

Message from the Alliance for Retired Americans Leaders



Democratic Super PAC Ads Focus on Social Security as Election Day Draws Closer
 The Senate Democrats' top super PAC is focusing on Social Security in new **ad buys**, each worth at least \$1 million, aimed at Republicans in Arizona and North Carolina.



Robert Roach

The **ad running in North Carolina** notes that Rep. Ted Budd, the GOP Senate nominee, cast votes in the House to cut Medicare and Social Security, including voting to raise the retirement age. The Arizona cut shows Blake Masters saying, "Maybe we should privatize Social Security, right? We've got to cut the knot at some point."

"Seniors' most important issues are front and center as Election Day approaches," said Robert Roach, Jr., President of the Alliance. "Make a plan to vote for candidates who will protect you from plans to cut and privatize Social Security and Medicare."

Arizona Alliance and Voto Latino File Lawsuit To Stop Harassment and Intimidation at Arizona Ballot Drop Boxes

The Arizona Alliance for Retired Americans and Voto Latino filed a lawsuit Monday in the United States District Court for the District of Arizona seeking a temporary restraining order against Clean Elections USA, its founder Melody Jennings, and the individuals who have been gathering at and surveilling



Rich Fiesta

drop boxes. A copy of the complaint is **HERE**. The lawsuit alleges that Clean Elections USA and its founder are recruiting people to conduct an organized campaign to suppress the vote by harassing and intimidating voters at early ballot return drop boxes. The Alliance and the lawsuit were mentioned on the **Rachel Maddow Show on MSNBC** and in dozens of other news outlets.

Recently the sheriff for Arizona's Maricopa County increased security at ballot drop boxes following **a number of incidents** involving individuals keeping watch on the boxes and taking video of voters. Last Friday, deputies responded after two people carrying guns and wearing masks and bulletproof vests appeared at a drop box in the Phoenix suburb of Mesa.

At least five Arizona voters **filed three complaints** with the Arizona Secretary of State's office describing people who identified themselves as representing Clean Elections USA who were photographing them and their license plates and in some cases accusing the voters of illegal activities. Jennings has implied that she will use the images and video captured by those crowds to "dox" people; opening them up to harassment by the general public.

Federal Judge Michael Liburdi said he hopes to decide by Friday whether to approve an emergency order that would stop ballot drop box monitors from staking out Arizona voting locations.

Early voting in Arizona began October 7 and will continue until October 30. Although the Arizona Secretary of State

referred the complaints to the U.S. Department of Justice for investigation, the plaintiffs argue that a restraining order is needed immediately to prevent additional intimidation. "Older Arizonans are the most likely to vote by early ballot, and must be confident that they can easily and safely deposit their ballots at a drop box," said Sandra Cole, President of the Arizona Alliance.

"Voter suppression is taking many forms in 2022, and we are committed to stopping it wherever we can," added Richard Fiesta, Executive Director of the Alliance

Note: Judge Denied temporary restraining order. Alliance Hosts Teletown Hall with Wisconsin Members and Mandela Barnes

The Wisconsin Alliance hosted a telephone town hall meeting Thursday with Mandela Barnes, the state's Lieutenant Governor and the Alliance's endorsed candidate for the U.S. Senate. During the town hall, Mr. Barnes discussed prescription drug prices and threats to Social Security. In addition, he described coming from a proud union family: his father worked 3rd shift at a GM factory and his mother was a Milwaukee school teacher for 30 years. His support for expanding and increasing Social Security benefits stands in stark contrast to his opponent, Sen. Ron Johnson, who has earned a lifetime score of just **4% in the Alliance's Congressional Voting Record**. Johnson does not support protecting Social Security benefits. In fact, he wants to gut Social Security and Medicare by

requiring Congress to vote on whether to continue the programs every year. Johnson called Social Security a **"Ponzi Scheme"** and voted to raise the retirement age to 70.

"Mandela won't let anyone take away the benefits we've earned, and he wants to increase those benefits by making the wealthiest pay their fair share," said Fiesta

Alliance and AFL-CIO Educate Voters During National Retirement Security Week



Joseph Peters

The AFL-CIO and the Alliance marked Retirement Security Week by highlighting the positions of key 2022 federal candidates on Social Security, Medicare, prescription drug prices, and pensions.

The Alliance's Senate candidate side-by-side fact sheets detail the records and positions of several GOP Senate candidates who are pushing for cuts for Social Security and Medicare, including Ted Budd (NC), Ron Johnson (WI), Adam Laxalt (NV), Blake Masters (AZ), Mehmet Oz (PA), Marco Rubio (FL) and JD Vance (OH). "Every older American should understand that their retirement security is on the ballot," said Alliance Secretary-Treasurer Joseph Peters Jr. "We should take these candidates at their word, and make sure our family, friends and neighbors understand who is on their side and who wants to slash their earned benefits." You can check your voter registration and find your polling location online at **www.vote.org**

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

Congress has the power to improve services at Social Security

Earlier this month, a front-page article in the **Washington Post** described the turmoil at Social Security offices since the Covid 19 pandemic. Services at Social Security offices have deteriorated. In an **opinion piece** for the Washington Post, Nancy Altman, president of Social Security Works, explains that Congress is to blame; only Congress has the power to ensure Social Security offices operate smoothly.

The Washington Post reports that millions of poor, sick and older Americans are not receiving Social Security benefits or not getting assistance from Social Security offices as a result of limited services since the pandemic. Claims are taking much longer to process, people

due disability benefits are having to **wait long periods** and lines outside Social Security offices can stretch 40-people long.

The 1,230 Social Security field offices began re-opening earlier this year. But, they have served 46 percent fewer people. Some 20 million people have not been able to get help. Pre-pandemic, these offices served 43 million people a year. To address this enormous challenge, Social Security officials have asked Congress for an additional \$800,000,000. But, the money has not been forthcoming.

Many Americans do not know that Social Security is an earned benefit. Much like life insurance,



you pay in during your lifetime of work and then, when you retire, you receive

benefits. Social Security pays for itself, including for its administration. Like traditional Medicare, it is extremely cost-effective.

However, Congress needs to appropriate funds from the Social Security Trust Funds for Social Security's administration. And, for years, "decades" explains Altman, Congress has not appropriated the funds needed for Social Security to administer benefits as it should. Its workload has increased, but its staff has decreased 25 percent, from 81,000 in 1985 to 60,000 today.

To repeat, funds to administer Social Security benefits do not contribute to the deficit. They come directly from the Social Security Trust Fund. Social Security today has a surplus of \$2.9 trillion. Still Congress appropriates less than one half of one percent of Social Security's surplus for its administration.

If Congress increased its appropriation for Social Security only slightly, Social Security would have the funds to do the important work it needs to do. Hundreds of thousands, if not millions, of Americans who are struggling to make ends meet, would have the earned income they paid for and now need. What's stopping Congress from doing right by them?

