

## September 24, 2023 E-Newsletter



### Message from the Alliance for Retired Americans Leaders

#### Alliance Supports Striking UAW Workers



Robert Roach, Jr.,  
President, ARA

Contracts between the United Auto Workers union and Detroit's Big Three expired at 11:59 p.m. Thursday, and autoworkers **began a stand-up strike** Friday at three assembly plants. UAW president Shawn Fain said it is still possible that all 146,000 UAW members could walk out.

"The 4.4 million retiree members of the Alliance for Retired Americans stand shoulder to shoulder with the United Auto Workers' fight to secure better wages and retirement security for their working members and retirees," said **Robert Roach, Jr., President of the Alliance**. "No one wants a strike, but sometimes they are necessary. In this case, the auto corporations are making money hand over fist but they don't want to give their workers a fair share of the wealth they helped create."

This is the first time in the union's history that it has **struck** all three companies at the same time. The Big Three are General Motors, Ford Motor Company and Stellantis, a multinational corporation formed from the merger of the Italian-American conglomerate Fiat Chrysler Automobiles and the French PSA Group.

Profits at the "Big 3" **skyrocketed 92%** from 2013 to 2022, totaling \$250 billion, and

forecasts for 2023 expect more than \$32 billion in additional profits. CEO pay at the Big 3 companies has jumped by 40% during the same period as the companies paid out nearly \$66 billion in shareholder dividend payments and stock buybacks.

"The UAW believes that a fair share means wage increases and retirement security," President Roach continued. "UAW workers who were hired after 2007 do not have guaranteed pensions. Their 401(k) plans are without the security of a pension. Workers deserve better. Our Alliance retiree members stand in solidarity with the UAW. One More Day!

#### Action Needed:

#### How You Can Help

**If you live near the following locations, please join the picket lines.**

- ♦ **General Motors assembly plant in Wentzville, Missouri: 1500 State Highway A;**
- ♦ **Ford assembly plant in Wayne, Michigan: 38303 Michigan Avenue; and**
- ♦ **Stellantis Jeep plant in Toledo, Ohio: 3800 Stickney Avenue**

#### Alliance Members Rally to Repeal Social Security Provisions That Punish Public Servants

Alliance members and their allies rallied on Capitol Hill Wednesday to pass the bipartisan **Social Security Fairness Act**, which repeals the unfair Windfall Elimination Provision (WEP) and Government Pension

Offset (GPO). left: President Roach with Maryland/DC Alliance President Carol Rosenblatt Wednesday; right: President Roach with AFT President Randy Weingarten

The WEP reduces the Social Security benefits of a public sector worker who collects a pension from a job not covered by Social Security, while the GPO reduces Social Security spousal or survivor retirement benefits of a worker who collects a public pension from a job not covered by Social Security. Hundreds of thousands of Americans who worked as teachers, fire fighters, police officers or in government and their families are affected by the reductions as they currently stand.

Representatives Garret Graves (LA) and Abigail Spanberger (VA) and Senators Sherrod Brown (OH) and Susan Collins (ME) introduced the Social Security Fairness Act in the House as H.R. 82 and Senate S.597, respectively.

American Federation of Teachers President Randy Weingarten, Alliance President Roach and Connecticut Alliance President Bette Marafino each spoke at the Wednesday event in front of dozens of supporters. Ms. Marafino and the

Connecticut Alliance played a key role in creating the National WEP/GPO Repeal Task Force that organized the event.

The Social Security 2100 Act, introduced by Rep. John Larson (CT) in the House as H.R. 4583 and in the Senate by Sen. Richard Blumenthal (CT) as S. 2280, also repeals the WEP and the GPO while strengthening Social Security

"The WEP and GPO are cruel and affect moderate and low-income retirees the most," said President Roach. "83% of all Americans subject to the GPO are women, who are already more likely to fall into poverty as they age."

#### Sign Our Petitions Below

There are over 111,000 singers on our **Repeal The WEP/GPO Petition**

**NEA Fully Repeal Unfair Social Security Penalties Petition**

**AARP Supports the Repeal of the WEP/GPO Petition**



American Federation of Teachers  
President Randy Weingarten  
Alliance President Robert Roach, Jr.

ADD  
YOUR  
NAME

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

Rhode Island Alliance for Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381

[riarajap@hotmail.com](mailto:riarajap@hotmail.com) • <http://www.facebook.com/groups/354516807278/>

## A newly reintroduced bill, the SSI Savings Penalty Elimination Act (H.R. 5408)

### New Bill Would Raise Harsh Supplemental Security Income Savings Limits



Joseph Peters  
ARA  
Sec.-Trea.

A newly reintroduced bill, the **SSI Savings Penalty Elimination Act** (H.R. 5408 in the U.S. House), would provide relief for people with low incomes or

disabilities and older people who receive Supplemental Security Income (SSI), all of whom face the **strictest savings limits** of

any federal program. Advocates for people with disabilities and economically disadvantaged seniors say asset limits of no more than \$2,000 for individuals and \$3,000 for couples means these don't leave enough to weather an emergency, let alone provide stability or save for the future.

The bipartisan bill that adjusts those low figures, introduced by Sens. Sherrod Brown (D-OH) and Bill Cassidy (R-LA) and Reps. Brian Higgins (D-NY) and Brian Fitzpatrick (R-PA), would

raise the limits to \$10,000 for individuals and \$20,000 for couples, improving beneficiaries' well-being. The bill would also improve program administration, reducing strain on an underfunded Social Security Administration (SSA).

Because the current limits aren't indexed to inflation and have been updated only once in over 50 years, their value erodes each year. They now stand at only one-fifth of their 1972 value.

"Many individuals who

receive SSI want to work and do work," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "However, the extremely low asset limits prevent people from saving money from paid work for fear that they could be kicked off SSI if they save over \$2,000."

That fear of disqualification is justified: tens of thousands of recipients see their benefits suspended or permanently revoked each year for exceeding the asset cap.

## How Much Will Your "Free" Medicare Advantage Plan Really Cost?

When it comes time to shop for Medicare coverage, Medicare Advantage plans have become a very popular option. **More than half (51%) of eligible Medicare beneficiaries are enrolled in Medicare Advantage in 2023. That's an increase of 19% to 46% from 2007 to 2021.**

What makes these plans so popular? One reason might be costs, specifically the low monthly premiums. **Zero-premium plans are available to 99% of beneficiaries.** And for many, no premium equates to free. I lost count of the number of times someone has talked about their "free" Medicare Advantage plan.

Consider this recent situation. In August, a large health system reported that it may stop accepting Medicare Advantage

plans. A local news station interviewed a Medicare Advantage plan member, who said that this will "be a financial burden for a lot of people because (her plan) is free."

The article noted the insurance company but did not identify her specific plan. In her community, this insurer sponsors four plans with health and drug coverage so I decided to check them out. Three have monthly premiums, ranging from \$40-\$200 so they could not be considered free.

