



Message from Alliance for Retired Americans Leaders

Senators Brown and Collins Urge Senate Leadership to Bring the Social Security Fairness Act to the Floor



Robert Roach, Jr
 President, ARA

This week Senators Sherrod Brown (D-OH) and Susan Collins (R-ME) sent a letter to Senate Majority Leader Chuck Schumer

Americans, unfairly denying them their full benefits.

The Social Security Fairness Act has 62 cosponsors in the Senate. The 62 cosponsors is significant because a bill needs 60 votes in the Senate to prevent a filibuster.

"The WEP and GPO deny millions of public sector retirees and their families the benefits they have earned," said **Roach**

Roach, Jr., President of the Alliance. "We strongly urge the Senate to heed Sen. Brown's and Sen. Collins' call for a vote."

Seniors Praise Choice of Governor Tim Walz as Running Mate

Citing his long record of public service as a member of the U.S.

House and Governor of Minnesota, Alliance members applauded Vice President Kamala Harris' choice of **Governor Tim Walz** as her Vice Presidential nominee Tuesday.

"Vice President Harris' selection of Governor Tim Walz as her running mate is another exciting and promising sign for seniors and their families. She has clearly chosen someone who understands what matters most to older Americans and will fight for us," said President Roach.

"Tim Walz understands that Social Security is essential. After his father died, his mother **relied** on those benefits to keep the household running," he added. "Like Vice President Harris, he will fight to make sure the benefits we've earned will be there for current and future

retirees."

As a member of the U.S. House from 2007-2019, Rep. Walz earned a 92% lifetime score in

the Alliance's annual Congressional Voting Record. He voted to pass the Affordable Care Act in 2010, which gave 65 million Medicare beneficiaries

screenings at no cost for diabetes, heart disease, breast, colon and prostate cancers and lower drug prices by closing the Medicare Part D doughnut hole.

"If he is elected Vice President, retirees should feel confident that the Harris-Walz administration will work hard to strengthen and protect their hard earned Social Security and Medicare benefits," said **Richard Fiesta, Executive Director of the Alliance.**

Governor Walz has been a pro-senior governor of Minnesota. He signed paid family and medical leave into law which helps seniors and families in times of need. His budgets included provisions to support retirees and family caregivers, prioritizing vaccines for seniors during the pandemic.

Fiesta noted that Older Americans can trust the Harris-Walz team to build on Vice President Harris' record of lowering drug prices and protecting retirees' hard earned pensions from their first day in office. In contrast, J.D. Vance earned just a 13% lifetime

Pro-Retiree Score in the Alliance's Congressional Voting Record for his votes against pro-retiree legislation when he served in the U.S. Senate. Read the Alliance's full statement [here](#).

In Case You Missed It: Executive Director Fiesta Joins "Seniors for Harris" Organizing Call with Second Gentleman Doug Emhoff and his Parents

Last Sunday's "Seniors for Harris" organizing call to elect Kamala Harris included not only Second Gentleman Doug Emhoff's parents Michael and Barbara Emhoff, Reps. Jim Clyburn (SC) and Sylvia Garcia (TX), actor/singer Richard Chamberlain, Executive Director Fiesta and other special speakers – it also included a surprise appearance by Emhoff himself.

"The issues for seniors are very stark, it's all in Project 2025... they want to take away Social Security benefits, Medicare, the progress we've made on lowering costs for Insulin for seniors, \$35 a month, negotiating with big pharma," said Emhoff, who has

been married to Vice President Harris since 2014. "Not only will Kamala Harris fight for seniors

but she's gonna fight for your children, and your grandchildren."

If you weren't able to attend the organizing call live, watch it [here](#).



Senators Sherrod Brown and Susan Collins



(D-NY) and Senate Minority Leader Mitch McConnell (R-KY) expressing the need for their bill, the Social Security Fairness Act, to be brought to the Senate floor for a vote as soon as possible.

The Social Security Fairness Act, S. 597 in the Senate and H.R. 82 in the House, would repeal the Windfall Elimination Provision (WEP), which limits Social Security benefits for people who receive disability benefits or a pension from an employer that did not withhold Social Security taxes. It also repeals the Government Pension Offset (GPO), which reduces the Social Security benefits of spouses, widows, and widowers who also receive a government pension. In total, these programs reduce the Social Security benefits of nearly 3 million



New Social Security Bill Phases Out Payroll Tax Cap

High earners would get bigger benefits in exchange for paying FICA taxes on all their wages.

The new legislation would phase out the wage cap on the payroll taxes that fund Social Security over the next seven years and encourage contributions “above the cap in exchange for additional benefits.”

Phasing out the cap on wages subject to Social Security contributions would ensure “that all benefits can be paid in full and on time for the foreseeable future,” according to Sen. Mazie Hirono and Rep. Jill Tokuda, the Hawaii Democrats co-sponsoring the **Protecting and Preserving Social Security Act**, introduced on Aug. 2.

The Hirono-Tokuda bill would also use the index formerly known as the Consumer Price Index for the Elderly (CPI-E) to calculate the relevant cost-of-living adjustment (COLA), rather than the more generic Consumer Price Index for Urban Wage Earners (CPI-W).

Sen. Bob Casey, D-Pa.,

chairman of the Senate Special Committee on Aging, introduced similar legislation in March, the **Boosting Benefits and COLAs for Seniors Act**, that would direct the Social Security Administration to adjust benefits based on CPI-E.

Phase-In Is ‘Clever’

In 2024, the Social Security tax known as FICA “is assessed against all wages up to a maximum of \$168,600,” Nancy Altman, president of Social Security Works, told ThinkAdvisor Monday in an email.

“This proposal calls for the assessment against all wages (though no unearned income, as some other Democratic proposals do), phased in over 7 years. Since FICA is 12.4% of the wages, the phase in is clever,” Altman said. “One-seventh of the 12.4% or 1.8% of all wages in year one, up to 12.4% of all income in year 7. Those contributing more would receive higher benefits.”

