." Creditors generally can't access assets like your Social Security benefits, retirement accounts or things you need to maintain a home like household goods.



"Retirement funds are protected, Social Security benefits are exempt — they can't get them," says Haupt. "Virtually anything IRS recognizes as tax exempt is going to be exempt to a certain level."

There are a few exceptions. If you're withdrawing your retirement funds, that may be a problem: they are treated as income in the context of bankruptcy qualifications and lose protection once withdrawn. If your retirement funds are in the same account as retirement funds that were withdrawn, the Social Security funds will lose that protection, too, Haupt says. "You do need to segregate these Social Security funds," says Haupt.

If it ends up there's nothing for creditors to take, then bankruptcy doesn't really make sense. "Creditors want their money, If you can convince them there's nothing to get — most of the time they're not punitive," Haupt says.

The reverse situation is true, too. If you have too many assets, you might not benefit from bankruptcy. If you own assets that aren't protected from creditors, the chances are very high you would lose them in a Chapter 7 bankruptcy. You would probably be able to keep your home with a Chapter 13 bankruptcy repayment plan, but a Chapter 13 bankruptcy is also a longer, harder process....[Read More](#)

RI ARA HealthLink Wellness News

'Almost Like Malpractice': To Shed Bias, Doctors Get Schooled to Look Beyond Obesity

When Melissa Boughton complained to her OB-GYN about dull pelvic pain, the doctor responded by asking about her diet and exercise habits.

The question seemed irrelevant, considering the type of pain she was having, Boughton thought at the time. But it wasn't unusual coming from this doctor. "Every time I was in there, she'd talk about diet and exercise," said Boughton, who is 34 and lives in Durham, North Carolina.

On this occasion, three years ago, the OB-GYN told Boughton that losing weight would likely resolve the pelvic pain. The physician brought up diet and exercise at least twice more during the appointment. The doctor said she'd order an ultrasound to put Boughton's mind at ease.

The ultrasound revealed the source of her pain: a 7-centimeter tumor filled with fluid on Boughton's left ovary.

"I hate that doctor for the way she treated me — like my pain was no big deal," Boughton said. "She seemed to make a decision about me based off of a very cursory look."

Research has long shown that doctors are less likely to respect patients who are overweight or obese, even as nearly three-quarters of adults in the U.S. now fall into one of those categories. Obesity, which characterizes patients whose body mass index is 30 or higher, is pervasive in the South and Midwest, **according to the Centers for Disease Control and Prevention**. The state with the highest rate is Mississippi, where 4 in 10 adults qualify as obese.

Obesity is a common, treatable condition linked to a long list of health risks, including Type 2 diabetes, heart disease, and some cancers. Despite obesity's prevalence, it carries a unique stigma.

Doctors often approach the practice of medicine with an anti-fat bias and struggle to communicate with patients whose weight exceeds what's considered the normal range. Some obesity experts blame a lack of focus on the subject in medical schools. Others blame a lack of empathy.

To counter that, the



Association of American Medical Colleges plans to roll out in June new diversity, equity, and inclusion standards aimed at teaching doctors, among other things, about respectful treatment of people diagnosed as overweight or obese.

That's not happening for many patients, said **Dr. Scott Butsch**, director of obesity medicine at the Cleveland Clinic's Bariatric and Metabolic Institute. "This is almost like malpractice. You have these physicians or clinicians — whoever they are — relating everything to the patient's obesity without investigation," Butsch said. "The stereotypes and misperceptions around this disease just bleed into clinical practice."

The problem, Butsch argued, is that too little attention is paid to obesity in medical school. When he trained and taught at Harvard Medical School for several years, Butsch said, students received no more than nine hours of obesity education spread over three days in four years.

In 2013, the American Medical Association voted to recognize

obesity as a disease. But, Butsch said, doctors often approach it with a one-size-fits-all approach. "Eat less, move more" doesn't work for everyone, he said.