The fourth has no monthly premium, no health plan deductible, and no copayment for the primary physician, a good start toward free. However, there are out-of-pocket costs for many services. For example, up to \$40 for a specialist visit, \$40 for a



physical therapy visit, \$405 for the first four days of inpatient hospitalization, and 20% for chemotherapy. Those who chose this specific coverage will write checks up to the plan's maximum out-of-pocket limit, which is \$6,200 in-network this year.

### A chance to review your coverage

Open Enrollment begins next month, October 15. This is the opportunity to shop for and change Medicare Advantage plans. If you're in the market for a new plan, here are some tips to help you find the most cost-effective one.

- ◆ When shopping for coverage, go beyond the monthly premium.
- ◆ Investigate the healthcare

services you will/may need and the costs. The plan's Evidence of Coverage will have the details. (Find this document on the plan's website.)

### ◆ Pay attention to the plan's out-of-pocket maximum.

This is the most you could pay if you have an accident or face a serious medical issue. In 2023, Medicare has set the maximum limits at **\$8,300 for in-network services and \$12,450 for in- and out-of-network combined.** **The average limits for those with Medicare Advantage are \$4,835 and \$8,659.**

- ◆ And remember this. A zero-premium Medicare Advantage plan is free only if you never need any medical care.

## US Chamber of Commerce urges judge to block Medicare drug pricing program

A lawyer for the U.S. Chamber of Commerce on Friday urged a federal judge to block President Joe Biden's administration from implementing a new program that would let Medicare negotiate prices with pharmaceutical companies for selected costly drugs.

Jeffrey Bucholtz, the business group's attorney, told U.S. District Judge Michael Newman in Dayton, Ohio, that the program violated drugmakers' due process rights by giving the government the power to effectively dictate prices for their medicines.

"There is a very, very high risk, maybe a guarantee, but certainly a very, very high risk, that this regime will result in prices that are unfair," Bucholtz argued.

The program, which was established by Biden's signature Inflation Reduction Act, aims to save \$25 billion annually by 2031 through price negotiations for the drugs most costly to Medicare, which mostly serves Americans aged 65 and older.

Americans pay more for prescription medicines than people in any other country.

Bucholtz urged Newman to block the program before Oct.



1, when the makers of the first 10 drugs picked by the U.S.

Centers for Medicare and Medicaid Services for inclusion in the program must agree to start negotiations over prices.

Those drugs, **announced on Aug. 29,** include the blood thinners Eliquis from Bristol-Myers Squibb, Pfizer, and Xarelto from Johnson & Johnson; Merck & Co's diabetes drug Januvia; and AbbVie's leukemia treatment Imbruvica.

Pricing changes following negotiations on the 10 drugs would take effect in 2026.

Bucholtz argued the program effectively establishes "price controls" that will result in unfair rates that violate the due process clause of the U.S.

Constitution's 5th Amendment.

Bucholtz said that far from establishing a real negotiation, the drugmakers either must agree to whatever the government deems to be the "maximum fair price" or face draconian penalties in the form of an excise tax of up to 1,900% of U.S. sales of the drug...**Read More**



## What happens when a Medicare Advantage plan endangers people's health?

Medicare Advantage plans **delay and deny care inappropriately**, putting their members' health at risk. Enrollees with serious medical conditions can find themselves unable to get critical care. As a general rule, the government does nothing to stop the wrongful delays and denials of care or to protect people in Medicare Advantage plans that are failing to cover their enrollees' medically necessary care. Before signing up for a Medicare Advantage plan or deciding to remain in one, consider the consequences if you take a big fall or are diagnosed with a serious health condition.

Twice now, the HHS Office of the Inspector General has found widespread and persistent delays and denials of care and coverage in Medicare Advantage plans. But, the government never names names. Similarly, the **American**

**Hospital Association** has reported that some Medicare Advantage patients are not able to get essential hospital care. "Inappropriate denials for prior authorization and coverage of medically necessary services are a pervasive problem among certain plans in the MA program. This results in delays in care, wasteful and potentially dangerous utilization of fail-first requirements for imaging and therapies, and other direct patient harms."

The Centers for Medicare and Medicaid Services (CMS), the government agency that oversees Medicare, tells people that MA plans "must" cover the same services as Traditional Medicare, but there's a profound difference between theory and practice. Despite reports of bad acts by insurers offering MA, CMS does



not have the resources to monitor the Medicare Advantage plans adequately. Even when the OIG identifies bad actors, CMS appears to lack the political will to name the bad actors, let alone punish the bad actors appropriately. Moreover, some MA plans are failing to pay hospitals and other providers adequately, **denying 18 percent of their claims inappropriately**, according to the OIG. People enrolled in these Medicare Advantage plans are at **risk of losing access to their local hospitals**, which cannot afford continuing contracts with Medicare Advantage plans that don't pay their bills.

On rare occasions, CMS will temporarily freeze enrollment in some Medicare Advantage plans as a penalty for their bad acts. But, when it does, CMS does not

alert members to the inappropriate denials. Moreover, it has no way to prevent these Medicare Advantage plans from continuing to delay and deny care inappropriately.

Worse still, even when cautioned about bad actor Medicare Advantage plans—for example, **by a local hospital**—enrollees have little recourse. They generally cannot enroll in Traditional Medicare because, as a rule, they have no ability to buy supplemental coverage to fill coverage gaps. When they can get supplemental coverage, they often can't afford it.

Here's what must happen to protect people with Medicare enrolled in, or thinking of enrolling in, a Medicare Advantage plan:....**Read More**

## Three Proposed Rules Would Improve Equity, Comprehensive Coverage, and Access to Care

This week, Medicare Rights submitted comments on three proposed rules. One would improve access to needed services. A second would limit the sale of junk insurance. And the third would restore nondiscrimination in grants funded by the Department of Health and Human Services (HHS).

The first proposed rule, the 2024 Physician Fee Schedule, includes provisions that would extend the availability of **medically necessary dental treatment**, as well as expanding access to some mental health and substance use disorder providers. **Our comments** reflect the importance these issues have for beneficiaries and Medicare Rights'

commitment to expanding access to necessary, whole-body care and improving the equity of the Medicare program.

The second proposed rule, the Short-Term, Limited Duration Insurance rule, would **limit the sale of junk insurance** that misleads consumers into thinking they have comprehensive coverage. This type of insurance product was sharply curtailed by the Affordable Care Act because it does not qualify as comprehensive insurance since it lacks guarantees of coverage for pre-existing and other conditions and applicants can be denied coverage. Later, these products were made more available by the



Blog

last administration—**a move we strongly opposed. Our comments** reflect our

goal of ensuring that people have access to affordable, comprehensive coverage, not **misleading junk plans**. Finally, the third proposed rule, the Health and Human Services Grants Regulation, would restore **nondiscrimination protections in regulations implementing HHS grant programs**. The proposed rule would, among other changes, clarify the HHS interpretation of the prohibition of discrimination on the basis of sex to include (1) discrimination on the basis of sexual orientation and (2) discrimination on the basis of

gender identity, consistent with the Supreme Court's **Bostock v. Clayton County** decision. **Our comments** reflect our support for these and other clarifications.

