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November 28, 2021 E-Newsletter

Publication 2021 Issue 48
Published in house by then RI ARA

House Passes Historic Build Back Act

The House voted 220-213 to pass the Build Back Better Act, H.R. 5376, Friday morning, sending President Biden's sweeping plan to invest in middle class families and expand long-awaited social programs to the U.S. Senate. The bill contains numerous benefits for older Americans, including:

Lower prescription drug prices for all Americans by allowing Medicare to negotiate lower prices for some medicines and through several other mechanisms;

- a $35 per-month limit on the cost of insulin under Medicare and a cap on out-of-pocket prescription drug costs at $2,000 per year;
- $150 billion to expand home health care services for seniors and people with disabilities, along with increased wages and benefits for caregiving workers. Hundreds of thousands more Americans would be able to receive the long-term care and services they need at home, rather than in an institution;
- Guaranteed hearing benefits for Medicare beneficiaries, including coverage for new hearing aids every five years;
- Medicare coverage of all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) -- such as shingles, which would be covered at no cost;
- Extended Affordable Care Act subsidies, which would be especially helpful to older Americans who are not yet eligible for Medicare.

According to the Congressional Budget Office, drug negotiations will save Medicare $262 billion. The bill must now go to the Senate, where it will likely be amended, then sent back to the House, before it can become law.

Rich Fiesta, Executive Director, ARA

"The Alliance applauds the House passage of the historic Build Back Better bill that will significantly improve the lives of older Americans," said Richard Fiesta, Executive Director of the Alliance. "Seniors appreciate that the bill takes steps to lower prescription drug prices for retirees and all Americans. Now that the House has voted, it's time for the Senate to deliver for the American people without delay."

CMS Announces Part B Premium Increase

On Friday, the Centers for Medicare & Medicaid Services (CMS) **announced** the Medicare Part B standard monthly premium would be increasing by 15% ($21.60) in 2022, from $148.50 to $170.10. While this significant jump is the largest in 15 years, for most beneficiaries, the 5.9% cost-of-living adjustment (COLA) to Social Security benefits in 2022—the largest COLA in 30 years—will absorb the increase.

Among the key reasons CMS **cites** for the premium spike is the need for a contingency reserve to cover the potential costs of the expensive and controversial Alzheimer's drug Aduhelm, for which a coverage decision is expected next year.

As previous **Kaiser Family Foundation analysis** shows, Aduhelm could significantly increase Medicare spending and premiums:

- If one million Medicare beneficiaries were to receive the drug, Medicare spending on Aduhelm alone would exceed $57 billion dollars in a single year—far surpassing spending on all other Part B-covered drugs combined, and roughly equating to what Medicare paid for all hospital outpatient services in 2019.
- Since Part B premiums must equal 25% of projected annual Part B expenditures, the billions of dollars in new spending would increase premiums for all 56 million Part B enrollees.
- Beneficiaries would also face high out-of-pocket costs, both for the drug itself and for related medical services. Their 20% coinsurance would be about $11,500 for one year of Aduhelm. This is nearly 40% of the median annual income for a Medicare beneficiary in 2019 ($29,650). And because Aduhelm is not a cure for Alzheimer's disease, patients could incur these costs over multiple years.

Friday's announcement shows just how exposed people with Medicare and the program are to high and rising drug prices in both Part B—which covers outpatient care and provider-administered drugs—and Part D—the prescription drug program. It also underscores the need for swift, meaningful solutions, including those in the latest version of the budget reconciliation bill that would allow Medicare to negotiate drug prices, limit annual price hikes and out-of-pocket costs, and realign financial incentives.

We urge Congress to build on these policies in the final bill, to ensure Medicare can best fulfill its promise of affordable coverage and care. We specifically support making Medicare's low-income assistance programs—the Medicare Savings Programs (MSPs) and the Part D Low-Income Subsidy (LIS)—more available and accessible.

For those who qualify, MSPs and LIS can be a lifeline, helping them afford their coverage and prescription drugs. But the programs' complex application processes and outdated eligibility thresholds unnecessarily limit participation. In recent years, over 40% of Medicare Rights' helpline callers who were struggling with affordability and screened for Part D assistance did not qualify due to overly stringent financial rules. Absent congressional action to expand this assistance and control the underlying prices, more and more beneficiaries may find the cost of care, help paying these costs—or both—to be out of reach.

The budget reconciliation bill presents lawmakers with the opportunity to prevent this. Coupling drug pricing reforms with updates to MSP and LIS—including eliminating the programs' asset limits and aligning eligibility at 200% FPL—would best provide immediate and lasting relief to people with Medicare and their families. It would also strengthen Medicare. As the non-partisan Congressional Budget Office (CBO) previously noted, making prescription drugs more affordable would improve adherence and outcomes. This, in turn, would reduce the need for, and federal spending on, other more costly services, like hospital care paid for by Part A.

ADD YOUR NAME

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

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Analysis Shows Benefits for People with Medicare in the Current "Build Back Better" Bill

As the "Build Back Better" (BBB) budget reconciliation bill begins its journey through Congress, the Kaiser Family Foundation (KFF) has updated a **valuable resource** explaining the budgetary effects and huge public good of many of the bill's major health provisions. These provisions include several that have been long-standing goals of the Medicare Rights Center, including **Medicare prescription drug negotiation** to lower drug costs, especially insulin; **limiting the amount Part D enrollees pay** out-of-pocket each year; adding a hearing benefit to Medicare; **expanding availability of Home- and Community-Based Services (HCBS)** through Medicaid; and closing the **Medicaid coverage gap.**

One of the most promising aspects of the BBB would be the proposal to allow Medicare to negotiate prescription drug prices. Currently, the program is not permitted to negotiate, **unlike other programs like the Veteran's Administration** that negotiate steep discounts on many drugs. While the BBB's current negotiation provisions are not as robust as some **previous bills,** they would be a meaningful step toward reducing prices for people with Medicare. KFF notes that it is unclear currently how many people would be affected, but it would be likely to reduce Part D premiums for all enrollees and reduce costs for insulin-dependent diabetics.

KFF also notes that the cap on beneficiary out-of-pocket spending for Part D medications would greatly help those with high drug costs, potentially saving thousands of dollars for those in the highest spending brackets. And the impact of this provision would grow through time as more and more beneficiaries would reach the out-of-pocket limit.

The addition of a hearing benefit in Medicare would fill a significant gap in coverage and give options to the millions of people with Medicare who currently lack any access to hearing care. Currently, some Medicare Advantage enrollees have access to some limited hearing benefits, but this would level the playing field for those with traditional Medicare by covering hearing rehabilitation, treatment, and hearing aids.

Another vital proposal in the BBB would increase funding for HCBS through Medicaid, which would increase access, reduce waiting lists, strengthen the workforce, and create new processes to monitor quality. Older adults and people with disabilities overwhelmingly want to stay safely in their homes rather than move to a congregate setting like a nursing facility. While the funding that the BBB would provide would not do everything necessary to make HCBS universally available, this proposal would improve the options individuals have and set the stage for future improvements.

