Rhode Island Alliance for Retired Americans®

RI ARA

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Message from Alliance *for* Retired Americans Leaders

Poll: Most Americans Oppose Social Security, Medicare Cuts

Robert Roach, President, ARA

According to a new AP-NORC poll, a majority of adults support increasing taxes on high income households to pay for Medicare, a plan proposed by President Biden last month. In addition, **few are in favor of changes** to Medicare or Social Security, such as raising eligibility ages.

Seventy percent of Americans oppose raising the eligibility age for Medicare benefits from 65 to 67, while 75% of Americans oppose raising the eligibility age for Social Security benefits from 67 to 70.

Democrats, including President Biden, and some **Republicans in Congress** have publicly promised not to cut Social Security or Medicare benefits. However, other Republicans in Congress and **several possible GOP presidential candidates** continue to promote the idea of raising the eligibility age for Social Security and Medicare.

"Make no mistake: raising the retirement age is a benefit cut," said **Robert Roach, Jr., President of the Alliance**. "Americans of all ages should be alarmed when powerful members of Congress are threatening their earned retirement benefits."

Did You Know…What Happens If You Work While Collecting Social Security Retirement Benefits?

You can get Social Security retirement benefits and work at the same time. However, if you are younger than full retirement age and make more than the yearly earnings limit, the Social Security Administration (SSA) will **reduce** your benefit. Starting with the month you reach full retirement age, SSA will not reduce your benefits no matter how much you earn. (Source: SSA)

Rich Fiesta, Executive Director, ARA

If you are under full retirement age for the entire year, SSA deducts $1 from your Social Security benefit payments for every $2 you earn above the annual limit. For 2023, that limit is $21,240.

In the year you reach full retirement age, SSA deducts $1 in benefits for every $3 you earn above a different limit, but it only counts earnings before the month you reach your full retirement age. If you reach full retirement age in 2023, the limit on your earnings for the months before full retirement age is $56,520. Click **here** for more information from SSA.

"We urge retirees who are unsure of any tax implications of work they are performing to contact the SSA, a tax advisor, or the **IRS website**," said **Richard Fiesta, Executive Director of the Alliance**.

McCarthy's 100th day as Speaker: Not Much to Show So Far

As Kevin McCarthy approaches his 100th day as House Speaker, Republicans are generally united behind McCarthy's attempts to force President Biden to negotiate spending cuts as a condition for raising the debt ceiling. However, The Hill **reports** significant internal disputes over policy priorities within the caucus and major behind-the-scenes tensions between McCarthy and some of his top lieutenants. In addition, the GOP has failed to coalesce around a long-term budget blueprint to counter Biden's proposal heading into the talks.

Joseph Peters ARA Sec.-Trea.

"So far Speaker McCarthy and his members have not been able to find agreement on the most basic issues," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "If Republicans continue threatening to bring the nation closer to a default on the national debt, things are likely to get worse for them."

Judge Grants Attorney's Fees in Arizona Alliance Voting Lawsuit

There was a significant development in the Arizona Alliance's **lawsuit** in Cochise County. The two members of the County Board of Supervisors who resisted certifying results in the November election as required by state law are now personally on the hook for $37,000 in legal and court fees.

Last year, Republican county supervisors Tom Crosby and Peggy Judd refused to certify the canvass of the countywide election results for several weeks, jeopardizing the state certification process and risking the votes of thousands. They cited phony allegations that the county's electronic tabulators Gov. Katie Hobbs weren't properly certified. Only after then -Secretary of State Katie Hobbs and the Arizona Alliance took them to court and a judge ordered them to complete their statutorily mandated duties did they finally certify the results.

"We are gratified by the court's ruling to require the payment of fees and costs from the two members of the Cochise County Board of Supervisors who tried to ignore the law," said Dora Vasquez, Executive Director of the Arizona Alliance. "The decision should put elected officials on notice that anyone who ignores the law, interferes in elections or tries to suppress the vote will be held accountable."

Kaiser Health News: No-Cost Preventive Services Are Now in Jeopardy. Here's What You Need to Know

By Julie Appleby

When a federal judge in Texas declared unconstitutional a **popular part** of the Affordable Care Act that ensures no-cost preventive care for certain services, such as screening exams for conditions such as diabetes, hepatitis, and certain cancers, it left a lot of people with a lot of questions.

On the face of it, the March 30 decision **could affect ACA and job-based insurance plans** nationwide and a host of medical services now free for patients.

What does this mean, really, for people with insurance? Policy and legal experts say there are some unanswered questions and a whole lot of nuances. **Read more here**.

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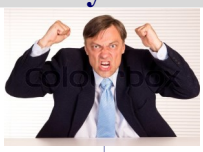
Raising the Social Security FRA to 70 gaining traction

Among the proposed changes to **Social Security** is to raise the full retirement age for recipients, which proponents say will bolster the program's finances as one of its reserve funds heads for depletion. Now a pair of lawmakers have moved a step closer to bringing such a plan up for a vote.

U.S. Sens. Angus King (I-Maine) and Bill Cassidy (R-La.) are leading a group of legislators in a proposal to raise the FRA to 70 from 67, according to reports this week from MarketWatch and Semafor.

The two senators have also proposed creating a sovereign-wealth fund that could be funded with $1.5 trillion or more in borrowed money. If the fund fails to generate an 8% annual return, both the maximum taxable income and the payroll tax rate would be increased to ensure Social Security stays on track to be solvent for another 75 years.

Other options on the table include changing the formula that calculates monthly Social Security benefits from one based on a worker's average earnings over 35 years to a formula based on the number of years spent working and paying into Social Security.



Proposals to raise the FRA have been floated for quite a while amid reports that the Old-Age and Survivors Insurance (OASI) Trust Fund — which funds about 25% of Social Security benefits — will run out of money as early as 2032. When that happens, Social Security will have to rely solely on payroll taxes for funding under the current system.

The idea behind raising the FRA is that it will push more Americans to wait an extra couple of years to start claiming Social Security benefits, which could save money over the short term. So far, the idea has not advanced much past the discussion stage. The King-Cassidy initiative represents a much more concrete stop toward bringing such a plan up for a Congressional vote.

Social Security advocates and many lawmakers have pushed back against raising the FRA because of the potential financial impact it would have on seniors who are already struggling to make ends meet.

But spokespersons for Cassidy and King wrote in an email to MarketWatch that their plan doesn't include any cuts for Americans currently receiving Social Security benefits, and that "many will receive additional benefits." They also said the plan is not finalized and "the final framework is still taking shape."

Even if the plan makes it to a Congressional vote, its chances of eventually passing into law are not great. The Senate and House would have to approve it, and then President Joe Biden would have to sign it — and as GOBankingRates previously reported, he has shown **no inclination to support Social Security changes that would cut or delay access to benefits.**

If the FRA ever does get raised to age 70, it would "significantly cuts benefits for anyone retiring before their new full retirement age," according to the National Committee to Preserve Social Security and Medicare (NCPSSM), a nonprofit advocacy group.