Each of these proposed rules, if finalized, will protect consumers and improve access to equitable care for people with Medicare and for anyone seeking insurance coverage or services overseen by HHS. We applaud these steps and will continue to advocate for improvements to Medicare and the larger health system.

- ◆ Read the **Physician Fee Schedule proposed rule** and **our comments**.
- ◆ Read the **Short-Term, Limited-Duration Insurance proposed rule** and **our comments**.

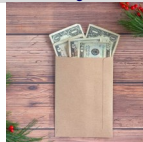
## Congress must update insanely low asset limits for SSI benefits

U.S. Senators Sherrod Brown (D-OH) and Bill Cassidy (R-LA), along with Representatives Brian Higgins (D-NY-26) and Brian Fitzpatrick (R-PA-1), **introduced the SSI Savings Penalty Elimination Act**.

Social Security Works strongly endorses this important legislation and applauds its visionary cosponsors. The Supplemental Security Income program, a vital companion to

Social Security, is a lifeline to millions of people with disabilities and seniors. Yet the last and only time Congress increased its stringent asset limits was forty years ago, in 1984. It is well past time that Congress update these limits, as the SSI Savings Penalty Elimination Act does.

As the name of the legislation indicates, the current, overly



restrictive and out-of-date asset limits penalize savings. Even one dollar in savings above the limits of \$2,000 for an individual or \$3,000

for a couple results not just in the loss of SSI cash benefits but also can result in the loss of Medicaid, housing assistance, and other benefits. And the limits penalize marriage as well—married couples can only save three-fourths of the amount two individuals are

allowed to save. Moreover, these stringent and intrusive limits are extremely costly for the Social Security Administration to administer.

Congress should immediately pass the SSI Savings Penalty Elimination Act into law. It should then eliminate the program's other marriage penalties, as well as update and expand it in other ways."

## Family caregiving: Costly, lonely and stressful work

Most Americans want to grow old in their homes, where they are most comfortable, not in a facility. But, because the US does not support paid caregiving, which is extremely costly, the job generally falls to family caregivers, which is challenging financially, emotionally and logistically. Michelle Cottle writes an opinion piece for **The New York Times** on the costly and too often lonely job of family caregiving.

With little if any help, about 42 million Americans care for an aging person, 50 and older. That is challenging work emotionally and financially. Because the US is an aging nation, more Americans will find themselves as unpaid caregivers needing

support.

By AARP's projections, unpaid family caregiving amounts to some \$600 billion of free services in 2021. A lot of caregiving time can be spent commuting. The cost of not being able to work fulltime or at all drives some caregivers into bankruptcy. Caregivers forego a projected \$522 billion a year in income.

Typically, 25 percent of caregivers' income goes to helping with expenses of the people they are caring for, such as **home modifications, medical bills and housing.**

The stress too often causes declines in health, both mental and physical. Studies show that



caregivers are more prone to suffer from depression and cancer and are more likely to die younger than people who are not caregivers.

We have no system in place to train caregivers to undertake their myriad responsibilities. As the health care system evolves and creates additional burdens on individuals, caregivers often must assume responsibility for providing treatment to their loved ones, such as caring for wounds, administering injections and taking care of IV lines. They must also tackle the myriad health insurance obstacles to care and coverage, generally without assistance.

Caregivers need to take a rest

periodically. But, the cost of hiring caregivers can be extremely high. And, paid caregivers are few and far between in many communities.

The Biden Administration planned to invest \$400 billion in strengthening home care, providing training for caregivers and ensuring they are paid well enough to want to take on the responsibilities. But, Congress ended up cutting these provisions out of the Build Back Better bill in 2022. The President's current budget proposal calls for \$150 billion in Medicaid home care services, but Republicans are unlikely to support it....**Read More**

## Dear Marci: Does Medicare cover the RSV vaccine?

**Dear Marci,**  
***I called my pharmacy to schedule an appointment to get my flu vaccine. They told me I could also schedule my RSV vaccine, which was news to me. Does Medicare cover this?***  
**-Matteo (St. Louis, MO)**

**Dear Matteo,**

What a timely question! Earlier this year, the Food and Drug Administration (FDA) approved the RSV vaccine. **According to the Centers for Disease Control and Prevention**, the RSV vaccine can help prevent lower respiratory tract disease caused by respiratory syncytial virus

(RSV). RSV season varies from year to year, but usually starts in the fall and peaks in the winter. RSV can affect people of all ages but may be especially serious for infants and older adults.

**Medicare Part D covers the RSV vaccine if it's recommended for you by the Advisory Committee on Immunization Practices (ACIP)**, a government agency that gives advice about who should get certain vaccines. At this time, **the RSV vaccine is recommended for adults over**



*Dear Marci*

**the age of 60.**  
**There should be no cost to you to get**

**this vaccine.** This means your pharmacy shouldn't charge you a copay or deductible to get the RSV vaccine. If you have **Medicare Part D**, it should be free to you.

If you have Medicare Part D and your doctor or pharmacy tries to charge you for the RSV vaccine, you should call 1-800-MEDICARE (1-800-633-4227) for help.

If you have non-Medicare drug coverage (like drug coverage

from an employer or union), you should check to see its coverage rules for the RSV vaccine. Because this is a newer vaccine, it may not be listed on an insurance plan's list of covered drugs yet, so you should check with your plan before making an appointment.

Remember that while the RSV vaccine is covered by Part D, your **flu and COVID-19 vaccines** will still be covered by Part B.

I hope this helps!

**-Marci**

## Social Security Overpays Billions to People, Many on Disability. Then It Demands the Money Back

Justina Worrell, 47, works part time as a kitchen helper in an Ohio nursing home. She has cerebral palsy, an intellectual disability, and a cardiac condition that required she get an artificial heart valve at age 20.

A year ago, she was earning \$862 a month and receiving about \$1,065 in monthly Social Security disability benefits when a letter arrived from the federal government. The Social Security Administration had been overpaying her, the letter said, and wanted money back.

Within 30 days, it said, she should mail the government a check or money order.

For \$60,175.90.

"Social Security should be to help people, not to destroy them," **said Addie Arnold,**

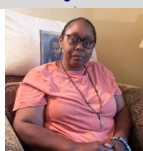
Worrell's aunt and caregiver.

The Social Security Administration is trying to reclaim billions of dollars from many of the nation's poorest and most vulnerable — payments it sent them but now says they never should have received.

During the 2022 fiscal year, the agency clawed back \$4.7 billion of overpayments, while another \$21.6 billion remained outstanding, according to a report **by SSA's inspector general.**

One consequence is a costly collection effort for the government and a potentially devastating ordeal for the beneficiary.

"We have an overpayment



crisis on our hands," said Rebecca Vallas, a senior fellow at the Century Foundation think tank. "Overpayments push already struggling

beneficiaries even deeper into poverty and hardship, which is directly counterproductive to the goals" of safety-net programs.

The Social Security Administration declined an interview request from KFF Health News and Cox Media Group and would field questions only submitted by email.