Though eliminating the Medicaid coverage gap would not directly affect people with Medicare, it is still very important for the program and future beneficiaries. This proposal would provide coverage to approximately 2.2 million uninsured people with incomes under the poverty level, mostly in Texas, Florida, Georgia, and North Carolina. As KFF notes, half of those in the coverage gap are working and six in 10 are people of color. This would be a very important step to ensure that people have access to care and coverage before they are eligible for Medicare, improving both their well-being and the financial stability of the Medicare program.

At Medicare Rights, we are hopeful that the BBB will pass and make these important changes that will greatly improve the lives of people with Medicare and their families. Many of the provisions fill significant gaps and have been long-standing priorities for us and for many of our partner organizations. It is not too late to make your voice heard. Use our **Action Center** to send an email to your member of Congress, or call the U.S. Capitol Switchboard (202-224-3121) to connect by phone.

Read the KFF analysis.

Read more about drug price negotiation.

Read why investing in HCBS is so important for Medicare.

Public Opinion Is Unified on Lowering Drug Prices. Why Are Leaders Settling for Less?

Democrats and Republicans are crystal clear in polls that they want government to be allowed to negotiate down high drug prices. Americans pay **nearly three times as much for drugs** as patients in dozens of other countries. In the past two years, numerous **Democratic candidates** — including **President Joe Biden** — have campaigned on enacting such legislation.

This year, **the polling group at KFF** asked respondents about support for drug price negotiations after giving them the commonly offered arguments, pro and con: On the pro side, lower prices mean people can better afford their medicines; on the con side, lower profits mean the possibility of less innovation and fewer new drugs. Large majorities **supported the idea** of Medicare negotiating with pharmaceutical firms to get lower prices for both its beneficiaries and people with private insurance: 83% overall, including 95% of Democrats, 82% of independents and 71% of Republicans.

Similarly, **in recent polling funded by the Robert Wood Johnson Foundation,** 84% of respondents said the government should be allowed to put limits on prices for drugs that save lives and for common chronic illnesses, like diabetes. (Funding from the foundation supports KHN's journalism.)

No wonder groups **linked to PhRMA,** the pharmaceutical industry's trade association, are blanketing the airwaves with ads featuring patients with serious illnesses **who say that price negotiation would mean people would not get vital medicines** and could die. Voters aren't buying it: 93% of Americans and 90% of Republicans said they believe that drugmakers would still make enough money to develop drugs if prices were lowered, the KFF poll found. (KHN is an editorially independent program of the Kaiser Family Foundation.)

With public opinion so unified in our politically divided society, why are congressional Democrats settling on a menu of weaker, halfway measures to address the problem of sky-high drug prices?

The current proposal on drug prices in Biden's Build Back Better spending package with support from Congress (so far) contains strong consumer protections — such as limiting out-of-pocket prescription drug payments for Medicare beneficiaries to $2,000 annually and limiting yearly price increases, which have long outpaced inflation.

But when it comes to allowing the government to negotiate better prices, the provisions are narrow, byzantine and distant. The government would identify 100 high-cost medicines and **choose 10 for price negotiation annually**, with those prices first taking effect in 2025. It could negotiate only on medicines that had been on the market for **at least nine to 13 years**, depending on the drug type.

There are many reasons the public's strong view on this issue hasn't translated to more forceful law.

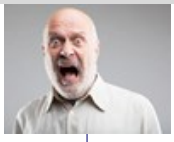
While the idea of drug price negotiations is extremely popular, the benefits of such a program are diffuse — affecting patient pocketbooks here and there. And politicians generally don't expect to be punished by voters for failing to deliver on this single issue. ….**Read More**

No Need to Panic: Social Security Is NOT Running Out

Social Security is a great, noble and necessary government program established by President Roosevelt in 1935. In almost 90 years, there have been minimal changes to Social Security benefits. And with people living longer, a new program is needed. Given this history, it is no surprise that changes are coming to Social Security. To eradicate panic, it is essential to understand that the worst-case scenario is an **almost 25% reduction in benefits.** So, while not ideal, changes to Social Security – or as others have reported "running out" – will not mean zero benefits.

There Will Not Be Dramatic Changes to Social Security

Despite the possibility of a decrease in benefits down the road, there are important reasons why dramatic changes will not be made to Social Security. First and foremost, it would be economically catastrophic to eliminate Social Security. Many retirees and future retirees rely entirely on Social Security as their primary source of income. So, to remove its financial benefits would be inhumane and cause irreparable financial implications to the United States government.



It is also political self-annihilation for the U.S. to consider eliminating the Social Security program. In a country that continues to face dramatic political polarization, Social Security is one of the only bipartisan issues that neither party is willing to touch.

Social Security changes are happening in general because the program is outdated. The reason these benefits are changing now and the changes that we are seeing are related to three significant factors: COLA (cost-of-living adjustment), FICA (Federal Insurance Contributions Act) and FRA (full retirement age).

Inflation's Effect on Social Security

COLA is the increase made to Social Security and Supplemental Security Income to counteract the effects of inflation. In 2022, individuals currently receiving Social Security benefits will receive a **5.9% increase**, the highest raise since 1982. To determine the exact dollar amount you will receive in 2022, take your current benefit, and multiply it by 1.059%.

The increase in Social Security is to counteract the current uptick in the cost of consumer goods. These price increases include essential commodities such as oil and gas. And the expected rise in prices for most goods is 5.9%. So, by understanding how COLA works, the likely outcome in the foreseen future is a combination of smaller Social Security increases, later ages to collect these benefits, and more income tax.

FICA's Impact on Social Security

FICA stands for the Federal Insurance Contributions Act and is the dollar amount deducted from each paycheck. Your nine-digit Social Security number helps accurately record your covered wages or self-employment. As you work and pay FICA taxes, you earn credits for Social Security benefits.

With the expected increase in the cost of living, the limits on the income subject to FICA taxes are naturally increasing. In 2021 you were taxed on your first $142,800 in income to help fund Social Security. But with the almost additional 6% COLA for 2022, the government is increasing taxable FICA wages to $147,000 next year.

The Social Security Trust Fund Depletion

The other expected change on Social Security is that the **trust fund is estimated to deplete by 2033**, an entire year sooner than initially expected. The depletion is due to many factors, such as COVID, an aging population, more people dying than being born, and more money being withdrawn than being contributed. Another reason for our trust fund rundown is our government's propensity to beg, borrow and steal from it over the past few decades.

Americans Strongly Agree on These 3 Changes to Social Security

Americans appear to disagree on many things these days, but they find common ground on one subject: the need to fix the Social Security system.

Three-quarters of Americans in a recent study — 76% — said they either somewhat agree or strongly agree that the Social Security system needs to change, according to the **Nationwide Retirement Institute's 2021 Social Security Survey**.