One of Social Security’s “most



important features is an annual automatic cost-of-living adjustment, so benefits don’t erode over time,” Altman said.

“Unfortunately, the current measure is out of date and under-measures the costs experienced by Social Security beneficiaries. Both bills update that important measure.”

Social Security Lifeline

The bill “will make significant progress toward extending the Social Security lifeline,” Hirono and Tokuda said in a statement.

According to the **Social Security Administration’s Office of the Chief Actuary**, the Protecting and Preserving Social Security Act is expected to extend the ability of the Old Age, Survivors, and Disability Insurance (OASDI) program to pay scheduled benefits in full and on time for an additional 19 years, moving the date of projected depletion from 2035 to 2054, the lawmakers said.

The bill would also reduce the

federal deficit by approximately \$13.3 trillion by the end of the 75-year projection period, according to the chief actuary.

The bill is co-sponsored by Sens. Jeff Merkley, D-Ore. and Tina Smith, D-Minn., as well as Reps. Steve Cohen, D-Tenn. and Jan Schakowsky, D-Ill.

The Protecting and Preserving Social Security Act is endorsed by the National Committee to Preserve Social Security and Medicare (NCPSSM); Alliance for Retired Americans (ARA); and Social Security Works.

“By adopting the CPI-E as the measure for calculating COLAs, the legislation assures that the purchasing power of Social Security benefits are more fully protected from the ravages of inflation, Max Richtman, president and CEO of the National Committee to Preserve Social Security and Medicare, said in a statement. “This legislation represents a bold step on behalf of seniors and all Americans.”

Social Security's Historic 2025 Cost-of-Living Adjustment (COLA) Is on Track to Yield a Trio of Disappointments

A record-breaking cost-of-living adjustment (COLA) in 2025 is unlikely to benefit most seniors.

For most retired Americans, a Social Security check isn't just another piece of paper. It represents a vital income source that an overwhelming majority of people age 62 and above would struggle to live without.

For the last 23 years, national pollster Gallup has been surveying retirees to gauge how much they rely on the income they receive from America's top retirement program. Consistently, between 80% and 90% of retirees lean on their monthly payout to cover at least some portion of their expenses. In Gallup's 2024 survey, only 11% of respondents noted that their **Social Security income** wasn't needed

Nothing matters more to the 86% of Social Security beneficiaries who are age 62 and above than the annual cost-of-living adjustment (COLA) reveal, which is slated for Oct. 10.

Although Social Security's

2025 COLA is on track to make history, it also **appears set to deliver a host of disappointments for seniors.**

What purpose does Social Security's COLA serve, and how is it calculated?

In a perfect world, the price for the goods and services we buy would remain static and we'd never have to worry about our wage, salary, or Social Security benefits failing to keep up with **inflation** (rising prices). But in the real world, the price we pay for all sorts of goods and services is dynamic. The purpose of Social Security's COLA is to ensure that benefits don't lose purchasing power over time.

Before 1975, cost-of-living adjustments were assigned without rhyme or reason by special sessions of Congress. Following the 1940s, when zero adjustments were made to benefits, **Congress passed along 11 COLAs from 1950 through 1974.**

Beginning in 1975, the Consumer Price Index for Urban

Wage Earners and Clerical Workers (CPI-W) became the inflationary measure used by Social Security to calculate annual cost-of-living adjustments. The CPI-W has over a half-dozen major spending categories and a multitude of subcategories, all of which possess unique percentage weightings. These weightings are what allow the CPI-W to be whittled down to a single figure at the end of a month, which makes for quick and easy year-over-year comparisons to determine if prices are collectively rising or falling.

Although the CPI-W is reported monthly by the U.S. Bureau of Labor Statistics (BLS), **only trailing-12-month readings from the third quarter** (July

through September) are used in the COLA calculation.

If the average CPI-W reading in the third quarter of the current year has risen from the comparable period in the previous year, inflation has taken place, and Social Security recipients are in line to see their benefits increase the following year. The amount of this increase is determined by the year-over-year percentage change in average third-quarter CPI-W readings, rounded to the nearest tenth of a percent....**Read More**



Senators Probe Social Security Administration's AI Use



Top senators have asked Martin O'Malley, the Social Security Administration commissioner, to detail steps that the agency is taking to ensure that its artificial intelligence systems "are being deployed responsibly, especially in contexts involving decisions about benefit eligibility and payment amounts."

In a letter Wednesday to O'Malley, Ron Wyden, D-Ore., the Senate Finance Committee chairman, and Mike Crapo, R-Idaho, the committee's top Republican, state that the SSA "is entrusted with ensuring accurate

and timely payment of more than \$1 trillion in Social Security benefits and Supplemental Security Income (SSI) payments to millions of seniors, individuals with disabilities, and their families each year."

In light of the agency's "important mission," Wyden and Crapo asked O'Malley to provide information by Sept. 3 on the SSA's use of AI, "including SSA's risk management frameworks for AI, positions for qualified personnel to develop and oversee AI, and the processes used to expedite disability

determinations and appeals." In November, Wyden and Crapo asked federal agencies about their use of AI "to ensure it is used appropriately."

SSA "systems help with important tasks such as reviewing and expediting certain disability claims, identifying possible fraud or abuse, and flagging cases with high expected overpayment for additional review," Wyden and Crapo said.

However, the senators noted that AI "is not a cure-all that can address all challenges" facing the

agency.

"Without the proper structure and guidelines for the procurement, deployment, and monitoring of AI systems, SSA's use of AI could reduce the effectiveness of its benefit administration processes, exacerbate improper payments, and jeopardize beneficiaries' financial security," the senators wrote. "To mitigate the risks associated with deploying AI across its programs, SSA must have strong governance frameworks in place that, among other important aspects, clarify the role of human discretion."

Home medical devices pose risks for Medicare beneficiaries and their caregivers

Increasingly popular home medical devices can be a huge help for Medicare beneficiaries (particularly ones with chronic conditions) and their family caregivers. The devices offer vital health assistance and treatment in a comfortable, convenient setting and are often used in **hospital at home** programs.