People in Medicare Advantage trade away access to care

Both the **Wall Street Journal** and **MedPage Today** recently have run compelling stories on the tradeoffs of opting for Medicare Advantage. They focus on the fact that people in Medicare Advantage, health plans offering Medicare benefits run by corporate health insurers, lose access to care from the doctors, hospitals and other health care providers they might want to use. And, Medicare Advantage enrollees can end up paying a lot more out of pocket for their care than they would in Traditional Medicare with supplemental coverage, if they get sick.

Medicare Advantage is not always low-cost or easy to use. One enrollee diagnosed with pancreatic cancer needed a PET scan to determine whether his cancer had spread and whether surgery was appropriate. But, the Cleveland Clinic told him that if he was in an MA plan, it would take at least three weeks for MA approval of the PET scan, during which time his cancer could be spreading. Fortunately, he was in Traditional Medicare and got the PET scan three days later. The **MA ads and sales agents** don't begin to tell people the full story. In addition to restricted access to providers and undue and inappropriate delays

in receiving care, MA plan **denial rates can be quite high**. So, even if your treating physician says you need care, your MA plan might overrule that physician's decision. Then, your only choice is to pay out of pocket and/or appeal the denial.

The **Office of the Inspector General** found that "among the prior authorization requests that MAOs [Medicare Advantage organizations] denied, 13% met Medicare coverage rules; in other words, these services likely would have been approved for these beneficiaries under" Traditional Medicare.

Most of the time, denials are **overturned on appeal**, especially with a letter from your treating physician documenting your need for care. The process is easy and costs you nothing, but it takes time. During that time, people's health can deteriorate.

Insurance agents are paid more to enroll people in Medicare Advantage than in supplemental coverage that fills gaps in traditional Medicare. So, many of them steer people to Medicare Advantage and, often, to the Medicare Advantage plans that pay the biggest commissions. Sometimes, agents direct people to Medicare Advantage plans that don't meet their needs—their doctors are not



in-network, out-of-pocket costs are prohibitive, and administrative hurdles are too challenging.

The federal government reports that complaints about Medicare Advantage have more than doubled between 2020 and 2021, from nearly 16,000 to nearly 40,000! And, most people do not bother complaining to the federal government. **Hospitals have begun complaining in a big way**, as well; in fact, the **Mayo Clinic** just announced that it won't be contracting with Medicare Advantage plans any longer, in most parts of the country, telling its patients in Florida and Arizona to enroll in Traditional Medicare with supplemental coverage.

So far, neither the administration nor Congress has begun to act to address the fundamental flaws with Medicare Advantage. Here are **ten ways to improve it**, none of which are under consideration at the moment.

For its part, the Medicare Advantage trade association points to all the people enrolling in Medicare Advantage who are satisfied. It's easy to be satisfied when you need few health care services, and the MA plan gives you free health memberships and discounts on eyeglasses to ensure

you stick with it. The 50 percent of people with Medicare who use the fewest health care services cost Medicare well under \$1,000 each. But, the government pays the MA plans more than 11 times that amount to cover their care. Talk about a waste of money.

MedPage Today concludes its story with this: "Numerous beneficiaries told *MedPage Today* that they signed up for their MA plans when they were younger and healthier. Their premiums were zero or low. But after they needed care for newly diagnosed chronic conditions, they found themselves paying far more in co-pays and deductibles than a supplemental plan would have cost them. Now with pre-existing conditions they're ineligible to sign up for a supplement. They're stuck." Of course, you never know when you will be diagnosed with costly chronic conditions.

One physician explains that MA enrollees are "trading money for access," that is low or no premiums for a limited network, and they may not be able to see the best specialist for their problem. I have to tell them, 'Your plan does not offer that,' he said."

The high costs of Medicare Advantage and how to address them

Taxpayers and people with Medicare are overpaying big time for Medicare Advantage, the corporate health plans that offer Medicare benefits. In a [letter to the New York Times](#), Richard Kronick, a former government official, explains that the administration has the power to address Medicare Advantage's high costs and reduce the heavy financial load Medicare is bearing. The Centers of Medicare and Medicaid Services ("CMS") needs to adjust the way it pays Medicare Advantage plans.

Right now, CMS pays MA plans a flat fee per enrollee and that fee is adjusted up, based on the diagnosis codes Medicare Advantage (MA) plans associate with each enrollee, thereby incentivizing the MA plans to find as many diagnosis codes as possible for each enrollee.

Kronick estimates that, if CMS does not fix its method for calculating payments to Medicare Advantage plans, overpayments to Medicare Advantage will be more than **\$600 billion in the next nine years**. Some Medicare Advantage plans are engaging in **fraud and inappropriately adding diagnosis codes to patient records**. But, stopping their behavior, were it possible, won't fix the overpayments. Because of the way the government pays them, all Medicare Advantage plans are adding as many appropriate diagnosis codes to patient records as possible—so that they will be paid more—even when these patients might not need or receive any additional services.

Kronick suggests that CMS



payments to Medicare Advantage could be adjusted to be more in line with Traditional Medicare, instead of **about four percent more**. His fix would correct one piece of the problem with payments to Medicare Advantage plans. But, the big problem lies with the government paying Medicare Advantage plans a fixed amount per enrollee unrelated to the cost of covering their health care services. So long as Medicare Advantage plans profit more when they deny or withhold care, they are likely to deny or withhold care or send enrollees to low cost providers as much as they can.

As I see it, if the government wants to ensure Medicare Advantage plans well-serve the needs of people with costly

conditions, it must pay them based on the cost of services they cover. On top of that, Medicare Advantage plans should receive a care management fee. To contain costs, the total payment amount should be capped.

Here's what you need to think about when it comes to costs in Medicare Advantage:

Medicare Advantage (MA) often costs less than Traditional Medicare and supplemental coverage for people who use relatively few health care services. But, people in MA plans cannot buy supplemental coverage to pick up deductibles, copays and other out-of-pocket costs. These out-of-pocket costs can total as much as \$7,550 a year for in-network care alone.

Home Health Care Threatened by Medicare Cuts

Home healthcare has gained great popularity with many seniors in the U.S. It was especially welcomed during the Covid pandemic because it allows seniors to get the health care, they needed without having to go to a hospital or nursing home, where chances of infection were so much greater.

However, despite the popularity and advantages of home health care, Medicare is considering implementing a permanent nearly 8% cut in payments to home health services. This would mean dramatic cuts in services that were provided to seniors and disabled people during the first

two years of the Covid-19 pandemic and getting back an estimated \$1.2 billion that has already been spent for services provided in 2022 – something that is called a clawback. These cuts and clawbacks, which could reach an estimated \$18 billion over the next 10 years, would be a devastating blow to the more than 3.5 million people whose home health care is covered by Medicare.

One analysis suggests that the cuts and clawbacks could put 44% of America's home health agencies at risk of closing, seriously risking beneficiaries' access to care, especially in rural



and underserved communities.