The NCPSSM noted that when the full retirement age was 65, workers retiring at age 62 received an initial benefit that was 20% less than their full benefit amount. When the FRA rises to 67, workers retiring at age 62 will receive a 30% cut in benefits. If the age were increased to 70, a worker claiming retirement benefits at age 62 would have their benefits reduced by nearly half, according to the NCPSSM.

"Instead of protecting future generations, raising the retirement age will dramatically cut benefits for younger generations of workers, especially those at lower-income levels," the NCPSSM said in a blog. "The cuts will have their greatest impact on those who can afford them the least — lower income workers with a shorter life expectancy, who are less likely to be able to continue working to age 70."

HHS quietly trims inaugural list of price capped Medicare drugs from 27 to 20

The Department of Health and Human Services' (HHS') **highly publicized list** of the first Medicare Part B prescription drugs hit with rebates under the Inflation Reduction Act discreetly dropped from 27 to 20, prompting critiques from the pharma lobby over the Biden administration's swift implementation of the legislation's drug controls.

As spotted by **Endpoints**, the press release and accompanying guidelines released by HHS were updated on March 30 with the removal of several previously listed drugs: Gilead's Yescarta and Tecartus, Bausch + Lomb's Xipere, Acrotech Biopharma's Folotyn, Shionogi's Fetroja, Kamada's WinRho and Stemline Therapeutics' Elzonris.

Drugs included on HHS' list were those with price increases that outpaced the rate of inflation. Under last year's legislation, the manufacturers of those products are required to repay Medicare the difference via rebates, the savings from which the Centers for Medicare & Medicaid Services would then pass along to enrollees.

The discounts were also heavily touted by President Joe Biden as a major victory against the pharma industry's "exorbitant profits at the expense of the American people." "You name the drug you have to take, and I can take you to France and get it a hell of a lot cheaper, [or] to Canada and throughout Europe," Biden **said during a March 15 speech** to reporters. "It's not fair. But after decades of trying to take on Big Pharma, we finally, finally won."

In an emailed statement, the Centers for Medicare and Medicaid Services said the change was the result of a "standard procedure" in which the the agency releases the Average Sales Price public files ahead of the quarter before they go into effect for public review and potential adjustment.

"Last week, CMS issued a restatement correcting the calculation of the coinsurance adjustment percentage for Part B rebatable drugs," the agency wrote in its statement. "We have updated the files and supplemental materials to reflect the accurate calculations and updated the list of now 20 drugs for which reduced coinsurance applies."

The agency now expects Medicare enrollees could save anywhere from $1 to $372 per average dose of their prescriptions during the period begun April 1 as a result of the price cap—a slight adjustment from the $2 to $390 range highlighted back in March.

HHS has not publicly stated why it walked back the initial list of affected drugs. Fierce Healthcare has reached out to the department for any additional comment.

In an emailed statement, a representative of industry group PhRMA said "it's fair to ask what else the administration may be getting wrong" as it "races to implement an unprecedented government price-setting scheme with little time. It's also further evidence of why it's critical to have a robust and timely process in place to address concerns with the law's implementation."

The statement also reiterated PhRMA's earlier talking points that the vast majority of Part B treatments, about 95%, are unaffected by the administration's rebate cutoff. The group said that Part B-covered medicines "have long grown below the rate of inflation … because prices for medicines under Part B already benefit from robust negotiations that take place in the private market."

HHS plans to send invoices for the remaining 20 listed products to drug manufacturers "no later than fall 2025."

Meanwhile, the administration is targeting 2026 for the implementation of another Inflation Reduction Act-permitted price control, the Medicare Drug Price Negotiation Program….**Read More**

July goal set for final US Medicare drug negotiation guidance

The U.S. government aims to publish the final guidance for its Medicare drug price negotiation program in early July and is currently talking to companies about its contents, a top health official said on Wednesday.

The guidance will finalize the details of how President Joe Biden's signature drug pricing reform will be carried out. The U.S. Centers for Medicare and Medicaid (CMS) released a draft in March and gave a 30-day window for public comments. It is unclear how much will change in the final guidance.

The agency is accepting feedback until Friday and has already been talking to drugmakers and other stakeholders over the past few months, CMS Administrator Chiquita Brooks-LaSure said in an interview.

CMS will select in September Medicare's 10 costliest prescription medicines, based on gross spending, for negotiating price cuts that will go into effect in 2026.

Companies are trying to get more details around how CMS will measure what and how big the benefits of their drugs are, she said, as well as the kind of data they will have to provide.

Other industry concerns, Brooks-LaSure said, include how the negotiation process will affect drugs in the same class as those that are selected for negotiation.

"Let's say one of the 10 we choose is for hypertension," she said. "How will that affect the other drugs in that same class that we won't be negotiating directly on? What will be some of those implications?"

The program was established under the Inflation Reduction Act, signed into law last year. It will for the first time allow Medicare, the government health insurance program for Americans age 65 and older, to negotiate prices on prescription drugs.

In drafting the guidance, Brooks-LaSure said the agency was deliberately focused on closing potential loopholes companies could use to get around being selected for negotiations.

The draft guidance showed the agency would include spending on all formulations or dosage forms of a drug, even if it received a separate U.S. Food and Drug Administration (FDA) approval for a different use.

"We are very focused on making sure that at the end of the day, this negotiation process is effective, and that means that it delivers lower costs for the people who are on the program, Medicare beneficiaries, as well as for the program as a whole."

Final Rule Makes Important Changes to Medicare Advantage and Part D

This week, the Centers for Medicare & Medicaid Services (CMS) **finalized proposed policy changes** to Medicare Advantage (MA) and Part D that may improve equity, access to care, and information for people with Medicare.

At Medicare Rights, our **comments** were **largely supportive**, and we are glad to see so many of our priorities and recommendations reflected in the final rule. This includes policies to expand and improve equity in MA by adding more explicit language around cultural competence; requiring more information about cultural and linguistic capabilities in provider directories; establishing a health equity index to further incentivize MA and Part D plans to improve care for disadvantaged populations; building in support for people with low digital health literacy to improve access to telehealth; and requiring that MA organizations' quality improvement programs include efforts to reduce disparities.

For behavioral health, the rule changes include adding new provider types—Clinical Psychologists and Licensed Clinical Social Workers—and creating network adequacy standards for them. In addition, the rule improves access standards by clarifying that prior authorization cannot be used for behavioral health, including in emergency situations, and by establishing wait time standards for behavioral health to meet network adequacy needs.

The rule made important changes to prior authorization more broadly by clarifying that MA plans may not deny coverage for services that are covered by Original Medicare, though it may use some processes to determine medical necessity. In addition, the rule should increase public information about a plan's prior authorization procedures and rationales, though it is unclear if this will be at a level beneficiaries will be able to use when choosing a plan.

