

Kaiser Health News: Supreme Court to Hear Nursing Home Case That Could Affect Millions

When Susie Talevski sued the agency that managed her elderly father's care before he died, she hoped to get justice for her family. She did not expect the case would grow into a national bellwether. A ruling against her could strip millions of vulnerable Americans of their power to hold states accountable when they do not receive benefits allowed by law.

"This case has taken on, really, a life of its own way beyond what I could have foreseen," said Talevski, a resident of Valparaiso, Indiana.

Talevski filed a lawsuit in 2019 alleging that her father's rights were violated at a nursing home where he lived to get care for his dementia.

"He went from being able to walk and talk ... to not being able to move," Talevski said. "[The nursing facility] treated my dad like trash, like a dog. In fact,

dogs are treated better than that."

In court filings, the Talevski family claims that Gorgi Talevski was overmedicated to keep him asleep, his dementia wasn't properly managed, and he was involuntarily transferred to different facilities hours away from the family's home, which accelerated his decline. Her father died a year ago, in October.

Talevski sued the Health and Hospital Corp. of Marion County, the public health agency in Indiana that owns the nursing facility. The agency, known as HHC, declined to comment on the case but has denied any wrongdoing. In court documents, it argued that Gorgi Talevski was **violent and sexually aggressive**, which affected his care. It tried to dismiss the case, saying Talevski didn't have the right to sue. But federal courts said the lawsuit could move

forward.

So, the public health agency made an unexpected move. It took the case to the nation's highest court and posed a sweeping question: Should people who depend on initiatives funded in part by the federal government — such as Medicaid and programs that provide services for nutrition, housing, and disabilities — be allowed to sue states when they believe their rights have been violated?

A ruling in favor of the HHC **could mean millions** of Americans who rely on federal assistance programs would lose that right. The Supreme Court is scheduled to hear oral arguments on Nov. 8.

"The reach of an adverse decision would be catastrophic," said **Jane Perkins**, an attorney at the National Health Law Program. "It would leave these programs really standing out

there without a true enforcement mechanism."

HHC of Marion County owns and operates 78 skilled nursing facilities across Indiana in a **public-private partnership with American Senior Communities**.

The answer to the question of whether people who depend on federal assistance programs can sue over rights violations has been settled precedent for decades, said Perkins, who has litigated numerous civil rights cases for Medicaid beneficiaries.

For that reason, she was shocked when she learned the Supreme Court had chosen to hear this case. The Supreme Court **is asked to review nearly 7,000 cases** each year and they often agree to look at only 1%-2% of them....**Read More**

On November 10th RI ARA Vice President Roger Boudreau presented Congressman Jim Langevin with an Appreciation Award that read....

With Our Greatest APPRECIATION

We hereby Proudly Present this Award On Your Retirement to Rhode Island Second Congressional District Congressman James (Jim) Langevin 2000-2022

For Your Unwavering Support, Unconditional Commitment and Dedicated Service to the People of Rhode Island Especially to the Members of the Rhode Island Alliance for Retired Americans

Thank You

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The Rhode Island Alliance for Retired Americans looks forward to working with you on matters concerning the retired and senior citizens of Rhode Island as we did with Congressman Langevin.

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CVS, Walgreens Announce \$10 Billion Opioid Settlements

Years of litigation over the opioid epidemic could end soon, as the national pharmacy chains CVS and Walgreens announced Wednesday that each company has agreed to a nearly \$5 billion settlement.

While neither of the companies admitted wrongdoing, the settlements are part of the fight over the drug industry's role in the epidemic that has led to 500,000 U.S. deaths in the past 20 years, the *Associated Press* reported. The pharmacies' role was in filling prescriptions they should have flagged as inappropriate, according to lawsuits from various state governments.

Most of the money will go toward programs that expand treatment for people with addiction, provide overdose antidotes and support prevention efforts. Exactly how much the pharmacies pay will depend on how many governments join the settlement, the *AP* reported.

"We are pleased to resolve these longstanding claims and putting them behind us is in the

best interest of all parties, as well as our customers, colleagues and shareholders,"

Thomas Moriarty, CVS chief policy officer and general counsel, said in a **statement**. "We are committed to working with states, municipalities and [Native American] tribes, and will continue our own important initiatives to help reduce the illegitimate use of prescription opioids."

CVS announced its settlement plan while submitting its earnings report, while Walgreens shared its details in a filing with the Securities and Exchange Commission.

"As one of the largest pharmacy chains in the nation, we remain committed to being a part of the solution, and this settlement framework will allow us to keep our focus on the health and well-being of our customers and patients, while making positive contributions to address the opioid crisis," Walgreens said in a **statement**.



"These agreements will be the first resolutions reached with pharmacy chains and will equip

communities across the country with the much-needed tools to fight back against this epidemic and bring about tangible, positive change," lawyers for local governments said in a statement, the *AP* reported. "In addition to payments totaling billions of dollars, these companies have committed to making significant improvements to their dispensing practices to help reduce addiction moving forward."

Completed opioid settlements so far have reached more than \$50 billion.

Earlier this year AmerisourceBergen, Cardinal Health and McKesson, all of whom are distributors, settled for a combined \$21 billion. Drugmaker Johnson & Johnson settled for \$5 billion.

The Sackler family and Purdue Pharma, which make

OxyContin, have proposed to settle for up to \$6 billion in cash plus the value of the company, the *AP* reported. In that settlement proposal, the company would become a new entity with profits fighting the epidemic. A court has put that plan on hold.

"One by one, we are holding every player in the addiction industry accountable for the millions of lives lost or devastated by the opioid epidemic," Connecticut Attorney General William Tong said in a statement. "The companies that helped to create and fuel this crisis must commit to changing their businesses practices, and to providing the resources needed for treatment, prevention and recovery."

Opioid deaths have reached record levels of about 80,000 a year. Most now involve illicit, lab-made fentanyl. The opioid crisis began with prescription drugs but has shifted, including to heroin, as they have become harder to obtain.

4 Huge Social Security Changes Taking Effect in January 2023

A whopping 97% of retired Americans say they've noticed inflation's effect on their expenses, according to a 2022 survey from The Motley Fool, and 85% of those respondents say that inflation is stretching their budget.

Social Security can be a significant source of income, particularly during tough economic times. But the program is on track to face some big changes in 2023, and these changes will affect your benefits in some way or another. Here's what you can expect starting in January.

1. Retirees will see an 8.7% boost in benefits

Next year's cost-of-living adjustment (COLA) is historic, as it will be the largest in more than 40 years. Beneficiaries will see their monthly payments **increase by 8.7%**, which will amount to around \$146 per month for the average retiree.