The population of Medicare home health beneficiaries has grown older and sicker. More than 25% of home health users across the country are over the age of 85, and 43% have five or more chronic health conditions, compared to just 22% of all Medicare patients. That means these cuts will target some of the sickest, most at-risk older Americans.

These cuts would further limit access to home health care, which is already being stretched by booming demand as many Americans want to stay out of the hospital to avoid contracting

the coronavirus and other infectious illnesses and made worse by a shortage of home health workers, sparked in part by low pay.

That's why TSCL is pleased that lawmakers in Congress have introduced the Preserving Access to Home Health Act of 2022 (H.R. 8581 and S. 4605). This bipartisan legislation, currently before the House and Senate, would prevent Medicare from imposing these cuts until 2026, ensuring that people have continued access to care and giving providers the stability, they need while Medicare takes more time to improve its payment system.

Post Office Warns People Not to Use Its Mail Boxes

The U.S. Postal Service (USPS) has warned people not to use its blue boxes on specific dates. It particularly warned about the chances of theft from these on Sundays and holidays. It raises the question of why USPS bothers to keep these boxes, which must be expensive to service at all.

The USPS's warning suggested how people dodge the trouble. "If customers simply used retail service or inside wall drop slots

to send their U.S. Mail, instead of depositing it to sit outside overnight or through the weekend, blue collection boxes would not be as enticing after business hours to mail thieves for identity theft and check-washing schemes."

As a solution, people should go to their local post office or put mail in boxes after the last dispatch time. It is a complicated way to decide when to mail a letter. It is also inconvenient.



The USPS already spends and loses too much money. The blue box requires trucks to pick up mail from them two times a day. It is hard to imagine a system more expensive, particularly because USPS has over 30,000 offices. It also has over 600,000 full-time employees, many of whom deliver the mail. One reason there are so many is the inefficiency of delivering mail six days a week. Although it might merely be a

gesture, one to save money, USPS could junk the blue boxes. While the postal service warning targets holidays and Sundays, the problem exists throughout the week. Customers have to worry if checks or other valuable letters make it to their intended destinations.

Like so many other things, the blue box is becoming a thing of the past.

Issue Brief Outlines How and Why People with Medicare Choose Between Coverage Options

This week, the Commonwealth Fund released an **issue brief** on how and why people with Medicare choose between Original Medicare (OM) and Medicare Advantage (MA). The issue brief discusses the tradeoffs between the options and how beneficiaries tend to rate them.

Those who choose OM have access to any provider who accepts Medicare and may save money by coupling OM with supplemental coverage like **Medigap**. But OM does not have a cap on out-of-pocket spending, and benefits are statutorily limited.

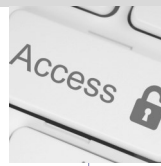
Those who choose MA have an annual cap on out-of-pocket spending, though it is still quite high (**\$8,300 in 2023**). They may also have access to additional benefits. However, MA plans often have networks that restrict choice of providers, may impose prior authorization or other restraints on access to care, generally have very limited extra benefits, and **may ultimately cost more** than the combination of OM and supplemental

coverage.

According to the issue brief, 24% of those who opted for MA were drawn by the extra benefits, with another 20% citing the out-of-pocket cap. People with lower incomes were more likely to find the extra benefits appealing, but people with both Medicare and Medicaid were less likely to choose MA for the extra benefits than were people with Medicare only.

For those with OM, 40% cited free choice of providers as the top reason. This number climbed to 50% for enrollees with OM and supplemental coverage.

Importantly, the issue brief shows that most people who receive help choosing between their coverage options turn to brokers and agents. But these individuals are not always objective; they receive commissions, which may not be equal between products. For example, **commissions currently are higher for MA plans** than for supplemental coverage like Medigap. This may



create an incentive for agents and brokers to steer consumers into MA.

Additionally, the brief shows that marketing by MA plans is a major source of information for many consumers. Such marketing is not objective; it only touts the benefits of MA, not the tradeoffs. **Complaints about misleading marketing are on the rise** as TV ads become more prevalent. This points to the need to extend and improve information access about the pros and cons of OM and MA to ensure people are getting the full picture.

The extra benefits that many find appealing are also problematic. Little is known about their delivery or efficacy, and any that provide high-quality care should be available to everyone with Medicare. In addition, it is vital that MA not be permitted to funnel **overpayments** into supplemental benefits that, in turn, lure people into MA. Medicare's annual open

enrollment period started on October 15, which means millions of people with Medicare are grappling with their coverage decisions. Choosing between OM and MA is just the first step. People who opt to remain in Original Medicare still need to explore options around Part D prescription drug coverage and supplemental insurance like Medigap. Those who choose MA must determine which plan is best. We encourage all people with Medicare to consider their health care needs and assess whether they are in the best coverage for their circumstances. Need help with your Medicare coverage? Contact your local **State Health Insurance Assistance Program (SHIP)** for unbiased, one-on-one counseling; contact Medicare online at <https://www.medicare.gov/> or by calling 1-800-MEDICARE; or call the Medicare Rights Center's national helpline at 800-333-4114.

[Read the issue brief.](#)

CMS to Release Audit Findings on Overpayments to Medicare Advantage Plans

The Centers for Medicare & Medicaid Services (CMS) has **agreed** to release the audits of 90 Medicare Advantage (MA) plans conducted between 2011 and 2013. The records are expected to detail more than \$600 million in MA overpayments due to “upcoding,” plan abuses of patient categorization rules. Access to this information was the subject of a **lawsuit** filed by Kaiser Health News (KHN) against the agency in 2019 under the Freedom of Information Act.

At Medicare Rights, we agree more transparency on plan operations and more accountability for plan use of public dollars is long overdue. It is also ever-more urgent as plans, enrollment, and spending continue to grow.

As a share of total Medicare spending, payments to MA plans **increased** from 26% in 2010 to 45% in 2020 and may reach 54% by 2030. By itself, upcoding could **cost** Medicare \$600 billion over the next

decade. At the same time, MA enrollment **more than doubled** over the last decade. The **share** of beneficiaries enrolled in MA, now at 48%, may hit 61% by 2032. Yet, the data are **unclear** when it comes to MA quality, and there is a dearth of reported demographic information, further undermining transparency and stymieing equity advancement efforts.

Policymakers must intervene. Inflated payments to MA plans require robust reforms, including updated payment methodologies, better data collection, and stronger plan oversight. And we can't stop there. As watchdog research has **long shown**, plans also regularly seek to pad profits by stinting on care. Each year, prior authorization and inappropriate denials leave **millions** with high costs and care delays.

We frequently hear from beneficiaries trying to navigate



such denials. Many are upset and confused about what to do

next. **Despite** sky-high overturn rates, most avoid the intimidating appeals process. Instead, they pay out-of-pocket, go into debt, or go without care entirely. Even successful appeals come at a cost, generating access delays and administrative burdens. Others may leave MA and return to Original Medicare. This switch is **particularly common** among the sickest and highest-cost enrollees, suggesting barriers may multiply alongside health needs and expenses. While this can ease access, it often takes **months** and carries no guarantee of affordable **supplemental coverage**.