We also appreciate the stronger marketing rules, in particular for television ads. Though we are disappointed that third parties and brokers will still be able to collect contact information from potential enrollees, the rule will require these agents to disclose information about the plans they are selling or marketing. Marketers will also have additional restrictions on how, when, and where they can contact or solicit enrollees.

Getting information will also be easier for people who require translated or accessible format materials. Currently, people may have to ask for these materials each time, but the new rule will treat a request as a standing order, allowing future materials to be delivered to them in the requested formats.

Importantly, the rule implements recent low-income program modifications. It effectuates the aspects of the Inflation Reduction Act which expand access to Extra Help, the low-income subsidy (LIS) that helps people pay for prescription drugs. It also makes permanent Medicare's Limited Income Newly Eligible Transition (LI NET) Program, which provides transitional prescription drug coverage to those who need it. These critical assistance pathways will help more beneficiaries afford coverage and care.

We applaud these changes and will continue to work with CMS, the rest of the Biden-Harris administration, and lawmakers to improve the affordability of Medicare for current and future beneficiaries.

Types of Rooms in Assisted Living Communities

This article is based on reporting that features **expert sources.**

Explore the different types of rooms available in assisted living communities, including studio, one-bedroom and shared apartments

Independent but supported living

For most people, it's inevitable: As you age and your health concerns increase, you'll probably need some help with previously easy **tasks like shopping or housekeeping**. Many families turn to **assisted living communities** to support and care for older relatives.

"An assisted living community is housing for seniors that provides **long-term senior care**, including daily support around personal care services like meals, medication management, bathing, dressing and transportation," says Sue Johansen, a San Francisco-based executive vice president with A Place for Mom, a senior referral service. These communities also offer a wide range of activities to help seniors live vibrant and enjoyable lives….**Read More on the different types of rooms.**

This story was previously published at an earlier date and has been updated with new information.

Medicare Home Health Coverage: Reality Conflicts with the Law

Medicare home health coverage can be an important resource for Medicare beneficiaries who need health care at home. When properly implemented, the Medicare home health benefit provides coverage for a constellation of skilled and nonskilled services, all of which add to the health, safety, and quality of life of beneficiaries and their families. Under the law, Medicare coverage is available for people with acute and/or chronic conditions, and for services to improve, or maintain, or slow decline of the individual's condition. Further, coverage is available even if the services are expected to continue over a long period of time.

Unfortunately, however, people who legally qualify for Medicare coverage frequently have great difficulty obtaining and affording necessary home care. There are legal standards that define who can obtain coverage, and what services are available. However, the criteria are often narrowly construed and misrepresented by providers and policy-makers, resulting in inappropriate barriers to Medicare coverage for necessary care. This is increasingly true for home health aide services – the very kind of personal care services vulnerable people often need to remain safely at home.

A. The Law: What Home Care Is Covered Under the Medicare Act?

Home health access problems have ebbed and flowed over the years, depending on the reigning payment model, systemic pressures, and misinformation about Medicare home health coverage. Regrettably, these problems are increasing and, if current and proposed policies and practices continue, they will only get worse. Accordingly, it is important to know what Medicare home health coverage should be under the law, especially for people with longer-term, chronic, and debilitating conditions.

1. Medicare Home Health Qualifying Criteria

Medicare covers home health services under both Parts A and B when the services are medically "reasonable and necessary," and when:

- A physician or other authorized practitioner has established a plan of care for furnishing the services that is periodically reviewed as required;
- The individual is confined to home (commonly referred to as "homebound"). This criterion is generally met if non-medical absences from home are infrequent, and leaving home requires a considerable and taxing effort, which may be shown by the patient needing personal assistance or the help of an assistive device, such as a wheelchair or walker.. (Occasional "walks around the block" are allowable. Attendance at an adult day care center, religious services, or a special occasion is not a bar to meeting the homebound requirement.);
- The individual needs skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology (or, in the case of an individual who has been furnished home health services based on such a need, but no longer requires skilled nursing care or physical or speech therapy, the individual continues to need occupational therapy); and
- Such services are furnished by, or under arrangement with, a Medicare-certified home health agency.

2. Medicare-Covered Home Health Services

If the qualifying conditions described above are satisfied, Medicare coverage is available for an array of home health services. Home health services that can be covered by Medicare include:

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- Physical therapy, speech-language pathology, and occupational therapy;
- Part-time or intermittent services of a home health aide;
- Medical social services; and
- Medical supplies.

As described above, skilled nursing, physical therapy, and speech-language pathology services are defined as "qualifying skilled services" for the purpose of establishing eligibility for Medicare home health coverage. A patient must initially require and receive one of these skilled services in order to receive Medicare for other covered home health services. Home health aide, medical social worker, and occupational therapy services are defined as "dependent services," (*dependent* upon a skilled service being in place) as are certain medical supplies. While occupational therapy is not considered a skilled service to begin Medicare home health coverage, if the individual was receiving skilled nursing, physical or speech therapy, but those services end, coverage can continue if occupational therapy continues.

The term "part-time or intermittent" means skilled nursing and home health aide services furnished any number of days per week as long as they are provided less than 8 combined hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week).

Medicare tests a solution to soaring hospice costs: Let private insurers run it

Hospice doctor **Bethany Snider** sees the writing on the wall: "The hospice care we've known and loved won't be the same 10 years from now."

Hosparus Health, the Louisville-based hospice agency where Snider serves as chief medical officer, is one of more than 100 provider organizations partnering with some of the country's largest health insurers on a **federal experiment** that could transform hospice care for millions of people.

For the last four decades, Medicare has **covered hospice services** — including grief counseling, spiritual support and pain management — for terminally ill people. The benefit has helped more than 25 million Americans die more on their own terms, often at home, with the support of chaplains, social workers, nurses and others.

Research shows hospice can **reduce** unwanted medical interventions, **improve** families' satisfaction and, in some cases, save Medicare thousands of dollars.

Now Snider and others believe this popular benefit, whose structure has remained largely unchanged since its debut in 1983, is in the early days of an inexorable overhaul. Critical aspects of the 40-year-old policy no longer fit the needs of the people using the service — or the providers delivering it. Concerns about access, fraud and runaway costs, which topped $20 billion in **2019**, dog the program.

In response, Medicare has begun a federal pilot project to test handing the reins of some hospice care over to private insurers, giving them more flexibility to control costs while also expanding access. The experiment, which began in 2021, involved several thousand patients in its first year, but multiple experts told *Tradeoffs* that they believe it is likely to eventually become national policy and reshape the hospice care available to roughly 30 million Americans.

In an email to *Tradeoffs*, **Liz Fowler**, deputy administrator at the Centers for Medicare and Medicaid Services, said the agency hopes the effort will help ensure all beneficiaries have "access to high quality and coordinated care."