But these devices—known as **durable medical equipment** in Medicare Part B parlance and ranging from infusion pumps to nebulizers to CPAP machines to home dialysis machines—also come with five potential problems for users and **caregivers**:

- ◆ They often come with little or no support for the person

using the device when the Medicare beneficiary or caregiver lacks the knowledge and expertise to operate them effectively.

- ◆ They can be problematic in certain home environments.
- ◆ When they're recalled, users don't always know about it.
- ◆ Medicare doesn't cover their entire cost.

Medicare Part B pays for 80% of the cost of durable medical equipment (after the Part B deductible, which is \$240 in 2024) if a health provider determines it's medically necessary and prescribes it. You must purchase or rent the device



through a Medicare-enrolled supplier; if you have a **Medicare Advantage** plan from a private insurer, you must get the device from a company on its list of suppliers.

The aging population, technology improvements and Covid have contributed to the explosion in home medical devices, says Rene Quashie, vice president, digital health at the Consumer Technology Association.

But Scott Lucas, vice president for device safety at the ECRI nonprofit safety organization, says the devices are typically designed, and intended, for acute-care hospital use.

"Now we put them in the home and the expectation is for the patient or the caregiver to understand how to use those devices, interpret alarms, figure out settings, understand recall notices and effectively respond to those recalls," Lucas says.

Home medical devices: "a pressing safety hazard"

All these factors, Lucas says, create a system ECRI feels is hazardous.

In fact, ECRI named medical devices at home "**the most pressing health technology safety hazard for 2024**," based on its lab testing, investigations, assessments of hospital practices and research reviews....[Read More](#)

Medicare Poised to Add Important HIV Drug to Preventive Service List

In 2023, the Centers for Medicare & Medicaid Services (CMS) **opened a review** to determine if Medicare should cover Preexposure Prophylaxis (PrEP)—drugs used to prevent HIV—as a preventive service for people at high risk of HIV acquisition. Medicare Rights strongly supports this coverage, and CMS appears poised to make it official in September.

The Affordable Care Act (ACA) enabled Medicare to establish **preventive services** that people with Medicare can access without paying a deductible or other cost sharing. These services include care like vaccines to prevent flu

or pneumonia and various screenings and exams for early detection.

To determine if a service should qualify as a preventive service, CMS first gets a recommendation from the United State Preventive Services Task Force (USPSTF). If the USPSTF recommends or strongly recommends the service, CMS launches a national coverage determination process to ask for feedback and comments from stakeholders. CMS then weighs the recommendation and feedback to determine if it is appropriate to cover the service as a preventive



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service. **The USPSTF strongly recommended that PrEP be included as a preventive service** for

adolescents and adults at increased risk of HIV. In its exploration of the issue, the agency **demonstrated a strong link** between people adhering to their PrEP regimen and its effectiveness in preventing HIV.

Preventing new cases is vital. Despite breakthroughs in treating and managing HIV/AIDS, it remains a serious condition for over 1 million people in the United States, with nearly half **age 50 and older**. This population has an average of 4 core chronic diseases (including

HIV/AIDS), takes 12 Part D covered drugs (including 8 maintenance drugs), and incurs high prescription drug costs. And it is a matter of equity as well. Individuals with HIV/AIDS are more likely to be members of populations affected by disparities, including Black, Latino, and LGBTQ communities.

Though PrEP is already covered by Medicare, it can accrue significant costs. **Research has demonstrated** a clear link between drug costs and adherence, with adherence rising as costs fall, especially for people with lower incomes. [Read More](#)

Home visits: Another way Medicare Advantage plans gouge taxpayers

Policymakers who claim to be tough on crime continue to turn a blind eye to what appears to be multi-billion dollar corporate health insurer crimes in Medicare Advantage. Anna Wilde Mathews and colleagues report for [The Wall Street Journal](#) on millions of home visits to Medicare Advantage enrollees that increased insurer revenues by \$15 billion in three years.

The government's defective payment system to insurers rewards them for adding diagnoses codes to their enrollees' medical records. When nurses conduct home visits, they identify new diagnoses that increase insurer revenues from the government. Insurers can add diagnosis codes to enrollee records even if a doctor doesn't perform a procedure to treat the diagnosis.

By the WSJ's account, the nurses conduct screenings during their home visits that permit the

insurers to collect \$1,818 more on average per visit. In total, between 2019 and 2021, those visits lined the insurers' pockets by an additional \$15 billion.

UnitedHealth was best equipped to squeeze money out of those nurse home visits, collecting \$2,735 per visit on average. It conducted 2.7 million nurse visits last year alone. Humana did a relatively good job of maximizing revenues from those home visits, collecting \$1,525 per visit on average. CVS/Aetna received an additional \$232 per nurse home visit.

One former UnitedHealth nurse explained that she did an average of six home visits each day. As part of the visit, she would warm up people's toes to see how well blood flowed to them. The goal was to diagnose them with peripheral artery disease, which would mean an average of \$2,500 a year more for UnitedHealth.



The nurse said she did not believe that the device she used for the test worked properly to diagnose peripheral artery disease.

But, no one seemed to care, and she was told to keep using it. UnitedHealth added the diagnosis to 568,000 medical records over the three years, as a result of using this device.

UnitedHealth received \$1.4 billion from the peripheral artery disease diagnosis. Medicare says it is no longer making additional payments to insurers for peripheral artery disease diagnoses.

"Other nurses interviewed by the Journal said many of the diagnoses that home-visit companies encouraged them to make wouldn't otherwise have occurred to them, and in many cases were unwarranted."

UnitedHealth appears to take the cake when it comes to additional patient diagnoses from

the nurse home visits. Its nurses detected hyperaldosteronism 246,000 times over the three-year period the WSJ investigated, which was worth \$450,000 to the company. All other insurers combined diagnosed the condition less than 24,000 times and collected \$42 million as a result.

The WSJ had previously reported that insurers billed Medicare \$50 billion for enrollee health conditions that physicians never treated. Of that, thirty percent stemmed from nurse home visits. The WSJ found that many diagnoses were wrong or questionable.

