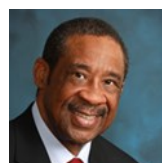




Message from the Alliance for Retired Americans Leaders

Alliance Marks Hispanic Heritage Month



Robert Roach, Jr.
President, ARA

Alliance members in marking **Hispanic Heritage Month**, which runs from September 15 - October 15, 2023. Social Security is particularly important for the Hispanic community, according to the **Centers for Disease Control and Prevention (CDC)**,



Hispanic-Americans have higher life expectancies once they reach ages 65 and 75 than the population at large and are likely to rely on their earned benefits for longer.

However, according to the Social Security Administration the average annual Social Security benefit for Hispanic men 65 years and older was just \$14,579, compared to \$11,628 for Hispanic women in 2021.

"During Hispanic Heritage month, we celebrate the accomplishments of our friends in the Hispanic community who have played such a major role in building our nation, and applaud the work of our allies and partners in the Labor Council for

Latin American Advancement (**LCLAA**)," said **Robert Roach, Jr., President of the Alliance**.

"But we must also re-double our work to increase Social Security benefits and strengthen the system, so all Americans can enjoy a secure retirement.

First Time in History: Kevin McCarthy is Ousted as Speaker



Rich Fiesta,
Executive
Director, ARA

A stopgap funding bill signed by President Biden on Saturday funds the government through November 17, but cost House Speaker Kevin

McCarthy his job as House Speaker. The spending measure passed with more Democrats than Republicans voting for it, enraging a group of extremists led by Rep. Matt Gaetz (FL).

On Tuesday Gaetz called for a vote to remove McCarthy, which was passed **216-to-210**. Eight Republicans voted with all the House Democrats to oust McCarthy. The House is now in recess while Republicans deliberate on who the next Speaker will be. Current House Majority Leader Steve Scalise (LA) and Rep. Jim Jordan (OH) are the leading contenders.

"It's a relief that the federal government did not shut down, but we are in uncharted waters," said **Richard Fiesta, Executive Director of the Alliance**. "A government shutdown affects seniors and all Americans. It isn't a game."

Fiesta Addresses APWU Retiree Conference

Executive Director Fiesta traveled to Las Vegas this week to address the American Postal Workers Union (APWU) Retiree Conference. Fiesta gave an



Richard Fiesta with APWU retirees Yoggi Riley (left), Joanne Romero (second from right) and Tish Ochoa. Ms. Romero is an Arizona Alliance board member. Ms. Riley and Ms. Ochoa are California Alliance members.

overview of retiree issues in Washington, including threats to Social Security and Medicare, prospects for Social Security expansion, and an update on the implementation of the lower drug price provisions in the Inflation Reduction Act. He also discussed senior voting patterns and the 2024 elections. Richard Fiesta with APWU retirees Yoggi Riley (left), Joanne Romero (second from right) and Tish Ochoa. Ms. Romero is an Arizona Alliance board member. Ms. Riley and Ms. Ochoa are California Alliance members.

Ten Drug Corporations Meet Medicare Drug Price Negotiation Deadline

The manufacturers of the ten high-priced drugs selected for the first round of Medicare drug price negotiations all formally



Joseph Peters
ARA
Sec.-Trea.

agreed to negotiate by the October deadline although several said they were doing so 'under duress.' Separately, a conservative federal court judge on

Friday denied the U.S. Chamber of Commerce's bid for a preliminary injunction against the Inflation Reduction Act's Drug Price Negotiation Program—the first legal test to stop the Biden administration's implementation of the Medicare cost-cutting initiative.

The ten prescription drugs are Eliquis, Jardiance, Xarelto, Januvia, Farxiga, Entresto, Enbrel, Imbruvica, Stelara, and Fiasp. Out of pocket costs for Medicare beneficiaries taking these drugs was \$3.4 billion in 2022.

The negotiated prices will take effect on January 1, 2026.

"We are pleased that all of the corporations have agreed to come to the negotiating table," said **Joseph Peters, Jr., Secretary Treasurer of the Alliance**. "The Inflation Reduction Act is already delivering lower drug prices for Medicare beneficiaries who take insulin and punishing corporations that raise prices more than the rate of inflation. More savings will come down the road when lower prices are in place for these outrageously expensive drugs."

Ignore Medicare Advantage ads; they misrepresent costs and benefits

Two new reports, one from **the Commonwealth Fund** and one from **the Kaiser Family Foundation**, highlight the deceptive marketing in Medicare Advantage, a program administered by corporate health insurers that too often misrepresents their benefits and costs. Many Medicare Advantage plans fail to cover the care, particularly the costly care, their enrollees need. In short, if you want care from the doctors you know and trust, without insurance companies overruling their treatment decisions, you should enroll in Traditional Medicare.

The marketing of Medicare Advantage has meant endless ads everywhere you turn. There are literally hundreds of billions of dollars in profits available to be reaped by corporate health insurers each year. And, they want as much of these profits as they can get their hands on. The problem is that they profit more when their enrollees get less care.

With lots of people complaining about countless marketing calls, misleading

advertising and unscrupulous sales tactics, the Biden administration has put in place new regulations in the past year. It's not at all clear that they work, given that the corporate health insurers know that they can get away with a lot and face little if any accountability for their bad acts.

The Commonwealth Fund survey found that sales agents wrongly asked people for their Social Security or Medicare numbers in many cases. You should not give this information out; it is not used in most instances.

People are generally overwhelmed by their Medicare choices. They have too many options and it is virtually impossible to distinguish among them. So, they often stay with their current coverage. The Kaiser Family Foundation reports that "in 2023, Medicare beneficiaries can choose from an average of **43 Medicare Advantage plans, offered by 9 different insurers, the highest**



number ever available. Traditional Medicare beneficiaries selecting prescription drug coverage can choose from an average of **24 stand-alone Part D plans.**"

A lot of people turn to friends and family for advice. Others rely on insurance brokers. Don't trust insurance brokers who profit from steering you to particular Medicare Advantage plans. Contact your **state health insurance assistance program**, SHIP, or the Medicare Rights Center at 800-333-4114 for free unbiased counseling.

In the Commonwealth survey, about a third of people with Medicare wanted to know more about their out-of-pocket costs and benefits in a Medicare Advantage plan v. Original Medicare. It's critical people understand them as there have been **a large number of complaints from people with Medicare about misleading information by the Medicare Advantage plans and the insurance brokers they hire**

about costs and benefits.

Unfortunately, costs and benefits are not as simple to understand as they should be. Here's what you need to know: In Medicare Advantage, out-of-pocket costs can be as high as \$8,300 in 2023 for in-network care, and you will pay for the full cost of care if you go out of network. Because many plans engage in **widespread denials and delays of care** and have **networks with limited numbers of physicians**, it can be hard to get in-network care.