The changes to hospice are "inevitable," said **Torrie Fields**, a consultant who has advised Medicare and private insurers. "The hope is this pilot sheds some light on the guidelines and guardrails needed."...**Read More**

The Drug Company That Prospered Without Creating Any Drugs

The new drug looked so promising — except for that one warning sign

At the American College of Rheumatology's annual meeting in 2008, Duke University's Dr. John Sundy proudly announced that pegloticase, a drug he'd helped develop, was astoundingly effective at treating severe gout, which affects perhaps 50,000 Americans. In about half of those who had taken it, the drug melted away the crystalline uric acid deposits that encrusted their joints to cause years of pain, immobility, or disfigurement.

But Sundy also disclosed an unsettling detail: In one clinical trial, patients who got the drug were more likely to develop heart problems than those who didn't. The day after Sundy's talk, the stock price of Savient Pharmaceuticals, which developed the drug with Duke scientists, plunged 75%.

That danger signal would disappear in later studies, and the FDA approved pegloticase, under the trade name Krystexxa, two years later. But the small biotech company never recovered. In 2013, Savient was sold at auction to **Crealta, a private equity venture** created for the purpose, for $120 million.

Two years later, a young company now called Horizon Therapeutics bought Crealta and its drug portfolio for $510 million.

Even at that price, it proved a good deal. Krystexxa brought in $716 million in 2022 **and was expected** to earn $1 billion annually in coming years.

Although Horizon says it now has 20 drugs under development, in its 15 years of existence it has yet to license a product it invented. Yet the company has managed to assemble a war chest of lucrative drugs, in the process writing a playbook for how to build a modern pharmaceutical colossus. As the White House and both parties in Congress grapple with reining in prescription drug prices, Horizon's approach reveals just how difficult this may be.

Horizon's strategy has paid off handsomely. Krystexxa was just one of the many shiny objects that attracted Amgen, a pharmaceutical giant. Amgen announced in December that it intends to buy Horizon for $27.8 billion, in the biggest pharmaceutical industry deal announced in 2022.

Horizon's CEO, Tim Walbert, who will reportedly **get around $135 million** when the deal closes, has mastered a particular kind of industry expertise: taking drugs invented and tested by other people, wrapping them expertly in hard-nosed marketing and warm-hued patient relations, raising their prices, and enjoying astounding revenues.

He's done this with unusual finesse — courting patients with concierge-like attention and engaging specialist clinicians with lunches, conferences, and research projects, all while touting his own experience as a patient with a rare inflammatory disease. Walbert's company has been particularly adept at ensuring that insurers, rather than patients, bear the costly burdens of his drugs.

A **federal prosecutor in 2015** began examining allegations that Horizon's patient assistance program had worked with specialty pharmacies to evade insurers' efforts to shun Horizon's expensive drugs. A separate **probe opened in 2019** over alleged kickbacks to pharmacy benefit managers, companies that negotiate to get Horizon's drugs covered by insurers. ….**Read More**

Experts Propose Tax Cap as Social Security Solution — Which Americans Would Be Most Affected?

If nothing is done to change course, Americans on Social Security may **see their monthly benefits drop by 25%** in the years ahead. That's because the Social Security trust fund reserves could become insolvent within the next decade. Some experts say raising the Social Security payroll tax cap **could help solve the problem**.

Currently, workers pay 6.2% of their wages, and their employers match that contribution.

However, any earnings over the income cap of $160,200 are exempt from the tax (a limit that roughly 6% of wage earners hit).

Raising the Cap

Raising the income cap to $250,000 (or more) or eliminating it altogether could replenish the trust fund reserves and keep the program running at full capacity beyond the next decade. Doing so would also shift some of the burden of funding Social Security from the middle class to wealthy, high-wage earners.

Currently, those earning over the cap pay an effective Social Security payroll tax rate of 1% or less. However, those earning under the cap get stuck footing a bill that's six times higher.

Other Potential Solutions

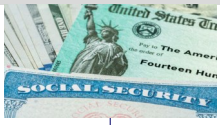
- Not all experts and lawmakers agree that increasing the Social Security payroll tax cap is the best way to solve the problem. Other **proposed solutions** include:
- Raising the full retirement age to 70 (now 66 to 67).
- Increasing the payroll tax rate to 15.6% (from 12.4%).
- Privatizing **Social Security**.
- Imposing a Social Security tax on business and investment income (currently exempt).

Social Security's next COLA may be 'lower than 3%'

Next year's Social Security cost of living adjustment, or COLA, may fall below 3% if the numbers on prices continue to fall in line with forecasts, the Senior Citizens League now predicts.

That's on top of cost of living adjustments over the past two years that have failed to keep up with inflation, the pro-senior think tank reports.

The average Social Security recipient is more than $1,000 a year worse off in real, purchasing -power terms as a result of surging inflation, senior analyst Mary Johnson says.



Meanwhile this year's COLA, nominally 8.7%, has been entirely wiped out by rising costs of Medicare part B premiums, she adds.

"The 8.7% COLA increase in 2022 exceeded the actual rate of inflation every month so far this year by an average of 2.6%," Johnson estimates. "That's about $44.90 per month based on an average Social Security benefit of $1,694.00. But that so-called cushion is completely consumed by the $164.90 a month Medicare Part B premiums which are automatically deducted from Social Security benefits."

Social Security calculates annual cost of living adjustments every fall, to take effect at the start of the following year. The adjustments are based on a comparison of average consumer prices over the summer with the same prices during the summer a year earlier. But because the adjustments don't take effect until the following year, during periods of rising inflation senior citizens are left behind the curve.

A new survey of 1,055 senior citizens conducted by the Senior Citizens League found a jump in the numbers of seniors feeling the economic pain. An astonishing 45% told pollsters they were carrying credit card debt for 90 days or more. And the number saying they have depleted a retirement account over the past 12 months rocketed during the fourth quarter from 20% to 26%.

Cancer's Financial Toll on Couples Hurts Both Partners

Financial stress and work lost to cancer treatment affects patients and their partners alike.

Partners also experienced pain, fatigue and sleep issues owing to these fiscal worries, **a new study** found.

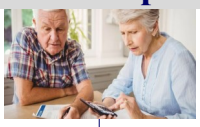
"We know that financial toxicity or hardship is a significant effect of cancer and its treatment and is associated with poor health issues for patients and survivors," said lead author **Lauren Ghazal**. She is a postdoctoral fellow at the Rogel Cancer Center and the University of Michigan School of Nursing.

"Financial toxicity extends to caregivers or partners, too," she said in a university news release.

Her team wanted to understand how that toxicity affects the caregiver's health, including anxiety, depression, fatigue and overall quality of life.

"It is important to examine the full effect of financial toxicity on a household in order to develop multilevel interventions that center the patient," she explained.

For the study, the researchers surveyed patients who had been treated for stage 3 colon cancer one to five years earlier, as well as their spouses, domestic partners or significant others from the same household.



In all, 307 patient-partner pairs responded.

The survey asked about potential stressors including cutting spending, missing bill payments and debt from unpaid bills, bank loans or money borrowed.