All retirees currently collecting Social Security will

receive this boost in benefits starting in January 2023. The COLA also applies to Supplemental Security Income (SSI) as well as other types of benefits, such as spousal or divorce benefits.

2. Workers can earn more without seeing a benefit reduction

Many retirees choose to continue working in some capacity even after filing for Social Security benefits. That can be a smart move in some situations, but if you haven't yet reached your **full retirement age** (FRA), your benefits could be reduced depending on your earnings. The annual earnings limit is the amount you can earn before facing benefit reductions. If you earn more than this limit, a portion of your benefits will be temporarily withheld until you reach your FRA.

Year 2022, Earnings Limit if You're under FRA, \$19,560 per year. Earnings limit if you

**The Motley Fool.**

will reach FRA this year, \$51,960 per year.

Year 2023, Earnings limit if you're under FRA, \$21, 240 per year. Earnings limit if you will reach FRA this year, \$56,520 per year

If you **continue to work after taking Social Security**, a higher earnings limit means you'll be able to earn more before your benefits are reduced. In other words, you'll be able to keep more of your checks starting in January 2023.

3. The wage cap will increase substantially

Workers contribute to the Social Security program through payroll taxes. Those taxes then fund benefits for current retirees. But workers won't owe payroll taxes on all of their income, and the wage cap dictates how much of your earnings will be subject to Social Security taxes.

In 2022, that wage cap is \$147,000 per year, and any earnings above that limit aren't taxed for Social Security. In

2023, though, the wage cap is increasing to \$160,200 per year.

If you're earning between \$147,000 per year and \$160,200 per year, you'll likely see your tax bill go up in 2023.

4. Work credits will be harder to earn

Workers are not eligible for Social Security immediately, and to earn retirement benefits, you'll need to accumulate at least 40 work credits throughout your career. The maximum number of credits you can earn per year is four, and the value of each credit changes from year to year.

In 2022, one credit is valued at \$1,510. Starting in 2023, a single credit will be worth \$1,640. This means workers will need to earn more to collect the credits they need for retirement benefits.

Social Security plays an integral role in retirement for many seniors. By staying informed of upcoming changes to the program, it will be easier to make the most of your benefits in 2023 and beyond.

New Medicare Advantage rules won't stop the misleading marketing

The Centers for Medicare and Medicaid Services (CMS), the agency that oversees Medicare, is implementing new rules regarding marketing of Medicare Advantage plans—corporate health plans offering Medicare benefits. The rules are designed to help protect people with Medicare from joining a Medicare Advantage plan without understanding the risks. These new rules could help at the margins, but there's no stopping the misleading marketing.

Medicare Advantage plans are raking in billions of dollars in profits and will do everything they can to expand their market share. Directing their marketing towards enrolling healthy people is the best way to grow their profits. The penalties they face for misleading people are negligible relative to what they

gain; they only pay penalties when they are caught.

CMS does not have the resources to detect a lot of the misleading Medicare Advantage marketing or the power to **put the kibosh on it**. Medicare Advantage plans have always misled the public about what they offer as compared to Traditional Medicare, and CMS has never succeeded at stopping the misleading marketing.

Of course, marketing is by definition misleading. Unless CMS required Medicare Advantage plans to highlight all their limitations—their limited networks, inappropriate delay and denial rates and out-of-pocket costs for people with complex conditions—in all their communications with enrollees, people have no sense of what



they are giving up when they enroll in a Medicare Advantage plan. They cannot compare Medicare Advantage plans with Traditional Medicare in a meaningful way.

CMS found that the vast majority of sales agents' communications with people with Medicare were misleading in a secret shopper exercise. Eighty percent of sales agent calls to potential enrollees are "inaccurate or insufficient."

At best, CMS' closer review of sales agents' calls and Medicare Advantage TV ads before they are aired could help at the margins. When the sales agents are paid more to steer people to Medicare Advantage than to Medicare supplemental coverage, you can expect that they will steer people to Medicare

Advantage. Curiously, CMS set the start date for tougher reviews of TV ads for January 1, after the open enrollment period is over. CMS has never held Medicare Advantage plans to account in meaningful ways. Rather, it has **raised payments to them 8.5 percent in 2023**, when the data show that they are overpaid 4 percent already. And, CMS has never even identified the Medicare Advantage plans with **high inappropriate denial rates or delays**, let alone cancelled contracts with them. In fact, its own 2023 **Medicare and You Handbook misleads** people by not mentioning many of the risks of Medicare Advantage, including the maximum \$8,300 out-of-pocket limit and the prior authorization hurdles people often face.

Administration expands Medicare special enrollment periods

Most people enroll in Medicare in the three months before their 65th birthday month so that their coverage begins on the first day of their birthday month. But, some people miss this **initial enrollment period** and often pay a penalty for delaying their enrollment. A **new Biden administration rule** gives more people the right to enroll during a special enrollment period, eliminating penalties for late enrollment.

As of January 1, 2023, more people who do not enroll in

Medicare at 65 will be eligible for a special enrollment period, ending coverage delays and penalties for late enrollment. Without this change, these people would only be eligible to enroll in Medicare during the General Enrollment Period, between January and March of each year. They also would need to wait several months after enrolling for their Medicare coverage to begin. And, they would pay a 10 percent Part B premium penalty for each year they delayed



enrollment in Medicare Part B.

A special enrollment period (SEP) will be available to people who did not enroll in Medicare because of exceptional conditions. As of January 1, 2023, people affected by a disaster or government-declared emergency, people whose employer or health plan materially misrepresented information regarding timely enrollment, people who were in prison, and people whose Medicaid coverage ended after

the COVID public health emergency ends will be eligible for a special enrollment period.

In addition, some people who have had a kidney transplant and would lose Medicare coverage will have a new immunosuppressive drug benefit, giving them immunosuppressive drug coverage.

If you need help enrolling in Medicare or have questions about your coverage, contact your State Health Insurance Assistance Program through www.shiphelp.org.

How to ensure your hospital bill is correct

Most of us likely do not check our health care bills too carefully. We do as we are told by the doctors and hospitals and pay for insurance deductibles and copays largely without questioning the bills. It can be difficult to make sense of the bills, let alone to figure out if your health care bill is correct.

Bram Sable Smith reports for **Kaiser Health News** on a billing expert who saved her family a lot of money by questioning her husband, Dr. Bhavin Shah's, medical bill. The hospital charged Shah more than \$3,000 out of pocket. It took more than a year for the hospital

to recognize that the procedure it claimed to have performed had never been performed and correct its bill. And, it paid no penalty for its error. During that time, Shah's bill was sent to debt collections.