And, as for the "extra" dental and hearing benefits that many Medicare Advantage plans promote, beware. They sound great in theory, but are often difficult to take advantage of. In many cases, you must use a set of providers who are inconvenient or unavailable or your out-of-pocket costs can be extremely high. The data show that more people in traditional Medicare get dental care than in Medicare Advantage.

Trump Misplaced Blame When He Said Drug Shortages Were Biden's Fault

"Under 'Crooked Joe' Biden, there has been a catastrophic increase in shortages of essential medicines."

Former president and current Republican presidential candidate Donald Trump, in a July 24 **campaign video**

In **a recent campaign video**, former President Donald Trump blasted President Joe Biden for "a catastrophic increase" in drug shortages.

"It's a mess," Trump said in the video, adding that new drug

shortages were up last year by 30%, with "295 active drug shortages" by the end of 2022.

This article was produced in partnership with **PolitiFact**. It can be **republished for free**. The continued availability of lifesaving drugs is a concern in this country. Reports of shortages of medicines on which many Americans rely — from **widely used cancer medications** like



cisplatin to over-the-counter painkillers such as **Children's Tylenol** — have been widespread in recent years. The shortages have caused treatment delays or forced clinicians to substitute alternatives in place of preferred therapies.

But is Biden responsible, or is Trump's claim an oversimplification?

We contacted the Trump campaign for answers, but got no reply. So, we poked around on our own. What we found didn't align with Trump's claims. By some measures, drug shortages increased more on Trump's watch than on Biden's.

Where to Place the Blame?
...Read More

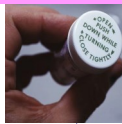
Major Drug Companies Agree to Price Negotiations With U.S. Government

Pharmaceutical companies that make the 10 prescription drugs chosen to be the first for price negotiations for Medicare patients have agreed to talks with the government.

The Biden administration announced Tuesday that the drugmakers, including Merck, Bristol Myers Squibb and Johnson & Johnson, will take part in price negotiations despite ongoing lawsuits over this same requirement, **NBC News** reported.

This negotiation is a component of the Inflation Reduction Act, which allows Medicare to work with the drug companies to reduce prices for older Americans. Negotiations are to occur next year with resulting prices going into effect in 2026.

The first 10 drugs named by the Centers for Medicare and Medicaid Services include diabetes drug **Januvia**, **Enbrel** for rheumatoid arthritis, and the



blood thinners **Eliquis** and **Xarelto**. Last year, about 9 million Medicare enrollees paid \$3.4 billion out of pocket for these 10 specific drugs, **NBC News** reported.

Additional drugs will later be added to negotiations.

The federal government had given manufacturers one month to decide if they would participate in talks or face tax penalties, **NBC News** reported. Drugmakers could avoid the

penalty if they removed their drug from the Medicare program, but that, too, could be costly.

Companies who are suing, including Merck and Johnson & Johnson, have said that allowing negotiations could affect their profits and as a result, spending on research and development.

Medicare provides health insurance to more than 65 million older Americans.

Are you age 70 or older and not yet receiving benefits?

By Cheryl Tudino Social Security Public Affairs Specialist

Retirement is not one-size-fits-all. It can mean different things to different people. Perhaps you have not applied for Social Security retirement benefits because you're still working or are delaying applying so you can get the higher benefit. If you're age 70 or older, you should apply now for the benefits you're owed. Your benefits will not increase if you continue to delay applying for them because you

are 70 or older.

Did you know that you can receive benefits even if you still work? Your earnings can increase your monthly benefit amount – even after you start receiving benefits. Each year that you work, we check your earnings record. It's possible your latest year of earnings is one of your highest 35 years. If so, we will automatically recalculate your benefit amount and pay you any increase due.

You can claim your retirement



benefits now. The best and easiest way to apply is with a

personal my Social Security account. You can create your free account at

www.ssa.gov/myaccount.

Once you create your account, you can get an estimate of how much you might receive each month based on when you want to start receiving benefits and then apply.

In your account, you can also:

- ◆ Access our publications – like the fact sheet for workers ages

70 and up.

- ◆ Find your Full Retirement Age.
- ◆ Learn about benefits for your spouse and family members.
- ◆ Apply for benefits.
- ◆ Manage your benefits once you start receiving them.

We're here to help you secure today and tomorrow and we invite you to learn more about applying for retirement benefits at <http://www.ssa.gov/apply> on our website. Please share this information with those who need it.

Medicare open enrollment: if you're confused, this program can help

Medicare's annual enrollment period is less than two weeks away, a time when enrollees can make changes to their health insurance coverage — but may need help doing so.

Not all beneficiaries want to change their coverage, but it doesn't hurt to look at the options available. Choosing the wrong plan could cost a beneficiary hundreds, if not thousands, of dollars, with more money spent in out-of-pocket costs, prescriptions or other fees and procedures.

State health insurance assistance programs, known as

SHIPs, offer Medicare beneficiaries resources and representatives to navigate Medicare on the local level, and are funded by the U.S.

Administration for Community Living. Each state, as well as the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands, has a SHIP, which individuals can find on the program's [website](#).

Beneficiaries can use these programs for free, unbiased one-on-one conversations with representatives about coverage changes during open enrollment,



as well as ask about their eligibility and out-of-pocket expenses.

The annual enrollment period begins Oct. 15 and ends on Dec. 7. During this time frame, beneficiaries can review alternatives to their current plans and switch if they'd like. This period is separate from any special enrollment periods, such as the one individuals get during a major life event (marriage or adopting a child, for examples) or when they become eligible for Medicare at age 65, which spans seven months (three months prior to their birth month,

their birth month and the three months following).

This period is also separate from an open enrollment period specifically for Medicare Advantage plans in January through March, when they can switch between Advantage plans or switch to Original Medicare from an Advantage plan. Beneficiaries can switch from Original Medicare to Medicare Advantage during the October to December period, however.

Will a Medicare Part B Premium Hike Wipe Out Your 2024 Social Security COLA?



We're getting really close to finding out what cost-of-living adjustment, or COLA, seniors on Social Security will be getting in 2024. The reason that raise hasn't been officially announced yet is that it's based on third quarter inflation data.

While we've wrapped up the third quarter of the year, a 2024 COLA can't be calculated until data on the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) arrives for September. And that information won't be released until Oct. 12.

Meanwhile, based on CPI-W readings from July and August, the non-partisan Senior Citizens League is projecting a 3.2% Social Security COLA for 2024. That number has the potential to wiggle a little bit based on

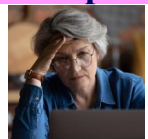
September's CPI-W reading, but it's a reasonable assumption based on the data we have to date.