Patients and partners were also asked about physical function, anxiety, depression, fatigue, sleep disturbance, social roles, social activities and pain.

About 39% of partners who worked full- or part-time when the patient was diagnosed said they missed between one week and one month of work. About 38% said they lost income due to their loved one's cancer.

Nearly two-thirds of the partners reported financial burden. This included cutting down on expenses, activities, and food or clothes. They also tapped savings. About one-third of the partners reported high financial worry. The more income or work they lost, the more they worried. About 29% of partners reported debt related to the cancer diagnosis and treatment.

Financial toxicity was associated with benchmarks of poorer quality of life, according to the report.

Partners reported extra emotional spending, disrupted social lives, having to ask family and friends for help with medical expenses and worry over what could have been if they hadn't had insurance.

Younger partners were significantly more likely to report financial burden and debt, the study authors said, noting that colon cancer is on the rise among younger adults.

"When you think of key developmental milestones young adults expect to achieve, they are driven by money: completing education, establishing employment, cultivating romantic relationships, starting a family. All of these milestones impact becoming financially independent, and all are susceptible to disruption. And of course, a cancer diagnosis is a major disruption," said senior author **Dr. Christine Veenstra**, associate professor of medical oncology at Michigan Medicine.

"As we see colorectal cancer becoming more common at younger ages, it is imperative we assess for financial hardship among patients and their partners, and connect them with services and support both within and outside the hospital setting," Veenstra added.

Future research is expected to analyze the impact of financial toxicity on patients and partners together.

The researchers said they hope to identify employer-level considerations and other interventions to ease the burden.

88% of Americans Don't Trust That Social Security Will Fund Comfortable Retirement, Do You?

While lawmakers haggle over **how best to fix Social Security before one of its major funding sources is depleted, the vast majority of Americans doubt that the program will offer enough money to finance a comfortable retirement.**

Nearly nine in 10 (88%) Americans say it is "critical" to have another source of guaranteed income beyond Social Security benefits in order to retire comfortably, according to a new survey from Allianz Life Insurance Company of North America.

The survey of 1,005 U.S. adults, conducted in March and released on April 10, found that roughly three-quarters (74%) of respondents say they can't count on Social Security benefits when planning their retirement income.

Seventy-eight percent worry that they might not be able to afford the lifestyle they want in retirement due to the increased cost of living, while 62% would rather have their money sitting in cash accounts instead of putting it into stocks and other assets subject to market swings.

"Social Security benefits are often the backbone of a retirement strategy but it cannot be your entire strategy," Kelly LaVigne, Allianz's vice president of consumer insights, said in a press release. "A strong retirement strategy will ensure you have enough guaranteed income to cover your essential expenses. That guaranteed income can come from Social Security benefits along with other investments and protection products such as annuities."

The economy remains a concern to many Americans, with more than half (57%) of respondents saying they worry about a major recession. Although that is down from last year's figure, roughly four in 10 (41%) of Americans are still concerned they'll be laid off because of an economic downturn in 2023.

"A strong retirement strategy will address potential risks like inflation and taxes," LaVigne said. "You can't prepare for everything, but you can prepare for anything — if you start preparing for retirement early."

However, uncertainty surrounding Social Security makes retirement planning a tricky endeavor.

As previously reported by GOBankingRates, the annual Trustees' report, released on March 31, estimates that the program's Old Age and Survivors Insurance (OASI) Trust Fund **will become depleted in 2033** — one year earlier than projected in the 2022 report. When the fund runs dry, Social Security benefits would have to be funded solely through payroll taxes, which cover only about 77% of current benefits.

Lawmakers are at loggerheads about what to do about it. Many Democrats advocate increasing revenues through higher Social Security payroll taxes, while some Republicans aim to pare down the program by privatizing part of it or raising the full retirement age to collect benefits.

With the prospect of reduced Social Security benefits, many Americans want to increase retirement savings. But even that is a worry — especially for Gen Xers, many of whom will hit retirement age over the next decade just as the OASI fund is running out.

The Allianz survey found that 43% of Gen Xers worry their employer will suspend their 401 (k) match. That compares to 38% of millennials and only 24% of boomers. Two-thirds of Gen Xers say they are keeping more money out of the stock market than they should, and 85% worry that they might not be able to afford the lifestyle they want in retirement because of the increased cost of living.

"Gen Xers are entering … critical years of retirement preparation," LaVigne said. "Many people are often in their highest earning years in their 40s and 50s and finally able to really save a significant amount of money for retirement. This is when they need to establish strategies and really focus in on how they are setting themselves up for the retirement lifestyle they want."

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Can Smarts Help Shield Folks from Obesity? Maybe Not

A teenager's brain power appears to have little bearing on whether they will become overweight or obese as adults.

British researchers found that, on average, sharper teens weighed only slightly less in adulthood than siblings who scored lower on tests of thinking skills, according to a new study published April 13 in the journal *PLOS Medicine*.

The difference amounted to just under a half-pound for a 6-foot-tall adult, said lead author **Liam Wright**, a senior research fellow in population health at University College London.

"We found a very small association that in practice means that, on average, siblings with higher cognitive ability are unlikely to weigh much less than siblings with lower cognitive ability," he said.

The research refutes prior studies that have linked low cognitive scores in teens to higher risk of obesity in later life.

That's because those earlier studies looked at general populations, and didn't take into account other powerful factors besides smarts that could influence a person's weight, Wright said.

"The problem with comparing people from the general population according to their cognitive ability and BMI is that unobserved factors may explain the association," he said. (BMI, or body mass index, is an estimate of body fat based on height and weight.)

To account for those unknown factors, Wright and his colleagues analyzed data on 12,250 siblings from more than 5,600 U.S. households. These sibs were followed from adolescence to age 62 as part of four separate studies.

Comparing siblings could help account for some hidden factors that might influence weight, since brothers and sisters share a common background, Wright said. For example, they have similar genetics and are raised in the same household.

"Many studies by necessity use simple observational designs where correlations can be explained by factors that were not measured in the study," he said. "Sibling designs are an improvement, in the sense that they can account for factors that are shared between siblings without needing to measure them."

The researchers first looked at everyone included in the combined data set and found that low-scoring teens did indeed appear to weigh more. Cognitive ability was measured through math and reading tests.

But when researchers specifically compared siblings, the difference in weight based on cognitive ability all but vanished.

Mayo Clinic neurologist **Dr. David Knopman** noted that low-scoring teens in this study should not be considered developmentally disabled.

"This article was definitely not talking about cognitive impairment. It was merely talking about high versus low cognitive test scores in presumably cognitively intact adolescents or children," Knopman said. "I would definitely not use the word impaired to refer to the low-performing folks."

The findings run counter to the general assumption that obesity is a condition guided strictly by self-control and decision-making, said **Andrew Brown**, biostatistics core director for the Center for Childhood Obesity Prevention at the Arkansas Children's Research Institute.