The agency declined to say how many people have been asked to repay overpayments.

"We do not report on the number of debtors," spokesperson Nicole Tiggemann said in a statement.

The agency rejected a May 2022 Freedom of Information Act request for documentation of every overpayment notice sent over several years, and a March 2023 appeal is pending.

Jack Smalligan of the Urban Institute, who has done research on Social Security, estimated that millions of people have received notices saying the agency overpaid them.

Most are on disability, and many cannot afford to repay the government, Smalligan said.

Overpayments can result from Social Security making a mistake or from beneficiaries failing to comply with requirements, intentionally or otherwise. But much of the fault lies within the system — for example....**Read More**



# New Survey Highlights Overwhelming, Confusing, and Misleading Medicare Plan Marketing

**A new survey** from the Commonwealth Fund examines beneficiary experiences with marketing outreach from private Medicare Advantage (MA), Medigap, and Part D plans.

The surveyors asked beneficiaries about these interactions, including any impact on their Medicare coverage decisions. The survey was conducted during the latter part of last year's Fall Open Enrollment period (between November 30 and December 8, 2022). Key findings include:

- ◆ Plan marketing is often overwhelming. Nearly all beneficiaries saw advertisements and received phone calls, mailings, and emails on a weekly basis. Some experienced even more. Every day, over 75% saw TV or online ads, while 33% received phone calls.
- ◆ Fraudulent tactics endure. Many respondents reported

Medicare marketing that runs afoul of federal rules, including communications from "Medicare" promoting a specific plan (51%) and unsolicited calls from plans and brokers (74%). Few know what to do about it. About one in five survey participants said they did not know how to file a complaint about Medicare marketing and didn't think they could figure out how.

- ◆ Harmful marketing practices disproportionately target and impact lower-income beneficiaries. Of the 14% of people who stayed on the phone after an unsolicited marketing call, nearly one in three lived on \$25,000 or less per year. They were also more likely than those with higher incomes (defined as \$50,000 or more) to be asked their Social Security or Medicare numbers outside the enrollment process (22% vs.



6%) and to feel pressured by an insurance broker or agent (21% vs 7%).

- ◆ Misleading marketing is widespread. Across all income groups, similar shares of beneficiaries (11% to 12%) chose plans because they believed their doctor to be "in network," only to discover otherwise post-enrollment. However, lower income respondents were more likely to report seeing, reading, or receiving advertising information that was later found to be untrue (28% vs. 15%).
- ◆ All reported seeing, reading, or receiving advertising information that was later found to be untrue (28% vs. 15%).
- ◆ Growing plan numbers further complicate beneficiary decisions. Most respondents (96%) said that when they have too many plan options,

they are more likely to stick with their current plan than switch.

- ◆ But these underlying choices may be sub-optimal. Most of the survey participants turned to friends and family (27%) and insurance brokers or agents (22%) for enrollment advice. But less than half knew there were barriers to switching from MA to Original Medicare with a Medigap, suggesting these and other strategies are inadequate.
- ◆ Beneficiaries need clear, comprehensive, and unbiased enrollment assistance. More than one in three said they would like to know more about out-of-pocket costs and benefits of their coverage options, and one in four said that they would like more one-on-one help to make their coverage decision....[Read More](#)

## 1 in 4 Older, Low-Income Americans Are Uninsured

As people age, health issues tend to mount, but roughly a quarter of low-income adults over 65 have no medical insurance.

That's the age when most Americans become eligible for Medicare, the federal health insurance for seniors. But many of the uninsured seniors are Hispanic Americans who aren't eligible for that coverage, or lower income people who may not be able to afford Medicare premiums.

"It's particularly concerning to think of older adults not having health insurance, given that the prevalence of disease and related

complications increase with age," said study first author **Nathalie Huguet**, an associate professor of family medicine at Oregon Health & Sciences University.

"It's more challenging to manage health conditions in the United States without insurance," she said in a university news release. "This can lead to costly hospital stays and avoidable illnesses that require expensive health care services."

For the new study, researchers examined electronic health record data for more than 45,000 patients



who became eligible for Medicare between 2014 and 2019.

These records covered visits at community health centers, which largely serve people with limited finances. They provide care regardless of a patient's ability to pay.

The study found that it was more common for Hispanic Americans to lose insurance coverage at 65.

Medicare requires participants to be U.S. citizens or permanent legal residents. Undocumented immigrants are unable to receive

this health coverage.

In addition, patients with low incomes may be unable to afford Medicare premiums.

The study also revealed that patients are often diagnosed with new chronic health conditions like diabetes or high blood pressure after they become eligible for Medicare.

In all, about 86% of patients studied had two or more chronic health conditions after they turned 65 -- compared to 77% of patients younger than 65....[Read More](#)

## Provider groups warn proposed Medicare payment cuts will pinch docs, hamper access to care

Provider groups are urging the Biden administration to reconsider proposed cuts to physician payments in its annual fee schedule rule, arguing that the cuts could force service and staffing reductions as practices feel the financial pinch.

In July, the Centers for Medicare & Medicaid Services (CMS) proposed a 3.34% cut to the fee schedule's conversion factor, which is used to calculate Medicare payouts to docs. Under the **proposed rule**, payments

overall would decrease by 1.25% compared to 2023. However, CMS set the conversion factor at \$32.75, down \$1.14 or 3.34% from last year.

Under the physician fee schedule, the conversion factor is the number of dollars assigned to the relative value unit, a key element in how CMS calculates payouts for physicians in Medicare. In the release, CMS said that while it is decreasing overall payments and adjusting



the conversion factor, it is proposing pay hikes for primary care and other services. These increases require cuts elsewhere to achieve budget neutrality, CMS said.

"The proposed cuts are bad policy, bad timing and bad for patients. Physicians are facing a triple whammy as pay reductions are pending on several fronts. This unsustainable approach is threatening access to care," the American Medical Association (AMA) said in a **press**

**release** after it submitted a 120-page public comment letter about the proposed rule.

"With higher costs for everything associated with practicing medicine, another year of Medicare payment cuts jeopardizes patient access and imperils the physician practices on which so many seniors rely," said AMA President Jesse M. Ehrenfeld, M.D. "These cuts are unsustainable and unconscionable."....[Read More](#)

## A 'SAD' Story: Patient Stuck With \$176K Bill After Medicare Policy Switch

For 5 years, retiree George Beitzel went to a Sacramento-area clinic every 2 months so a nurse could give him an injection of the costly drug ustekinumab (Stelara), which his doctors prescribed for his Crohn's disease.

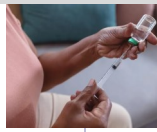
To have a licensed professional give the shots was especially important for Beitzel, now 84, because he has Parkinson's disease.

"I shake like a bug," making it impossible to safely give himself the injections, Beitzel told *MedPage Today*.

Even though Stelara is among the most expensive drugs on the

market, costing upwards of \$40,000 per dose, Medicare had always paid for his injections under Part B, which covers drugs delivered by a doctor's office or a clinic. With his co-payments covered by his supplemental plan, "I never had to pay a thing," he said.