To be sure, a nurse's home visit could be helpful to a patient. The nurse could help with medication management, for example. Of course, these visits are more than helpful to the health insurance companies.

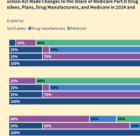
Medicare Part D drug costs: What to expect in 2025

If you have Medicare, you will likely see many changes to your Medicare Part D drug costs in 2025. The Inflation Reduction Act of 2022 should lower your drug costs. Here's what the [Kaiser Family Foundation](#) says to expect.

Your Medicare Part D premiums probably will increase in 2025. That's because your total annual out-of-pocket drug costs will be capped at \$2,000. To avoid higher costs and lower profits, Medicare Part D insurers will spread the cost of this cap across everyone who enrolls.

The Inflation Reduction Act anticipated a Part D premium increase. It includes a provision that does not allow the Part D "base premium" to rise more than six percent from the prior year. What does that mean exactly? If only it was as simple as a limit on your individual premium increase.

A new voluntary demonstration, through the Centers for Medicare and Medicaid Services, might also help some people in Traditional Medicare who buy stand-alone



drug coverage avoid big premium increases. It lowers the base premium by \$15 a month and limits the premium increase from 2024 to 2025 to \$35 a month.

The base premium for Part D will be \$36.78 in 2025. Unfortunately, that does not tell us what the Part D premiums will be. We will know that in September.

Here's what we know now: The standard Part D benefit is changing in significant ways. Enrollees getting the standard benefit will meet their deductible

and then pay 25 percent of the cost of their drugs until they reach the \$2,000 maximum out-of-pocket cap.

N.B. This year, if you are willing to give up access to the physicians and hospitals of your choice and subject yourself to huge administrative hurdles when you need complex and costly care by enrolling in a Medicare Advantage plan, your Part D premiums are, on average, significantly lower than the Part D premiums for stand-alone plans available to people in Traditional Medicare, \$9 v. \$43 a month.

This Is Elder Abuse: Types, Warning Signs, and How to Report It

Have any types of elder abuse ever affected you or anyone you know? Have you ever suspected that you or a vulnerable senior in your life might be suffering from neglect or mistreatment? Do you feel conflicted, afraid, embarrassed, or unsure of what to do about it? Each day, millions of older people in America and around the world are negatively impacted by elder abuse. It's an ugly problem that needs to be better understood and taken more seriously by everyone, in every

community. Nobody deserves to be neglected, exploited, or abused.

Unfortunately, the warning signs of abuse are often missed, ignored, or rationalized away—even by well-meaning people. In fact, it's likely that most cases of elder mistreatment go unreported, which means that Adult Protective Services, law enforcement agencies, and other relevant authorities often don't get the chance to intervene on



behalf of seniors who need help. As a result, countless older adults experience a poorer quality of life and worse

health outcomes than they otherwise would. (For victims of elder abuse, the risk of premature death is estimated to be three times higher than for seniors who haven't been abused, according to the [U.S. Department of Justice](#).)

By learning more about this subject, you can better protect yourself or those you care about.

Plus, our communities need more advocates for the elderly. People like you can be lights who shine hope in the darkness and help create positive change. This article will teach you what constitutes abuse and neglect, who and what to pay attention to, how to report elder abuse, and how to potentially prevent it from happening.

◆ [What is elder abuse? How prevalent is it?](#)
...[Read More](#)

How SHIPs Can Help With Your Medicare Questions and Problems

State Health Insurance Assistance Programs (SHIPs) offer free and unbiased insurance counseling and assistance to Medicare-eligible individuals, their families and caregivers. Are the unsolicited calls I'm getting from "Medicare" really offering me free medications, or is it a scam? What's the difference between **Medigap Plan F, Plan G and Plan N?** Should I enroll in a **Medicare Advantage plan** instead?

More than 2 million Americans with Medicare questions and problems like these call the State Health Insurance Assistance Program every year. SHIPs offer unbiased counseling and advice on all things **Medicare**.

"I liken Medicare assistance to getting tax advice," says Scott Maibor, the managing director at Senior Benefits Boston LLC in Massachusetts. "You can hire a CPA, or you can call the IRS

helpline."

In between, Maibor adds, there are other options, like volunteers or do-it-yourself software.

In the world of Medicare, a SHIP falls into the in-between category. It's useful if you don't want to hire a private broker but you need more assistance than what you could get calling the Medicare helpline.

Read on to learn more about how to take advantage of SHIPs' unique properties and how they can help seniors with **Medicare questions** and problems.

What Is a SHIP?

SHIP is a volunteer-staffed, free health benefits counseling service for Medicare beneficiaries. SHIP is funded by the U.S. Administration for Community Living and is not affiliated with any commercial insurance plans.

The SHIP in your state might



go by a different name. For example, the program in Florida is called Serving Health Insurance Needs of Elders in

Florida. To find the name of the program in your state, you can search on **CMS.gov**.

Take advantage of the program offerings, including:

- ◆ A helpline, which offers free one-on-one counseling
- ◆ The website, which has a **blog** containing helpful information about Medicare updates
- ◆ Local offerings, such as webinars or in-person **enrollment** events, to help you understand Medicare "Its mission is to empower, educate and assist Medicare-eligible individuals, their families and caregivers through objective outreach, counseling and training. This is to help people make informed health insurance

decisions that optimize access to care and benefits," adds Tasya C. Peterson, the press secretary of the Office of Strategic Communications at the Arizona Department of Economic Security in Phoenix. The DES Division of Aging and Adult Services in Arizona oversees SHIP.

SHIP also emphasizes helping communities that may be underserved due to isolation, poverty or cultural or language barriers.

How Do SHIPs Help Seniors With Medicare?

SHIPs help seniors with Medicare in many ways, says Ginny Paulson, the Cedar Rapids, Iowa-based SHIP Technical Assistance Center director. The SHIP Technical Assistance Center is a central source of information for and about SHIP programs nationally....**Read More**

New Rules May Curb Ongoing Discrimination in Medigap Plans

In late April, the U.S. Department of Health and Human Services (HHS) **updated regulations** for **Section 1557** of the Affordable Care Act (ACA), making its important nondiscrimination protections more widely available.