If a 3.2% COLA ends up becoming official, the average **Social Security** benefit would rise by \$57.30 a month in 2024. And that's a decent bump, even if it's nowhere close to the 8.7% COLA Social Security recipients got at the start of 2023.

But the big question mark surrounding 2024's COLA is **Medicare**. If the cost of Medicare Part B increases a lot, seniors' upcoming COLA could be whittled down in a very big way. So that's something Social Security recipients need to keep in mind.

Will Medicare hikes be a problem for Social Security recipients?

Seniors who receive coverage through Medicare and benefits



through Social Security pay their Part B premiums out of their Social Security benefits directly. In 2023, the cost of Part B went down for the first time in years, so Social Security recipients got to keep their generous 8.7% COLA in full.

But Medicare Part B premiums aren't expected to drop again. Rather, they're expected to rise. The result? Less net monthly income for Social Security recipients.

Now earlier in the year, the Medicare Trustees projected that the cost of Part B would rise from \$164.90 a month in 2024 to \$174.80. That's about a \$10 increase. Meanwhile, we just learned that a 3.2% COLA would raise the average Social Security benefit by about \$57 a month. So even when we deduct \$10, the typical beneficiary is looking at a \$47 monthly raise.

But that assumes the cost of Medicare Part B *only* rises about \$10. The Senior Citizens League expects the cost of Part B to go up to \$179.80 per month in 2024 based on added costs the program is likely to encounter (namely, a new Alzheimer's drug). That's a \$15 increase instead of \$10.

We'll have to wait and see

News on 2024's Social Security COLA should arrive within the week, and updates on Medicare costs should follow shortly after that. Until then, all we can do is guess at the amount of money seniors will gain in the new year. But it's fair to assume either way that any increase in monthly income will pale in comparison to what Social Security recipients were privy to at the start of the current year.

Does Medicare supplemental insurance cover long term care?.

As everyone ages, their financial concerns and needs will change.

While you may be able to get away with a reduced amount of health insurance when younger, for example, you'll likely need a more robust policy after retiring. Similarly, you may find that your health insurance and Medicare coverage may not be enough. In these instances, a **Medicare supplemental** policy could be of use. You also may find yourself coming up short when it comes time to pay for in-home care or a nursing home or assisted living facility. In these unique

circumstances, you will have options to explore.

But does Medicare supplemental insurance also cover long term care? Or do you need to explore alternatives to help make ends meet? That's what we'll break down below.

Does Medicare supplemental insurance cover long term care?

In short, Medicare supplemental insurance (also known as Medigap) will only cover the gaps in coverage remaining after your Original Medicare plan has been applied. But that won't extend to covering



long term care, at least not for very long.

"Medicare and most health insurance, including Medicare Supplement Insurance (Medigap), don't pay for long-term care," **Medicare.gov**, a federal website, notes online.

"These plans are designed to fill in some of the gaps in Medicare coverage, but they do NOT cover most long term care services," the **Department of Financial Services** in New York explains.

That said, there may be some circumstances where a

supplement policy can assist, albeit not for an extended period of time.

"In general, Medicare Supplement plans don't cover long-term care or care longer than 100 days," insurance company **Humana** says online. "However, Medicare Supplement plans can help cover costs that Original Medicare doesn't cover. For example, Medicare Supplement plans can pick up the cost of daily coinsurance when staying at a skilled nursing facility from day 21 through day 100."

Private equity profiting wildly on home care at the expense of older adults

A new **report** from the Center for Economic and Policy Research, "Profiting at the Expense of Seniors: The Financialization of Home Health Care," finds that new policies at the Centers for Medicare and Medicaid Services (CMS), which administers Medicare, let private equity and other corporate players profit wildly from owning home health care agencies. At the same time, these corporate players shortchange people with Medicare, keeping them from getting **medically necessary home care** that Medicare covers.

Unlike in days of yore when home care agencies were often mom and pop shops and nonprofit agencies, today private equity firms and health insurance companies often own home health care agencies. And, their

incentive is to stint on care. The less care they cover, the more they profit. So, they override your treating physician regarding the care you need. They tend to think you don't need care or need less care.

CMS says it wants to crack down on fraud. But, in many ways, it is encourage it, allowing health insurance companies and private equity firms to direct care and not overseeing these profit-maximizing entities or holding them accountable for their bad acts.

The fraud and bad acts go beyond home health care; it is **pervasive in Medicare Advantage**. The CMS Medicare Advantage payment system is defective, allowing corporate insurers who run Medicare



Advantage plans to charge the government way more for their services than is appropriate. By CEPR's calculations, based on various Medicare Payment Advisory Commission (MedPac) studies, Medicare Advantage plans receive about 19 percent more for each enrollee than CMS spends on people in traditional Medicare.

Corporate insurance company overcharges drive up Medicare Part B premiums for everyone with Medicare. As a result, people in Original Medicare are helping to subsidize the corporate health insurers running Medicare Advantage. Everyone, including taxpayers, are paying more for Medicare than they should be paying.

"Medicare services are almost

entirely funded by the payroll taxes of working people. They deserve a health care system in their older years that is patient-centered, not profit-driven," said Eileen Appelbaum, one of the authors of the report. "The goal of CMS is to change Medicare as we know it by 2030, and Congress must rise to the occasion to protect patients and taxpayers."

Among other things, the report's authors recommend that Congress strengthen Traditional Medicare. CMS also must oversee the insurance companies and private equity firms operating home health agencies and hold them accountable for their bad acts.

Feds rein in use of predictive software that limits care for Medicare Advantage patients

Judith Sullivan was recovering from major surgery at a Connecticut nursing home in March when she got surprising news from her Medicare Advantage plan: It would no longer pay for her care because she was well enough to go home.

At the time, she could not walk more than a few feet, even with assistance — let alone manage the stairs to her front door, she said. She still needed help using a colostomy bag following major surgery.

"How could they make a decision like that without ever coming and seeing me?" said Sullivan, 76. "I still couldn't walk without one physical therapist

behind me and another next to me. Were they all coming home with me?"

UnitedHealthcare — the nation's largest health insurance company, which provides Sullivan's Medicare Advantage plan — doesn't have a crystal ball. It does have naviHealth, a care management company it bought in 2020, and one of several businesses that use computers to help insurance companies make coverage decisions.

Its proprietary "nH Predict" tool sifts through millions of medical records to match patients with similar diagnoses and characteristics, including age,



preexisting health conditions, and other factors. Based on these comparisons, an algorithm anticipates what kind of care a specific patient will need and for how long.

But patients, providers, and patient advocates in several states said they have noticed a suspicious coincidence: The tool often predicts a patient's date of discharge, which coincides with the date their insurer cuts off coverage, even if the patient needs further treatment that government-run Medicare would provide.