Here's what you can do to ensure you are not overpaying for your medical care in hospital

1. When you receive a bill, immediately call the hospital and ask for an explanation of all the charges. Make sure that the bill is itemized, with standardized billing codes.
2. Focus on the items with the



biggest charges and compare the charges for those billing codes with charges for the same billing codes at other hospitals in your area. All

- hospitals are required to disclose this information. You can visit fairhealthconsumer.org for information on typical hospital charges in your area. You can also check **Medicare's online tool**. You should be able to see whether your bill is comparable to bills at other hospitals or completely out of line.
3. If your hospital charges a lot more than other hospitals,

contact the hospital and challenge its charges. Also, complain to your health insurer. Or, if that doesn't work, complain to your state attorney general's office.

4. Ask for your medical records. You might find that the medical records do not show evidence of services for which you were billed.
5. To protect your credit score and avoid more hassle, ask the hospital to hold off sending the bill to a debt collector while it is being disputed.

Home health providers get reprieve from Medicare cuts

Home health providers will avoid significant Medicare pay cuts next year, after the Biden administration announced a net **0.7% increase** in fees.

But the industry is still pushing Congress to delay future rate cuts.

Why it matters: The \$125 million increase announced Monday is a reprieve of sorts after the Centers for Medicare and Medicaid Services proposed an **\$810 million cut** in June. Providers hinted at legal action following the proposal. Instead, reductions will be phased in over two years, spreading out the pain for a health sector that's grappled with staffing shortages and rising costs.

Behind the scenes: The

adjustment stemmed from a new home health reimbursement system CMS launched in 2020 that pays agencies based on patient characteristics rather than how many hours of therapy were provided.

- ◆ The new system isn't supposed to increase Medicare spending, so CMS cut home health agency payments starting in 2020 to account for how it thought agencies would respond to the system change.
- ◆ The 2023 payment rule is meant to even things out.
- ◆ CMS decided to phase in the cut over two years because of the potential difficulties providers would face with a



more than \$800 million payment cut in one year.

The finalized method for calculating the rate still goes against Medicare law, home health leaders said Monday. Home health companies like AccentCare and LHC have been **appealing to Congress** for help since June, while also weighing legal action to stop them.

- ◆ "We're at an impasse at this point," Bill Dombi, president of the National Association for Home Care & Hospice, told Axios. "Once [CMS] decided that they have to do what they have what they did under the law, nothing else comes into play other than their ability to do it."

- ◆ A lawsuit is a last resort, Dombi added. He hopes Congress can step in and change the law faster than the courts would.

Look ahead: Sens. Susan Collins (R-Maine) and Debbie Stabenow (D-Mich.) have introduced a bill to push off the cuts until 2026. But the legislation may not get taken up before the end of the year, and the bill doesn't get at the agency's root cause for the cuts.

Additionally, CMS still plans to claw back the extra \$2 billion it paid to home health providers in 2020 and 2021 as a result of the new payment system. A roadmap for that could come in next year's rule.

Oil Companies Are Seeing Record Profits — Here's Why

Gas prices are already sky high – averaging \$3.804 per gallon according to AAA as of November 7 – but they could go even higher now that OPEC+ decided to reduce oil production by 2 million barrels a day in a bid to hike up oil prices amid stalling global economic growth.

Amid the strain, which is largely driven by the Russia-Ukraine war, consumers are hurting. Oil companies, however, aren't suffering one bit; in fact, they're seeing major paydays.

Here's a look at three of the biggest oil corporations and how

they're profiting right now:

- ◆ **Exxon:** Grew earnings to \$19.7 billion and \$24.4 billion in Q3 2022. Shares rose 3% to \$110.70, a record high, according to Reuters.
- ◆ **Chevron:** Grew earnings to \$11.2 billion in Q3 2022, compared with \$6.1 billion the previous year.
- ◆ **Shell:** Grew earnings to \$9.45 billion for Q3 2022, compared with \$4.13 billion from the same period in 2021.



Why are these oil corporations making so much money? Huge Profits Are Part Of Oil Companies'

Business Model

"There are a couple of reasons why the oil companies are making a killing," said Irina Tsukerman, Esq, a geopolitical analyst, a member of the American Bar Association's Oil and Gas Committee and the president of **Scarab Rising Inc.** "First, energy companies are considered a 'means of production.' They are free

enterprise, and like any other commodity in the U.S they are not controlled by the government, nor can the government regulate prices."

"In fact, in the event of tax hikes either on the product itself or on the companies, the companies can pass off the losses to the consumer, as what companies typically do during inflation with any other product. And private companies are structured around making profit for themselves and their shareholders," she continued....**Read More**

Half of Americans Over 50 Are Now Caregivers

More than half of Americans aged 50 and up are helping an older adult manage tasks ranging from household chores to care for medical conditions, a new national poll shows.

Researchers said the **findings** highlight the critical role that everyday people are playing in the lives of older family members, friends and neighbors.

The results come from the University of Michigan's *National Poll on Healthy Aging*, an ongoing series of surveys on older Americans' well-being.

This go-around, researchers wanted to find out how many people in the 50-and-older

demographic are acting not only as caregivers for an older adult, but as a "helper," too.

"Not everyone who helps an older person considers themselves a caregiver," said **Courtney Polenick**, an assistant professor of psychiatry at Michigan Medicine who worked with the poll team.

That could include people who help a relative, friend or neighbor with tasks like household repairs, yard work, shopping or finances. It's distinct from helping with care for medical conditions, going to doctor appointments, or assisting with personal care, like dressing and bathing.



"But those tasks are important," Polenick pointed out. "They're part of helping older adults remain independent and living in the community."

And Americans appear to be doing a lot of them.

Of nearly 2,200 poll respondents aged 50 to 80, 54% said they'd helped an older adult with "care tasks" in the past two years.

Most often, that did mean helping with health care "encounters" — like making or attending appointments and communicating with medical providers. But people also commonly helped with home

repairs, yard work, grocery shopping, making meals and managing finances.

About one in six respondents helped an older person with personal care, like bathing and dressing.

In close to half of cases, people were helping a parent. But it was also common for respondents to be helping a friend or neighbor, a spouse or another relative.