Meanwhile, just 17% said they somewhat disagree that there is a need for change, and a scanty 6% strongly disagree.

In particular, the Americans surveyed agree about three changes that can be made to help strengthen the Social Security system. Here are the percentages who said they somewhat agree or strongly agree with the following fixes:

1. Ensuring Social Security **cost-of-living adjustments** (COLAs) are enough to, at minimum, keep up with inflation: 89%
2. Reinstating Social Security payroll taxes on people earning more than $400,000 per year: 79%
3. Providing a Social Security credit to unpaid caregivers: 74%

There is more moderate support for a host of other fixes, including:

- Applying COLAs only to lower- or middle-income households' Social Security benefits: 64%
- Eliminating the earnings cap on Social Security payroll taxes (**which is $142,800 for 2021**): 63%
- Privatizing a small portion of benefits: 58%
- Means testing: 58%
- Eliminating early retirement age with reduced benefits: 49%
- Raising the **full retirement age**: 46%
- Linking full retirement age to life expectancy: 46%
- Raising payroll taxes: 46%

There was low support for one other idea — cutting benefits for everyone currently receiving Social Security. Not surprisingly, just 21% of survey respondents supported it.

The Harris Poll conducted the Nationwide Retirement Institute's survey of more than 1,900 U.S. adults age 25 and older between April 19 and May 7, 2021.

Avoiding key Social Security mistakes

Social Security is the foundation of retirement income for millions of Americans. Making the wrong decisions regarding the government program can tarnish your golden years, leaving you with less money to spend.

For example, claiming Social Security early can be costly. As we have reported:

"Claiming early can be risky because once you claim benefits, you will be stuck with the same size payment for life. The amount of a person's monthly benefit typically will never increase except for inflation adjustments."

For more on avoiding such mistakes, check out "**7 Social Security Blunders That Can Ruin Your Retirement.**"

You can also find help with Social Security decisions through Money Talks News' Solutions Center. To learn how you can get a discount on a personalized analysis of your claiming options, see "**A Simple Way to Maximize Your Social Security.**"

The 5 Biggest Social Security Changes on the Horizon in 2022

In 2022, Social Security will look different than it does this year. Every household needs to be prepared for the changes, as it's not just retirees who could be affected.

So, what are the biggest changes to be aware of with one of the country's most popular entitlement programs? Here are five of them.

1. **There's a higher average benefit**

In 2021, the average benefit retirees received was $1,565. In 2022, the average benefit will be $1,657. **Average benefits are increasing** because of a 5.9% cost of living adjustment (COLA) applicable to all Social Security benefits.

But, even after this benefit increase, the new average benefit will offer just $19,884 in annual income. For the vast majority of seniors receiving income close to the average (or below it), benefits will not provide nearly enough to live on.

Seniors should remember that Social Security checks replace only about 40% of income, so they must be supplemented with another funding source.

2. **There's a higher maximum benefit**

The maximum Social Security benefit is also going up next year. The maximum a retiree can receive at full retirement age will be $3,345 per month -- up from $3,148 per month in 2020.

A maximum benefit exists because retirement income is based on average monthly income during a worker's 35 highest-earning years -- but only income up to a certain threshold counts.

To get the maximum monthly benefit, a retiree would have needed to earn the maximum countable income for at least the 35 years of work included in the Social Security benefits formula.

3. **There are new rules for Social Security taxes**

As mentioned above, only income up to a certain threshold is counted when Social Security benefits are calculated. That threshold is called the "wage base limit." The wage base limit also caps the amount of income subject to Social Security tax.

In 2021, for example, the wage base limit was $142,800. Anyone who earned above that amount paid Social Security taxes only on $142,800 of income, so anything earned above that wasn't subject to the tax.

In 2022, however, the wage base limit **will go up to $147,000**. So workers who have an income above $142,800 will be taxed on more of their money -- potentially as much as $4,200 more.

Workers pay a 6.20% tax on Social Security (with their employer covering the other half), so their tax bill for retirement benefits could increase by $260.40. Self-employed workers who pay the full amount of Social Security tax could end up owing $520.80 more.

4. **There are new rules for earning work credits**

To become eligible for Social Security checks, workers have to earn 40 "work credits" over their careers. Paying Social Security taxes on income is how work credits are earned. A maximum of four credits can be earned each year, and there's a certain amount of money you must make to earn each one.

In 2021, you could earn a work credit by earning $1,470. But in 2022, you'll need to earn $1,510 to earn each credit. That means your income will need to be a **little higher next year** to qualify for work credits that entitle you to future benefits.

5. **The rules for working while getting benefits are changing**

Finally, there are different rules for retirees who want to work while simultaneously getting benefits.

Nothing is changing for seniors who have already reached full retirement age, as they can always work as much as they want with no impact on their checks. But those younger than FRA who are earning a paycheck are subject to forfeiting some of their benefits if they earn too much. And they'll be impacted by the change to the rules.

In 2021, seniors who wouldn't hit FRA at any point during the year would begin losing $1 in benefits for each $2 in earnings above $18,960. In 2022, these retirees will be able to earn as much as $19,560 before they start to forfeit benefits.

Those who are reaching FRA at some time during the year will be allowed to earn $51,960 per year in 2022 before losing $1 in Social Security income for every $3 extra they make. This is up from $50,520 in 2021.

These changes will affect both current and future retirees, so everyone needs to be aware of them to understand what to expect from Social Security in 2022.

Becerra Says Surprise Billing Rules Force Doctors Who Overcharge to Accept Fair Prices

Overpriced doctors and other medical providers who can't charge a reasonable rate for their services could be put out of business when new rules against surprise medical bills take effect in January, and that's a good thing, Health and Human Services Secretary Xavier Becerra told KHN, in defending the regulations.

The proposed rules represent the Biden administration's plan to carry out the **No Surprises Act**, which Congress passed to spare patients from the shockingly high bills they get when one or more of their providers unexpectedly turn out to be outside their insurance plan's network.

The law shields patients from those bills, requiring providers and insurers to work out how much the physicians or hospitals should be paid, first through negotiation and then, if they can't agree, arbitration. Doctor groups and medical associations, however, have lashed out at the interim **final rules** that HHS unveiled last month, saying they favor insurance companies in the arbitration phase. That's because, although the rules tell arbiters to take many factors into account, they are instructed to start with a benchmark largely determined by insurers: the median rate negotiated for similar services among in-network providers.

The doctor groups say giving the insurers the upper hand will let them drive payment rates down and potentially force doctors out of networks or even out of business, reducing access to health care.

The department has heard those concerns, Becerra said, but the bottom line is protecting patients. Medical providers who have taken advantage of a complicated system to charge exorbitant rates will have to bear their share of the cost, or close if they can't, he said.