"When an algorithm does not

fully consider a patient's needs, there's a glaring mismatch," said Rajeev Kumar, a physician and the president-elect of the Society for Post-Acute and Long-Term Care Medicine, which represents long-term care practitioners. "That's where human intervention comes in."

The federal government will try to even the playing field next year, when the Centers for Medicare & Medicaid Services begins restricting how Medicare Advantage plans use predictive technology tools to make some coverage decisions. **Read More**

Insurers Are Gaming Medicare — To The Tune Of \$140 Billion

Medicare Advantage lets private insurance plans step in as a middle man. When the program was established in its current form in 2003, its proponents argued it would help save the government money on Medicare spending. However, **research** from the Medicare Payment Advisory Commission (MedPAC), an independent agency that advises Congress on Medicare, shows that the program has not yielded savings in the two decades since it was established.

Medicare Advantage plans receive a flat payment for the care they provide, strongly incentivizing the insurers sponsoring the plans to **ration care** — leading to high rates of wrongful claim denials, worse health outcomes, and costly

administrative headaches for providers.

These private plans have been under fire for the rate at which they deny patient care. As *The Lever* **reported**, these claims have a devastating cost to health outcomes but frequently save insurance companies money as patients forgo treatments they cannot afford.

Since then, claim denials have only increased. A report from the KFF (formerly known as the Kaiser Family Foundation), a major foundation that studies health policy issues, found that **two million** prior authorization requests were denied by Medicare Advantage in 2021 — significantly higher than the rates for traditional Medicare.



Since 2007, the share of beneficiaries enrolled in Medicare Advantage plans has tripled, far outpacing the growth of traditional Medicare enrollment.

Many people leave traditional Medicare for private plans, and once they do, an **administrative barrier** makes it difficult to return. That's because while Medicare covers 80 percent of patients' health care costs, the last 20 percent are usually covered by the individual or a supplementary plan called Medigap. But in most states, when someone leaves Medicare Advantage, often due to illness necessitating broader coverage networks, Medigap insurers can deny future coverage — effectively making their return to traditional Medicare

impossible.

As of this year, Medicare has reached a turning point: Medicare Advantage now **manages** care for over half of all eligible beneficiaries.

As patients are joining these for-profit plans, providers are leaving. Scripps Health, a major health care provider in San Diego, announced in late September that it would decline most Medicare Advantage plans moving forward, because of their practices.

Scripps CEO Chris Van Gorder **told MedPage Today**, "We are a patient care organization and not a patient denial organization and, in many ways, the model of managed care has always been about denying or delaying care — at least economically."

Aging in Place: What You Need to Know About Healthy Aging

Aging in place means living in the home of your choice—safely and independently—as you get older. It's about living out your golden years in comfort. But it requires planning for how you will deal with any challenges that may arise. In essence, healthy aging involves creating the right environment and putting supports in place that allow you to meet your ongoing physical and emotional needs.

Did you know that American seniors are healthier today than they have been in years past? One study found that older adults were **14 percent more likely** to say they were in excellent or very good health in 2014 than in 2000.

Successful aging is influenced by a range of factors, including diet, lifestyle, and genetics. The reality is that you can be healthy



at 50 or any other age by adopting a lifestyle that features regular exercise and a well-balanced diet. Of course, staying healthy and safe may require adapting your home to accommodate your changing needs, which you can read more about below.

This article outlines how the definition of successful aging has evolved over the past few decades. It also describes some

common diseases that often come with age and explains what you can do to reduce your chances of being affected by them. And it provides practical tips on how to successfully age in place.

- ◆ **What is successful aging? Changing definitions**
- ◆ **7 common diseases of aging and how to lower your odds of getting them**
- ◆ **4 tips on aging in place**

Republicans in Congress "outraged" by billions in Social Security overpayments to vulnerable older adults, silent about overpayments to insurers selling Medicare Advantage plans

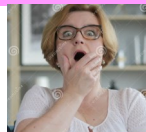
Kaiser Health News reports that Republicans in Congress are "outraged" by \$20 billion in Social Security overpayments to vulnerable older adults. What no one has reported is the silence among Republicans in Congress about the **hundreds of billion of dollars in overpayments over the last several years to insurers offering Medicare Advantage plans**. Apparently, when the recipient of billions in overpayments is a big corporation that supports their campaigns, Republican policymakers can look the other way.

These members of Congress want the Social Security Administration to answer for the Social Security overpayments. But, they don't seem to want the Centers for Medicare and Medicaid Services to answer for

the overpayments to insurance companies offering Medicare Advantage plans. Their silence suggests that they don't seem to want the corporate health insurers to return the tens of billions of Medicare dollars they have received.

Unlike the health insurers who have billions of dollars in their coffers to return the billions they were overpaid, a lot of the people who received Social Security overpayments are poor and no longer have the money they were overpaid. They can't repay it.

"The government's got to fix this," said Senator Sherrod Brown (D-Ohio). He chairs a Senate panel that oversees Social Security. Senator Brown also has called for **CMS to address the Medicare Advantage**



overpayments. Republicans in Congress are calling for a Congressional hearing and a fix to the Social Security overpayments but have been silent about Medicare Advantage overpayments. For example, Senator Rick Scott of Florida, who is a member of the Committee on Aging, asked about how the Social Security overpayments grew to \$20 billion and wants someone to be held accountable "for, you know, messing this up." He has never spoken about Medicare Advantage overpayments. let alone called for a hearing about them or questioned CMS for making them.

Older adults are receiving overpayment notices from Social Security. They are losing sleep,

unable to pay the money back. In one case, Social Security demanded a woman repay \$5,575 in retirement benefits. It then stopped sending her checks in order to recoup the money. No one in Congress has suggested that CMS should withhold payments to Medicare Advantage plans to collect the tens of billions in overpayments CMS has not received back.

Some members of Congress are calling for Social Security to stop trying to collect the overpayments from their constituents. It was not their mistake. But, again, few in Congress and no Republicans are calling on CMS to collect back overpayments from corporate health insurers, stemming from their overcharges.

Medicare Rights' Helpline Trends Report Shows Increasing Need for Help Affording Care

This week, we at Medicare Rights released our annual **Medicare Trends Report**, which features key challenges facing people with Medicare and recommends ways to improve the program. Drawn from our work helping people with Medicare, caregivers, and professionals in 2022, the report includes an analysis of call data from our **national helpline**, professional email channels, and online reference tool **Medicare Interactive** (MI). As in prior years, calls about affordability, enrollment, and coverage denials were the most common.

Last year, our staff and volunteers addressed more than 27,000 questions through our helpline and email channels and provided more than 2.6 million answers through MI. We assisted clients in all 50 states, Puerto Rico, and the U.S. Virgin Islands, as well as U.S. citizens living abroad. Most of the beneficiaries who reached out were Medicare eligible due to age (78%), while 17% were eligible due to a disability and 1% due to a diagnosis of End-Stage Renal Disease (ESRD). People who were dually eligible for both Medicare and Medicaid accounted for 20% of all helpline callers.