Parents and medical providers need to take special care when talking to children who have been diagnosed with obesity about their weight, psychologists have warned. The way parents and providers talk to kids about their weight can have lifelong consequences and in some cases trigger unhealthy eating habits. For children who are obese, obesity experts agree, weight loss isn't always the goal.

"There are many different forms of obesity, but we're treating them like we're giving the same chemotherapy to all kinds of cancer," Butsch said.

All but four of the country's 128 M.D.-granting medical schools reported covering content related to obesity and bariatric medicine in the 2020-21 academic year, according to curriculum data provided to KHN by the Association of American Medical Colleges, which does not represent osteopathic schools....Read More

Spring's Double Trouble: Asthma Plus Seasonal Allergies

If you have both asthma and seasonal allergies, there are ways to reduce the impacts of that double whammy, an expert says.

People with **asthma**, a chronic lung condition, should try to control or prevent allergic outbreaks, said Dr. Miranda Curtiss, an assistant professor at the University of Alabama at Birmingham School of Medicine.

Nasal steroids and nasal antihistamines are among the easiest and most effective way to defend against seasonal allergies, she said. Moreover, they're inexpensive and available over-the-counter or by prescription, Curtiss added.

Allergy shots are another option.

"Allergy shots can be helpful for patients with seasonal and

year-round allergies," Curtiss said in a university news release. "However, these are a long-term investment that require planning to continue therapy for three to five years for maximal benefit. Asthmatics who want to start allergy shots need to have their asthma under good control first before starting shots."

During peak pollen conditions, it's also important to keep your house or car windows closed and use central air conditioning, she advised.

"Changing your clothes when possible and showering after entering the house can be helpful as well," Curtiss said.

Indoor allergens — such as dust mites, molds, cockroaches and pets — tend to be present



year-round, but can fluctuate with factors that affect outdoor allergens. "Because these are perennial, it's more difficult to notice how much they affect asthma and allergy symptoms, as compared to seasonal allergens, but they can have profound effects on asthma symptoms," Curtiss said. "Overall, exposure to allergens seems to make allergic asthmatics more prone to have an exacerbation when they are sick with a viral infection."

Regular use of **asthma inhalers** can help asthma patients control their symptoms. "This is the absolute most important way for patients to protect themselves," Curtiss stressed.

Pay attention to how often you

reach for your inhaler, she said. If you need to use your rescue inhaler more than two times during the day per week or more than two times at night a month, your asthma is not controlled and you should talk to your doctor about boosting your treatment, she added.

"All asthma patients can protect themselves from severe exacerbations by paying attention to their symptoms each day and seeking help early at the start of a flare, when it's more likely to respond to treatment," Curtiss said. "If an asthma patient is using more than one rescue inhaler per month, this is a major red flag and needs an urgent evaluation by a specialist."

Falls Can Be a Serious, Poorly Understood Threat to People With Heart Disease

(American Heart Association News) -- Falls pose a major risk to people with heart problems, and health experts need to do more to understand and prevent the danger, a new report says.

"Falls are very common," said Dr. Sarah Goodlin, senior author of the scientific statement from the American Heart Association. They are associated with serious injuries, and just the fear of falling can limit a person's quality of life.

"And falls are particularly common in adults with cardiovascular disease," said Goodlin, medical director of

geriatrics and palliative medicine at the VA Portland Health Care System in Oregon. "Yet they're very underrecognized."

The report, published Thursday in the AHA journal Circulation: Cardiovascular Quality and Outcomes, said basic information is lacking on how often and why people with heart disease fall, as well as on how severely they are injured.

One 2018 study published in that same Circulation journal estimated that 60% faced a moderate to high risk of falling.



That's based on records from 2,456 people hospitalized with heart disease in one Minnesota county.

Overall, the potential harm from falls is clear, said report co-author Stephanie Turrise, a nurse-scientist at the University of North Carolina Wilmington. The Centers for Disease Control and Prevention says about 36 million falls are reported among older adults each year. About 3 million of those who fall will end up in an emergency room for treatment, and more than 32,000 will die.