Under this line of thinking, sharper people are better able to use nutritional and other health-related information to avoid excess weight.

"Implicitly, a lot of people indicate that obesity is caused by choices, and choices relate to cognition," Brown said. "It's the ability to think about and understand choices, if you use cognitive ability as a proxy for the ability to 'make good choices.'"

Mental ability also is associated to higher pay and better education, which, theoretically, would lead people to live in safer neighborhoods with access to healthier food.

But factors other than smarts likely have a greater impact on obesity risk, Wright said.

"The heritability of BMI is high -- greater than 50% -- so genetics are important within a population," he said. "But obesity rates have also increased massively over the past four decades, far faster than any genetic changes could have occurred, so it's clear that environmental factors have large effects on obesity, too."

One such factor could be the increased "availability of cheap, energy-dense foods" like fast food and processed foods, Wright said.

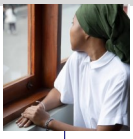
Black Cancer Patients Much More Prone to Chemo-Linked Heart Trouble

Sometimes cancer, and the treatments meant to eradicate it, can damage the heart and blood vessels. Now, a new analysis finds that damage may be much more likely if the patient is Black.

Black patients had 71% higher odds of developing what is known as cardiotoxicity following chemotherapy when compared to white patients. They also had increased odds of being diagnosed with congestive heart failure.

This doesn't mean Black cancer patients shouldn't get the cancer treatment they need, stressed lead study author **Wondewossen Gebeyehu**, a medical student at the University of Toronto.

"We definitely advise all patients, regardless of race, to seek appropriate cancer treatment and therapies as recommended by clinicians," Gebeyehu said. The review is "more an investigation into how we can best help Black patients throughout the process of cancer treatment to try to address these disparities."



The **research** is scheduled for presentation Friday at an American College of Cardiology conference in Washington, D.C. Findings presented at medical meetings should be considered preliminary until published in a peer-reviewed journal.

A review published online in December 2020 in the journal ***Cancers*** summarized how cancer treatments can damage the heart, noting that cardiotoxicities linked to cancer treatments include cardiomyopathy (heart disease), atrial fibrillation (irregular heartbeat), arterial high blood pressure and myocarditis (heart inflammation).

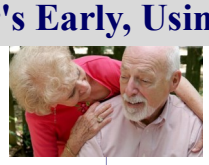
A number of different therapies were implicated, including radiation, treatments directed at certain breast cancers, anthracyclines, fluoropyrimidines, platinums, tyrosine kinase inhibitors and proteasome inhibitors, immune checkpoint inhibitors, and chimeric antigen-presenting (CAR)-T cell therapy.

In his review, Gebeyehu screened more than 7,000 studies from several databases before honing in on 24 studies representing nearly 684,000 participants.

This is not the only health care area where significant disparities exist for Black patients. Although it's difficult to point to a specific cause, there are a number of possible reasons, including socioeconomics and systemic racism, Gebeyehu said.

"We also know that Black and African American patients are often underrepresented in clinical trials for drug development. One has to wonder whether that could play a role in cancer treatment, drugs being optimized in patient samples where Black patients are underrepresented and thus the agents are not optimized to effectively treat Black patients' cancers with low levels of side effects or complications," Gebeyehu said….**Read More**

AI Might Spot Alzheimer's Early, Using Folks' Speech Patterns



Cutting-edge AI technologies that can detect subtle changes in a person's voice may help doctors diagnose Alzheimer's disease and other cognitive impairments even before other symptoms begin.

In a **new study**, researchers used advanced machine learning and natural language processing (NLP) tools to assess speech patterns of 206 people. Of those, 114 participants met the criteria for mild cognitive decline.

"Our focus was on identifying subtle language and audio changes that are present in the very early stages of Alzheimer's disease but not easily recognizable by family members or an individual's primary care physician," said lead researcher **Dr. Ihab Hajjar,** a professor of neurology at UT Southwestern Peter O'Donnell Jr. Brain Institute in Dallas.

Study participants were already enrolled in a research program at Emory University in Atlanta. They completed several standard assessments of mental ability before being asked to record a spontaneous one- to two-minute description of an artwork.

"The recorded descriptions of the picture provided us with an approximation of conversational abilities that we could study via artificial intelligence to determine speech motor control, idea density, grammatical complexity and other speech features," Hajjar said in a UT Southwestern news release.

Researchers then compared participants' speech analytics to samples of their cerebral spinal fluid and MRI scans. This helped them determine how accurately the digital voice biomarkers detected both mild mental impairment and Alzheimer's disease status and progression.

"Prior to the development of machine learning and NLP, the detailed study of speech patterns in patients was extremely labor intensive and often not successful because the changes in the early stages are frequently undetectable to the human ear," Hajjar said. "This novel method of testing performed well in detecting those with mild cognitive impairment and more specifically in identifying patients with evidence of Alzheimer's disease -- even when it cannot be easily detected using standard cognitive assessments."

The strategy also was also far more time-efficient than other methods. Traditional neuropsychological tests typically take several hours; researchers spent fewer than 10 minutes capturing a patient's voice recording.

"If confirmed with larger studies, the use of artificial intelligence and machine learning to study vocal recordings could provide primary care providers with an easy-to-perform screening tool for at-risk individuals," Hajjar said.

He said earlier diagnosis would give patients and families more time to plan for the future and provide more flexibility for clinicians to recommend beneficial lifestyle changes.

Study findings were recently published in the Alzheimer's Association publication ***Diagnosis, Assessment & Disease Monitoring***.

Allergies: Climate Change Is Worsening 'Sneezin' Season'

Allergy and asthma sufferers may think their symptoms are harsher and lasting longer this spring.

They're not imagining it. The changing climate means that allergy seasons are starting about 20 days earlier, are 10 days longer and include 21% more pollen than they did in 1990, according to the U.S. National Institute of Food and Agriculture.

"It's a pretty simple equation," said allergist **Dr. Kathleen May**, president of the American College of Allergy, Asthma and Immunology (ACAAI).

"More pollen means more days of suffering with asthma and allergy symptoms," she said in a College news release. "People across the country are aware they need to start allergy and asthma medications sooner because symptoms arrive earlier and stay longer. As allergists, we're watching our patients sneezing, wheezing and dripping more. But we have the tools to help."

Warmer temperatures, longer growing seasons and decreased air quality all play their part.

A person dealing with seasonal allergies may experience sneezing, nasal congestion, runny nose, watery eyes, an itchy throat and eyes and wheezing. Pollen can also aggravate asthma symptoms. Allergists can help people get all of those symptoms under control.

In addition to avoiding pollen as much as possible, the ACAAI suggests two immunotherapy options for those with severe pollen allergies.

Allergy shots can help your body become less sensitive to pollen. For those who suffer from grass or ragweed allergies, tablets that dissolve under the tongue are another option. They're available with a prescription.

It's best to start these treatments 12 weeks before symptoms are expected to begin.