The only clear winners in these scenarios are the plans. They collect enrollee premiums and capitated payments, then later avoid paying for promised care through denials and disenrollments.

Not all MA insurers are bad actors, of course. But surging **plan numbers** make it easier for those who are to skirt the rules and exploit loopholes. Rapid **enrollment** growth—in part due to overpayments, which plans use to offer benefits unavailable in Original Medicare—is entangling more people in a flawed system.

We urge a thorough restructuring to deter overpayments; equalize Medicare benefits; realign payment incentives; and ease access to care, including by limiting prior authorization, preventing erroneous denials, and streamlining appeals processes. All people with Medicare deserve a system that works for them, regardless of the coverage pathway they choose.

[Read the KHN article, “Lawsuit by KHN Prompts Government to Release Medicare Advantage Audits.”](#)

Five ways to ensure the people you love are safe and healthy

At least once a year, every caregiver should engage the older people they love in what can be difficult conversations. No child looks forward to being a parent to her mom or dad; no one wants to have to speak with a spouse about exercising more, rethinking a medication regimen or considering stopping driving. But, that's often what needs to happen. Here are five ways you can help ensure the people you love are safe and healthy.

1. **Make sure they get an annual flu shot.** This should be easy since often the local pharmacy will administer the shot. The shot minimizes the risk that older adults will develop flu-related health problems, including pneumonia and worsening

chronic conditions. [Editor's note: Also make sure they get their **Covid-19 vaccine and booster shots.**]

2. Check out what drugs they are taking. And, make a list of them, along with the names and phone numbers of their doctors, both for yourself and for their wallets. If they keep the list on them, and you have a backup copy, it will help ensure their doctors are best prepared to treat them.

3. Ask them about painkiller prescriptions they take as well as over the counter drugs, like Tylenol. **Too much acetaminophen can be dangerous.** Prescription painkillers, such as **Percocet or Vicodin, can be even more dangerous,** particularly if



mixed with alcohol, tranquilizers or other drugs.

4. Try to nudge them to exercise. **A brisk walk can reduce the likelihood of stroke and help prolong their lives.** If they are not inclined to move, ask them what might get them out of the house. Sometimes, a companion can make all the difference. **Anything they can do to move their bodies is great, including in hospital.** Sometimes, showing them some easy exercises can work. **You can find simple balance exercises that the National Institutes on Health recommends here.** For information about free and low-cost exercise programs in your community, visit

the **eldercare locator.**

5. **Talk to them about driving if they are still driving.** Many people can drive all their lives. But, both mental and physical reflexes can weaken as you age. The National Institute on Aging offers great advice on when and how you can help someone you love decide to stop driving. And, if you need help motivating them to **change an unhealthy behavior, here are six tips that could help.**

Of course, there's more you can do, including **making their homes easier and safer to live in:** for example, make sure floor surfaces are smooth to reduce the likelihood of tripping, install ramps and raise toilet seats. More on that in a separate post.

New Research Shows Need for Better Insulin Access Beyond Medicare

Research published this month shows that over one million adults rationed insulin doses in the past year due to the drug's high costs. These cutbacks took various forms, including delaying purchase, skimping on doses, or skipping the medication altogether.

In the United States, insulin prices far outstrip costs in other countries, **often by five to ten times.** This puts life-saving insulin out of reach for many. According to the research, uninsured people were the most likely to ration, at 29.2%. Those

with private insurance were second, at 18.8%. Despite this clear need, Congressional attempts to cap insulin costs for people with private coverage were **stripped out** of the **Inflation Reduction Act (IRA)** by Senate Republicans, who challenged their inclusion under budget reconciliation rules.

But the IRA will help insulin users with Medicare. In January, the IRA will limit Part D enrollee insulin costs to \$35 per prescription per month for covered products. On July 1, this



cap goes into effect for insulin used with a pump under Part B.

Medicare open enrollment is ongoing, and we urge insulin users to determine whether their insulin is on their drug plan's formulary and therefore capped before they sign up or renew. Importantly, Medicare Plan Finder will not be updated to reflect the IRA's insulin cap until next year. To avoid inaccurate pricing in the interim, we **suggest** people use the tool to compare plans without insulin first, then run a search

adding in any insulin prescriptions to make sure they are covered. If you need assistance this fall, connect with your local **State Health Insurance Assistance Program (SHIP)** for unbiased, one-on-one counseling; contact Medicare online at <https://www.medicare.gov/> or by calling 1-800-MEDICARE; or call the Medicare Rights Center's national helpline at 800-333-4114.

Read more about insulin rationing research.

This Open Enrollment Season, Look Out for Health Insurance That Seems Too Good to Be True

It took nearly a year for Kelly Macauley to realize the health plan she bought while shopping for insurance coverage last October was not, in fact, insurance. Sure, red flags popped up along the way, but when she called to complain, she said, she was met with explanations that sounded reasonable enough and kept her paying her \$700 monthly premiums.

She said she was told that her medical bills weren't being paid because the hospital was submitting them incorrectly. That Jericho Share, the nonprofit that sent her a membership card

reading "THIS IS NOT INSURANCE," was just her policy's underwriter, not the actual insurer. That she hadn't received a policy welcome packet because the company was saving paper and passing those savings on to customers.

Then, this summer, the 62-year-old retired teacher who recently moved from the Philadelphia area to South Carolina, learned her plan had paid only \$120 of the bill for her hip replacement last year, leaving her with a balance of over \$40,000. She said she'd been assured the



procedure would be covered when she was shopping for insurance. But it turns out that the plan she purchased wasn't insurance at all but rather part of something called a health care sharing ministry.

Health care sharing ministries are an alternative to health insurance in which members agree to share medical expenses. They are often faith-based and can be cheaper than traditional insurance, although they don't necessarily cover their members' medical bills, according to a **Commonwealth Fund report.**

"That was never, ever mentioned to me," Macauley said. "I honestly believed I was buying legitimate medical insurance." Beginning Nov. 1, millions of Americans will purchase health insurance for 2023 in a period known as "open enrollment." Through the **federal** and **state insurance marketplaces,** consumers can shop for Affordable Care Act-compliant health insurance plans and find out whether they qualify for financial assistance.... **Read More**

Many Urban Seniors Rely on 'Broken' City Transit to Get to Medical Appointments

More than 700,000 older Americans rely on public transportation to get to and from their medical appointments.

That's roughly 1 in 10 seniors who live in cities.

But when individuals were frail, or used a wheelchair, or sidewalks along their route were damaged, they were less likely to take the subway or bus, pointing to a need for improvement, according to a [new study](#).