Also known as the Health Care Rights Law, Section 1557 is a core component of the ACA. It prohibits discrimination in health care based on race, color, national origin, age, disability, and sex. The updated rule reflects the U.S. Supreme Court's **2019 holding** that sex discrimination protections extend to discrimination based on sexual

orientation and gender identity. It further clarifies their application to discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; and pregnancy or related conditions.

Statutorily, Section 1557 applies to "any health program or activity, any part of which is receiving [f]ederal financial assistance." The final rule takes a more expansive view of this language than previous regulations by applying it to health insurance companies that receive direct or indirect federal



funding, and to all their plans if they are "principally engaged" in health care.

In so doing, the rule reaches Medigap plans for the first time. Historically, Medigaps have not had to comply with Section 1557 because they do not receive direct federal funding. This has allowed them to engage in discriminatory tactics like charging people more based on age and denying coverage completely due to health status.

However, under the new rule, this lack of federal funding is not the deciding factor. Instead, if a health insurance company offers

federally funded products—like Medicare Advantage, Medicaid managed care, or ACA marketplace plans, as many do—Section 1557 would apply to all their plan offerings, including Medigaps.

This would be a major shift, but not a complete solution. In a **new blog** for the Commonwealth Fund, Medicare Rights explains why, as well as what might happen next. To learn more about these potential changes, read the blog post, "**How a New Federal Rule Could Curb Discrimination in Medigap Plans.**"

Dear Marci: What is an Annual Notice of Coverage?

Dear Marci,

When speaking to my insurance company, I was told to look out for an Annual Notice of Coverage in the mail. Can you tell me more about this?
-Sara (Greenville, SC)

Dear Sara,

An Annual Notice of Coverage (ANOC) is sent out by your Medicare Advantage Plan or Part D plan, and provides information about changes to your coverage

in the upcoming year. It's usually sent out around September, since it can help you decide if you want to make changes to your coverage during Medicare's **Fall Open Enrollment** period, which runs from October 15th to December 7th.

There are three kinds of changes to look for in an ANOC:

- ◆ Changes to your plan's costs



Dear Marci

like premiums, deductibles, and copays

- ◆ Changes to the plan's network that might affect coverage for your current providers and pharmacies
- ◆ Changes to the plan's formulary that might affect coverage of your current drugs or their prices

After you've read about the changes to your coverage

coming up in the new year, you can decide if your plan will still meet your needs or if you'll want to change it during Fall Open Enrollment.

If you haven't received your notice by September 30th, contact your plan to request a copy.

I hope that helps!
-Marci

More Than 1 in 4 Americans Over 50 Are Now Caregivers

More than 1 in 4 Americans 50 or older are now caregivers, looking after at least one family member or friend who has a health problem or disability, a new poll has found.

In all, 30% of all people in their 50s and early 60s provide care to at least one person, the University of Michigan National Poll on Healthy Aging found.

By comparison, only 23% of people over 65 are caregivers, results show.

The poll also found that 1 in 10 caregivers in their 50s and early 60s are juggling the care of three or more people.

"Nationwide, these data confirm that caregiving for family and friends who have health challenges falls unevenly on people in their 50s and early 60s, and women," said [Sarah](#)

[Patterson](#), a University of Michigan demographer who worked with the poll team on the new survey.

About 32% of women aged 50 or older are caregivers, compared with 22% of men in the same age group, the poll found.

The poll also provided more information about who needs all this care.

About 23% of caregivers are looking after someone with an intellectual or developmental disability, while 66% are caring for a senior with a health problem or disability.

The most common health concern that required caregiving was a physical disability or mobility problem, affecting 59% of those needing care.

The next most common were



memory or thinking issues, affecting 42%, vision or hearing impairments at 28% and mental health concerns at 22%.

The results "show us more about the specific health issues and disabilities they're helping loved ones with, and about the need for more awareness of existing support programs for older adults and their caregivers," Patterson said in a university news release.

When asked who should be covering the cost of caregiving, 45% of people aged 50 and older felt the government should take the lead, while 27% said the person receiving care should pay. About 18% said it should be family or friends.

The poll also found that 61% of

caregivers didn't know about Area Agencies on Aging, which are local or regional groups that offer support to caregivers, seniors and the disabled.

"We hope these data will help policymakers and others understand who is providing care," said poll director [Dr. Jeffrey Kullgren](#), an associate professor of internal medicine at Michigan Medicine. "We also found that the majority of caregivers may not know about local or regional services that could help them or the person they're caring for."

The survey was conducted among nearly 3,400 people, including more than 900 caregivers, researchers said. The poll took place in February and March.

Social Security's 'Record' Backlog Caused \$1 Billion in Wrong Payments

Social Security has reached a "record-breaking" number of improper payments due to a substantial backlog in their system.

In February of this year, the Social Security Administration backlog had an "all-time high" of 5.2 million pending actions, which caused \$1.1 billion in improper payments.

The Inspector General announced the record-breaking backlog last week. The backlog has gradually been increasing since 2018, resulting in widespread over and underpayment errors.

"The improper payments have

to be gotten under control," Alex Beene, a financial literacy instructor for the University of Tennessee at Martin,

told *Newsweek*. "The issue is that's more easily said than done. So far, underpayments and overpayments remain key concerns, leading to issues where recipients either receive too little or too much and are in some cases asked to return the money, which causes even more complications."

The SSA attributed the backlog to the agency being short-staffed and facing a higher workload alongside limited overtime



funding. "Customer satisfaction has been an ongoing concern for SSA. This report continues to highlight the

urgency for SSA to reach its pending actions performance goal and to ensure beneficiaries receive their proper payments as promptly as possible," said Michelle Anderson, Assistant Inspector General for Audit serving as the Acting Inspector General for SSA, in a statement.