"Falls, especially in older adults, can be absolutely devastating," Turrise said.

Problems can persist even after someone has recovered and becomes afraid of falling again, Goodlin said. That can start a vicious cycle where older adults with cardiovascular problems become less active and more prone to problems, Turrise said. "To keep them healthy, they've got to be active."

Heart problems can lead to falls both directly and indirectly....[Read More](#)

Good News, Bad News on Black Americans and Cancer

A new report on how Black Americans are faring against cancer offers up a decidedly mixed picture.

The risk that a Black man or woman in America will die from cancer has steadily declined over the last two decades, the [newly published research](#) found.

Unfortunately, that risk still remains higher for Black Americans than for other racial and ethnic groups, the research also showed.

"We found that from 1999 to 2019, rates of cancer deaths declined steadily among Black people in the United States by 2% per year, with a more rapid decrease among men (2.6% per

year) than women (1.5% per year)," said study lead author Wayne Lawrence, a cancer prevention fellow at the U.S. National Cancer Institute.

"Nevertheless, in 2019, Black men and women still had considerably higher rates of cancer death than people in other racial and ethnic groups," he added.

The conclusions stem from an analysis of death data for Black individuals and other ethnic/racial groups gathered by the U.S. National Center for Health Statistics. The data included people aged 20 and older.

During the two-decade study period, more than 1.3 million



Black men and women died of cancer, the data showed.

Still, cancer death rates among this group dropped 2% each year.

And death rates due to lung cancer dropped the most among men — 3.8% per year. Among women, the steepest drop was in stomach cancer, with death rates falling 3.4% annually, the investigators found.

But not all [the trends](#) were heading in the right direction. During the study period, liver cancer death rates rose among Black seniors. And the risk of dying from uterine cancer also rose among Black women.

As to what's driving the largely positive numbers, Lawrence said that the steady decline in overall cancer death rates among Black individuals likely owes to advances in cancer prevention, detection and treatment. He also cited changes in exposure to cancer risk factors, such as a decline in smoking rates.

At the same time, however, the researchers noted that for most cancers, death rates in 2019 were higher among Black Americans than among white people, Asians, Pacific Islanders, American Indians, Alaska Natives and Hispanics....[Read More](#)

Lower Incomes May Mean Lower Survival After Heart Attack

If you're poor and have a severe type of heart attack, the chance you'll live through it is significantly lower than that of someone with more money, new research shows.

The finding underscores the need to close a divide in health care that hits low-income people hard, said lead researcher Dr. Abdul Mannan Khan Minhas, a hospitalist at the Hattiesburg Clinic Hospital Care Service in Mississippi.

"A lot of work is being done in this area, but obviously, as has been shown in multiple studies, a lot more needs to be done," he said.

The type of heart attack his team studied is an [ST-elevation](#)

[myocardial infarction](#), also known as STEMI.

STEMI, which mainly affects the heart's lower chambers, can be more severe and dangerous than other types of heart attacks.

For the study, the researchers analyzed a database of U.S. adults who were diagnosed with STEMI between 2016 and 2018, dividing patients by ZIP code to gauge household income. They also created models that helped to compare patient outcomes.

In all, there were 639,300 STEMI hospitalizations — about 35% of patients were in the lowest income category. About 19% were in the top



income group. The poorest patients had the highest death rate from all causes — 11.8%, compared to 10.4% for those in the top income group, the study found. They also had longer hospital stays and more invasive mechanical ventilation.

But the amount of money spent on their care was less — about \$26,503 versus \$30,540 for the top-income group, the researchers reported.

Though they were more likely to die, poor patients were, on average, almost two years younger than their affluent counterparts (63.5 years versus 65.7).

They were also more likely to be women, and to be Black, Hispanic or Native American. Most importantly, they had more than one disease or condition.