But all of that changed on October 15, 2021, unbeknownst to Beitzel and the clinic that continued administering his injections for another 7 months. That's according to a class-action [lawsuit opens in a new tab or window](#) filed last week by the non-profit Center for Medicare



Advocacy (CMA) on behalf of Beitzel and another patient, in U.S. District Court, Eastern District of California, against HHS Secretary Xavier Becerra.

What CMS quietly and abruptly did that day was alter its payment policy on Stelara, said CMA's Litigation Director Alice Bers. It decided -- based on Medicare claims data whose use for this purpose is controversial -- that since more than 50% of Stelara users inject the drug themselves, to reclassify the drug as a "[SAD,](#)" or a [self-administered drug opens in a](#)

[new tab or window](#), for everyone, and would no longer cover it when administered in an outpatient setting.

Although he was unaware of it at the time, each injection he received at the clinic after October 15 will now cost Beitzel \$43,543.47, or as much as \$176,000. Medicare has told him as much in numerous letters denying his appeals.

"Some of the denial letters said Mr. Beitzel should have been aware that Stelara was not covered because he could have read it in his 2021 Medicare & You handbook," Bers said....[Read More](#)

## Should seniors buy Medicare supplemental insurance?

[Inflation](#) ticked up again in August, and interest rates could be heading higher later this year (they're already at [a 22-year high](#)). Against this backdrop, consumers need to be judicious about how they spend their money and where they keep it in the interim.

For older adults, many of whom rely upon [retirement savings](#) and [Social Security](#), it's particularly important to get the mix right. Seniors don't want to pay for an extra bill if they can avoid it. But they also don't want to leave themselves vulnerable and unprotected, particularly when it comes to their health and wellbeing.

This is where Medicare supplemental insurance comes into play. This additional insurance policy, purchased through a private company, can help fill the gap left by your other insurance types, thus avoiding unnecessary out-of-pocket costs. These policies can extend

coverage protections, too, leaving policyholders with peace of mind by knowing that they're thoroughly protected.

### Should seniors buy Medicare supplemental insurance?

Every senior's personal financial situation is different, and the benefits of one insurance type may not be applicable to another. That said, there are some compelling reasons seniors may want to buy Medicare supplemental insurance now. Here are three to know:

It can help with the remaining costs

While Medicare can be sufficient in many circumstances, it may not always cover everything the insured needs covered. And while Medicare supplemental insurance won't necessarily offer any new protections, it can greatly assist in covering the remaining balance of your healthcare. This can include, but is not limited to, Medicare



Part A and Part B deductibles, copays and any other coinsurance you may have that hasn't completely paid for your care.

### You'll have multiple provider options

Provided that you already have Medicare, a Medicare supplemental insurance policy won't limit your network of providers. You won't be restricted by network guidelines and the stressful decision to use in-network or out-of-network providers. This will help keep your care cohesive and consistent. If you like your provider, you can keep your provider (again, assuming they're already working with Medicare patients).

### You'll have flexible coverage

Unlike many other insurance types, with Medicare supplemental insurance, users will be able to change or enroll in a plan at any time of the year — not just during select enrollment periods. And

they're guaranteed to be renewable. This is a major advantage for those who have pre-existing medical conditions or those who develop these issues while enrolled. These users can rest easy knowing that any adverse medical conditions that arise won't wind up jeopardizing their coverage.

### Don't discount other help

While Medicare supplemental insurance can be a major help for many older adults, it's not the only insurance type worth exploring. [Long-term care insurance](#), meanwhile, could also be helpful for those seniors who need financial assistance covering items like nursing homes, assisted living facilities and even home caretakers. While it doesn't cover the same exact realm a Medicare supplemental policy does, it could still be worth it, particularly if you can get a cost-effective and valuable policy.

## Using a CBD Product? Be Sure to Tell Your Doctor

Cannabinoid products may interfere with some prescription medications, so people who use them should add these to the list of supplements they tell their doctors about.

This interference could have serious health consequences, according to Penn State Health, which offered some additional advice as legal medical and recreational cannabis becomes more common.

"Whether it's recreational cannabis, prescribed cannabinoid or medical marijuana, it's important your doctor knows you're using it," said [Kent Vrana](#), head of the pharmacology department at Penn State College of Medicine.

"A problem in Pennsylvania is that you can get a medical marijuana card without any involvement by your [primary



care physician], meaning your doctor may have no idea you're using if you don't say something,"

Vrana said in a college news release.

It's possible that over-the-counter cannabidiol, better known as CBD, could benefit millions of people because of its medicinal properties without the high feeling, Penn State Health said.

Recreational marijuana

contains tetrahydrocannabinol (THC), which makes users high. THC is sometimes present in CBD products.

CBD has been proven safe and effective in the treatment of seizure disorders and may be useful for treating some cancers, Vrana said, but science on the substance is still limited....[Read More](#)

## Dental Issues Plague America's Nursing Home Residents

Good oral health is one of the keys to healthy aging, but a sobering new study shows that many U.S. nursing home residents have significant dental issues.

Close to two in every 10 residents have missing teeth, about 8% have broken teeth/cavities and another 11% report pain while chewing, researchers found.

"Inadequate oral health has far-reaching consequences that extend beyond the mouth, profoundly affecting one's overall well-being, nutritional intake and

general health," said study author **Dr. Natalia Chalmers**, chief dental officer at the U.S. Centers for Medicare & Medicaid Services (CMS), in Baltimore.

Poor oral health can hinder a person's ability to chew properly, which can eventually lead to malnutrition. In addition, bacteria from gum infections can enter the bloodstream, increasing the risk for heart disease and other conditions, she explained.

"This interconnected relationship between oral health



and overall health underscores the importance of maintaining a healthy mouth," Chalmers said.

For the study, researchers analyzed data on the oral health of Medicare beneficiaries living in CMS-certified nursing homes in 2020. Overall, having no natural teeth or tooth fragments were the most common dental problems in seniors, followed by cavities or broken natural teeth, pain, difficulty chewing, broken dentures and inflamed gums, among other oral health issues

There are likely many reasons that dental health declines among nursing home residents, but a main driver is likely the lack of dental coverage. Fully 51% of people who receive Medicare don't have dental coverage, Chalmers noted. That may be because traditional **Medicare** doesn't cover routine dental services such as exams, cleanings and X-rays, or more expensive services such as fillings, crowns or dentures, so dental insurance has to be paid for separately....[Read More](#)

## MDMA/Ecstasy Shows Even More Promise in Easing PTSD

A new study is adding to evidence that the party drug "ecstasy" can boost the benefits of talk therapy for people suffering from post-traumatic stress disorder (PTSD).

In a clinical trial, researchers found that three months of talk therapy, assisted by carefully monitored doses of ecstasy (MDMA), worked significantly better than therapy alone.

Of 52 patients who completed MDMA-assisted therapy, about 87% were considered responders. That meant they had meaningful reductions in the recurring nightmares, flashbacks, crippling anxiety and other symptoms that plague people with PTSD.