Many people suffer from both nasal allergies and asthma. Allergic asthma is the most common type.

The frequency of children with nasal allergies who also have asthma can be as high as 80%, according to the ACAAI. About 75% of adults ages 20 to 40 with asthma have at least one allergy.

"What many people don't realize is that the same things that trigger your seasonal 'hay fever' symptoms -- things like pollen, dust mites, mold and pet dander – can also cause asthma symptoms," May said. "If you have allergies, and you are wheezing or coughing, an allergist can determine if you also have asthma. Allergists are specialists at treating asthma and can put together a treatment plan to help you deal with both conditions."

Therapeutic Cancer Vaccine Boosts Survival for People Battling Advanced Melanoma

An experimental vaccine whipped up to specifically target a melanoma patient's tumor cells significantly reduces the likelihood of the cancer recurring, early clinical trial data show.

Each dose of the vaccine, called mRNA-4157/V940, is crafted based on the unique genetics of an individual patient's melanoma cells, said senior researcher **Dr. Jeffrey Weber,** deputy director of the Perlmutter Cancer Center at NYU Langone Health in New York City.

When administered alongside an immune-boosting drug, the vaccine reduced the likelihood of melanoma either recurring or causing death by 44% compared to results from the immunotherapy alone, results showed.

The vaccine teaches a person's immune system how to find and target melanoma by looking for neoantigens, or mutated receptors found on cancer cells, Weber said.

"They're only mutated in the tumor, not in the normal tissue," he said of these receptors. "So by definition, if they could be recognized by the immune system, the immune system would only recognize them on the cancer, it would not recognize normal cells, which is good. That would technically avoid toxicity."

Early attempts at cancer vaccines have tried the same thing with common antigens shared by many tumor cells, but they haven't been specific enough to work well, said **Dr. Timothy Yap**, medical director of the Institute for Applied Cancer Science at the University of Texas MD Anderson Cancer Center in Houston. He was not involved in this study.

"The investigators really felt that a personalized vaccine that targets an individual's very unique set of cancer neoantigens may overcome this limitation of these previous vaccine approaches," Yap said...**Read More**

Long Daytime Naps Might Raise Your Odds for A-Fib

Daytime naps longer than a half-hour appear to nearly double a person's risk of developing an irregular heartbeat, a new study reports.

People who nap 30 minutes or more a day have a 90% higher risk of developing the heart rhythm disorder atrial fibrillation (a-fib) than those who take shorter naps, according to research presented Thursday at a meeting of the **European Society of Cardiology**, in Malaga, Spain.

"Our study indicates that snoozes during the day should be limited to less than 30 minutes," study author **Dr. Jesus Diaz-Gutierrez** of Juan Ramon Jimenez University Hospital in Huelva, Spain, said in a society news release. "People with disturbed night-time sleep should avoid relying on napping to make up the shortfall."

Research presented at meetings should be considered preliminary until published in a peer-reviewed journal.

A-fib causes the heart's upper chambers to beat irregularly, increasing a person's risk of stroke fivefold, the researchers said in background notes. It's the world's most common heart rhythm disorder.

For this study, the investigators tracked more than 20,000 Spanish university graduates. Participants were divided into three groups: those who don't nap; those who nap less than 30 minutes; and those who nap 30 minutes or more each day.

During an average follow-up of nearly 14 years, 131 participants developed a-fib.

Those taking longer naps had nearly twice the risk of atrial fibrillation compared to those taking short naps, according to the first analysis. Meanwhile, folks who didn't nap did not have any elevated a-fib risk compared to short-nappers.

Looking more closely at short-nappers, the researchers found that those who napped for fewer than 15 minutes had a 42% lower risk of developing a-fib, while those who napped 15 to 30 minutes had a 56% reduced risk compared with long nappers.

"The results suggest that the optimal napping duration is 15 to 30 minutes," Diaz-Gutierrez said. "Larger studies are needed to determine whether a short nap is preferable to not napping at all."

He said there are many potential explanations for the link between napping and health.

"For example, long daytime naps may disrupt the body's internal clock (circadian rhythm), leading to shorter night-time sleep, more nocturnal awakening and reduced physical activity," he said. "In contrast, short daytime napping may improve circadian rhythm, lower blood pressure levels and reduce stress."

While the study found an association between naps and a-fib risk, it could not prove cause and effect.

Blood Donors' Gender Doesn't Affect Outcomes for Recipients

Whether the gender of a blood donor could affect the recipient's survival was an unanswered question in medicine. Until now.

"Some observational studies had suggested female donor blood might be linked with a higher risk of death among recipients compared to male donor blood, but our clinical trial found that isn't the case," co-lead author **Dr. Dean Fergusson**, a senior scientist at the Ottawa Hospital in Ontario, Canada, said in a hospital news release.

The U.S. National Heart, Lung, and Blood Institute identified this question as a research priority in 2015.

To study this, researchers began a large, innovative clinical trial with more than 8,700 patients.

"To answer this question definitively we needed a large, randomized clinical trial, but those studies are incredibly expensive," said **Dr. Michaël Chassé,** co-lead author of the study.

"By embedding this trial in real-world practice and using practical methods, we answered this question for a fraction of what a trial would normally cost," added Chassé, an associate professor at the University of Montreal.

Instead of using typical trial methods, the researchers enrolled every adult patient at the Ottawa Hospital who might need a transfusion, and then randomly assigned them to receive male or female blood. The study team then collected data from existing hospital databases and provincial registries.

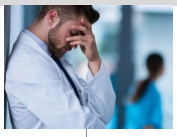
The research team estimated that using typical trial methods would have cost $9 million, compared to the $300,000 their approach cost.

The study excluded patients who did not have an Ontario Health Insurance Plan number and those who were massively bleeding and needed blood right away. Also excluded were those with a complex antibody profile that made it difficult to match blood.

About 80% of patients received their first transfusion as an inpatient, and 42% of those received it during surgery, the study authors noted.

The researchers collected data on patient characteristics, laboratory and clinical data, and blood bank data from the Ottawa Hospital Data Warehouse. Blood donor data from Canadian Blood Services was linked with hospital data and health administrative data.….**Read More**

Resident Doctors' Long Work Shifts Could Bring Peril to Patients



Early-career doctors were more likely to make mistakes when they had long work weeks or extended shifts, new research reveals.

Their patients were also more likely to experience adverse events as a result, according to the study. Moreover, doctors in their second year of training or above were more likely to experience safety events themselves, such as near-miss vehicle crashes and on-the-job exposures.

Nationwide work guidelines bar extended shifts for first-year resident physicians, but even second- and third-year physicians make these errors, researchers from Brigham and Women's Hospital in Boston learned.

"More experienced residents need sleep, just like anyone else, and when they work extended shifts or put in long weekly hours, they often do not have the opportunity to get the sleep that they need and are just as susceptible to these risks as first-year resident physicians," said corresponding author Laura Barger, an associate physiologist in the Division of Sleep and Circadian Disorders.