Lending a helping hand has its challenges. The poll found that two-thirds of caregivers/helpers reported problems like physical and emotional fatigue, difficulty balancing family responsibilities and work, and lack of time for self-care.....**Read More**

Important Rules Implement Key BENES Act Provisions to Simplify Medicare Enrollment

Today, the Centers for Medicare & Medicaid Services (CMS) **finalized rules** implementing the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act policies that were **signed into law** as part of the Consolidated Appropriations Act, 2021 (CAA). Those landmark provisions include:

- ◆ Eliminating the months-long wait for coverage that occurs when people enroll during the General Enrollment Period (GEP) or in the later months of their Initial Enrollment Period (IEP). Starting in 2023, Medicare will begin the month following enrollment.
- ◆ Giving Medicare the authority to establish Part B Special Enrollment Periods (SEPs) for “exceptional circumstances,” a flexibility long available within Medicare Advantage and Part D. Starting in 2023, people who qualify for a Part B SEP can enroll without having to wait for the GEP and without being subject to a Part B Late Enrollment Penalty.

In **draft rules** earlier this year, CMS outlined plans to put these changes into regulations and suggested several new Part B SEPs. The final rules largely align with those proposals but include vital updates Medicare Rights and others requested via **comment**.

Specifically, CMS is finalizing the following SEPs:

- ◆ An SEP for individuals impacted by an emergency or disaster. As proposed, this would have applied only to beneficiaries who missed an enrollment opportunity because they were in an area affected by a government-declared disaster

or emergency. **The final rule** creates an SEP that lasts six months, rather than the proposed two months, after the end of the emergency declaration. It also expands the SEP’s availability, allowing individuals to use it if the disaster or emergency occurs where their authorized representative, legal guardian, or person who makes health care decisions on their behalf resides.

- ◆ An SEP for health plan or employer error that constitutes “material misrepresentation” of information related to timely enrollment. The proposed rule sought to provide relief in instances where an individual could demonstrate that their non-enrollment was due to a misrepresentation or incorrect information provided by their employer or health plan. **The final rule** extends the SEP duration by four months; it will now last six months after the individual notifies the Social Security Administration (SSA) about the misrepresentation. Critically, it makes this notification process less burdensome by permitting the beneficiary’s written attestation to suffice when documentation from the employer or health plan is not available. It also expands the sources of misinformation to include plan brokers and agents.
- ◆ An SEP for formerly incarcerated individuals to enroll in Medicare following their release from a correctional facility. **The final rule** extends the SEP from six months post-release to 12. To reduce the risk of gaps in coverage, it allows qualifying individuals to choose between retroactive



coverage going back to their release date (not to exceed six months and for which premium payments would be owed) or coverage beginning the month after they enroll.

- ◆ An SEP to coordinate with the termination of Medicaid eligibility. This is a particularly timely flexibility given the inevitable **wind-down** of the COVID-19 public health emergency. **To minimize access problems, the final rule** permits affected individuals to choose their coverage effective date: either retroactive to their Medicaid termination (January 1, 2023, at the earliest, and premium payments would be owed for this back-dated period) or beginning the month after enrollment.
- ◆ An SEP for other unanticipated exceptional conditions. CMS will retain the ability to provide SEPs on a case-by-case basis for other unanticipated situations that involve exceptional conditions. **The final rule** provides for a minimum six-month SEP duration.
- ◆ Importantly, CMS notes that “[a]s a part of implementing this final rule, we will be updating CMS publications, websites, and outreach materials. We also intend to work with stakeholders (for example, SHIPs, beneficiary advocacy groups, etc.) to raise awareness and understanding of all the new SEPs.” We commend and welcome this promised engagement.
- ◆ The rule is not just related to the BENES Act; it additionally formalizes a new Medicare Part B immunosuppressive drug

benefit that was also created by the CAA. This policy allows certain people with Medicare due to end-stage renal disease (**ESRD**)—those who have no other insurance or Medicare eligibility and are 36 months post-kidney transplant and, **therefore**, set to lose their ESRD Medicare—to access continued immunosuppressive drug coverage through Part B. Eligible individuals can enroll now. The program begins on January 1, 2023. A monthly premium applies, and people who are eligible for the Medicare Savings Programs (MSPs) can access cost sharing.

- ◆ It also finalizes meaningful, largely administrative, updates to MSP operations, including limiting the premium liability of states in situations where a person is awarded retroactive Medicare enrollment and is eligible for both Medicare and Medicaid.
- ◆ Medicare Rights applauds these and other much-needed Medicare improvements. We appreciate CMS taking many of our suggestions into account when drafting the final rule and will continue to recommend reforms throughout the implementation process and beyond. We will also keep urging Congress to further modernize Medicare enrollment through the passage of the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) 2.0 Act (**S. 3675**). This important legislation would promote informed enrollment choices and more fully realize the goals of the original BENES Act.

Read the final rules.

Possible New Threat to Social Security and Medicare Emerges

Within the last two weeks TSCL has been troubled by the statements of some members of Congress about what could happen to Social Security and Medicare.

The four Republican lawmakers interested in serving as House Budget Committee chairman in the next Congress all said they would refuse to raise

the debt ceiling next year unless Democrats agreed to entitlement cuts (in other words, cuts to Social Security and Medicare) and to work requirements on safety-net programs — measures Dems would find abhorrent. This would set the stage for another high-stakes showdown.

Most political observers think



Republicans are likely to win the majority of seats in the House of Representatives and could even win a majority in the Senate.

If that happens, Republicans would be in a position to force the President to make those cuts or face a default in payments owed by the United States on the

money it has already borrowed and spent – borrowing that was previously approved by Congress.

The U.S. has never defaulted on its loans and most economists believe a default would have major negative economic consequences for this country and for the world economy.



Obesity Could Speed Disability When MS Strikes

Obesity is never healthy, and that may be especially true for people who also develop multiple sclerosis.

Obese people with MS are likely to see the disability linked to the disease rapidly worsen, said German researchers who followed more than 1,000 patients in a new study.

Weight loss, they suggested, might help slow the progression of the disease.

"The findings from this study raise important questions about the role of **elevated BMI** (body mass index) on mechanisms that drive neurologic disability in MS," said Dr. Fiona Costello, a professor of neurology at the Cumming School of Medicine at the University of Calgary in Canada.

Obesity correlates with a higher risk of developing MS, she said. "What has not been clear is how obesity is linked to disease severity and disability progression in individuals with MS. But a large body of published literature has shown that deleterious disease associations with obesity are not unique to MS."

Obesity already has been linked to an increased risk of heart disease and type 2 diabetes, as well as cognitive impairment and dementia, said Costello, who had no part in the study.

This study can't prove that obesity speeds up greater disability in patients with MS, only that the two seem to be connected, the researchers noted.

Still, "obtaining a normal weight is likely beneficial for people with MS," said Dr. Asaff Harel, director of the multiple sclerosis center at Lenox Hill Hospital in New York City. He played no role in the research.