"They were more sick to begin with," Minhas said. "For instance, these patients had more chronic lung disease, more [high blood pressure], more diabetes, more heart failure, more alcohol/drug/tobacco abuse, and more history of previous stroke as compared to the other group of patients. That's probably the most important factor that they could think is probably contributing to this disparity."...[Read More](#)

Restful Night's Sleep More Likely for Men Than Women

(HealthDay News) -- For many women, having it all may mean forgoing a decent night's sleep.

Women in the United States are less likely to get a good night's sleep and more likely to report **daytime sleepiness** than men, a new survey shows.

The online poll of more than 2,000 U.S. adults found that women are 1.5 times more likely than men to rarely or never wake up feeling well-rested — 32% versus 21%. Also, sleepiness affects the daily activities of 81% of women, compared with 74% of men.

The survey, commissioned by the American Academy of Sleep Medicine (AASM), was

conducted from Feb. 17 to 24.

"There's an incredible amount of pressure that some women feel — the need to work, manage a household and raise children, all with a smile. Sometimes, we need to put away our superhero capes. We need to get back to the pillars of health — **nutrition**, exercise and sleep," said Dr. Seema Khosla. She is medical director of the North Dakota Center for Sleep and chair of the AASM public awareness advisory committee.

"This doesn't need to be complicated. It's a matter of prioritizing sleep. Put the devices



away a little earlier, create a relaxing nighttime routine, and make sure that there's enough time to get at least seven to nine hours of sleep every night," Khosla said in an academy news release.

The AASM said adults should get at least seven hours of sleep a night and offered advice on how to do that:

- ◆ Keep a consistent sleep schedule. Get up at the same time every day, even on weekends or during vacations.
- ◆ Make your bedroom quiet and relaxing, and keep it at a comfortable, cool temperature.

- ◆ Limit exposure to bright light in the evenings and turn off electronic devices at least 30 minutes before bedtime.
- ◆ Don't eat a large meal before bedtime. If you are hungry in the evening, eat a light, healthy snack. Don't consume caffeine, nicotine and alcohol before bedtime.
- ◆ **Exercise regularly** and maintain a healthy diet.
- ◆ Don't go to bed unless you are sleepy.
- ◆ If you don't fall asleep after 20 minutes, get out of bed. Do a quiet activity without a lot of light exposure until you feel sleepy.

Two-Drug Inhaler Could Reduce Asthma Attacks

Two drugs are better than one when it comes to stopping asthma attacks in progress, a new clinical trial has found.

The study, of more than 3,100 asthma patients, found that a two-drug "rescue" inhaler worked better than a standard inhaler in thwarting severe asthma exacerbations -- helping some patients avoid trips to the hospital.

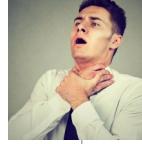
The inhaler, which is not yet approved, contains two long-used asthma medications: albuterol and budesonide.

Budesonide is a corticosteroid that controls the airway

inflammation underlying asthma; people with the disease commonly use a daily inhaler containing a corticosteroid (one brand is Pulmicort) to prevent attacks of wheezing, coughing and breathlessness.

That's in contrast to standard rescue inhalers, which are used to quickly quell a symptom flare-up. They contain medications called **short-acting beta-agonists** and work by relaxing and widening the airways. Short-acting beta-agonists include albuterol (branded as ProAir).

In the new trial, researchers



found that combining budesonide and albuterol into one rescue inhaler appears to be the better approach. On average, the two-drug inhaler cut patients' risk of a severe symptom attack by 26%, versus albuterol alone.

Experts said they think the new inhaler, if approved, should become the rescue medication of choice for most asthma patients.

"Current rescue therapy certainly works, but it's not the best," said Dr. Reynold Panettieri Jr., one of the researchers on the trial.

That's because while standard

inhalers open the airways, they do not address inflammation, explained Panettieri, a professor of medicine at Rutgers Robert Wood Johnson Medical School in New Brunswick, N.J.