In fact, 71% no longer qualified for a PTSD diagnosis by the study's end. That compared with a rate of 48% among the 42 patients given talk therapy plus a placebo.

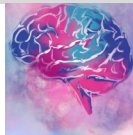
Experts said the findings, published Sept. 14 in the journal **Nature Medicine**, offer more evidence that MDMA-assisted therapy is a "real" treatment for PTSD.

"It's not a panacea," cautioned lead researcher **Jennifer Mitchell**, a professor of neurology at the University of California, San Francisco.

For one, not everyone responds to the approach. And a big unanswered question, Mitchell said, is how long do the benefits last after therapy has ended?

MDMA gained a bad reputation related to its use as a party drug, where it's better known as ecstasy or molly. Its intoxicating effects include feelings of well-being, empathy and emotional openness.

But the psychiatry field has long been interested in MDMA's



therapeutic potential. And in recent years, a growing number of studies have been looking at whether MDMA and other

"psychedelics" -- like psilocybin ("magic mushrooms") and ketamine -- can aid in the treatment of various psychiatric conditions.

Psychedelics essentially alter users' perceptions and thoughts about their surroundings and themselves.

In basic terms, MDMA floods the brain with serotonin, the same "feel good" chemical targeted by common antidepressants. That also leads to a "robust release" of oxytocin, Mitchell said.

Oxytocin, popularly known as the "love" or "bonding" hormone, seems to allow PTSD patients to feel a level of "self-compassion," Mitchell explained. And that, in turn, can help them stick with

psychotherapy.

That therapy asks people to face their trauma, and that's understandably tough.

"The problem with talking about distressing memories is that it's too distressing," said **Rachel Yehuda**, director of the Center for Psychedelic Psychotherapy and Trauma Research at Mount Sinai in New York City.

Yehuda, who was not involved in the new research, agreed that the self-compassion patients feel under the influence of MDMA is key.

"By the time people come to therapy," she said, "they've often developed narratives about how unworthy they are."

The concept of using MDMA to help people achieve breakthroughs in psychotherapy is not "just a new treatment," Yehuda said. "It's a new paradigm....[Read More](#)

## Falls are primary cause of harm and death for people over 65

Unintentional falls are the primary cause of harm and death for people over 65 reports the **Centers for Disease Control** in a new report. You might have thought it was car accidents or cancer. Fortunately, many falls are preventable.

Nearly one in four older adults (14 million) reported falling in 2021. Fall rates, or at least reporting of fall rates, are higher in some states than in others. In Alaska, nearly four in ten older adults reported falling in 2020. In

Illinois, just under two in ten reported falling. In 2021, overall, 100 older adults died each day from falling.

While women fall more than men, men are more likely to die as a result of a fall than women. Just over 91 men out of 100,000 died of a fall in 2020, while 68 women out of 100,000 died of a fall.

Death rates from unintentionally falling also varied dramatically from state to state.



In Alabama, 31 out of every 100,000 people died as a result of falling. In Wisconsin, 177 out of every 100,000 died as a result of falling.

Here's what you can do to minimize your risk of falling:

- ◆ Have your primary care doctor assess you for the risk of falling.
- ◆ If your risk is high, determine whether there are any specific causes that can be treated

and ask your doctor to check your medications.

- ◆ **Get physical therapy**—Medicare should cover it in full with a prescription from your doctor.
  - ◆ **Modify your home** to reduce trip hazards such as loose rugs and bedding.
- The National Council on Aging offers a free check-up that you can do yourself to determine if you are at risk of falling. To take the check-up, [click here](#).



## Folks With Chronic Reflux Face No Higher Risk for Esophageal Cancer

Rebutting conventional wisdom, a large Swedish study finds that most people with chronic acid reflux, or GERD, do *not* have a higher risk for developing cancer of the esophagus.

"Previous studies have shown that individuals with repeated symptoms of acid reflux — [such as] heartburn and/or regurgitation -- have a propensity to develop esophageal cancer," said lead researcher **Dr. Dag Holmberg**, a postdoctoral researcher at the Karolinska Institute in Stockholm.

"We found that these

individuals had the same risk of cancer as the general population," he said, adding "the results were clear virtually across the board. There was no association."

Chronic acid reflux — also known as GERD (gastroesophageal reflux disease) — has long been thought to drive up cancer risk, because of its potential to injure the lining of the esophagus, the long tube that carries food and drink from the throat to the stomach, Holmberg explained.

Over time, this process —



known as esophagitis — causes tissue in the tube to become more acid-resistant. When that

happens, he noted, prior research has demonstrated "a clearly increased risk of developing esophageal cancer."

But, Holmberg said, the majority of patients with acid reflux have a normal esophageal lining without any signs of injury. He and his team wanted to see if the long-standing presumption that GERD patients have an increased cancer risk might be misplaced.

To learn more, investigators

analyzed national health registry information for two groups of patients across Sweden, Denmark and Finland.

Patients in both groups had been treated for reflux disease between 1987 and 2019, either in a hospital or an outpatient setting.

The first group included more than 285,000 men and women with reflux disease but no evidence of esophagitis when examined with a scope.

The second group included roughly 200,000 patients with evidence of esophageal injury... [Read More](#)

## Cleaning Products, Even Green Ones, Emit Unhealthy Toxins

Everyday products used for cleaning or freshening the air may release hundreds of hazardous volatile organic compounds, according to new research.

Both conventional and "green" products emitted these VOCs in an analysis by the Environmental Working Group, though the green cleaners had less of them.

"This study is a wake-up call for consumers, researchers and regulators to be more aware of the potential risks associated with the numerous chemicals entering our indoor air," said lead research Alexis Temkin, a senior toxicologist at EWG.

"Our findings emphasize a way to reduce exposure to hazardous VOCs -- by selecting products that are 'green,' especially those

that are 'green' and 'fragrance-free,'" she said in an EWG news release.

In all, scientists tested 30 cleaning products. They included a mix of multipurpose and glass cleaners, as well as air fresheners.

The analysis detected 530 unique VOCs, including 193 with the potential to cause health harms such as respiratory system damage, increased cancer risk and developmental and reproductive problems.

While VOCs affect both indoor and outdoor air, their impact inside is much greater, according to the study. Their effect on indoor air is two to five times more than that on outdoor air, and possibly as much as 10 times more, researchers said.



Some products emit VOCs for days, weeks or even months.

On average, products labeled green emitted about half as many VOCs. Those labeled fragrance-free emitted nearly eight times fewer VOCs than conventional cleaners and four times less than green products containing fragrance.

On average, the fragrance-free green products contained four chemicals classified as hazardous, compared to about 15 in green products with fragrance and 22 in conventional products.

The health harms of VOCs are especially concerning because of how many Americans may be exposed to them in the workplace, EWG said.

Those in the cleaning industry

have a 50% higher asthma risk, according to EWG. They also have a 43% higher risk of chronic obstructive pulmonary disease, or COPD. Women who do this work also have a greater risk of lung cancer.