"I don't think when someone is overcharging, that it's going to hurt the overcharger to now have to [accept] a fair price," Becerra said. "Those who are overcharging either have to tighten their belt and do it better, or they don't last in the business."

"It's not fair to say that we have to let someone gouge us in order for them to be in business," he added.

Nonetheless, Becerra said he did not foresee a wave of closures, or diminished access for consumers. Instead, he suggested that a competitive, market-driven process will find a balance, especially when consumers know better what they are paying for.

"We're willing to pay a fair price," he said. But he emphasized that "I'll pay for the best, but I don't want to have to pay for the best and then three times more on top of that and get blindsided by the bill."

Becerra also pointed to a **report on surprise medical bills** that HHS released Monday and that was provided to KHN in advance, highlighting the impacts of negotiation and arbitration laws already in effect in 18 states….**Read More**

Dear Marci: *What vaccines are covered by my Part D plan?*

Dear Marci,
In your last newsletter you explained how Part B covers a few important vaccines. What vaccines are covered by Part D, though? I need to get the shingles vaccine and am hoping it won't be too expensive.
-Lucinda (Madison, WI)

Dear Lucinda,

If your provider recommends that you get a vaccine, in many cases it will be covered by your Part D plan. Part D plans must include most commercially available vaccines on their formularies, including the vaccine for shingles (herpes zoster). The only exceptions are flu, pneumonia, COVID-19, and hepatitis B vaccinations, which as we discussed in the last newsletter, are **covered by Part B.**

The amount you pay for your vaccine may vary depending on where you get vaccinated. Be sure to check your plan's coverage rules and see where you can get your vaccine at the lowest cost. Typically, you will pay the least for your vaccinations at:

- In-network pharmacies
- A doctor's office that
- coordinates with a pharmacy to bill your Part D plan for the entire cost of the vaccination process (the drug and its injection)

or, can bill your plan directly for the vaccination process using an electronic billing system

When you are vaccinated in either of the above settings, you should only need to pay the plan's approved coinsurance or copay for the drug and vaccination process. When you get a vaccine at your doctor's office, ask the provider to call your Part D plan first to find out if your provider can bill your Part D plan directly. If this is possible, you should not have to pay the full out-of-pocket cost and later request reimbursement from your plan.

You may end up paying more for your vaccination if your provider:

- cannot coordinate with a pharmacy to bill your Part D plan for the entire cost of the vaccination process (the drug and its injection)

and/or, cannot bill your plan directly for the injection using an electronic billing system

In these circumstances, your provider will bill you for the entire cost of the vaccination (the drug and its injection). You will have to pay up front and request reimbursement from your Part D plan. It is important to know that your provider may charge you more than the Part D approved amount for the vaccination, but your plan will only reimburse up to the approved amount—and you will not be refunded for any amount you pay the provider above the Part D approved amount.

If you have **Extra Help**, you can go to any provider or in-network pharmacy to get vaccines. You will be covered for your vaccination and will only be responsible for the Extra Help copay. However, if you get your vaccine from a provider who does not directly bill your plan, you may need to pay the entire bill up front and then request reimbursement from your plan.
-Marci

Social Security vs. Inflation: Are You Prepared To Stretch Your Checks?

The Social Security Administration's October announcement about the highest cost-of-living adjustment (COLA) in 40 years — at a 5.9% boost — was still being celebrated when the news was overshadowed by the Bureau of Labor Statistics' latest Consumer Price Index release, which saw inflation rise 6.2% over the past year. A few days after that, the Centers for Medicare and Medicaid Services announced Medicare Part B payment increases for 2022 — including premiums rising a whopping 15%. Coupled with the current historic inflation, that's quite a hike for those living on fixed (or nearly fixed) incomes, and the coming COLA can't possibly fill in the gaps.

How are those who rely on Social Security checks to cover monthly essentials supposed to stretch their budgets? First, anyone who has filed for benefits within the past 12 months can still withdraw their claim. If it's been longer than a year since an initial claim was filed, some planning may help **offset unavoidable increased expenses in 2022**. Small adjustments include buying less items or switching to cost-saving brands. Others, such as those with home equity looking into a reverse mortgage, selling their "extra" car or downsizing homes or hobbies, take more effort. More drastic options include moving somewhere with a lower cost-of-living (including tax-friendly states) or returning to the workforce part-time. And with the Fed acknowledging that the economy could remain inflationary until the end of 2022, it may take time before most people relying on SSA or SSI checks can enjoy their COLA jolt.

Bill to Stop Cuts in Medicare Payments to Doctors is Introduced

Last week there was some refreshing proof that Congress can still, on occasion, work together in a bi-partisan manner.

Representatives Larry Bucshon, M.D. (R-Ind.) and Ami Bera, M.D. (D-Calif.) announced the introduction of bipartisan legislation to provide critical relief to physicians responding to the COVID-19 pandemic who are currently scheduled to receive Medicare payment cuts next year. The *Supporting Medicare Providers Act of 2021* (H.R. 6020) would extend the 2021 Medicare physician payment adjustment of 3.75% for an additional year.

"Beginning on January 1, 2022, many specialists, therapists, and other physicians will be faced with substantial reimbursement cuts – up to 9 percent for many providers, if Congress does not act. These cuts would make our nation's doctors work longer hours for less pay during the worst global health crisis of our generation," said Dr. Bucshon. "I want to thank my friend and fellow doctor, Congressman Ami Bera (D-Calif.) for his partnership in leading the bipartisan *Supporting Medicare Providers Act of 2021*, which will ensure Americans continue to have access to quality care in their communities. I look forward to continuing to work with congressional leaders to find practical ways to pay for this proposal and advance this important bill into law before January 1, 2022."

"As an internal medicine doctor by training, I know that cutting payments for physicians during the middle of a global pandemic will only further strain our health care system and the ability for health care professionals to serve their patients," said Representative Bera, who previously served as Chief Medical Officer for Sacramento County. "That's why I'm introducing the bipartisan *Supporting Medicare Providers Act of 2021* with my good friend and fellow doctor Representative Bucshon, M.D. to prevent these harmful cuts from occurring. Our frontline health care workers are heroes keeping our communities safe and healthy during this pandemic, and they deserve our full and unwavering support."

Reps. Bucshon and Bera led over 245 Members of Congress in an October 2021 letter urging House Leadership to address the looming Medicare payment cuts to health care providers that will further strain patient access to care.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Fentanyl overdose deaths: Americans are overdosing on a drug they don't know they're taking

Fueled by the **coronavirus pandemic** and an increase in fentanyl use, the US drug epidemic exploded while Americans were locked down.

From May 2020 through April 2021, **more than 100,000 people died from drug overdoses** in the US, according to provisional data released Wednesday by the US Centers for Disease Control and Prevention.

That's a horrible new record for drug overdose deaths -- a near-30% rise from the same period a year earlier and a near-doubling over the past five years.

The drug epidemic grew in tandem with the Covid-19 pandemic, which claimed about 509,000 deaths in the same period.