MS is an **autoimmune disease** that affects the central nervous system. It can cause permanent disability or even death, and there is no cure. Symptoms usually start in the 30s or 40s.

The study team was led by Dr. Jan Lunemann, a professor of neurology at the University of Munster. The researchers collected data on 1,066 patients with **relapsing-remitting MS** who took part in a German nationwide MS study.

When their MS was diagnosed, 15% of the patients were obese, meaning they had a BMI of 30 or higher. Almost 7% also suffered from type 2 diabetes or high blood pressure -- **conditions linked to obesity**. The researchers checked participants' disability levels every two years over six years.

Although obese patients didn't have a greater relapse rate or



more nerve damage over the course of the study, they had greater disability at the time of diagnosis. And their levels of disability grew faster than those of people who weren't obese, the researchers found.

Obese patients reached a higher level on the Expanded Disability Status Scale in just under 12 months, compared with nearly 18 months for those who weren't obese. Patients with obesity were also more than twice as likely to reach this higher level of disability within six years, regardless of which drugs they were treated with, the researchers found.

Patients who were overweight but not obese did not face a higher risk of disability. "Our finding that obesity, but not overweight in MS patients, is associated with a poorer outcome suggests a threshold effect of body mass on disability accumulation in MS," the researchers wrote.

"These data suggest that dedicated management of obesity should be explored for its potential merit in improving long-term clinical outcomes of patients diagnosed with MS," they added.

Weight management should be explored as a potentially modifiable risk factor for disability progression in MS

patients, Costello said.

"It stands to reason for any individual with or without MS, working to achieve the best possible BMI will benefit their overall health, particularly since motor disability and cognitive decline, which independently co-associate with obesity, are challenges and concerns for people living with MS," she said.

Conversations between health care providers and MS patients about body weight need to be approached with an honest acknowledgment about what we know and don't know about the many implications of obesity, Costello said.

Also, "patient-centered discussions need to be handled with sensitivity, being mindful that body image perceptions are an important part of health and wellness," she added.

Harel said several studies have shown that obesity is a risk factor for the development of MS, and some have suggested that obesity is associated with worse MS outcomes.

"We do not precisely understand the pathophysiology of this," he said. "The treatment of MS is not solely about disease-modifying agents. One should take a holistic view, as regular exercise, healthy diet and adequate sleep likely impact MS severity."

Monkeypox Can Be Passed On Even Before Symptoms Appear

Monkeypox spreads even before a person shows any telltale lesions or other symptoms, a new study suggests.

More than half of monkeypox transmission in the United Kingdom occurred in the pre-symptomatic phase, the researchers said.

The new findings — published online Nov. 2 in the *BMJ* — may explain why monkeypox spread so quickly. More than 70,000 cases have been identified worldwide since an international outbreak started in May, but cases do seem to be on the decline.

Monkeypox is a cousin of the

smallpox virus, and the smallpox vaccine can protect people from monkeypox.

Monkeypox transmission was seen up to four days before symptoms started, and the researchers estimated that 53% of transmission occurred during this phase. Thomas Ward, head of infectious disease modeling at the UK Health Security Agency in London, led the new study.

In the past, it was thought that monkeypox only spreads when a person is showing symptoms, said **Hannah Newman**, director of infection prevention at Lenox Hill Hospital in New York City.



She has no ties to the research.

Currently, the U.S.

Centers for Disease

Control and Prevention states that people can transmit the infection only after they develop symptoms.

"Prior to this study, researchers were aware it was possible to shed the virus before symptoms appeared, however, it was unknown how common that may occur," Newman said.

"These findings could also have important implications for global infection control and raise questions on whether the current guidance — asking people to

isolate once symptomatic — is enough to prevent transmission of the virus."

For the study, the researchers tapped into routine surveillance and contact tracing data for more than 2,700 individuals in the United Kingdom who tested positive for the monkeypox virus between May 6 and Aug. 1, 2022.

The investigators looked at the time symptoms started in the first patient to symptom onset in the next contact, and at the time from exposure to onset of symptoms. They created two models....**Read More**

Biden-Harris Administration Broadens Medicare Coverage of Medically Necessary Dental Care

This week, Medicare Rights celebrates a Biden-Harris administration **announcement** that it would be extending its interpretation of medically necessary dental care. This decision ends a decades-long policy that unnecessarily limited access to life- and health-saving treatment for people with Medicare.

Medicare Part B currently pays for some dental services under very narrow circumstances when that service is integral to medically necessary services needed to treat a beneficiary's primary medical condition. Many individuals need dental care because oral conditions or

infections impede the safety of or access to other medical services. While some Medicare Advantage plans include some dental coverage, such coverage is generally quite limited and leaves people in Original Medicare with few options.

We have long **believed** that the Centers for Medicare & Medicaid Services (CMS) has the authority to allow Medicare to cover a broader scope of medically necessary care than it previously asserted. This final rule is the result of the administration reconsidering its previous position and determining it was too narrowly



framed.

Under the new framing, Medicare can pay for dental services under various clinical scenarios, including surgical procedures like cardiac valve replacement, organ transplants, and cancer treatments. The administration is also establishing a process to identify and cover additional dental services that are inextricably linked and substantially related and integral to the clinical success of other covered medical services.

We applaud the administration's decision and believe that this clarified definition will help mitigate

some of the current issues people with Medicare have in accessing needed oral and dental care. We will continue to advocate for coverage of oral and dental care under other clinical scenarios that make such care medically necessary.

In addition, while this decision is a vital step toward integrating oral health into whole-body health, we will continue our work to add a much-needed **comprehensive dental benefit** to Medicare. We regularly hear from callers to our national helpline that they cannot afford dental care and regularly go without critical care.

[Read the press release.](#)

Doctor's Office Stress Test Could Gauge Your Heart Risk

Evaluating a person's psychological stress can be a good way to gauge their risk of heart and blood vessel disease, new research suggests.

And a brief questionnaire could help with the assessment, the study findings showed.

"Our study is part of the accumulating evidence that psychological distress is a really important factor in a cardiovascular diagnosis, such as the other health behaviors and risk factors, like physical activity and cholesterol levels, that clinicians monitor," said co-author **Emily Gathright**. She is an assistant professor of psychiatry and human behavior at Brown University's Warren Alpert Medical School, in

Providence, R.I.

For the study, the team looked at research published within the past five years that included adults without a psychiatric diagnosis who were screened for depression, anxiety, post-traumatic stress disorder, stress or general mental health symptoms, and followed for more than six months. About 58% were women.