Higher use of certain indoor cleaners also appears to affect fetuses and infants. This was associated with a greater risk of asthma and wheezing in childhood.

"These cleaning products may hurt our health, but they may also harm the environment," **Samara Geller**, senior director of cleaning science at EWG, said in the release... [Read More](#)

## A New Covid Booster Is Here. Will Those at Greatest Risk Get It?

The Centers for Disease Control and Prevention recommends new covid-19 booster vaccines for all — but many who need them most won't get them. About **75% of people** in the United States appear to have skipped last year's bivalent booster, and nothing suggests uptake will be better this time around.

"Urging people to get boosters has really only worked for Democrats, college graduates, and people making over \$90,000 a year," said Gregg Gonsalves, an epidemiologist at Yale University. "Those are the same people who will get this booster because it's not like we're doing

anything differently to confront the inequities in place."

As the effects of vaccines offered in 2021 have diminished over time, boosters have been shown to strongly protect people against **severe covid and death**, and more modestly **prevent infection**. They can have a dramatic impact on those most likely to die from covid, such as older adults and immunocompromised people. Public health experts say re-upping vaccination is also important for those in group housing, like prisons and nursing homes, where the virus can move swiftly between people in close



quarters. A boost in protection is also needed to offset the persistent disparities in the toll of covid between racial and ethnic groups.

However, the intensive outreach efforts that successfully led to decent vaccination rates in 2021 have largely ended, along with mandates and the urgency of the moment. Data now suggests that the people getting booster doses are often not those most at risk, which means the toll of covid in the U.S. may not be dramatically reduced by this round of vaccines.

Hospitalizations and deaths due to covid have risen in recent

weeks, and **covid remains** a leading cause of death, with roughly 7,300 people dying of the disease in the past three months.

Tyler Winkelman, a health services researcher at Hennepin Healthcare in Minneapolis, said outreach of the intensity of 2021 is needed again. Back then, throngs of people were hired to tailor communication and education to various communities, and to administer vaccines in churches, homeless encampments, and stadiums. "We can still save lives if we are thoughtful about how we roll out the vaccines." ... [Read More](#)



## Digestive Diseases Can Take Toll on Seniors' Mental Health

A lot of older adults have digestive diseases that can be debilitating. They can also be linked to loneliness and depression; a new study says.

"These conditions are very common in ambulatory care," said gastroenterologist **Dr. Shirley Cohen-Mekelburg**, who specializes in problems like inflammatory bowel disease, Crohn's disease and ulcerative colitis at University of Michigan Medicine.

While there has been a greater emphasis on figuring out why so many Americans are developing digestive diseases, current approaches often fail to consider the impact of psychosocial factors, Cohen-Mekelburg said.

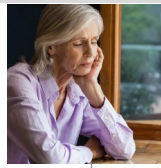
"As physicians, it's important for us to pay attention to psychosocial factors involved in the lives of our patients, but they often go overlooked," she said in a Michigan Medicine news release. "These factors have the potential to significantly impact

gastrointestinal health, and they also play a crucial role in the overall well-being of our patients."

A team of gastroenterologists and hepatologists (specialists in the liver, gallbladder and pancreas) examined rates of loneliness, depression and social isolation in older adults both with and without digestive diseases and "wanted to quantify these numbers with self-reported rates of poor health," Cohen-Mekelburg said.

They used data from 2008 to 2016 from the University of Michigan Health and Retirement Study, which has a representative sample of about 20,000 people ages 50 and up and their spouses.

Cohen-Mekelburg noted that loneliness is subjective -- distressed feelings from being alone. Social isolation is objective -- physical separation from other people but



independent of psychological well-being.

"Therefore, there are people who live in isolation but are well-adapted, not lonely and report high psychological well-being. But on the other hand, there are also people who are socially connected, yet suffer from low psychological well-being and loneliness. This, despite having a strong social network," Cohen-Mekelburg said.

From a group of more than 7,000 participants, the team identified 56% of individuals with a digestive disease and 44% without one.

Overall, about 60% and 56% of respondents with and without digestive diseases, respectively, reported loneliness. About 13% and 8% reported severe depression. Finally, roughly 9% in both groups reported social isolation.

"We found that individuals with a digestive disease were

more likely to report 'poor-or-fair' health when compared to those without one. And among patients with a digestive disease, loneliness, as well as moderate to severe depression, were associated with greater odds of self-reporting 'poor-or-fair' health," Cohen-Mekelburg said.

She hopes the findings eventually empower gastroenterologists to screen patients for depression and loneliness, in addition to their physical symptoms.

"By doing this, providers can better establish care pathways for mental health treatment for their patients, which is hugely important," Cohen-Mekelburg said. "Our research shows that gastroenterologists are in a unique position to help their patients achieve good overall health. Being aware of the link between loneliness, depressive symptoms and digestive diseases can really benefit your patients from a holistic perspective."

## 7 Lifestyle Factors Help Keep Depression at Bay

A healthy lifestyle -- especially getting enough sleep -- may offer substantial protection against depression, new research suggests.

The study, of more than 287,000 British adults, found that several lifestyle factors seemed to curb the risk of developing depression over the next nine years. Among them were eating a healthy diet, getting regular exercise, staying socially active, not smoking and -- most importantly -- regularly having a good night's sleep.

Each healthy habit mattered on its own, the study found. People who exercised had a lower risk of future depression than couch potatoes did, for example.

But the more good habits, the better: Study participants who adhered to at least five of seven healthy habits had a 57% lower risk of depression, versus those who followed none or only one.

Major depression is a complex disease, with genetic vulnerability playing a key role.

And one of the important findings in this study, the researchers said, was that a

healthy lifestyle benefitted people, regardless of the genetic cards they've been dealt.

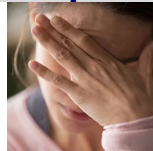
"Lifestyle has a strong protective role across different levels of genetic risk for depression," said study author **Christelle Langley**, a research associate at the University of Cambridge.

The findings, published Sept. 11 in the journal ***Nature Mental Health***, are based on data from the UK Biobank. It's a huge research project collecting health and genetic information from about a half-million middle-aged and older British adults.

In the study, Langley and her colleagues focused on over 287,000 participants who were depression-free when they entered the study between 2006 and 2010. All reported on their lifestyle habits at that time.

Over the next nine years, just under 13,000 people were newly diagnosed with depression. The risk was lower, however, among those who'd reported healthier lifestyles at the outset.

The big seven factors were:



◆ Sufficient sleep (7 to 9 hours a night)

◆ Regular exercise -- including moderate activities, like brisk walking, on most days of the week

◆ Limiting screen time and other sedentary activities

◆ A healthy diet high in foods like fruits and vegetables, fish and whole grains

◆ Not smoking

◆ Regularly seeing family and friends

◆ Drinking no more than moderate amounts (at most one drink per day for women, and two per day for men)

Sleep was the single most protective factor, the researchers found. People who got enough shut-eye were 22% less likely to develop depression than those with poor sleep habits. Not smoking was nearly as protective.