Synthetic opioids like fentanyl -- a painkiller 50-100 times more potent than morphine -- accounted for the bulk of those drug overdose deaths: around 64,000.

The pandemic played a role. "In a crisis of this magnitude, those already taking drugs may take higher amounts and those in recovery may relapse. It's a phenomenon we've seen and perhaps could have predicted," Dr. Nora Volkow, director of the National Institute on Drug Abuse, told CNN.

Enough fentanyl to kill 333 million people. Read this line from CNN's report: ***The US government has seized enough fentanyl this year to give every American a lethal dose, Drug Enforcement Administration Administrator Anne Milgram said Wednesday at a White House press briefing, calling the overdose epidemic in the US "a national crisis" that "knows no geographical boundaries, and it continues to get worse."***

Deadly fakes that look like prescription pills. Illegal drugs are often **made to look like prescription pills**, available online and sold through social media, according to a US Drug Enforcement Administration warning in September.

That same month the **DEA announced more than 800 arrests** and the seizure of more than 1.8 million pills as part of a two-month sweep.

The agency noted fentanyl has been **seized in every state** and it issued an urgent warning in September about fake prescription pills laced with the drug.

A scant 2 milligrams can be deadly, and they're often cut in with counterfeit Oxycontin, Percocet or other drugs

Who abuses drugs? A lot of people. An estimated 10.1 million Americans ages 12 and above misused opioids in 2019, including 9.7 million prescription pain reliever abusers and 745,000 heroin users, **according to CNN's reporting.**

Who is dying? A Google search yields scores of stories like these:

There's the 28-year-old man in Northern California who **died after taking a fake pain pill** that contained fentanyl.

There's the **11-month-old baby left unsupervised in North Carolina** who died from a fentanyl overdose. Her mother and grandmother are facing charges. (While searching on Google for specific cases of fentanyl deaths, I saw reports on a lot of toddlers eating their parents' pills: A **15-month old's father charged** in his overdose death in Southern California. A **mother of a 1-year-old in Alabama arrested** after the child overdosed.)

There's the family of **a prisoner in Alabama who died of a fentanyl overdose** but didn't find out until months later.

There's the **teenager outside Los Angeles** who bought what he thought were prescription painkillers from a friend of a friend and died from fentanyl poisoning.

There's the **25-year-old woman in Las Vegas** who thought she was buying Percocet but died after taking fake pills with fentanyl.

The stories are everywhere.

Where are they getting the drugs? Look at these two stories from Las Vegas: A **27-year-old man is accused of selling fentanyl-laced pills over Snapchat** to a 32-year-old man who died of fentanyl toxicity.

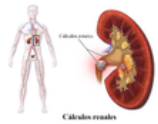
A 21-year-old woman who **went by the Snapchat username "yungdrugaddict"** was charged with second-degree murder for selling fentanyl-laced pills that killed a woman of the same age. ….**Read More**

Kidney stones and five tips to prevent them

The **National Kidney Foundation** estimates that one in ten people will develop a kidney stone sometime in their lives. Kidney stones are lumps that seem like stones in the kidneys, which can cause serious pain. Men are more prone to them than women, and they are most common among 30-60 year olds.

You can get kidney stones and not know it if they are small enough to pass out of you in your urine. Often, they are painful because they get stuck in the urinary system and block the tube connecting the kidney to the bladder or the tube urine passes through out of your body. Or, they can cause an infection.

Symptoms: You might feel an ache in your lower back, groin, or abdomen. You may also feel nauseous. Or, you may need to urinate often and feel pain when you do; there might also be blood in your urine.



Often the stones will pass out of you in your urine. But, you may need to take medications or have them broken up with X-rays or ultrasound in hospital or even taken out through surgery.

Most of us will never get kidney stones. But, if you do, you're likely to get them again. To avoid them, drink a lot of water and eat a healthy diet. Here are five **tips from the U.K's national health service:**

- **Drink lots of water, especially if you sweat a lot.** The best way to prevent kidney stones from developing is to make sure you drink a lot of liquids every day, so that minerals that make kidney stones do not settle in the kidneys and urinary tract. Water is good, as is coffee, tea and wine. We're talking 81 ounces a day, a lot, a lot!!!! But stay away from sugary drinks, which increase your risk of getting kidney stones.
- **Eat and drink foods with calcium and oxalate together.** Oxalate foods, such as nuts and fruits and chocolate are less likely to form kidney stones when you eat them with calcium-rich foods. Low-fat dairy products, whole grains and vegetables are also good. But, avoid beef and processed meats.
- **Eat less food with sodium.** Do not eat more than 2,300 milligrams of salt a day.
- **Drink juices high in citrate**, like lemons and limes and low in sugar.
- **Eat calcium-rich foods.** This might sound counter-intuitive as almost all kidney stones contain calcium. But, as it turns out, eating a lot of foods with calcium reduces your likelihood of getting kidney stones, especially for men under 60 years old. It also might help you to eat foods rich in magnesium and potassium. Eat foods with 1,000 to 1,200 milligrams of calcium a day.

Many Psychiatric Patients Are Getting Risky Drug Gabapentin 'Off-Label'

Most prescriptions for the medication gabapentin are for unapproved uses -- and many patients end up taking it along with drugs that create potentially dangerous interactions.

That's the conclusion of a new study that looked at "off-label" use of gabapentin. In the United States, the drug is officially approved for treating certain seizures and some forms of nerve pain.

It's known, however, that gabapentin is commonly prescribed for other uses, including various types of pain conditions and psychiatric disorders like depression and anxiety.

The new study highlights just how widespread that off-label use is: Of almost 130 million outpatient visits where gabapentin was prescribed, more than 99% were for off-label uses.

"We anticipated there'd be a lot of off-label use," said senior researcher Amie Goodin, an assistant professor at the University of Florida College of Pharmacy.

Even so, she said, it was surprising to see the magnitude of that use.

And one-third of the time, patients prescribed gabapentin off-label were also on a medication that can depress the central nervous system.

That's a concern because in 2019, the U.S. Food and Drug Administration issued a warning about combining gabapentin with central nervous system (CNS) depressants, saying sedation and serious breathing problems can result. The warning was particularly aimed at people with risk factors for depressed breathing -- including the elderly and people with lung diseases like emphysema and chronic bronchitis.

"CNS depressant" is a broad term, Goodin said. It includes drugs ranging from antidepressants and anti-anxiety medications, to antihistamines, to muscle relaxants.

This study looked at prescriptions made between 2011 and 2016 -- before the FDA safety warning.

But, Goodin noted, at the time there was another reason for careful prescribing. Starting in 2008, gabapentin and other anti-seizure drugs were required to carry a warning about an association with increased risk of suicidal behavior….**Read More**

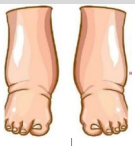
8 Tips for Swollen Ankles and Feet

Edema may be linked to your legs alone or be caused by a whole-body problem.