In all, Gathright and her colleagues analyzed findings from 28 studies that included more than 658,000 patients. Those reporting high levels of psychological distress had a 28% higher risk of heart disease, the investigators found.



According to study co-author Carly Goldstein, an assistant professor of psychiatry and human behavior, a brief mental health questionnaire can give clinicians a better idea not only of a patient's mental health risks, but also their associated risk for heart disease.

Based on the results of the questionnaire, the clinician can immediately advise the patient about how improving their mental health can help them improve their heart health, she added.

"This analysis shows that a patient's psychological distress is directly associated with their cardiovascular risk, providing opportunities for clinicians to

help a patient manage their risks over time, for better overall health, right at the point of care," Goldstein said in a Brown University news release. Before the study it was not known whether a brief mental health screening would help predict heart disease risk, she noted.

Most research examining links between psychological health and heart disease has focused on people who have already been diagnosed, said study co-author **Allison Gaffey**, a clinical psychologist at Yale School of Medicine in New Haven, Conn., who completed her predoctoral internship at Brown's medical school....**[Read More](#)**

Clinical Trials Could Help Stop Alzheimer's. But Who Will Join Them?

New drugs that could slow or prevent the start of dementia would be groundbreaking, but a new poll suggests many middle-aged adults may be reluctant to take part in the studies that test those medications.

Only about 12% of the roughly 1,000 people aged 50 to 64 who were surveyed said they're very likely to step forward to test a new dementia drug, according to the National Poll on Healthy Aging from the University of Michigan (U-M) Institute for Healthcare Policy and Innovation.

Another 32% said they were

somewhat likely, the survey found.

"Our analysis shows that the 56% of respondents who say they're not likely to take part in a dementia prevention drug trial mainly cite concerns over being a 'guinea pig' or the potential for harm, but nearly one in four said it's because they don't think dementia will affect them," said study first author **Chelsea Cox**, a doctoral student in public health at U-M.

"However, as other research has shown, one-third of people over 65 have dementia or mild



cognitive impairment, and the rate rises steadily with age," Cox added in a university news release.

Respondents who have a family history of Alzheimer's disease or dementia or who believed they were at risk were more than twice as likely to say they would participate in testing for a new drug. Those who had talked about dementia prevention with a doctor were also more likely to respond in this way, but that included only about 5% of those surveyed.

One-third of respondents had a family history of dementia, while

about 18% had cared for someone with dementia, the findings showed.

Half of participants said they think they're somewhat likely to develop dementia. About 66% reported that their memory was slightly or much worse than it had been when they were younger.

While the poll made it clear that participating in a trial would not cost the participant anything, about 15% were concerned about how much time it would take....**[Read More](#)**

Chest Pain, Shortness of Breath Linked to Long-Term Risk of Heart Trouble

Chest pain and shortness of breath may offer distinct warnings of future heart problems over 30 years' time, according to a new study.

Chest pain accounts for more than 6.5 million visits to U.S. emergency rooms each year. Yet little research has looked at what it might signify over the years to come, said the study's lead researcher, Dr. Kentaro Ejiri, a postdoctoral fellow at the Johns Hopkins Bloomberg School of Public Health in Baltimore. Similarly, he said, few studies have examined long-term implications of shortness of breath, called dyspnea.

Using three decades of data, Ejiri and his colleagues examined links between chest pain, shortness of breath and several cardiovascular problems. Chest pain and dyspnea were mainly linked to future heart attack, atrial fibrillation (a type of irregular heartbeat) and heart

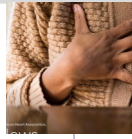
failure (when the heart doesn't pump well). Stroke was least associated with chest symptoms.

Chest pain was most strongly associated with a later heart attack, while dyspnea was most closely associated with future heart attack and heart failure. Having both symptoms appeared to increase risk even further.

The findings suggest the need to view both chest pain and dyspnea as warning signs of not just an immediate crisis but of possible long-term problems, said Dr. Kunihiro Matsushita, the study's senior author and a professor at Bloomberg School.

Even mild chest symptoms were linked to long-term risk of heart problems, although less so than with moderate to severe symptoms.

The study will be presented Monday at the American Heart Association's Scientific Sessions



conference being held in Chicago and virtually. The findings are considered preliminary until full results are published in a peer-reviewed journal.

The study involved more than 13,000 people with no previous cardiovascular disease who were taking part in the Atherosclerosis Risk in Communities, or ARIC, study. Their average age was 54; 56% were female, and 25% were Black.

After evaluating patients' records and using standard grading scales for chest pain and shortness of breath, the researchers assessed risks of heart attack, heart failure, atrial fibrillation and stroke over the coming decades. Researchers adjusted for factors such as age, sex, race, medications and smoking history, which could have affected the results.

Someone who experienced the lowest severity of chest pain had

a 21% greater chance of having a heart attack over the next 30 years compared with someone reporting no chest pain. Those with the highest level of chest pain had an 83% higher heart attack risk compared with those without chest pain.

People who reported the lowest level of shortness of breath had a 30% higher chance of having a heart attack in the next 30 years compared with someone who reported no breathing problems. Those with the highest level of shortness of breath were more than twice as likely to have a heart attack.

Those with the highest levels of both chest pain and shortness of breath were more than 2 1/2 times as likely to have a heart attack than someone with no issues. They also were more than twice as likely to have atrial fibrillation or heart failure, and 85% more likely to have a stroke....[Read More](#)

What's Better for Your Brain, Crossword Puzzles or Computer Games?

Older adults looking to slow down memory loss might find some help in a classic brain-teaser: the crossword puzzle.

That's the suggestion of a small study that followed older adults with mild cognitive impairment — problems with memory and thinking that may progress to dementia over time. Researchers found that those randomly assigned to do crossword puzzles for 18 months showed a small improvement in tests of memory and other mental skills.

That was in contrast to study participants who were assigned to a more modern brain exercise: computer games designed to engage various mental abilities. On average, their test scores declined slightly over time.

Experts cautioned that the study was small and had other limitations. For one thing, it lacked a "control group" of participants who did not perform brain exercises. So it's not clear whether doing crossword puzzles or playing games is significantly better than doing nothing.

"This is not definitive," said lead researcher [Dr. Davangere Devanand](#), a professor of

psychiatry and neurology at Columbia University in New York City.

He said that larger studies, including a control group, are still needed.

As it is, the current results were unexpected, according to Devanand. Going into the trial, the researchers suspected that computer games would reign superior. Past studies have found that such games can help older adults with no cognitive impairments sharpen their mental acuity.