Affordability

On the helpline, 36% of all calls related to problems affording Medicare premiums, cost-sharing, and Part D prescription drugs. This is a 24%

jump from the previous two years and the first time in recent memory that cost concerns outnumbered questions about Medicare enrollment. Many of these calls related to or revealed eligibility for low-income assistance programs. As we have **highlighted before**, many people who qualify for this help are not aware of or enrolled in the programs, including **Medicare Savings Programs** (MSPs), which pay Part B premiums and, in some cases, deductibles, copays, and coinsurance; **Extra Help** (also called the Low-Income Subsidy (LIS)), which lowers a beneficiary's Part D prescription drug costs; and **Medicaid**. Each of these programs offers critical financial assistance, which in turn allows beneficiaries to afford their coverage and care, as well as other basic services that may otherwise be out of reach.

In our policy recommendations, we recommend increasing eligibility, easing enrollment, and maximizing outreach to boost participation in these vital programs. Additionally, we urge structural changes to improve Medicare affordability, including the creation of an out-of-pocket cap for original Medicare and adequate funding for **State Health Insurance Assistance Programs** (SHIPs) that provide one-on-one counseling to people with Medicare, including to help



them evaluate their coverage options and apply for available assistance.

Enrollment

Medicare enrollment was again a top trend, comprising 26% of all calls. Frequent questions included **how to enroll in Medicare when first eligible**, how to qualify for **Special Enrollment Periods (SEPs)**, and when to use the General Enrollment Period (GEP). Often, clients were confused about enrollment rules and timelines, where to find clear information, and the consequences of delaying enrollment.

Historically, enrollment was the most common topic for calls to our helpline. Recent improvements to the enrollment process may have helped ease some enrollment concerns, but more must be done to help people connect with their coverage. We continue to urge policymakers to start **sending a notice to people who are approaching Medicare eligibility** to ensure they are aware of their rights and obligations. We also support reconsideration of Medicare's late enrollment penalties, better relief for those who make enrollment mistakes, and higher quality tools to support beneficiary decision-making, including when choosing between original Medicare and Medicare Advantage (MA) and selecting a Part D drug plan.

Denials and Appeals

A third key trend, denials and appeals, represented 29% of all calls. A majority were from MA enrollees experiencing care access issues, including uncertainty about covered services, billing problems, and coverage denials. Challenges navigating the complex MA and Part D appeals process were also prominent.

We urge policymakers to curb the **burden of prior authorization** and **inappropriate denials of care**, **streamline cumbersome appeals processes**, **improve data and transparency**, and standardize and improve supplemental benefits, including by **expanding such benefits** to people with original Medicare.

Medicare Interactive engagements show a similar pattern. The most common MI section visited was "Medicare-Covered Services," with 965,468 visits. **"Medicare Health Coverage Options," "Medicare Basics,"** and **"Cost-Saving Programs for People with Medicare"** also ranked highly.

These trends show continued and increasing needs for better affordability, better enrollment, and better access to care within the Medicare program. Medicare is a lifeline for millions of older adults and people with disabilities, and we will continue to pursue improvements to ensure its stability and value to beneficiaries for decades to come.

How to approach Medicare's 2023 enrollment period

The Inflation Reduction Act may affect how some beneficiaries want or need to structure their coverage

Medicare's annual enrollment period begins on Oct. 15 and lasts until Dec. 7, but beneficiaries shouldn't wait until the last minute to review their insurance coverage and make changes.

There are three P's to focus on, said Ari Parker, co-founder and lead adviser at Chapter, a company that specializes in maximizing Medicare coverage: providers, prescriptions, and priorities. The Medicare options a beneficiary chooses affect all three, and all three affect their

coverage in return.

For example, not all doctors may be covered under one option, so someone who wants to see a specific specialist (or more) should make sure they're in a network when switching plans. Beneficiaries should also be hyper-aware of the prescriptions covered under the drug plan they choose. If they choose to travel internationally, or if they expect to be in multiple states for months at a time throughout the year, they should take that into consideration when making Medicare coverage decisions too, Parker said.



Keep in mind what your budget is, and how your insurance fits within that budget, said Christopher Ciano, president of Aetna

Medicare. Look at all out-of-pocket costs, premiums, copayments, deductibles and coinsurance. What medication may you be expected to start next year, and how does that fit into your current or potentially new plan? Check that even if you were to stay with the plan you already have, these prices and figures aren't changing, he added.

Not everyone needs to switch insurance plans during this

period, but they should at least check their current plans as those may have changes for next year. Sticking with your current coverage could make sense, or it could cost individuals **hundreds or more dollars** a year.

The changes expected next year from the Inflation Reduction Act is another incentive to get serious about Medicare coverage this year. Older Americans won't see their annual medical costs cut, significantly for some, for a few more years, but they can expect to pay less for insulin beginning next year, Ciano said. ...**Read More**

'Boarding' Patients for Days, Weeks in Crowded ERs Is Common Now

When Hannah, a California marketing professional, showed up at her local emergency room in March 2023 for a pregnancy-related complication, she wasn't prepared for what happened next.

"I arrived at 2 p.m. and finally saw the obstetrics team at midnight," she recalled.

After an exam, doctors scheduled her for a procedure on the following day, but there wasn't a room available. "I ended up spending the night in a makeshift room in the lobby of the emergency room with a plastic sheet separating me from the rest of the people waiting for attention," Hannah said.

Unfortunately, this is not rare in U.S. emergency departments. Millions of people a day go to

emergency rooms to seek care, but many, like Hannah, end up in a holding pattern due to overcrowding.

This is known as boarding, and experts say the problem is only getting worse.

"We are facing a national public health crisis," **Dr. Aisha Terry**, associate professor of emergency medicine at George Washington University School of Medicine and Health Sciences in Washington, D.C., and ACEP's president-elect, said Tuesday.

Speaking at an ACEP press briefing, Terry said that "emergency departments are overflowing, emergency physicians are overwhelmed, and patient care is at risk."



Research consistently shows that boarding leads to worse outcomes, medical errors, privacy issues and in some cases, death, she said.

Some people spend weeks, even months, waiting to get a room in the hospital or be transferred to an outside facility.

"It's jaw-dropping when you think about the length of time that people are waiting in the emergency department since there is no space to care for them," Terry said.

Boarding has been an issue for decades, but stresses owing to the COVID-19 pandemic such as staffing shortages and an uptick in mental health conditions have made it much worse.