Healthy circulation includes upward blood flow in the veins from the legs to the heart. Unfortunately, the force of gravity works against this normal circulation. Prolonged sitting and standing can lead to swelling as weakened leg veins struggle. After a long day, puffy feet and ankles appear. This edema – a buildup of fluid in the feet and lower legs – is common. Often benign, you can take simple steps to prevent or at least ease day-to-day leg swelling.

Sometimes, however, lower-leg swelling can indicate serious medical conditions. "Heart failure, kidney failure, liver failure: All of those are systemic causes, the more whole-body problems that lead to leg swelling," says Dr. Elizabeth Ratchford, director of the **Johns Hopkins** Center for Vascular Medicine and an associate professor of medicine at Johns Hopkins University. "That's separate from having a leg vein issue." Pregnancy can also bring lower-leg bloating.

Harmful blood clots and **heart conditions** can cause swelling requiring urgent diagnosis and treatment. "It's that sudden onset that occurs with no apparent reason, that occurs with one leg that's painful, or it's associated with chest pain, shortness of breath or difficulty breathing, especially when you're lying flat or exerting yourself," says Dr. Rachel Bond, a cardiologist with Dignity Health in Arizona. Dizziness or fainting episodes that accompany swelling are also cause for greater concern, she says. "That's when medical care needs to be looked at immediately and urgently. Because the likelihood is that it's something coming from the heart, or even as dangerous as something coming from a blood clot."



Here's what you can do on your own to manage foot and ankle swelling or when you need to seek medical advice.

Easing Everyday Swelling

"The treatment for swelling – no matter what the cause – is usually compression, elevation, exercise and weight loss," Ratchford says. These simple tips can help keep swelling under control:

- **Elevate your feet in bed.** Put a pillow under your legs to prop them and put gravity to good use, Bond suggests. This promotes venous blood flow back to the heart.
- **Wear compression socks.** **Knee-high compression socks**, available over the counter or by prescription, can be really helpful to wear during the day when standing or sitting for long periods, Ratchford says. "You can get them in sporting goods stores to improve venous blood flow to the heart to improve endurance," she says. "You can also get them in medical supply stores, where they'll measure you to ensure proper fit." Learn more about compression therapy in the **vascular disease patient information page** in the June 2021 issue of the journal Vascular Medicine.
- **Avoid prolonged standing.** If your job includes standing in one spot most of the day, for instance working behind a register, ask for a stool so you can sit at least part of the time, and **move about** when you can.
- **Take breaks from sitting.** Conversely, if you're parked behind a computer for hours on end, use a small stool to elevate your feet and stretch your legs, and also, take breaks whenever possible. Consider using a **standing desk** intermittently. While traveling by plane, stand and stretch or take a short walk when the seatbelt sign goes off.
- **Exercise.** "Thirty minutes of exercise, seven days a week is key because of the calf muscle pump," Ratchford says. "That's something in the calf that pushes 70% of the blood out of the calf every time you walk. Sometimes people have neurological issues or spine problems that cause the calf muscle to shrink. That leads to swelling because you're not getting that pump pushing the blood back." Being in an orthopedic boot, where you can't move your ankle to point or flex your foot, is another culprit. "So, exercise like biking, walking, swimming or elliptical – anything where you're pointing or flexing your foot a lot, or toe raises, calf raises, that kind of thing – will help push the blood back to the heart."
- **Lose weight if needed.** Eliminating excess weight can help reduce the pressure on your leg veins. That's another good reason to exercise regularly. You may also want to speak with a dietitian about healthy eating plans.
- **Reduce salt in your diet.** Americans eat too much salt, which is why the Food and Drug Administration just recommended sodium-reduction guidelines for commercial food manufacturers. You can also take independent steps to **consume less salt**. "Cutting back on sodium can definitely help with the swelling," Ratchford says.
- **Talk to your doctor.** Don't hesitate to ask your health care provider about symptoms like swelling, particularly if it doesn't improve despite all your efforts.

Neurologists' Group Issues Guidance to Families on Controversial Alzheimer's Drug

THURSDAY, Nov. 18, 2021 (HealthDay News) -- Neurologists must make sure Alzheimer's patients and their families understand that the controversial drug aducanumab does not restore mental function, the American Academy of Neurology (AAN) said in new position statement that includes ethical guidelines.

"Aducanumab is not a cure for Alzheimer's disease, yet since it has been approved by the [U.S. Food and Drug Administration], patients are asking their doctors if this is an option for them," said statement author Dr. Winston Chiong, an associate professor at the University of California San Francisco and member of the AAN's Ethics, Law and Humanities Committee.

"This is a high-cost drug that was approved by the FDA without convincing evidence of benefits and with known harms, so the purpose of this position statement is to offer ethical guidance on how neurologists can help patients make informed decisions about this treatment," Chiong said in an AAN news release.

The U.S. Food and Drug Administration approved aducanumab (brand name: Aduhelm) based on two studies that were both stopped early because the drug showed no benefits for patients. The statement explained that a later analysis of data from one of those studies suggested a small benefit, while the other still showed no benefit.

The statement noted that while aducanumab reduces the beta-amyloid plaques in the brain that are markers of Alzheimer's, it's unclear whether that provides any meaningful benefits to patients.

There isn't sufficient evidence to offer the drug to patients with moderate or advanced dementia, or to those without evidence of beta-amyloid in the brain, according to the position statement published Nov. 17 in the journal ***Neurology.***

It also said the drug carries a risk of brain inflammation and brain bleeds, which occurred in a third of patients in the studies who received the dose approved by the FDA.

The statement said neurologists must inform patients and families about the drug's potential risks of and the need for more frequent monitoring with MRI scans.

Another issue is the lack of racial and ethnic diversity in the clinical trials of aducanumab. Patients in racial and ethnic minorities need to be told about the lack of safety and effectiveness data for them, the statement said.

In addition, it warned that pricing and insurance coverage of the drug may cause financial harm to patients and their families.

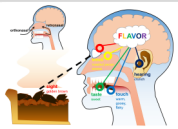
Aducanumab is priced at $56,000 a year. But the costs of infusing the drug, repeated imaging and medical management may push annual costs to more than $100,000. Medicare generally covers 80%, so patients and families must be told that the full cost of treatment may not be covered, the statement advised.

The statement said another concern is that availability of aducanumab may lead to lower patient enrollment in clinical trials of more effective treatments.

More information

The U.S. National Institute on Aging has more about **Alzheimer's disease treatment**.

As Many as 1.6 Million Americans Lost Sense of Smell Due to COVID-19



(HealthDay News) -- Lyss Stern lost her sense of smell when she was diagnosed with COVID-19 in March 2020, and it still hasn't returned.

Stern, 47, a New York City author and mother, has seen countless doctors and taken many types of medicine, vitamins and supplements to get her sense of smell back. She also undergoes acupuncture regularly and saw an energy healer -- all to no or very little avail.