The dual-drug inhaler gives people a dose of corticosteroids "right when they need it most," Panettieri said.

That does not mean the new rescue inhaler could replace corticosteroids used for daily asthma control: Patients in the trial were taking controller medications, and used the rescue inhaler "as needed" when symptoms flared....[Read More](#)

What Is Monkeypox, and How Worried Should Americans Be?

A worrisome international outbreak of monkeypox, a less harmful cousin of the smallpox virus, has now reached the United States and Canada. As of Saturday, 92 confirmed cases of the illness, and 28 more suspected cases, have been reported across 12 countries, according to the [World Health Organization](#).

Between 1 and 5 confirmed cases are currently under investigation in the United States, WHO said.

Monkeypox was first seen in the United Kingdom, Portugal, Spain and other parts of Europe in early May. On Friday, the U.S. Centers for Disease Control and Prevention was monitoring six people in the United States for

possible infection. They sat near to one infected traveler on a flight from Nigeria to the United Kingdom in early May.

CDC officials are also investigating a confirmed case of monkeypox in a Massachusetts man who recently traveled to Canada, according to CNN. And the New York City Health Department is probing a possible infection in a patient at Bellevue Hospital there.

Despite all of these recent infections in areas where the virus is uncommon, and newfound concern **that the disease may spread through sexual contact**, health experts are warning against overreacting. Unlike newly emerging diseases



like COVID-19, monkeypox is well understood and effective treatments are available. "Nobody should be panicking," said Anne Rimoin, chair of infectious diseases and public health at the University of California, Los Angeles. "Monkeypox is a known virus that is being introduced into a new population."

The illness begins with fever, swollen lymph nodes and other flu-like symptoms, followed by a telltale rash on the face that spreads to other areas, including genitals, hands and feet. **Sexual transmission a possibility**

The symptoms are similar to

those of smallpox but milder, Rimoin said.

"It can last for several weeks, and people can feel fairly ill," she said. Effective treatments are available, however.

Monkeypox is primarily spread from **animals to humans** — and less often from person to person because close contact with bodily fluids is needed, added Hannah Newman, director of epidemiology at Lenox Hill Hospital in New York City.

"Anyone experiencing an unusual rash or lesion and who has risk factors [or had sexual encounters with someone who has] should seek care immediately," she said....[Read More](#)

Gout Medicine May Also Help Fight Heart Failure

(HealthDay News) -- The anti-inflammatory benefits of a common gout medicine may help save the lives of heart failure patients, researchers say.

The medication, **colchicine**, could also reduce the risk of heart attack and stroke in patients whose arteries are clogged with cholesterol, according to the study authors.

"The signal for benefit with colchicine in these patients was very impressive, and I expect that these findings will have quite a significant impact on clinical care in heart failure and future research for patients with this condition," Dr. Kenneth Bilchick said in a University of Virginia (UVA) news release. He's a professor of cardiovascular medicine there.

For the study, Bilchick and his team analyzed the records of

more than 1,000 patients admitted to the university's Medical Center between March 2011 and February 2020 for worsening heart failure, which occurs when the heart can't pump enough blood through the body.

Survival rates were nearly 98% for those who received colchicine for a gout flare, compared with less than 94% for those who weren't given colchicine.

Many patients with heart failure also have **gout**, a type of arthritis caused by a buildup of uric acid crystals in the joints.

Common treatments for gout include colchicine, steroids and nonsteroidal anti-inflammatory drugs (NSAIDs), such as aspirin and ibuprofen. However, steroids and NSAIDs are not



typically given to heart failure patients because they could worsen **heart failure symptoms**.

Colchicine may benefit heart failure patients by reducing inflammation in the heart and blood vessels, the researchers suggested.

While these initial findings need to be confirmed in large studies, the research team said they are promising.

"These results highlight the importance of novel inflammatory mechanisms in heart failure," Bilchick said.