In a new **ACEP poll** of 2,164 U.S. adults, 44% of respondents said they or a loved one experienced long waits in emergency departments, with 16% waiting 13 or more hours before being admitted or transferred. Almost half of adults surveyed said they would delay emergency care if they knew they could face boarding.

In all, 42% said hospitals should be primarily responsible for improving the situation, while 17% said Congress should pass legislation addressing boarding. Sixteen percent said insurers should ease cumbersome prior-authorization policies that can result in days-long waits for transfer to a skilled nursing facility....**[Read More](#)**

Study Confirms Risk of Gastro Issues for People Taking Wegovy, Ozempic

While many have raved about the powers of popular weight-loss drugs like Wegovy and Ozempic, new research confirms the medications can trigger some nasty gastrointestinal side effects.

Known as GLP-1 agonists, they may increase the risk of stomach paralysis, pancreatitis and bowel obstruction, scientists found.

"Although the incidence of these adverse events are relatively rare, affecting only about 1% of patients, with millions taking these medications, thousands of people are likely to be affected by these

adverse events," said lead researcher **Dr. Mohit Sodhi**, from the University of British Columbia in Vancouver.

"Patients need to weigh the risks and benefits before taking these medications for weight loss," he said. "We encourage patients who are interested in using these medications to have a lengthy conversation with their physician to see if this medication is appropriate for their goals and what they hope to achieve."

GLP-1 agonists were originally developed to help manage type 2



diabetes by lowering blood sugar, but they also promote weight loss and have been used off-label for more than a decade. In 2021, some forms of these drugs were approved to treat obesity.

Most patients experience symptoms like constipation and nausea, so the possibility of these more serious side effects is not surprising, said **Dr. Caroline Messer**, an endocrinologist at Lenox Hill Hospital in New York City.

Still, "patients really shouldn't be worrying about pancreatitis

any more than vaguely worrying about pancreatitis anytime they were committed to losing an excessive amount of weight quickly," she said.

"We're all aware of all these side effects," Messer said, but the benefit of losing 40 to 50 pounds clearly outweighs the small risk of these side effects.

"You decrease your risk of gout, heart disease, strokes, heart attacks and diabetes, so these risks in no way convince me to stop prescribing these medications," Messer said....**[Read More](#)**

How to treat a runny nose?

Are you taking DayQuil or Sudafed PE for a runny nose? It's probably time to stop. An FDA panel recently declared that the decongestant in many over-the-counter oral cold medicines doesn't work, reports the **American Academy of Family Physicians**.

The decongestant in many over-the-counter oral cold and allergy medicines that appears to be no more than a placebo is phenylephrine. It's been around for many years now. And, you can find it in dozens of brand-name cold and allergy medicines you buy at the drugstore.

It took the FDA more than three decades to come out with a ruling. Experts have been calling for the FDA to make a finding about the lack of efficacy since at least 1992, reports Christina Jewett for **The New York Times**.

Sudafed PE, TheraFlu, Vicks NyQuil Sinex Nighttime Sinus Relief and Benadryl Allergy Plus Congestion are just a few of the common oral cold remedies that include phenylephrine. Shockingly, phenylephrine is more popular than any other oral decongestant in the United States.



It led to just under \$2 billion in sales last year. If phenylephrine worked, it would keep down the swelling in your nose.

But, when you take it orally, most of it does not travel to your nose. So, it cannot end your congestion; your nose remains stuffy.

The FDA now says that oral phenylephrine cannot be categorized as generally safe and effective since it is definitely not effective. As a result, manufacturers of decongestants with oral phenylephrine might have to pull their cold medicines

that include it from store shelves. The FDA has not ruled on that yet.

Phenylephrine has side effects, including headaches, inability to sleep and agita. It can also sometimes increase blood pressure.

Note: Phenylephrine sprays do work because they travel directly to your nasal passages. Moreover, many of the products containing oral phenylephrine contain other products that can help with cold and allergy symptoms.

Seniors With ADHD Face Higher Car Crash Risk

While studies of ADHD and driving usually target teens, a new one focused on seniors found they have a significantly higher risk of car crashes.

Older adults with attention-deficit/hyperactivity disorder (ADHD) were also more likely to slam on the brakes and get traffic tickets, **the study** found.

"Little is known about ADHD in seniors," said senior author **Dr. Guohua Li**, an epidemiology professor at Columbia University Mailman School of Public Health in New York City, explaining the motivations for studying this issue. "Secondly, the population has been aging and continues to grow older, and there are more and more older adult drivers on

the road."

The United States has about 48 million older drivers, a number that could reach 63 million within seven years, he noted.

This study included more than 2,800 drivers between 65 and 79 years of age. About 2.6% had ADHD.

The researchers linked ADHD to a 74% increased risk of crashes, a 102% increased risk in self-reported traffic tickets and a 7% increased risk of hard braking events.

ADHD is a neurodevelopmental condition that is often diagnosed during childhood and can persist throughout life.

About 8% of adults aged 18 to



44 are known to have ADHD, the researchers said in background notes, as are 9% to 13% of children under 18.

ADHD symptoms that might contribute to driving challenges include difficulty with concentration, focus and attention. Hyperactivity can increase distraction and decrease vigilance, Li said. Impulsivity may lead to behaviors like speeding and running red lights, he added.

"Those symptoms associated with ADHD could affect driving safety in different ways," Li said.

To study this, the researchers collected data between 2015 and 2017 from primary care clinics and residential communities in

Ann Arbor, Mich.; Baltimore; Cooperstown, N.Y.; Denver; and San Diego.

Participants were active drivers who were followed for 44 months using in-vehicle devices to record data.

Dr. Eugene Arnold, a resident expert for CHADD, a nonprofit that helps people with ADHD, said the study confirms what experts may have expected about older drivers with ADHD.

"Of course, there's impairment of the executive function, the ability to plan your work and work your plan," said Arnold, who reviewed the new study findings....**[Read More](#)**

Shorter Course of Radiation May Be Safe for Women Undergoing Breast Reconstruction

Breast cancer patients who undergo a mastectomy can probably benefit from a shorter course of more intense radiation therapy, a new study indicates.

Hypofractionated radiation therapy — which provides a higher dose each session over three weeks — provides the same protection against breast cancer recurrence and post-surgical complications as a standard course of lower-dose radiation over five weeks, researchers from Dana-Farber Brigham Cancer Center in Boston found.

"Our trial results suggest that hypofractionation can safely be used in this setting without compromising efficacy or increasing side effects," said

senior study author **Dr. Rinaa Punglia**, a radiation oncologist at Dana-Farber.

"Reducing the requirement to three weeks of radiation therapy would be a significant improvement in the quality of our patients' lives," she said in a Dana-Farber news release.

Punglia and her team reported the results of the clinical trial on Sunday at the American Society for Radiation Oncology's annual meeting in San Diego. Such research is considered preliminary until published in a peer-reviewed journal.