It's not clear why crosswords were the winner in this trial. But, Devanand said, there was evidence that the puzzles were specifically more effective for people in the "late" stage of mild cognitive impairment — which may suggest that crosswords were easier for them to manage.

The findings were published online recently in the journal [NEJM Evidence](#).

Mild cognitive impairment is common with age, and does not always progress to dementia. But in many cases it does. It's estimated that among adults age 65 and older who have such impairments, 10% to 20%



develop dementia over a one-year period, according to the U.S. National Institute on Aging.

Researchers want to find ways to delay or prevent that progression to dementia, and mentally stimulating activities are one avenue under study.

Some research has found that brain games may help people with mild cognitive impairment boost their memory and thinking skills — though studies have found a lot of variation in the types of improvements seen.

And one question, according to Devanand, is whether any particular types of brain exercises are better than others.

So his team set out to compare the effects of web-based computer games and web-based crossword puzzles.

The researchers recruited 107 older adults with mild cognitive impairment and randomly assigned them to either type of brain exercise. All participants received lessons on how to log on and use the games or puzzles.

Even though the crossword puzzles were online, Devanand noted, they were otherwise the same as old-fashioned paper-and

pencil ones. They were moderately difficult — at the level of a *New York Times* puzzle on a Thursday.

After 18 months, the investigators found, the crossword group had improved by about 1 point, on average, on a standard scale assessing cognitive decline — focused mainly on memory and language skills.

In contrast, people in the games group declined by a half-point, on average.

Individuals did vary, however. About one-quarter of the games group, for instance, improved their scores by at least 2 points.

And when the researchers looked closer, the difference between the two brain exercises was specifically seen among people in the later stages of mild cognitive impairment.

It's possible, Devanand said, that for older people with more substantial impairments, crossword puzzles were easier to manage....[Read More](#)

Combo Drug May Fight Tough-to-Treat UTIs

Doctors could soon have access to a new weapon in the ongoing battle against antibiotic-resistant bacteria.

An experimental combination antibiotic appears to offer a new option for doctors treating stubborn drug-resistant urinary tract infections (UTIs), according to new clinical trial results.

The new combo of cefepime and enmetazobactam outperformed an established antibiotic drug regimen in treating complicated UTIs, according to a recent report in the [**Journal of the American Medical Association**](#).

Nearly eight in 10 patients had their infection completely cleared by cefepime/enmetazobactam, compared with about six in 10 patients treated with the existing combo of piperacillin and tazobactam.

Based on these results, French drug maker Allegra Therapeutics is expected to file for U.S. Food and Drug Administration approval early next year, said senior researcher [**Dr. Keith Kaye**](#), chief of infectious disease at Rutgers Robert Wood Johnson Medical School in New Brunswick, N.J.

The FDA has fast-tracked the drug for approval as a Qualified Infectious Disease Product, the researchers said.

"I imagine we'll see this available in the next calendar year," Kaye said. "I'm hoping by the summer or fall."

The combo is specifically designed to treat bacteria like *E. coli* that have developed the ability to produce an enzyme that breaks down commonly used antibiotics like penicillins and cephalosporins, rendering them



ineffective.

Infections caused by bacteria that produce this enzyme, called extended spectrum beta-lactamase (ESBL), increased by more than 50% between 2012 and 2017, according to the U.S. Centers for Disease Control and Prevention.

ESBL-producing bacteria caused more than 197,000 hospitalizations and 9,100 deaths in 2017, the CDC estimated in a 2019 report that classified them as a "serious" antibiotic resistance threat.

"Bacteria were here millions of years before we were, and they're going to be here millions of years after," Kaye said. "It's like we saw with COVID — it's evolution. They will evolve to beat us and to beat our antibiotics."

Enmetazobactam is an

experimental drug that inhibits the ability of the ESBL enzyme to counteract cefepime, a well-established generic antibiotic.

In an advanced clinical trial, doctors tested the new combo drug against an already-established combo — the penicillin piperacillin combined with the ESBL-counteracting drug tazobactam.

The trial involved more than 1,000 patients treated at 90 sites around the world between September 2018 and November 2019.

The patients all had complicated UTIs that were associated with additional risk factors that increase the odds that antibiotic therapy will fail. These risk factors include fever, [**sepsis**](#), urinary obstructions and catheter insertions.....[**Read More**](#)

CDC Issues New Guidance on Prescribed Opioids for Pain

U.S. doctors prescribing opioids for pain relief now have a new -- and more nuanced -- set of guidelines from the federal government.

Issued by the U.S. Centers for Disease Control and Prevention on Thursday, the new recommendations incorporate new science developed since the last set of guidelines were released in 2016, at the height of the country's opioid epidemic.

For example, the guidelines now offer advice on short-term pain relief as well as treatment of chronic pain, [**Christopher Jones**](#), acting director of the CDC's National Center for Injury Prevention and Control, said

during a media briefing.

Doctors can also find advice on how to best taper off opioid use, if it's determined that a patient should no longer be on the medications, Jones added.

But most importantly, the 2022 guidelines are being presented not as hard-and-fast rules, but as a means to help doctors and patients decide the best course of treatment for their pain, Jones noted.

After the 2016 guidelines were issued, insurance companies and lawmakers placed inflexible and sometimes harsh limits on opioid prescribing that went beyond what the CDC had intended,



Jones explained.

"The guideline recommendations are voluntary and meant to assist and guide shared decision-making between a clinician and patient," Jones said. "The guidelines should not be used as a rigid standard of care or inflexible policy or law. It's not meant to be implemented at absolute limits of policy or practice by clinicians, health systems, insurance companies and governmental entities."

About 1 in every 5 U.S. adults deals with chronic pain, according to the report published Nov. 4 in the CDC publication [**Morbidity and**](#)

[**Mortality Weekly Report**](#).

While opioids can be essential for pain management, they also carry the risk of addiction and overdose. Opioid prescriptions and OD deaths both increased fourfold between 1999 and 2010, the report noted.

The recommendations focus on four major areas, Jones said: Determining whether to prescribe opioids for pain in the first place. Selecting the appropriate opioid and dosage for each patient. Deciding how long the opioid treatment will last, and when to reassess whether it's still needed. Assisting the risks and addressing the potential harms of opioid use....[**Read More**](#)

Pfizer Study Finds Big Rise in Immunity From COVID Booster

Getting an updated booster for COVID-19 is likely to boost protection substantially, according to a new study released by drug company Pfizer on Friday.

The news affirms a decision by the U.S. Food and Drug Administration to OK the bivalent booster without first requiring human testing, the [**Associated Press**](#) reported.