"Yesterday, my husband asked 'what's that smell?' and I had no idea," Stern recalled. "It was eggs boiling over in the kitchen that almost caught fire."

Unfortunately, she's not alone. As many as 1.6 million people in the United States will develop olfactory dysfunction or loss of smell from COVID-19, a new study projects. Some, like Stern, develop chronic dysfunction that lasts for six months or more.

"Given the surge in acute COVID-19 infections last fall and winter and the ongoing cases, there is a pending tidal wave of new cases of chronic olfactory dysfunction that deserves our attention," said study author Dr. Jay Piccirillo, a professor of otolaryngology—head and neck surgery at Washington University School of Medicine in St. Louis. "We have to try to figure out what to do for these people, and the sad news is that we don't have any effective treatments for chronic COVID-19-related loss of smell yet."

Without the ability to smell, you can't taste food or detect harmful odors such as gas and smoke. Like Stern, many people with chronic loss of sense of smell report a poorer quality of life, and feelings of depression as well.

Exactly how COVID-19 can rob you of your ability to smell isn't fully understood yet, but many viral illnesses cause similar symptoms.

"We think that the virus attacks the supporting cells in the nose that help olfactory nerves do their job," Piccirillo said. Olfactory nerves are responsible for our sense of smell.

To get a better sense of how many people will lose their sense of smell due to COVID, the researchers culled data on new daily U.S. COVID cases, frequency of loss of smell, and rates of recovery.

Based on these numbers, they estimate that more than 700,000 -- and possibly as many as 1.6 million -- Americans will have chronic loss of smell due to COVID-19. The actual number may be even higher as the data included only state-reported positive cases, and not all COVID cases get reported.

Once supporting cells in the nose recover, smell returns for about 90% of people with COVID, Piccirillo said. Researchers still aren't sure why some people, like Stern, experience chronic loss of smell.

"People whose supporting cells get more infected and had a heavier load of the virus are more likely to have persistent loss of smell," Piccirillo said.

The findings were published Nov. 18 in ***JAMA Otolaryngology–Head & Neck Surgery***.

Meanwhile, the phones have been ringing off the hook at the Smell & Taste Treatment and Research Foundation in Chicago due to the growing numbers of people with chronic loss of smell from COVID, said Dr. Alan Hirsch, its neurological director.

"There is no U.S. Food and Drug Administration-approved drug for smell and taste loss from COVID-19," said Hirsch, who reviewed the findings. "Instead, doctors will try medications and supplements that have shown to be effective in other virus-related smell and taste deficits."

Other causes of loss of smell include age, smoking and certain neurologic diseases such as Parkinson's or Alzheimer's, Hirsch said. These come on slowly, and many people don't notice or complain. COVID-related loss of smell comes on quickly.

People with COVID-related loss of smell are younger than those who are affected by other causes of olfactory dysfunction and will have to live with this troublesome symptom much longer as a result, he said….Read More

Intermittent Fasting May Protect the Heart by Controlling Inflammation

(American Heart Association News) -- Intermittent fasting could increase a key protein that controls inflammation and protects the heart, according to a new study.

Intermittent fasting limits a person's consumption of food and beverages to certain times of the day or week to achieve weight loss. There's no single way to practice it, though one popular routine involves alternating 24-hour periods of fasting with eating normally.

Researchers analyzed data from a clinical trial that had participants fast twice a week, drinking only water, for the first four weeks and then once a week after that. The trial lasted 26 weeks, about six months. Those results, published in September in the European Heart Journal Open, showed fasting didn't reduce LDL, the so-called "bad cholesterol." But it did improve scores on insulin resistance, which can increase blood sugar and lead to Type 2 diabetes, and metabolic syndrome, a cluster of conditions that can increase a person's risk for heart attack and stroke.

The new analysis of that trial, presented at the American Heart Association's virtual Scientific Sessions conference held this month, delved into just how intermittent fasting seemed to improve these cardiovascular disease risk factors.

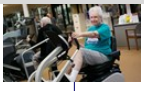
The study's lead researcher, Dr. Benjamin Horne, hypothesized the mechanism might be similar to the way a class of drugs called sodium-glucose co-transporter 2 (SGLT-2) inhibitors work to lower Type 2 diabetes and heart failure risk. The drugs also raise levels of a protein called galectin -3, which controls inflammation.

"It's a good marker for people at higher risk of having a poor outcome," Horne said, because inflammation is a major component of heart failure and Type 2 diabetes. Horne is director of cardiovascular and genetic epidemiology at Intermountain Heart Institute in Salt Lake City and a professor in the Division of Cardiovascular Medicine at Stanford University in California.

The new analysis, using 67 of the original trial participants' levels of galectin-3 and other markers for heart failure, found that higher levels of the protein were associated with better scores on insulin resistance and metabolic syndrome evaluations. Other markers were unchanged. The findings are considered preliminary until published in a peer-reviewed journal.

The increase in galectin-3 could be an adaptive response that prevents chronic disease by reducing inflammation, Horne said….**Read More**

Osteoporosis ("silent disease")



Osteoporosis is a disease that weakens bones to the point where they break easily—most often, bones in the hip, backbone (spine), and wrist. Osteoporosis is called a "silent disease" because you may not notice any changes until a bone breaks. All the while, though, your bones had been losing strength for many years.

Bone is living tissue. To keep bones strong, your body breaks down old bone and replaces it with new bone tissue. Sometime around age 30, bone mass stops increasing, and the goal for bone health is to keep as much bone as possible for as long as you can. As people enter their 40s and 50s, more bone may be broken down than is replaced.

A close look at the inside of bone shows something like a honeycomb. When you have osteoporosis, the spaces in this honeycomb grow larger, and the bone that forms the honeycomb gets smaller. The outer shell of your bones also gets thinner. All of this makes your bones weaker.

Who Has Osteoporosis? Risk Factors and Causes

Although osteoporosis can strike at any age, it is most common among older people, especially older women. Men also have this disease. White and Asian women are most likely to have osteoporosis. Other women at great risk include those who:

- Have a family history of broken bones or osteoporosis
- Have broken a bone after age 50
- Had surgery to remove their ovaries before their periods stopped
- Had early **menopause**
- Have not gotten enough **calcium and/or vitamin D** throughout their lives
- Had extended bed rest or were physically inactive
- Smoke (smokers may absorb less calcium from their diets)
- Take certain **medications**, including medicines for **arthritis** and **asthma** and some cancer drugs
- Used certain medicines for a long time
- Have a small body frame

The risk of osteoporosis grows as you get older. At the time of menopause, women may lose bone quickly for several years. After that, the loss slows down but continues. In men, the loss of bone mass is slower. But, by age 65 or 70, men and women are losing bone at the same rate….**Read More**

Memory, Forgetfulness, and Aging: What's Normal and What's Not?