"While our data was collected before the COVID pandemic, we know the [pandemic disrupted public transportation](#), which is still continuing due to financial strain, staffing shortages and cutbacks to transit services across the county," said senior author Jason Falvey, an assistant professor of physical and rehabilitation science at the University of Maryland School of Medicine.

"We worry about the impact that this disruption is having on

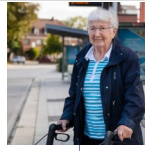
the nearly 700,000 older Americans who rely on subways and buses to get to their medical appointments," he said in a school news release.

Falvey and his team analyzed data from the National Aging and Trends Study, which included a survey of Medicare beneficiaries ages **65 and up**.

The study focused on those living independently in urban areas. Participants were asked about their use of public transportation during the previous month.

Black and Hispanic respondents, as well as those who were financially strained, were more likely to use public transit, the survey showed.

Those who used wheelchairs were 65% less likely to rely on these public options. Researchers noted that broken [sidewalks](#) and malfunctioning elevators at stations may also impede transit



use.

"Disruptions to public transportation may widen health care disparities for Black and Hispanic older adults who are more likely to rely on these services," said Dr. Mark Gladwin, vice president for medical affairs at the University of Maryland.

"We have an imperative to invest in transportation infrastructure because it is a vital public health need for our most vulnerable populations in Baltimore and beyond," Gladwin said in the release.

Wait times for mass transit are often up to 25 minutes, the study noted. Standing that long in extreme heat, rain or cold conditions could worsen chronic conditions like heart failure, kidney disease or diabetes.

The researchers plan a pilot study next year in West Baltimore to see if some steps can improve access to public

transit for seniors with disabilities.

These steps would include providing mobility-related equipment to help people navigate uneven sidewalks. It would also include free passes that would allow them to travel with a caregiver to and from medical appointments without added costs.

"Our current study found that transit users were more likely to go to their doctor visits alone compared to those who did not use public transportation, likely because of financial constraints," Falvey said. "Having a loved one at these visits can be a vital part of successful management of chronic health conditions common in seniors."

The U.S. National Institute on Aging provided funding for the study, which was recently published in the [Journal of the American Geriatrics Society](#).

Things Nursing Homes Don't Want You to Know

Who actually owns the nursing home? How's staffing at night? Some issues are less transparent than others.

This article is based on reporting that features [expert sources](#).

What Nursing Homes Won't Tell You

Most [long-term care facilities](#) strive to provide both excellent care and a comfortable home for their residents, who are oftentimes – but not always – the frail elderly.

However, there are harsh secrets in some [nursing homes](#): stark problems like resident neglect or abuse. And recently, [COVID-19 created difficulties](#) with infection control and put resident isolation and loneliness in the spotlight. As a prospective resident or their family member, you deserve to know a facility's past deficiencies and current situation.

"There is nothing that nursing homes should *not* tell family members or potential residents," says Katie Smith Sloan, president and CEO of LeadingAge, an association of nonprofit, mission-driven providers of aging

services. "The question is: What do family members want to know? We certainly encourage people to visit. We encourage them to talk to residents, talk to staff and talk to other people (such as) other family members who have other adults in a nursing home."

You may need to bring up issues yourself and research proactively to learn about the nursing home's quality and what goes on behind the scenes. Below, experts identify long-term care areas where transparency may be lacking, what's being done to address them and how you can learn more about an individual facility.

Nursing Home Issues You Should Know About

These are key nursing home concerns to be aware of as a prospective resident or family member:

- ◆ [Persistent and worsening staff shortages](#).
- ◆ [High staff turnover](#).
- ◆ [Too many residents per caregiver](#).
- ◆ [Fewer RNs onsite than recommended](#).



◆ [Ownership that's unclear and frequently fluctuating](#).

◆ [Supply shortages](#).

◆ [Recurring resident and family complaints](#).

◆ [Antipsychotic drug overuse for dementia](#).

◆ [Drug-resistant bacteria among residents](#).

◆ [COVID-19 vaccination gaps among staff](#).

◆ [Hospitalization challenges for residents](#).

Severe staff shortages

A nursing home you're considering may have to turn away new admissions because there isn't enough staff to care for them.

In April 2022, the Biden administration proposed requirements for mandatory minimum staffing levels in nursing homes. However, some nursing home trade groups are pushing back, asking for more flexibility and citing factors, like local labor availability, that can hamper staffing efforts.

An American Health Care Association [report](#) released in June 2022 highlighted survey

responses from 795 nursing home providers. It found that 60% are experiencing worsening staffing situations even since January. Nearly 50% face high-level staffing shortages, with 98% having difficulty hiring staff. And 61% of respondents are limiting new admissions.

The top obstacles, which developed or grew during the pandemic, include a lack of interested or qualified candidates, personal commitments preventing people from entering the workforce and facilities' inability to offer competitive wages with their current financial situations.

High staff turnover

High staff turnover threatens the continuity of care, leaving fewer caregivers who are really familiar with individual residents' preferences and needs. That can be particularly important for certain residents, such as those with dementia who may find it harder to express themselves....[Read More](#)

RI ARA HealthLink Wellness News

Pain Relief in a FLASH: Radiation Treatments Lasting Seconds May Advance Cancer Care

Flash radiotherapy, a new technology that uses targeted proton beams, is safe and effective in relieving pain for terminal cancer patients, a new, small study suggests.

Flash radiotherapy delivers radiation at dose rates more than 300 times higher than those used in conventional radiation, does it in only about three-tenths of a second, and doesn't damage adjoining tissue. The hope, according to researchers, is that this technology will eventually replace **current radiation therapy**.

"It's kind of in its infancy, so nobody anywhere else in the world is doing it. Our trial is really the first one in the world to show that it's safe and effective," said researcher Dr. Emily Daugherty, an assistant professor of clinical radiation oncology at the University of Cincinnati Cancer Center.

"Someday, this may revolutionize how we treat patients with radiation, if we continue to see that it's just as effective and patients have minimal side effects," Daugherty added.

The research was funded by California-based Varian Medical Systems, which makes the new radiotherapy. Daugherty said studies are underway to test the technology on more people and eventually on cancerous organs.

She believes the results of this first trial might well mean that Flash would be at least as effective in treating most cancers as current radiotherapy, with no damage to surrounding tissue. Why Flash has the effect isn't clear, but it performed well in animal studies, Daugherty noted.

"This is a brand-new way of delivering radiation that could potentially have practice-changing implications," she said. "Years down the road, perhaps we will treat patients' cancers faster and more effectively with fewer side effects."

For **the trial**, Daugherty and her colleagues used Flash radiotherapy on 10 patients whose cancers had metastasized to the bones. Treatments were delivered to 12 bone sites in patients' arms and legs.

This treatment uses a beam of protons instead of **X-rays** to destroy tumors without damaging healthy tissue and reduces the odds of long-term complications. Proton beams are only a few millimeters wide and are delivered through a crane that circulates 360 degrees around a patient.