The booster was tweaked to target the now dominant omicron variant along with the original

virus, and was cleared based on studies of a similar shot targeting an earlier variant, according to the [**AP**](#).

The new data "reassures us that this was a good decision to move to this bivalent vaccine," FDA vaccine chief [**Dr. Peter Marks**](#) told the [**AP**](#). "Right now is the time for people to consider going out and get the updated" booster, he said.

To study the new booster, Pfizer compared results for



adults who received it to those who received a fourth dose of its original COVID vaccine.

The new booster combines vaccines for the original COVID-19 strain and the now-dominant omicron BA.5 strain.

The results showed that people 55 and older who received Pfizer's new bivalent vaccine had antibody levels four times as high as those who given another dose of the original vaccine, the [**AP**](#) reported.

Those 55 and up who received the new booster had antibody levels 13 times higher than before getting the shot. Younger adults who had not received a vaccine in about 11 months also saw improved antibodies, about a 9.5-fold increase.

Pfizer said it's too soon to know how much real-world protection the antibodies provide and how long the protection will last. The study is continuing....[**Read More**](#)

Most Americans Admit to Driving While Drowsy: Poll

(HealthDay News) -- Most people consider drowsy driving dangerous, but an estimated 37 million Americans still get behind the wheel at least once a year when they're so tired they can barely keep their eyes open.

About six in 10 people admitted to drowsy driving in a new survey by the National Sleep Foundation (NSF).

"Drowsy driving is impaired driving," said Joseph Dzierzewski, the foundation's vice president of research and scientific affairs. "We see that while most Americans believe drowsy driving is risky, they still drive when not fully alert. The good news is — drowsy driving is preventable."

In a survey conducted this fall, nearly 20% of respondents were overly confident in their ability to drive after sleeping two hours or less the previous night.

Respondents who said they get the recommended amount of sleep — about seven to nine hours per night for adults and eight to 10 for teens — were less likely to drive drowsy.

Members of historically excluded groups were at higher risk for drowsy driving, according to the NSF, which said it may be an issue of sleep health equity. (In a position statement issued earlier this year, the foundation noted that people of color in the United States are



disproportionately affected by poor sleep health and sleep disorders.)

An estimated 6,400 people die in the United States each year because of car crashes linked to drowsy driving, according to the NSF.

"At NSF, we are dedicated to helping everyone prioritize their sleep," CEO John Lopos said in a foundation news release. "As we mark the 15th anniversary of Drowsy Driving Prevention Week, we hope to educate the public on the importance of getting the sleep they need and reduce the number of drivers who choose to get behind the wheel while sleep deprived."

If you aren't getting enough sleep to be your "best-slept self," you may be unfit to operate a motor vehicle, Lopos added.

The foundation said drivers should plan to take a companion on long trips to help look for signs of drowsiness and help driving when needed. A good driving companion stays awake to talk to the driver, the NSF said.

Take regular stops, the experts urged, about every 100 miles or two hours.

The foundation noted you may be drowsy if you're frequently blinking, yawning or having difficulty with lane and speed control.

Physicians Say Faulty Oxygen Devices Put Lives in Peril

Faulty readings by pulse oximeters may have resulted in more COVID deaths among minorities, doctors warned in testimony before a U.S. Food and Drug Administration advisory panel this week.

Pulse oximeters are small devices that read a person's blood oxygen levels via a fingertip. During the pandemic, health workers used the readings to help determine who should receive scarce medications, oxygen therapies and hospital beds.

But the devices appear to be

inaccurately reading oxygen levels of people who are Black and others with darker skin, the *New York Times* reported.

The panel urged the FDA to raise accuracy standards, as well as to alert doctors and consumers to the dangerous flaws.

They "most likely contributed to the several-fold greater number of deaths in COVID-19 in ethnic minority patients than in white patients," **Dr. Amal Jubran**, a pulmonary critical care doctor at Loyola Medicine in Chicago,



testified. This isn't a new problem, but it was one that emphasized disparities during the pandemic.

Jubran was among the physicians to identify inaccurate readings in people with darker skin color back in 1990, the *Times* reported.

While a pulse oximeter may show healthy blood-oxygen levels in darker skinned patients, blood tests often reveal different results.

"I guess my fear is that historically that the disparity in

health care is like it never stops," said **Veverly Edwards**, a community representative and the only African American on the panel. "When you lump African-Americans in with everyone else, we end up on the short end — because this started 30 years ago and here we are today addressing it."

Edwards, an assistant professor of teaching at the University of Memphis, said manufacturers should be held accountable and that Black people should have a sustained voice on this issue.

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Almost 20 Million Older Americans Live With Sight-Robbing Macular Degeneration

In a finding that suggests more Americans than ever are struggling with their sight as they get older, researchers report that nearly 20 million adults have age-related macular degeneration (AMD).

Broken down, about 18.3 million people aged 40 and up had an early stage of the condition in 2019, while almost 1.5 million people had late-stage AMD.

"There haven't been many new examination-based studies of the prevalence of AMD, and the only nationally representative data on AMD were last collected in 2008. So, this limits the ability of researchers to update the estimates," said study author **David Rein**, director of the public health analytics

program at NORC at the University of Chicago. "I think a strength of our study is our use of other data sources such as Medicare claims and population data from the Census Bureau to create contemporary estimates."

AMD is one of the leading causes of blindness in the United States. It is characterized by intermediate-sized drusen, which are deposits under the retina, and **retinal pigment epithelium abnormalities**. It affects the macula, which is part of the retina that controls sharp, straight-ahead vision, according to the U.S. National Eye Institute.

The condition comes in two forms: Dry AMD involves the



thinning of the macula, while wet AMD is less common and causes faster vision loss. With

wet AMD, abnormal blood vessels grow in the back of the eye and damage the macula, according to the institute.

While early-stage dry AMD has no symptoms, intermediate-stage AMD can involve some mild blurriness. By the time AMD is in late stage, straight lines can look wavy and the center of vision may be blurry or blank. Although some treatments exist for wet AMD, dry AMD is currently only treated with a specific combination of vitamins and nutrients.

The biggest predictor of developing AMD is older age,

Rein said. Adults over 50 should be regularly seeing an eye care provider to check for early signs of AMD and other eye disorders, he added.

"Especially if you have a family history of AMD, you should make sure to get your eyes examined regularly," Rein said.

People over 85 are a fast-growing age group in the United States due to the aging of baby boomers, Rein noted.

"Given the growing number of all Americans ages 50 and older, what we can expect is the total number of late AMD cases to increase in the future, even if the rate of occurrence at ages lower than age 80 is the same as previously estimated," Rein added....[Read More](#)