Heart failure is more than just a failure of the pumping function of the heart, said Dr. Sula Mazimba, a UVA School of Medicine researcher and cardiologist. "There are other processes that are involved, especially during an acute

hospitalization phase, such as elevated inflammation and neuro-hormonal process. Many of the therapeutic agents for heart failure target neuro-hormonal pathways, but few if any target inflammatory pathways," Mazimba said.

"Colchicine is a medication that has anti-inflammatory properties that could potentially attenuate the heightened inflammation that we see in patients who are hospitalized with heart failure," Mazimba added.

About 6 million Americans have heart failure and it causes more than 86,000 deaths a year, according to the American Heart Association.

The study findings were published online recently in the journal **Clinical Cardiology**.

Colon Cancer Death Rates Are Falling Among the Young — But Only for Whites

Race and ethnicity matter when battling colon cancer, with young white patients facing notably better odds than Black, Hispanic or Asian patients, new research warns.

A look at colon cancer survival among Americans younger than 50 turned up a glaring discrepancy: Survival five years after diagnosis improved to nearly 70% among white patients over two decades, but was less than 58% among Black patients.

All had been diagnosed with early-stage disease, starting in 1992.

Moreover, the researchers found that the size of the survival gap grew over time. "Survival for Blacks diagnosed from 2003 to 2013 remained even lower than for whites diagnosed a decade earlier," noted study lead author Dr. Timothy Zaki.

Colon cancer is striking younger people around the world. A study published in May in the **New England Journal of Medicine** reported



that 10% of colon cancer cases are now early-onset -- in patients younger than 50 -- and incidence is rising. As a result, screening is now recommended in the United States to start at age 45.

Prior research suggests these disparities in survival are not new, stressed Zaki, a resident physician at the University of Texas Southwestern Medical Center in Dallas.

Similar racial and ethnic survival rates gaps are also "well-documented" among colon

cancer patients over age 50, said Zaki.

Moreover, previous investigations have indicated that young white patients face a notably lower risk of developing colon cancer in the first place, he noted.

Zaki suggested there is no obvious explanation for what is going on, an observation echoed by Dr. William Dahut, chief scientific officer of the American Cancer Society....[Read More](#)

Medical Marijuana May Offer Safe Pain Relief for Cancer Patients

Cancer patients who use medical marijuana experience less pain and a better quality of life, Israeli researchers report.

And, their **new study** found, these patients were able to rely less on opioid painkillers, with minimal side effects.

"I hope people pay attention to the results of this study and use cannabis when appropriate for patients who need it," said Dr. Alex Bekker, professor and chairman of the department of anesthesiology at Rutgers New Jersey Medical School, in Newark.

Many doctors are still reluctant

to prescribe marijuana for chronic pain, he said.

"Physicians have a difficult time using cannabis, simply because of historical perspective, and it's still federally not authorized," said Bekker, who reviewed the study findings.

A majority of U.S. states and the District of Columbia have legalized **medical marijuana**.

But because it is still considered illegal by the federal government, it hasn't been approved by the U.S. Food and Drug Administration, and therefore is not covered by



government or private health insurance, Bekker explained.

"Articles like this are important to persuade lawmakers that there's something good for a patient and we're not using it for some strange reason, which is the kind of propaganda that's existed for many years," he said.

Pain, depression, anxiety and insomnia all affect patients undergoing cancer treatment and can lead to a poor prognosis, doctors say.

"Traditionally, cancer-related pain is mainly treated by opioid analgesics, but most oncologists

perceive opioid treatment as hazardous, so alternative therapies are required," researcher David Meiri said in a written statement. Meiri is an assistant professor at the Technion Israel Institute of Technology, in Haifa.

For the study, his team followed 324 **cancer patients who used medical marijuana** over six months. The patients experienced a median 20% reduction in pain symptoms, the researchers found. Median means half had greater pain reduction, half had less....[Read More](#)