Treatments took an average of 19 minutes. Over a median of five months of follow-up, side effects were mild and no different from conventional radiation. In all, for eight of 12 sites where



Flash was delivered, patients reported pain relief, and in six of 12 sites, patients reported no pain. In four of 12 sites, patients experienced pain flare-ups.

Four patients experienced darkening skin tone, one had skin discoloration, two had mild limb swelling, two experienced itchy skin, one had fatigue, one had skin reddening and one experienced extremity pain.

These results are similar to those seen with conventional radiotherapy, but achieved with a single treatment, Daugherty noted.

The findings were presented Sunday at the American Society for Radiation Oncology annual meeting in San Antonio, Texas, to coincide with the online publication of the study in *JAMA Oncology*.

Dr. Anthony D'Amico, a professor of radiation oncology at Harvard Medical School in Boston, said this small trial is promising, but this technique could only be used to help relieve pain in terminally ill cancer patients, at least for now.

"It's an interesting technology that can provide treatment at a much quicker burst," he said. "It's one treatment as opposed to a week or two of treatments. The treatments are longer and do take anywhere from 15 to 30 minutes, as opposed to the usual five to

seven minutes. But you get it all done in one day."

Still, it's too soon to tell if the pain responds to treatment as one would expect. "It's also too soon to tell whether or not those responses are durable," D'Amico said.

Right now, this treatment is for somebody who's not going to live three months, he said. "If you have somebody who's on the cusp of dying or transferring over to hospice, and you just want to give one treatment and quickly get them some pain relief for the next couple of months, this treatment might be helpful," D'Amico said.

Before Flash radiotherapy could be used to directly treat organs — such as the liver, pancreas, lung, prostate or brain — a lot more study is needed, he added.

"I'm optimistic because what you're really doing is increasing the dose rate and delivering it faster and more precisely. But you can't just assume because that's all you're doing, that it's equally effective," D'Amico said.

"I don't want people running out and saying I want the Flash radiotherapy to treat my prostate cancer in a week," he said. "We don't have the information to really prove that it's equally effective."

Did the Decline in PSA Testing Lead to More Cases of Advanced Prostate Cancer?

A large new study of U.S. veterans suggests that when prostate cancer screening rates go down, the number of men diagnosed with advanced cancer then rises.

Researchers found that across 128 U.S. veterans health centers, the rate of PSA screening for prostate cancer declined between 2008 and 2019 -- a period where guidelines came out recommending against routine screening.

But patterns varied among the individual centers, with some maintaining high **screening rates**.

And in subsequent years, the study found, a trend emerged: VA centers with higher PSA

screening rates had fewer cases of **metastatic prostate cancer**, while more cases were diagnosed at centers with lower screening rates.

Metastatic refers to prostate cancers that have spread to distant sites in the body and cannot be cured.

Experts said the findings do not mean that all men at average risk of prostate cancer should be routinely screened for the disease.

But the results do add to a longstanding debate over the issue.

Prostate cancer is very common: About 1 in 8 men will



be diagnosed with the disease in their lifetime, according to the American Cancer Society. But the cancer is often slow-growing, and may never progress to the point of threatening a man's life: About 1 in every 41 men actually die of the disease.

That's why routine screening -- with **blood tests** that measure a protein called PSA -- has been controversial. The main concern is that it may often detect small tumors that would never have become harmful -- leading to "over-treatment" that exposes men to the risks of side effects such as incontinence and erectile dysfunction.

Adding to that, two major trials published about a decade ago came to conflicting conclusions about the value of screening. One, done in the U.S., found that annual PSA screening did not reduce men's risk of being diagnosed with metastatic prostate cancer, or of dying from the disease.

The other trial, done in Europe, found that screening did reduce advanced cancer diagnoses.

In 2012, the U.S. Preventive Services Task Force (USPSTF) recommended against routine PSA screening for average-risk men.... **Read More**

Radiation Therapy Can Safely Be Cut in Half for Patients With Early Breast Cancer

Women with early-stage breast cancer who are at high risk for the cancer coming back can do just as well with a shortened course of **radiation therapy**, researchers report.

"We can treat patients with early-stage breast cancer who have a higher risk of having their tumors recur in three weeks as opposed to four or six weeks and achieve just as good tumor control with no differences in cosmetic appearance or side effects," said study author Dr. Frank Vicini.

"This gives a lot of comfort to patients, and this approach cuts treatment time in half," added Vicini, a radiation oncologist and national director of research and breast care services at GenesisCare in Farmington Hills, Mich.

This is a major convenience, too, cutting trips to and from the clinic for radiation treatments.

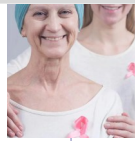
Previous studies have shown

that a three-week course of radiation is as safe and effective as a six-week therapy for people at low risk of breast cancer coming back. Still, some people with early **breast cancer** face a higher risk of recurrence due to slightly larger tumor size or other factors like older age.

For these people, whole-breast radiation is typically given after a tumor is removed via **lumpectomy** and followed by a radiation boost to the surgical site delivered over six to seven days. The new study shows that the boost can be given at the same time as whole-body radiation treatment.

Calling the new findings "practice-confirming," Vicini said this can be incorporated into clinical practice now since none of the techniques or concepts are new.

The study included about 2,300 people with early-stage



breast cancer who had an increased risk of breast cancer recurrence. They were randomized into two groups: one group underwent whole-breast radiation for four to five weeks, followed by a boost to the lumpectomy site delivered over six to seven days, and the other group received whole-breast radiation over three weeks, with the boost to the surgical site given at the same time.

There were 56 breast cancer recurrences after slightly more than seven years of follow-up. There were no differences based on the treatment protocol, the study showed.

Some questions remain, such as whether people whose cancer has spread to the lymph nodes can benefit from the three-week approach as well and whether treatment time can be trimmed even more, Vicini said.

The study was presented

Monday at the **American Society for Radiation Oncology annual meeting** in San Antonio. Findings presented at medical meetings are considered preliminary until published in a peer-reviewed journal.

Dr. Alphonse Taghian is a breast radiation oncologist at Massachusetts General Hospital and a professor of radiation oncology at Harvard Medical School in Boston.

"I am going to start using this protocol in people with early breast cancer at high risk for breast cancer recurrence as soon as I come back from the meeting," said Taghian, who was not involved in the study. "There is no reason not to. It will save a week or more for these women who must drive every day to come for radiation, without affecting the outcome."

Deadly Aneurysm-Linked Strokes Are Rising, Especially Among Black Americans

An often-deadly type of stroke -- subarachnoid hemorrhage -- is on the upswing in the United States, particularly among Black people, new research shows. Unlike the more common ischemic stroke, **subarachnoid hemorrhage** happens when there is bleeding in the space between the brain and the membrane that covers it. It is often caused by an **aneurysm**, a bulge in a blood vessel, that bursts or leaks.

This type of stroke, which comprises about 5% to 10% of strokes, is rising in certain groups, especially older men and women, middle-aged men and disproportionately in Black people, researchers say.