Many patients with breast cancer opt for a mastectomy as part of their treatment, to reduce



the risk of their cancer coming back. One out of three of those patients will need post-mastectomy radiation therapy to further reduce

the risk of recurrence, the researchers explained in background notes.

More women now also opt for implant-based reconstruction to be done as part of the mastectomy, but radiation therapy increases the risk of complications with the breast reconstruction, the researchers added.

These complications can include infection and the formation of scar tissue around the breast that causes hardness and asymmetry.

"We know that radiation can cause unwanted changes to cosmetic results in patients who have mastectomy and reconstruction," said lead researcher **Dr. Julia Wong**, a radiation oncologist at Dana-Farber Brigham Cancer Center. "With this trial, we were looking for a way to improve quality of life and cosmetic results without sacrificing efficacy."

To compare the two different courses of radiation therapy, researchers recruited 400 breast cancer patients who were treated with mastectomy and breast reconstruction. The patients were randomly assigned to either hypofractionated or standard radiation therapy....**[Read More](#)**

Ketamine Nasal Spray Shows Promise Against Tough-to-Treat Depression

A nasal spray containing a ketamine derivative appears to beat one of the standard drugs used for people with difficult-to-treat depression, a new clinical trial has found.

The trial, of nearly 700 people with treatment-resistant depression, found that esketamine nasal spray was more effective at sending patients into remission than a standard oral drug called quetiapine (Seroquel).

After eight weeks, 27% of esketamine patients were in

remission, versus 18% of those given quetiapine. By week 32, half of esketamine patients were faring that well, compared with one-third of those on quetiapine.

Experts said the findings, published in the Oct. 5 issue of the ***New England Journal of Medicine***, strengthen the case that esketamine is a good option for people with treatment-resistant depression.

The condition, which plagues up to 30% of people with



depression, is generally diagnosed when a person's symptoms have failed to yield to at least two standard antidepressants. It's a situation that places people at increased risk of hospitalization and suicide.

There are a few medications approved in the United States as an "augmentation" therapy for treatment-resistant depression — meaning they are used along with a standard antidepressant.

Quetiapine is one of them, and so is esketamine nasal spray,

which has been available since 2019 under the brand-name Spravato.

That approval was based on research testing esketamine against a placebo nasal spray.

The new trial is the first to compare esketamine against another commonly used add-on drug, said lead researcher **Dr. Andreas Reif**, head of psychiatry at University Hospital Frankfurt-Goethe University, in Germany....**[Read More](#)**

CPAP Helps Cut Heart Risks — But You Have to Actually Use It

For sufferers of sleep apnea, continuous positive airway pressure (CPAP) machines may guard against having a second heart attack, stroke or other cardiovascular crisis, but they have to use it consistently, a new study finds.

CPAP works by keeping your airways open during sleep, but because it requires wearing a mask, many people find it uncomfortable so they don't keep it on the amount of time needed to protect against heart problems. CPAP needs to be used at least four hours a night, and preferably six hours, to effectively prevent second strokes or heart attacks, experts say.

"This is the first analysis that, based on existing trials, demonstrates that the use of CPAP is associated with a 31% reduction in the risk of having a second heart attack or stroke," said lead researcher **Dr. Ferran Barbe**. He is chair of respiratory medicine at the Hospital Universitari Arnau de Vilanova de Lleida of the University of Lleida in Catalonia, Spain.

Still, "treatment compliance is a key factor in secondary cardiovascular prevention in patients with sleep apnea," he said.

For the study, Barbe and his



colleagues examined the outcomes of nearly 4,200 patients included in 24 previously published studies. All the patients had sleep apnea, suffered a cardiovascular event and were using CPAP.

The investigators found that patients who used CPAP for four or more hours a night were less likely to suffer a second heart attack or stroke than those who used the device less often.

The report was published Oct. 3 in the ***Journal of the American Medical Association***.

"Sleep apnea is associated with an increased risk of cardiovascular illnesses and

cerebrovascular illnesses, namely high blood pressure, atrial fibrillation, heart attacks and strokes," said **Dr. Harly Greenberg**, medical director of Northwell Health Sleep Disorders Center in New Hyde Park, N.Y.

A number of studies done in Europe, particularly in France, have shown a positive effect of CPAP preventing death and future occurrence of cardiovascular events, Greenberg said, "but you have to use the therapy for at least four hours, preferably six hours, a night to get an impact." ...[Read More](#)

Largest-Ever Study of Suicide Genetics Gives Clues to Who's at Risk

New research has discovered 12 gene variants that may be tied to an increased risk of attempting suicide.

These genes also may have links with physical and mental health woes, including chronic pain, attention-deficit/hyperactivity disorder (ADHD), lung conditions and heart disease.

The researchers hope this finding, published online Oct. 1 in the ***American Journal of Psychiatry***, will lead to better understanding of the biological causes of suicide.

"Many people who die from suicide have significant health conditions associated with that risk," said study corresponding author **Anna Docherty**, an associate professor of psychiatry at the Huntsman Mental Health

Institute (HMHI) at the University of Utah. "If we can use genetic information to

characterize the health risks of those who attempt suicide, we can better identify those patients who need contact with the mental health care system."

For the study, the investigators analyzed data from 22 different populations, including people of diverse ethnic backgrounds.

What they found wasn't one single gene influencing risk, but the cumulative effect of different genes.

"In psychiatry, we have many tiny genetic effects, but when we account for all of them together, we start to see a real genetic risk signal," Docherty explained in a university news release.



To assess that risk, the team broke down data from the Million Veteran Program and the International Suicide Genetics Consortium.

That data included nearly 44,000 documented suicide attempts and more than 915,000 ancestry-matched people who served as the study's control group.

After a meta-analysis of the studies uncovered the genetic variants associated with suicide attempt, the team compared these with previously published genetic data on more than 1,000 other health issues.

"That allowed us to look at how genetic risk for suicide overlaps with genetic risk for depression, heart disease and many other risk

factors," Docherty explained. "It showed significant overlap with mental health conditions, but also a lot of physical health conditions, particularly for smoking and lung-related illnesses. This is something we can't necessarily see in medical records of people who die from suicide."

That doesn't mean that someone with one of these health factors is at high risk for attempting suicide, said study co-author **Hilary Coon**, a professor of psychiatry at HMHI, but genetic predisposition combined with other stressors could increase risk. ...[Read More](#)

What Every Woman Needs to Know About Breast Cancer Screening

Catching breast cancer early is key to making it easier to treat and survive, according to the American Cancer Society (ACS).

The organization aims to highlight early detection, noting that screening with mammography has helped breast cancer death rates drop 43% since 1989.