Overpayments are a particular concern when it comes to the SSA's improper payments, as they often force seniors to pay

back thousands of dollars while unable to make ends meet. The SSA often doesn't realize its error until years later when suddenly the recipient is on the line for \$50,000 to \$100,000 in payments.

"Not dealing with the backlog isn't just causing issues for recipients, but also for taxpayers in the form of billions of dollars going mismanaged," Beene said. "When people pay into Social Security, they expect the system to support them in retirement."....[Read More](#)

Medicare Advantage Is Denying More Requests for Seniors' Care: Report

Medicare Advantage has denied more prior authorization requests from seniors in recent years, according to a new report from health policy research firm KFF that was published Thursday.

Medicare Advantage, the privatized version of Medicare, serves a little more than half of all seniors on Medicare. The health insurance has several pros compared to traditional Medicare, including lower premiums and dental or vision coverage as an add-on.

However, seniors on Medicare

Advantage often have to get prior authorization to get certain types of treatments and they are also restricted to select providers within their network.

The number of prior authorization requests denied by Medicare Advantage grew between 2021 and 2022 from 5.8 to 7.4 percent. Altogether, 3.4 million prior authorization requests were denied, according to KFF.

In 2020, just 5.6 percent prior authorizations for seniors were



getting denied, showing seniors might be facing increasing frustration when it comes to their overall health care through Medicare

Advantage.

Prior authorization requirements are meant to ensure that a health service is medically necessary before getting approval for its coverage, however some seniors feel the treatments they need were rejected without a real reason.

"The recent uptick in Medicare Advantage denials is concerning,

to say the least," Michael Ryan, a finance expert and the founder of [michaelryanmoney.com](#), told *Newsweek*. "A former client called me in tears because her plan denied coverage for a specialist visit she'd been waiting months to get."

Issues with how Medicare Advantage insurers decide on prior authorization requests could be more pervasive than seniors know. While KFF found only one in 10 denied requests were appealed in 2022, the vast majority, 83 percent, of those appeals ended up overturning the original denial.



RI ARA HealthLink Wellness News

Please Note: All Articles In This Section Are For Information Only And Not Medical Advice

High diastolic blood pressure linked to 16% higher migraine risk in women

High blood pressure — specifically high diastolic pressure, when the heart is resting between beats — was linked to a slightly higher risk of **migraine** in women, says a new study funded by the Dutch Research Council and recently published in *Neurology*.

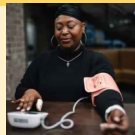
According to study author **Antoinette Maassen van den Brink, PhD**, of Erasmus MC University Medical Center in Rotterdam, the Netherlands, plenty of research exists about how migraine is linked to cardiovascular events like strokes, heart attack, and heart disease.

However, to date there has not been as much investigation into how cardiovascular health is linked to developing migraine.

Women with high blood pressure more likely to develop migraine

The recent study, which involved 7,266 men and women with a median age of 67, examined how smoking, obesity, high cholesterol, and cardiovascular disease like diabetes might be connected to the development of migraine.

Fifteen percent of the participants had previous or



current migraine. All participants provided blood samples and were given physical exams.

No connections between migraines and cardiovascular issues were found in the study's male participants.

There was no connection to systolic blood pressure, which is the maximum pressure in arteries during heartbeats. Blood pressure is measured as systolic over diastolic.

Maassen van den Brink suggested this was consistent with the idea that a constriction of the small blood vessels is more associated with migraine than any

reduced function of larger blood vessels.

Steven Alder, MD, consultant neurologist at Re:Cognition Health, who was not involved in this research, told *Medical News Today* that the study does indeed back up this concept.

"The theory that migraines are associated with reduced function in small blood vessels is supported by this study, which found a link between higher diastolic blood pressure — related to small vessel function — and migraines," Alder said....[Read More](#)

Sitting time may increase risk of all-cause mortality in adults with diabetes

For people with **type 2 diabetes** who spend a great deal of their time sitting, a new study finds that meeting recommended physical activity guidelines can offset the **reduction in longevity** associated with a sedentary lifestyle for people with the disease.

Previous studies have found that physical activity did not improve the all-cause mortality risk of people with diabetes who are sitting for a significant portion of their day. The new study finds otherwise.

The study from Columbia University's Mailman School of Public Health did suggest, however, the higher mortality rate among people with diabetes who spend **too much time**

sitting and who do not get sufficient exercise.

In their investigation, the researchers analyzed data from the 2007-2018 National Health and Nutrition Examination Surveys (NHANES). This included adults 20 years of age or older in the United States. All had diabetes according to the standards established by the American Diabetes Association or by a physician's diagnosis. They were followed through 2019.

During a median follow-up of 5.8 years, 1,278 deaths and 354 deaths due to heart disease were documented, with a higher sitting time combined with no or insufficient activity being associated with most of the



deaths.

The authors of the study report that inactive U.S. adults with diabetes who sat for eight hours or more each day had a 73% higher risk of all-cause mortality, and insufficiently active people had a 74% increase in risk.

Various health organizations, including the **American Diabetes Association** and American Heart Association, endorse the 150-minutes-per-week level of physical activity for optimal health for anyone.

People who were classified as active avoided increased all-cause death more often, as well as deaths from heart disease.

How sedentary lifestyle affects chronic disease risk

For some people, a sedentary, inactive lifestyle is a choice, while for others — such as drivers and office workers — it is a career necessity. For anyone, and for people with diabetes in particular, it is a hazardous habit.

Senior author of the study, the Mailman School's **Sandra S. Albrecht, PhD**, explained why:

"Sitting for a long time can lead to problems with blood flow, especially to the lower body, and can lead to the development of blood clots. Blood clots can trigger heart attacks and stroke, among other consequences."...

[Read More](#)

Why is rheumatoid arthritis tied to a higher risk of cognitive decline?

Studying the link between systemic inflammation and cognitive decline

For this study, researchers recruited 140 participants with an average age of 56, 80% of whom were women. Half of the study participant pool had rheumatoid arthritis, while the other half did not.