"It's on the rise, but the rise is not universal," said study co-author Dr. Fadar Otite, assistant professor of neurology at SUNY Upstate Medical University in Syracuse, N.Y.

Some of this can be explained by risk factors like **high blood pressure**. Black people have been more likely to develop high blood pressure at earlier ages and to have uncontrolled blood pressure, Otite said.

"But I truly believe that the

underlying factors responsible, especially for the racial differences in subarachnoid hemorrhage, actually go beyond risk-factor control, but into other factors like access to health care, access to poverty and even structural racism," Otite said.

A characteristic of subarachnoid hemorrhage is having the worst headache of your life, Otite said. "A particularly severe headache that just comes out of the blue and gets to maximum severity within a very short term," he noted.

This would be less likely to occur with other forms of stroke, such as ischemic stroke, which is due to a blood clot rather than a bleed.

"Although other signs of strokes, such as weakness and facial droop and speech disturbances, can also occur in subarachnoid hemorrhage, headache would be much more consistent with subarachnoid hemorrhage compared to the others," Otite said.

Additional signs could be severe vomiting, confusion, sleepiness or even becoming



comatose within a short period of time.

For the study, researchers reviewed state hospitalization databases in New York and Florida between 2007 and 2017. They found more than 39,000 people were hospitalized for non-traumatic subarachnoid hemorrhage -- caused by a ruptured aneurysm or high blood pressure rather than trauma.

The team then used U.S. Census data to calculate the annual rates for this type of stroke in those two states, breaking down the information by age, gender, race and ethnicity.

While numbers of this type of stroke were 11 per 100,000 in all participants, women had 13 cases per 100,000 and men had fewer -- 10 per 100,000.

For middle-aged men, 45 to 64, rates were 4 per 100,000. But incidence rose with age, with men 65 and up having 22 cases per 100,000.

In Black people, the rate was 15 per 100,000 compared to white people's average of 10 per 100,000.

Incidence increased by almost 2% a year for Black adults while

it didn't change for other racial groups, the study found.

Overall, incidence increased by 0.7% on average per year, rising 1.1% in middle-aged men, 2.3% in older men and 0.7% in older women, the study showed.

Otite said the increase in older groups of patients may be related to increased usage of blood thinners for treating conditions like abnormal heart rhythm (**atrial fibrillation**). "And it can also be in part due to increased utilization of imaging over time to screen for patients presenting with neurological complaints like headache in the emergency room," he said.

Better preventive health care could help reduce the racial gap, Otite noted.

Some of these aneurysms could be found before the rupture, and that's more likely to happen with good access to health care, Otite said.

not able to differentiate between patients whose strokes were caused by aneurysms and those who had strokes that weren't, which is a study limitation.... **Read More**

Keeping Blood Pressure in Check Could Cut Your Odds for Dementia

Controlling **high blood pressure** in older adults may be one of the "best bets" for reducing the risk of developing dementia, Australian researchers report.

"Given population aging and the substantial costs of caring for people with dementia, even a small reduction could have considerable global impact," said researcher Ruth Peters, an associate professor at the University of New South Wales (UNSW) Sydney and program lead for dementia in the **George Institute's Global Brain Health Initiative**.

In the study of more than 28,000 people, her team found strong evidence that lowering blood pressure could cut dementia risk.

Five double-blind, placebo-

controlled randomized trials were analyzed that included individuals from 20 countries. The trials used different treatments to lower blood pressure. The researchers followed patients until the development of dementia. Patients were an average age of 69 and mid-range follow-up was about four years.

"We found there was a significant effect of treatment in lowering the odds of dementia associated with a sustained reduction in blood pressure in this older population," Peters said in a George Institute news release. "Our results imply a broadly linear relationship between blood pressure reduction and lower risk of dementia, regardless of which



type of treatment was used."

Without significant dementia treatment breakthroughs, reducing risks may help. An estimated 50 million people live with dementia worldwide, and the numbers could triple by 2050.

"Our study suggests that using readily available treatments to lower blood pressure is currently one of our 'best bets' to tackle this insidious disease," Peters said.

Though there may be hesitation about how far to lower blood pressure in older age, Peters said the study showed no evidence of harm in lowering blood pressure for the study participants.

"But what we still don't know is whether additional blood

pressure-lowering in people who already have it well-controlled or starting treatment earlier in life would reduce the long-term risk of dementia," she added.

Most previous trials stopped early because of the significant impact of blood pressure-lowering on cardiovascular events, which tend to occur earlier than signs of **dementia**, Peters said.

"This work is an important foundation for clinical trials to provide reliable estimates of the benefits and risks of preventative treatments, and how best to apply them across different populations," said Craig Anderson, director of the Global Brain Health program at the George Institute.

Too Often, Women Aren't Told of Sexual Side Effects of Cancer Treatments

When a man has cancer in an area that affects sexual function, his doctor is likely to discuss it with him.

But the same is not true for a woman who has cancer in a sex organ, according to new research. Investigators found 9 in 10 men were asked about their sexual health, yet only 1 in 10 women received the same care.

"There seems to be a big disparity in the way we approach sexual dysfunction with our patients, where female patients are asked about sexual issues much less often than male patients are," said lead author Dr. Jamie Takayesu. She is a radiation oncology resident physician at the University of

Michigan Rogel Cancer Center.

"Equally importantly, we see this trend on a national level in clinical trials," Takayesu said.

The **findings were presented** at the annual meeting of the American Society for Radiation Oncology, in San Antonio.

In the United States, about 13,000 women are diagnosed with **cervical cancer** each year, while more than 220,000 men have new cases of **prostate cancer**.

Radiation therapy and other treatments are often used in both cases.

The potential for long-term



side effects, including sexual dysfunction, is important to consider, Takayesu said. About 96% of patients with prostate cancer and 67% of those with cervical cancer survive for at least five years.

In **brachytherapy** for prostate or cervical cancer, doctors insert radioactive sources directly into the tumor. This can affect organs in the genital region.

About half of the women who receive cervical brachytherapy experience sexual side effects, among them uncomfortable and sometimes painful changes to vaginal tissue and dryness, according to the research team.

Somewhere between one-quarter and half of men who receive prostate brachytherapy end up with erectile dysfunction during, after or well after treatment.

Takayesu said the lack of openness toward women's sexual health isn't limited to medical offices.

"Culturally, there are differences in how we talk about sexual dysfunction that affects men versus women. We see ads on television about erectile dysfunction, for example, but there's no equivalent to these for women," Takayesu said in a meeting news release...**Read More**

Dove, Tresemme Dry Shampoos Recalled Due to Possible Carcinogen

Unilever announced Monday that it has recalled certain dry shampoo sprays because they may contain elevated levels of **benzene**.

The propellant used in the products, which are sold under the brand names Dove, Nexxus, Suave, TIGI (Rockaholic and Bed Head) and TRESemmé, appears to be the source of the benzene.