But, Langley said, people saw the most benefit when multiple good habits were practiced together.

Among those who reported at

least five of the seven healthy habits, the risk of depression was 57% lower, versus people who adhered to no more than one. In the intermediate group -- two to four healthy habits -- depression risk was cut by 41%.

Next, the researchers looked at genetic risk. They analyzed participants' blood samples, looking for genetic variants that have been linked to depression, and assigned each person a genetic risk score.

Again, healthy habits appeared powerful -- guarding people against depression regardless of their genetic risk, Langley said. The findings do not prove cause-and-effect, but they are "compelling," said **Dr. Ken Duckworth**, chief medical officer at the nonprofit National Alliance on Mental Illness. He noted that the genetics of depression are complex and have not been "nailed down," so the risk scores assigned in this study have limitations.

But the bottom-line message is a positive one, Duckworth said: "You're not helpless vis-a-vis your genes."...**Read More**

## Why officials aren't calling this year's new COVID shots "boosters"

Earlier in the COVID-19 pandemic, as signs of waning immunity and changes in the virus prompted the rollout of additional doses of vaccine, health authorities took to urging Americans to seek out "booster" shots to improve their protection against the virus.

Now, with an **updated vaccine formula rolling out** for the fall, officials are changing that message to move away from the word "booster."

Instead, doctors and health departments are now working on getting used to **calling** this year's newly recommended shots the "2023-2024 COVID-19 vaccine"

or simply the "updated COVID-19 vaccine."

### ◆ **Looking for the new COVID vaccine booster? Here's where to get the shot.**

Virtually all Americans ages 6 months and older **are now recommended to get one dose** of these updated shots from Moderna or Pfizer, regardless of what vaccines they have or have not received before.

"Bye bye, booster. We are no longer giving boosters, and it's going to be very difficult to stop using that word because that word has become pervasive," Dr. Keipp Talbot, a member of the



Centers for Disease Control and Prevention's committee of vaccine advisers, said.

Talbot was speaking Thursday at a **webinar** hosted by the Infectious Diseases Society of America titled, in part, "COVID-19 New Booster Vaccine & Variants Update."

**"We are beginning to think of COVID like influenza. Influenza changes each year, and we give a new vaccine for each year. We don't 'boost' each year," said Talbot. No more "primary series"**

The change in terminology stems from a **proposal**, first

backed by a panel of the Food and Drug Administration's outside advisers back in January, to dramatically simplify the schedule of authorized and approved COVID-19 vaccines.

Most Americans originally received a "primary series" of shots that were targeted at the original strain of the virus early in the pandemic. Then, a mix of "booster" doses were offered — some targeted at more recent variants — with varying guidelines depending on a person's age and what shots they previously received....**[Read More](#)**

## Heavy Drinking Tied to Dangerous Buildup of Fat Around Heart, Liver

Before pouring another drink, consider this sobering new research: Heavy drinkers can develop fat around the heart, leading to heart failure and other cardiac problems.

This so-called pericardial fat is associated with increased risk of heart disease.

Researchers also linked heavy drinking to excess fat deposits around the liver and kidneys, which can result in diseases of these organs, too.

"The accumulation of fats in these areas, especially at the heart, has been linked to higher risk of heart disease like heart failure, atrial fibrillation as well as coronary heart disease, which is the major killer of U.S. adults," said lead researcher **Dr. Richard Kazibwe**, an assistant professor

of internal medicine at Wake Forest University School of Medicine in Winston-Salem, N.C.

Alcohol affects how the body handles fat, he said. "Drinking is a known risk for obesity. We know from the past that alcohol can influence metabolism. It can influence levels of hormones in the body that can lead to the distribution of fat in general, but also in various areas of the body," Kazibwe said.

That's how fat ends up surrounding the heart, but if you stop imbibing will that fat disappear? Kazibwe said fat around the liver can be reduced if you stop drinking, but it isn't known if the same is true for fat around the heart.

The bottom line, in his mind, is



clear: "Drinking alcohol can increase the risk of heart disease, not to mention the dangers of alcohol drinking in general that may not have anything to do with the heart, like cancer," Kazibwe said. "Drinking less is good for your heart."

For the study, Kazibwe and his colleagues collected data on more than 6,700 people from the Multi-Ethnic Study of Atherosclerosis, a study of heart disease. Volunteers identified themselves as never drinkers, former drinkers, light drinkers (less than one alcoholic drink daily), moderate drinkers (one to two drinks a day), heavy drinkers (more than two drinks a day), or binge drinkers (five or more drinks in a single day).

Participants also had CT scans so the researchers could see fat buildup around the body's organs, which is called ectopic fat.

Kazibwe's team found that heavy drinkers and binge drinkers had significant fat around the heart, compared with people who never drank alcohol. They also had fat around the liver and kidneys, Kazibwe said.

The lowest levels of fat were seen in light to moderate drinkers, he said. The highest levels of fat were seen among those who drank beer or liquor compared to wine drinkers, Kazibwe noted. The beneficial compounds found in wine called polyphenols might explain this finding, the researchers said....**[Read More](#)**

## A Single Drug Could Treat America's Top Two Killer Diseases

What would you guess are the two biggest killers in the world? Based on media coverage, maybe you guessed gun violence, accidents, or **COVID-19**. But the top two killers are actually cardiovascular disease and **cancer**. These two diseases combined account for **nearly 50 percent of deaths in the US**.

Cardiovascular disease and cancer seem to be quite different on the surface. But **newly discovered parallels** between the origins and development of these two diseases mean that some treatments may be effective against both.

I am a **biomedical engineer** who has spent two decades studying and

developing ways to improve how drugs travel through the body.

It turns out that tiny, engineered nanoparticles that can target specific immune cells may be a way to treat both cancer and cardiovascular disease.

### **Cardiovascular disease and cancer**

**Atherosclerosis** is the most deadly form of cardiovascular disease. It **results from** inflammation and the buildup of fat, cholesterol and **other lipids** in the blood vessel wall, forming a plaque.

Most heart attacks are caused by **plaque rupture**. The body's attempt to heal the wound can form



a blood clot that blocks blood vessels and result in a heart attack.

On the other hand, cancer usually arises from genetic mutations that make cells divide uncontrollably. Unrestrainable, rapid cell growth that is untreated can be destructive because it is difficult to stop without harming healthy organs. Cancer can start from and occur in **any organ of the body**.

Although cardiovascular disease and cancer appear to have different origins and causes, they **share many risk factors**. For example, obesity, smoking, chronic stress and certain lifestyle choices like poor

diet are linked to both diseases.

Why might these two diseases share similar risk factors?

Many of the similarities between cardiovascular disease and cancer can be traced to inflammation. Chronic inflammation is a **primary cause of atherosclerosis** by damaging the cells lining the blood vessels and progressively worsening plaques.

Likewise, chronic inflammation can **initiate cancer** by increasing mutations and **support cancer cell survival and spread** by increasing the growth of the blood vessels that feed them nutrients and suppressing the body's immune response....**[Read More](#)**