Scientists reported that about three out of four, or 72%, of rheumatoid arthritis participants had moderate to high levels of systemic inflammatory activity

caused by the disease.

All 140 participants took part in comprehensive neurological and psychological assessments, cognitive tests, and mood assessments at the beginning and end of the study.

Study participants were given scores for their cognitive ability based on the **Montreal Cognitive Assessment (MoCA)** test, where a score of less than 26 is considered a



cognitive impairment. Additionally, researchers tested participants for specific cognitive abilities including:

processing and ordering **visuospatial information** [Trusted Source](#)

- memory
- ◆ attention span
- ◆ language abilities
- ◆ abstract thinking
- ◆ ability to recall information after being distracted

- ◆ orientation — a person's ability to explain what time, place, and situation they are in
 - ◆ executive functions of working memory, concentration, and inhibition.
- Cognitive impairment higher in people with rheumatoid arthritis**[Read More](#)

Red Cross Issues Blood Shortage Alert as Summer Heat Cuts Donations

This summer's blistering temperatures have helped prompt an emergency blood shortage, the American Red Cross has warned.

Heat waves affected almost 100 blood drives last month, either by hurting turnout or forcing the events to be canceled. Since July 1, the national blood supply has fallen by more than 25%, the organization said in a [news release](#).

Blood donations do tend to slow down during the summer because of travel and holidays, but the Red Cross noted that last month's extreme heat contributed to a shortfall of more than 19,000 blood donations in July.

Donated blood is used routinely during operations and childbirths. The Red Cross has said donations help save the lives of women with pregnancy complications, patients with traumatic injuries and people fighting cancer and blood disorders.

"Working with patients who critically need a blood transfusion, I can't imagine blood not being available for someone I cared about and [who] needed it, especially a new mom or an infant that was needing a transfusion," Melissa Destross, a registered nurse in the labor and



delivery unit at a hospital in Detroit, said in the Red Cross news release. "I've seen moms in a hemorrhage situation, post-delivery, have massive blood transfusions, like blood losses over seven liters."

The Red Cross said type O blood is urgently needed. Type O blood is routinely in short supply because type O positive is the most common blood type, and type O negative is the universal blood type needed for emergency transfusions.

"Type O is especially important for people injured in accidents and other trauma who receive

emergency care," [Dr. Barry Siegfried](#), medical director of the Red Cross Michigan Region, said in the Red Cross news release. "Donors of all blood types can help ensure hospital shelves are restocked to prevent patient care from being impacted."

People can donate blood by finding a local blood drive or making an appointment at a donation center (which can be found by visiting RedCrossBlood.org or calling 1-800-RED-CROSS).

Those who donate by Aug. 31 will receive a \$20 Amazon gift card, the Red Cross added.

Cost Keeps Many Who Need Them From Getting New Weight-Loss Meds

Medicare and Medicaid patients are less likely to get cutting-edge weight-loss drugs than people with private insurance are, a new study finds.

Medicaid accounted for less than 10% of semaglutide ([Ozempic](#), Wegovy) prescription fills in 2023, researchers found.

Similarly, Medicare Part D accounted for less than 29% of Ozempic fills and a little more than 1% of Wegovy fills.

"If only certain patient populations get access to these medications -- those primarily with private insurance, more generous health plans -- then there's a huge percentage of the U.S. population that isn't getting access to these medications. And that brings up a very significant equity issue," said lead

researcher [Dr. Christopher Scannell](#), a postdoctoral researcher at the University of Southern California's (USC) Center for Health Policy & Economics.

For the study, researchers reviewed a pharmaceutical database that captures about 92% of prescriptions filled and dispensed at retail pharmacies in the United States.

Ozempic is a once-weekly semaglutide injection approved for use in treating type 2 diabetes in 2017. A higher-dose version called Wegovy was approved in 2021 specifically for weight loss.

Ozempic costs about \$1,000 a month, while Wegovy is \$1,350 a month, researchers noted.

Prescription fills



for [semaglutide drugs](#) skyrocketed by more than 400% between 2021 and 2023, reaching 2.6 million by December 2023, researchers found.

However, most of those prescriptions went to people with private insurance.

Access to semaglutide through Medicaid is a state-level decision, researchers noted. A state's budget -- or its politics -- might lead some programs to not cover the pricey medications.

Meanwhile, Medicare Part D doesn't cover semaglutide to treat obesity unless a patient also has another health problem like heart disease, the researchers added.

"If Medicare is only covering these drugs for patients who have obesity and a co-morbidity, it

may be forcing patients who only have obesity to develop these additional chronic conditions before they can get access to the medications," Scannell said in a USC news release. "It's like saying 'You have to be sick enough, then we'll cover that medication for you.'"

Diabetics are getting the short end of the stick as a result of the semaglutide craze, Scannell added.

"I think all the current attention in the media on semaglutide's anti-obesity effect obscures the fact that the drug is also hugely important for treating diabetes," Scannell said. "It's the reason why I've been able to get some of my patients off insulin."...[Read More](#)

Almost 50% of Global Dementia Cases May be Preventable

According to a [new report](#) published last week by the Lancet Commission on dementia prevention, intervention, and care, nearly half of all global dementia cases could be prevented or delayed by eliminating 14 risk factors throughout an individual's lifetime. The most recent Lancet Commission report, the third on the subject, identified 14 preventable risk factors that account for almost 50% of all dementia diagnoses.

The 14 risk factors identified by the Lancet Commission are lower levels of education, hearing loss, hypertension, smoking,

obesity, depression, physical inactivity, diabetes, excessive alcohol consumption, traumatic brain injury (TBI), air pollution, social isolation, untreated vision loss and elevated low-density lipoprotein (LDL) cholesterol.

Of all of the risk factors, the two tied to the largest number of dementia patients are hearing impairment and high LDL cholesterol, which both account for 7% of dementia cases worldwide. Almost as dangerous are limited education early in life and social isolation in later life,



which are both responsible for 5% of worldwide dementia cases.