"Our research shines a light on an issue that affects both resident physicians and their patients and should prompt a reexamination of national guidelines," Barger said in a hospital news release.

In 2011, guidelines set by the Accreditation Council for Graduate Medical Education (ACGME) limited first-year residents to work shifts of 16 hours or less. This was based on recommendations from the National Academy of Medicine and informed by studies conducted by Brigham investigators over the last four decades, researchers noted.

However, the council endorsed extended-duration work shifts of up to 28 consecutive hours for more experienced resident physicians. All residents were allowed to work as much as 80 hours a week.

In the European Union, meanwhile, resident physicians are allowed to work no more than 48 hours per week.

To study the effects of longer shifts and work weeks on second-year and more experienced residents, researchers surveyed more than 4,800 U.S. resident physicians over eight academic years -- from 2002 to 2007 and 2014 to 2017. Respondents answered questions about patient safety outcomes as well as their own health and safety….**Read More**

U.S. Suicide Rates Began to Rise Again in 2021

In a disappointing finding, a new report shows that suicide rates in America are on the upswing again after a momentary, and minute, decline.

According to researchers from the U.S. Centers for Disease Control and Prevention, the suicide rate increased from 10.7 people per 100,000 people in 2001 to 14.2 per 100,000 in 2018. The rate then dropped to 13.5 per 100,000 through 2020, but rose again to 14.1 per 100,000 in 2021.

Why suicide rates rose, then dropped, then rose again isn't entirely clear, said senior study author **Sally Curtin,** a statistician at CDC's National Center for Health Statistics.

"We're not exactly sure what happened, because we know that many of the suicide risk factors increased, depression increased and money problems increased, we know all that," she said.

And early numbers from the first half of 2022 show that the suicide rate continues to climb, Curtin added, so the short-lived decline might just have been a blip.

"Unfortunately, the suicide rate bounced back after a couple of years of decline," she said. "If you look at the long, long picture, 20 years, it's been almost steadily increasing."

For the study, Curtin's team used data from the U.S. National Vital Statistics System.

The researchers found that suicide rates among women increased between 2020 and 2021, but that increase was significant only for women aged 75 and older. Suicide rates also increased significantly for young men, ages 15 to 24, for men ages 25 to 44 and older men ages 65 and older.

Suicide rates also increased for both Black and white women and for American Indian, Alaska Native and Black and white men, the researchers found.

In a separate report, using data from the National Hospital Ambulatory Medical Care Survey, CDC researchers found the rate of visits to emergency rooms for suicidal thoughts was 40 people per 10,000 between 2015 and 2020. That rate was higher among men (46 per 10,000) than women (34 per 10,000).

Among males, those aged 35 to 44 were those most likely to go to emergency rooms for feelings of suicide (97 per 10,000), while among women those aged 14 to 18 had the highest rate of emergency room visits for suicidal thoughts (128 per 10,000). Among minorities, the highest rate was among Black men and women (68 per 10,000), the researchers noted.

"Suicide is complex and is rarely caused by a single issue," said researcher **Deb Stone**, a behavioral scientist in the CDC's Division of Injury Prevention. "A combination of risk and protective factors at the individual, relationship, community and societal levels can contribute to suicide….**Read More**

Mouse Study Points to New Way to Shrink Pancreatic Tumors

New research in mice shows promise for a potential therapy for pancreatic cancer, which can be aggressive and hard to treat.

Researchers from Houston Methodist **tested a device** that, while smaller than a grain of rice, could deliver immunotherapy directly into a pancreatic tumor. It's called a nanofluidic drug-eluting seed (NDES).

The scientists invented the implantable device to deliver CD40 monoclonal antibodies at a sustained low-dose.

Tumors shrank at a dose that was four times lower than traditional systemic immunotherapy, the study authors reported. However, the findings are early and research done in animals is often different when repeated in people.

"One of the most exciting findings was that even though the NDES device was only inserted in one of two tumors in the same animal model, we noted shrinkage in the tumor without the device," said study co-author **Corrine Ying Xuan Chua**, an assistant professor of nanomedicine at Houston Methodist Academic Institute.

"This means that local treatment with immunotherapy was able to activate the immune response to target other tumors. In fact, one animal model remained tumor-free for the 100 days of continued observation," she said in an institute news release.

By the time pancreatic ductal adenocarcinoma is typically diagnosed, it has already spread in about 85% of patients.

Immunotherapy is promising for treating cancers that have lacked good treatment options. But it can cause many side effects, because it is delivered throughout the body.

By delivering the treatment directly into the tumor, the body is protected from exposure to toxic drugs, according to the study. This allows for a better quality of life during treatment….**Read More**

About 100,000 U.S. Nurses Left Workforce During Pandemic

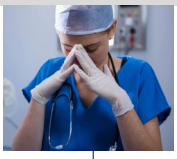
During the pandemic, nearly 100,000 U.S. registered nurses called it quits, a new survey shows.

Why? A combination of stress, burnout and retirements created a perfect storm for the exodus.

Even worse, another 610,000 registered nurses (RNs) said they had an "intent to leave" the workforce by 2027, citing those same reasons. And an additional 189,000 RNs younger than 40 reported similar intentions, the study from the National Council of State Boards of Nursing (NCSBN) found.

Put together, this means about one-fifth of the 4.5 million registered nurses nationally could leave the health care workforce in a short time period.

"The data is clear: the future of nursing and of the U.S. health care ecosystem is at an urgent crossroads," said **Maryann Alexander**, chief officer of nursing regulation at the NCSBN.



"The pandemic has stressed nurses to leave the workforce and has expedited an intent to leave in the near future, which will become a greater crisis and threaten patient populations if solutions are not enacted immediately," Alexander said in an NCSBN news release.

The survey laid bare the pandemic's impact on nursing, and examined the personal and professional characteristics of nurses experiencing heightened workplace burnout and stress due to the pandemic.

Data was gathered as part of a biennial **nursing workforce study** conducted by NCSBN and the National Forum of State Nursing Workforce Centers.

Among the findings: 62% of nurses sampled said they had an increase in workload during the pandemic; nearly 51% said they felt emotionally drained; and 56% said they felt used up. About 50% of nurses reported being fatigued; 45% said they were burned out; and 29% were at the end of their rope "a few times a week" or "every day."

These concerns were most pronounced in nurses with 10 or fewer years of experience, according to the report. This drove an overall 3.3% decline in the U.S. nursing workforce in the past two years. Meanwhile, the number of licensed practical/vocational nurses, who generally work in long-term care settings, declined by nearly 34,000 since the beginning of the pandemic.

Pandemic disruptions in nursing programs have also raised concerns about the supply and clinical preparedness of new nurse graduates. Early career data for these new nurses suggests decreased practice and assessment proficiency, according to the researchers.

Survey Shows 800,000 Nurses Plan To Quit By 2027