Benzene is a human carcinogen that may cause leukemia, blood cancer of the

blood marrow and life-threatening blood disorders.

Still, daily exposure to benzene in the recalled products at the levels detected in testing "would not be expected to cause adverse health consequences," Unilever noted in its **recall notice**.

This is not the only benzene-linked recall by Unilever in recent months. The company, which makes a variety of beauty and food products, **recalled** two



Suave-brand 24-hour protection aerosol antiperspirants in March after it found benzene in samples during an internal review, *CBS News* reported.

Unilever is also not the only company with these issues.

Procter & Gamble **recalled** aerosol dry shampoo and conditioner last December from six of its brands because of benzene. Three other companies also recalled products this year for the same reason, as

did others last year, *CBS News* reported.

Benzene is found in both gasoline and cigarette smoke. People can also absorb the chemical by touching petroleum products or eating contaminated foods and beverages, *CBS News* reported.

Anyone who has the affected aerosol dry shampoo products at home should visit **UnileverRecall.com** to seek reimbursement.

Cutting Carbs Could Cut Your Risk for Diabetes

People at risk for developing diabetes could help themselves now by eating fewer carbs, according to new research.

While low-carb diets are a common next step for someone diagnosed with the disease, people who are **prediabetic** or with diabetes not treated with medication don't need to wait to cut back and see benefits to their blood sugar levels.

"The key message is that a **low-carbohydrate diet**, if maintained, might be a useful approach for preventing and treating type 2 diabetes, though more research is needed," said lead author Kirsten Dorans. She's an assistant professor of epidemiology at Tulane University School of Public Health and Tropical Medicine in New Orleans.

For the **study**, the researchers studied two groups of 75 people each. In one, participants were assigned to a low-carb diet. The other ate as usual.

Six months later, the low-carb diet group had greater drops in hemoglobin A1C, which is a marker for blood sugar levels. That group also lost weight and had lower fasting blood sugar levels.

While the study doesn't prove that a low-carb diet prevents diabetes, it opens the door to further research on how to work through health risks of those with prediabetes and diabetes not treated by medication, Dorans said.

"We already know that a low-carbohydrate diet is one dietary approach used among people who



have **type 2 diabetes**, but there is not as much evidence on effects of this diet on blood sugar in people with prediabetes,"

Dorans said in a university news release. "Future work could be done to see if this dietary approach may be an alternative approach for type 2 diabetes prevention."

Study participants' blood sugar ranged from prediabetic to diabetic levels. The low-carb group saw A1C levels drop 0.23% more than the usual diet group.

That is "modest but clinically relevant," Dorans said.

While fats comprised about half of the calories eaten by those in the low-carb group, they were mostly healthy monounsaturated and polyunsaturated fats found in

foods like olive oil and nuts.

The findings were published Oct. 26 in **JAMA Network Open**.

About 37 million Americans have diabetes and 96 million have prediabetes. More than 80% of those with prediabetes don't know it, according to the U.S. Centers for Disease Control and Prevention.

Prediabetes puts someone at increased risk for developing type 2 diabetes, as well as heart attack or stroke.

Diabetes occurs when the body doesn't use insulin as it should and can't regulate blood sugar levels. About 90% of people who have the condition have type 2 diabetes. Symptoms can include blurred vision, numb hands and feet, and overall tiredness. It can lead to heart disease, vision loss and kidney disease.

Black Americans Less Likely to Receive Lifesaving CPR: Study

When someone collapses in front of witnesses, the chances of receiving potentially lifesaving CPR may partly depend on the color of their skin, a new study suggests.

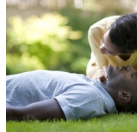
Researchers found that when Black and Hispanic Americans suffer cardiac arrest, they are up to 37% less likely than white people to receive bystander CPR in public places and at home.

The reasons for the disparity are not certain, but there are potential explanations, said senior researcher Dr. Paul Chan, of Saint

Luke's Mid America Heart Institute in Kansas City, Mo.

CPR trainings, he said, are less available in Black and Hispanic communities, and there are other barriers like cost, which may help account for the disparities in responses to at-home cardiac arrests.

But going into the study, the researchers expected that disparities would be lessened when cardiac arrests happened in public. With more people around, the chances that a bystander



would be trained in CPR are greater.

Instead, the disparities were greater: Among cardiac arrests that happened at home, Black and Hispanic individuals were 26% less likely than white people to receive CPR. In public settings, that gap grew to 37%.

"That was striking. It wasn't what we expected to see," Chan said. "And it raises a lot of questions about why."

Unfortunately, bias -- conscious or not -- could play a role, said

Chan and other experts.

Bystanders may be less likely to "make assumptions" about a white person who collapses, versus a Black or Hispanic person, Chan said.

Disparities were not, however, confined to cardiac arrests that struck in white neighborhoods, he noted.

Across neighborhoods of all incomes, and even in those that were majority Black or Hispanic, white cardiac arrest victims were more likely to receive bystander CPR... **Read More**

Treated or Untreated, COVID Symptoms Can Ease and Then Return, Study Finds

Nearly everyone has heard of **Paxlovid rebound**, where COVID-19 symptoms return after taking the antiviral and then feeling better. It even happened to President Joe Biden. But new research shows it also happens to patients who don't take the medication.

"Our study suggests that people can experience rebound of symptoms and virus after feeling completely better for two days or more," said study author Dr. Davey Smith, head of the division of infectious diseases and global public health at the University of California, San Diego

"In fact, return of symptoms is very common, with over a third

of people reporting return of symptoms even without any therapy," Smith added.

In 2020, Smith and his colleagues spent a month tracking 158 COVID-19 patients between the ages of 34 and 55. The patients were evenly divided between men and women, and no one was seriously ill when they first enrolled in the investigation. At the same time, about four in 10 said they also struggled with some type of health condition that put them at relatively high risk for COVID complications, such as **high blood pressure** or **obesity**.

During the four-week tracking period, 5% ended up hospitalized, though none died.



Throughout, all were monitored for the presence of 13 key COVID-19 symptoms, including coughing, fatigue, headaches, sore throats, stuffed nose, body and muscle pain, shortness of breath, fever, nausea, diarrhea, vomiting, and chills.

None of the patients received any treatment for COVID-19. Yet during the study, nearly 70% reported complete symptom resolution, which was defined as being symptom-free for at least 48 hours.

But during tracking, the investigators discovered that 44% of those who had experienced complete symptom relief — meaning more than one-third

of *all* the patients in the study — went on to experience a recurrence of at least one COVID-19 symptom.

Coughing, **fatigue** and headaches were the most commonly recurring symptoms.

The good news: About 85% of those who did experience some symptom rebound said those symptoms were mild.

Smith stressed that the issue at hand is not to be confused with **long COVID**, given that he and his colleagues "only looked at the 29 days after someone contracted COVID, and long COVID is beyond this."... **Read More**