Many older adults worry about their memory and other thinking abilities. For example, they might be concerned about taking longer than before to learn new things, or they may sometimes forget to pay a bill. These changes are usually signs of mild forgetfulness — often a normal part of aging — not serious memory problems.

What's normal forgetfulness and what's not?

What's the difference between normal, age-related forgetfulness and a serious memory problem? It's normal to forget things once in a while as we age, but serious memory problems make it hard to do everyday things like driving, using the phone, and finding your way home.

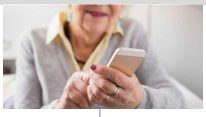
Talk with your doctor to determine whether **memory** and other cognitive problems, such as the ability to clearly think and learn, are normal and what may be causing them. Signs that it might be time to talk to a doctor include:

- Asking the same questions over and over again
- Getting lost in places a person knows well
- Having trouble following recipes or directions
- Becoming more confused about time, people, and places
- Not taking care of oneself — eating poorly, not bathing, or behaving unsafely

...**Read More**

Normal aging	Alzheimer's disease
Making a bad decision once in a while	Making poor judgments and decisions a lot of the time
Missing a monthly payment	Problems taking care of monthly bills
Forgetting which day it is and remembering it later	Losing track of the date or time of year
Sometimes forgetting which word to use	Trouble having a conversation
Losing things from time to time	Misplacing things often and being unable to find them

Reminder Apps on Smartphones May Help in Early Dementia



Despite stereotypes about seniors and technology, a small study suggests that older adults in the early stages of dementia can use smartphone apps as memory aids.

The researchers found that older people with mild impairments in memory and thinking were not only able to learn how to use the apps, they said the digital aids made their daily lives easier.

The apps were not specially designed. The study tested the effects of two basic smartphone features: a reminder app that gives notifications of a scheduled event and a digital recorder app (such as the voice memo app on iPhones).

"We weren't trying to reinvent the wheel," said lead researcher Michael Scullin, an associate professor of psychology and neuroscience at Baylor University in Waco, Texas.

For the 52 older adults in the study, both types of apps turned out to be user-friendly, and helped with remembering daily tasks. By the end of the four-week trial, participants were giving higher ratings to their quality of life.

"We were pleased to see that it actually improved their daily lives," Scullin said.

It did take some coaching. Each participant was given a training session not only in using the app, but the smartphone, too.

Scullin said most had owned a smartphone prior to the study, but typically did not use it much. "Maybe that was because no one had ever walked them through the steps," he said.

Scullin's team started with the basics — including how to turn the phone on — and then progressed to lessons on the phone's standard memory-aid app.

"It's not 'too hard' for them to learn," Scullin said.

There may be a stereotype that older adults are adverse to technology. But that's a myth, according to Dr. Howard Fillit, founding executive director of the nonprofit Alzheimer's Drug Discovery Foundation.

"I don't think the data show that older adults can't or don't want to use technology," said Fillit, who was not involved in the study.

For one, he noted, many seniors see technology as a way to stay socially engaged.

But beyond that, Fillit said, there is growing interest in using digital technology to support older adults' health — the Apple Watch, and its ability to detect certain heart arrhythmias, being one example.

And, in fact, Fillit said, research is already underway to develop digital technologies that can help detect Alzheimer's sooner, by collecting data on users' behavior and mental performance.

Part of what's noteworthy about the new study, according to Fillit, is the focus on practicality.

"It addresses a common and prevalent problem in people with mild cognitive impairment," he said….**Read More**

Wearable Vibration Device May Ease Parkinson's Tremor

Physiotherapist David Putrino was working on a vibrating glove to help deaf people experience live music when a friend mentioned that the same technology might stop tremors in people with Parkinson's disease.

Putrino, director of rehabilitation innovation for Mount Sinai Health System in New York City, was intrigued. The friend's father had Parkinson's, so they placed the new device on his wrist, and the tremors stopped in their tracks.

"He was a former pianist and sat down and started playing. It was quite dramatic," Putrino recalled.

And that's when Putrino and his team pivoted and began investigating the new device for Parkinson's-related tremors.

A new study shows that they're on to something. The device, which is worn on the wrist or ankle and is roughly the size and weight of a smartwatch, may be a safe and effective way to reduce resting tremors in people with Parkinson's disease.

The technology sends signals to the brain to disrupt the abnormal rhythms that cause resting tremors. The typical Parkinson's tremor tends to occur when muscles are relaxed, such as when hands are resting on the lap. The tremors tend to lessen when the body is engaged in another activity or during sleep.

"Drugs and even some of the more invasive interventions like deep brain stimulation (DBS) therapy aim to break up the abnormal synchrony between brain regions to improve symptoms" for Parkinson's patients, Putrino explained.

For the new study, 44 people with Parkinson's used the device on their wrists or ankles with two vibration patterns to make sure it was safe.....**Read More**

Pulmonary Embolism Is Common and Can Be Deadly, But Few Know the Signs

Public radio fans knew NPR books editor Petra Mayer as an exuberant lover of science fiction, romance novels, comic books and cats. "If it's fun and nerdy, I'm all about it," she declared.

Friends and family now are mourning the loss of the witty, bubbly 46-year-old. She died earlier this month of what her parents said was a pulmonary embolism. Few details were released about the circumstances of her sudden death. But experts said it highlights the need for greater understanding of pulmonary embolism, also known as PE.

"Unfortunately, PE can strike people at all stages of life, from the young and healthy to the older and not as healthy," said Dr. Karlyn Martin, an assistant professor of medicine at Northwestern University Feinberg School of Medicine in Chicago.

Pulmonary embolism is the third-leading cause of cardiovascular death. But, Martin said, people are much less aware of its symptoms.

"I think if someone had chest pain, they immediately think, 'Heart attack!' and go to the hospital. But they don't similarly think, 'Oh, I could have a pulmonary embolism! I should go to the hospital right away.' So, it's not infrequently that we have patients who had symptoms for days to weeks even before going to the hospital to find out what's wrong."

According to American Heart Association statistics, pulmonary embolism was a factor in more than 36,000 deaths in 2018, the most recent year for which data was available. The rate has been climbing for reasons that Martin, who led a 2020 study on the trend, said are not clear.

Pulmonary embolism is usually described as a blood clot that travels to the lungs. Blood clots in arteries, which carry blood from the heart, can cause heart attacks and strokes. But clots in veins are called deep vein thrombosis, or DVT. Those clots, often originating in the leg, can travel, or embolize, to the lungs.

When those clots stop in the lungs, pressure builds up in the right side of the heart, Martin said. "Eventually, the heart can fail, because it's strained so much."

Even large blood clots might not produce symptoms, said Gary Raskob, a board member of the National Blood Clot Alliance. He's also dean of the Hudson College of Public Health at the University of Oklahoma Health Sciences Center in Oklahoma City.

About a quarter of the time, according to the Centers for Disease Control and Prevention, the first symptom of pulmonary embolism is death….**Read More**