"Breast cancer is the most common cancer in women (after skin cancer) and the second most common cause of cancer mortality. Breast cancer screening with mammography is important because early detection saves lives," said **Robert Smith**, senior

vice president of early cancer detection science for the cancer society.

"Research has shown regular mammograms are associated with a substantially reduced risk of dying from breast cancer," Smith said in an ACS news release.

ACS guidelines encourage average-risk women to begin regular screening mammograms — a low-dose X-ray image of the breasts — at age 45. It's an option to begin screening as early as age 40, according to the guidelines, which were created by a panel of doctors and patient advocates.



Annual screening should continue up until age 55 and then can transition to biennial screening, if a woman prefers.

Women should also speak with their doctor about family history, genetics and lifestyle choices that can influence risk, as well as familiarize themselves with how their breasts normally look and feel.

At age 75, women can continue getting mammograms if they're in good health and expected to live at least 10 more years, the ACS suggests.

Particular women who are at

high risk for breast cancer based on certain factors should get a breast MRI and a mammogram every year.

"Women who receive regular mammograms and are diagnosed with breast cancer are more likely to be diagnosed earlier, less likely to need aggressive treatments and more likely to be cured," Smith said. "Once a woman begins breast cancer screening, it is important that she commits to regular, on-time examinations. Regular screening, rather than irregular or occasional screening, offers the greatest benefit."

In Early Trial, Promising Results for Moderna's Combo COVID-Flu Vaccine

Moderna Inc. announced Wednesday that it has seen positive early results with a new vaccine that would guard against four strains of flu plus COVID-19.

In interim findings from a Phase 1/2 trial, the vaccine showed both a strong immune response compared to the standard dose of flu vaccine in adults aged 50 to 64 and an enhanced flu shot in people aged 65 to 79. It also showed a strong response in comparison to Moderna's COVID vaccine.

The new shot also appeared to be safe, with side effects similar to those people had with Moderna's COVID shots.

"With today's positive results from our combination vaccine against flu and COVID-19, we continue to expand our Phase 3 pipeline," Moderna CEO **Stéphane Bancel** said in a company [news release](#).

"Flu and COVID-19 represent a significant seasonal burden for individuals, providers, health care



systems and economies. Combination vaccines offer an important opportunity to improve consumer and provider experience, increase compliance with public health recommendations, and deliver value for health care systems," Bancel added.

Moderna noted that the flu places a substantial burden on health care systems every year, severely sickening 3 million to 5 million people and causing between 290,000 and 650,000

deaths. Older adults are disproportionately affected.

Meanwhile, COVID-19 is the leading cause of severe illness and death throughout the world since the pandemic began in 2020.

Globally, there have been about 770 million cases of COVID-19 and 7 million deaths reported globally. Severe illness and death are also seen in greater numbers in older people and those with pre-existing medical conditions....[Read More](#)

Cancer Drug Shortages Persist Across U.S.

U.S. cancer centers continue to have shortages of commonly used chemotherapy drugs, a new survey shows, though the medications are not as scarce as they were last June.

The National Comprehensive Cancer Network (NCCN), a nonprofit alliance of leading cancer centers, [surveyed](#) its network in September. In all, 72% of cancer centers surveyed reported a continued shortage of **carboplatin**. And 59% were still seeing a shortage of **cisplatin**.

These two platinum-based generic chemotherapy

medications are recommended for treating many different cancers.

Overall, 86% of centers surveyed said they were short on at least one type of anti-cancer drug.

A survey in June showed that 93% of cancer centers had a shortage of carboplatin, and 70% of cisplatin.

"Everyone with cancer should have access to the best possible treatment according to the latest evidence and expert consensus guidelines," said **Dr. Robert Carlson**, chief executive officer for NCCN.



"Drug shortages aren't new, but the widespread impact makes this one particularly alarming. It is extremely concerning that this situation continues despite significant attention and effort over the past few months. We need enduring solutions in order to safeguard people with cancer and address any disparities in care," Carlson said in a NCCN news release.

Twenty-nine of the NCCN's member institutions responded to the September survey. They include leading academic centers across the United States.

The findings may not reflect additional challenges that smaller community practices serving rural and marginalized patients are experiencing.

The centers surveyed were using strict waste management strategies, so nearly all were still able to provide the medications to all patients who needed them.

Other medications in short supply included methotrexate, with 66% of centers reporting a shortage; 5-fluorouracil, with 55% falling short; fludarabine at 45%; and hydrocortisone at 41%....[Read More](#)

Common Age-Related Eye Diseases: What to Know and What You Can Do

While it's normal to experience some vision changes as we age, we shouldn't assume that all gradual or sudden vision changes are simply part of growing older.

Of course, natural changes occur in our eyes over time. And with age, we are also at increased risk for developing age-related eye diseases, including cataracts, glaucoma, diabetic retinopathy, macular degeneration, and more.

Regular eye exams help your eye doctor identify which vision changes are expected with aging versus conditions requiring continued monitoring or targeted treatment. If anyone experiences sudden vision loss, any sudden changes in distance vision, arm's length vision, or near vision—changes in central or peripheral vision—or experiences any pain in the eyes—they should always have that checked by an eye doctor.

Early diagnosis of any age-related eye diseases is crucial. For example, if you have diabetes, you should have a dilated eye examination every year. Depending on the condition, you might need ongoing eye care on a more routine basis. It's also important to let your eye doctor know about eye conditions experienced by your family members. Again, being proactive with your doctor about your eye health.

What are some common age-related eye diseases?

- ◆ **Cataracts**
- ◆ **Glaucoma**
- ◆ **Refraction changes, floaters, dry eyes, and other age-related eye issue**
- ◆ **Macular degeneration**
- ◆ **Diabetic retinopathy**



Hope and acceptance with vision loss

Despite age, hope and acceptance are crucial to living a full life with blindness or low vision. Eye doctors, including low-vision specialists, can help patients manage their eye treatment effectively and provide a vital referral for comprehensive, multi-disciplinary vision rehabilitation services. This referral is clearly in the patient's best interests because it addresses the eyes, the head, and the heart. From a psychosocial side, a person with vision loss can access support and begin to walk that bridge of acceptance. Rather than building anger, depression, and frustration, they can avoid defining themselves by their vision loss through vision rehabilitation, counseling, and other support.

Living a safe, confident, and independent life with vision loss

Advocacy from a supportive family, caregivers, and friends, self-advocacy, and interactions with older adults facing similar challenges - including support groups - can help ease the transition one experiences with blindness and low vision.

How can vision rehabilitation help with vision loss?

Vision rehabilitation can help adults with blindness and low vision remain active and independent. For example:

- ◆ **Independent living skills training**
- ◆ **Access technology training Orientation and mobility training**
- ◆ **Vocation rehabilitation**
- ◆ **Support groups...[Read More](#)**