The Commission report also provides 13 recommendations to

help mitigate the risk of dementia. They include preventing and treating hearing loss, vision loss, and depression; being cognitively active throughout life; using head protection in contact sports; reducing vascular risk factors (high cholesterol, diabetes, obesity, hypertension); providing supportive community environments to increase social



Joseph Peters, Jr.
Secretary
Treasurer ARA

contact; and improving air quality.

"Learning the risk factors for dementia and prevention strategies is incredibly important

for both seniors and the not-so-old," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "The possibility of preventing or delaying half of dementia cases is groundbreaking for older citizens all over the world and their loved ones."

Feel Judged by Your Doctor? You Might Not Be Imagining It

It's tough to open up to a doctor, even though it's vital if patients want the best care for what ails them.

Why the reticence? People worry they'll be judged by their doctor if they share mistaken beliefs or false ideas.

Now, a new study finds that's not an unfounded worry.

Doctors really do take strongly negative views of patients who share conspiracy theories or unreasonable beliefs, researchers found.

"People worry about their doctors looking down on them -- and it turns out that's an entirely rational concern," said lead researcher **Samantha Kleinberg**, an associate professor with the Stevens Institute of Technology, in Hoboken, N.J. "Our study suggests that doctors really do judge patients harshly if they share information or beliefs that they disagree with."

For the study, published Aug. 2 in the journal **Medical Decision Making**, the research team surveyed more than 350 patients and 200 physicians, asking how they would view people who had a range of different medical beliefs.

Some of the beliefs were unreasonable, like, "Drinking carrot juice will cure diabetes." Others bordered on conspiracy theory, like, "Medications intentionally cause diabetes as a side effect to create more customers for insulin."

Results showed that the more unreasonable a person's health beliefs, the more negatively they were viewed by both other people as well as health care professionals.

"We found that our subjects viewed people negatively if they held mistaken beliefs -- but viewed them much more



negatively if they held more unreasonable or conspiratorial beliefs," Kleinberg said in an institute news release.

"The degree to which healthcare professionals held negative perceptions towards patients espousing misinformation surprised us, and suggests doctors may need additional support and resources to effectively treat such patients," said researcher **Onur Asan**, an associate professor with the Stevens Institute.

Interestingly, doctors even viewed people negatively when they expressed mistaken beliefs about technical health-related topics, researchers found.

"That was a surprising result, and frankly a depressing one," Kleinberg said. "Laypeople aren't expected to have medical expertise, so doctors often have to correct mistaken beliefs on health issues. That shouldn't be

something that leads doctors to view patients more negatively."

Most people hold at least some incorrect health-related beliefs, researchers noted -- like taking vitamin C will cure a cold or eating a sugary snack can cause **diabetes**.

That makes it vital that patients feel free to ask their doctor for their expert opinion, Kleinberg said.

"We rely on our doctors to educate us and help us overcome these medical misconceptions -- but that's only possible if we're able to express our ideas freely, without fear of being judged when we get things wrong," Kleinberg said.

Patients also had little time for nonsense, even those with lots of personal experience related to health care, the study found. . . . **Read More**

Cancer screenings bring benefits at substantial cost

We've come a long way in being able to screen for a variety of cancers and less far in curing people with mid- to late-stage cancer. We still need to make sure everyone takes advantage of these cancer screenings; they are important for ensuring survival from cancer. Fortunately, people with Medicare can get several **cancer screenings** at no cost.

One **recent study** found that only about 50-60 percent of people with Medicare get breast and colorectal cancer screenings as recommended.

The cost of screening Americans for five different types of cancer is now \$43 billion a year, according to a new estimate published in the **Annals of Internal Medicine**, reports Gina Kolata for **The New York Times**. The researchers estimated the cost of breast, cervical, colorectal, lung and prostate cancer screenings.

Of the \$43 billion spent each year on cancer, more than \$22 billion is to cover the cost of colonoscopies. But, colonoscopies can both detect and



prevent cancer. Physicians can remove growths on the colon that can become cancer over time.

How beneficial are screenings? The U.S. Preventive Services Task Force, an independent entity that grades the value of screenings, recommends lung, breast, cervical and colorectal screenings as a way to reduce the likelihood of death. It does not take a position on the value of prostate screenings.

Cancer death rates have dropped significantly in the last

40 or so years, some say because many people have stopped smoking, improved their diets and otherwise take better care of themselves than in the past. The death rate from colon cancer has dropped by half. Today, about half of all eligible individuals are screened for colon cancer.

One **clinical trial** found that screening possibly reduced the likelihood of death from colorectal cancer by one third over 30 years. The overall risk fell to two percent from three percent.

Get These 9 Screenings to Keep Your Medicare Costs Down



Health care costs are high and only rising, and for older adults on Medicare, keeping costs down is important. These nine screenings and other tips can help you control costs and stay healthier longer.

While aging may come with wisdom, it also comes with an inevitable slew of health conditions -- and increasing medical costs.

As we age, our bodies go through physical and cognitive

decline, explains Roger Miller, a licensed clinical psychologist and neuropsychology team lead with Aviv Clinics in The Villages, Florida. This downward slope in health can not only make you more vulnerable to chronic and acute illnesses, but it can also affect your body's immune system, making it harder to fight off germs.

That doesn't mean you need to just accept that you'll be less healthy -- and spend more money on medical treatments-- as you age. Staying on top of routine



health care and getting several common **health screenings** can help control costs, especially for older adults enrolled in **Medicare**.

9 Screenings You Need

Of the routine health screenings your doctor may recommend, there are a handful that may help you stay healthier and keep costs down later in life, says Tina R. Sadarangani, a board-certified primary care nurse practitioner and assistant professor at NYU who specializes in care of older adults. These include:

- ◆ **Blood pressure screenings**
- ◆ **Cholesterol checks**
- ◆ **Blood glucose testing**
- ◆ **Colorectal cancer screenings**
- ◆ **Vision and hearing tests**
- ◆ **Skin examinations**
- ◆ **Dental exams**
- ◆ **Depression screenings**
- ◆ **Screenings for cognitive impairment**

Emergency or urgent care? Why it matters

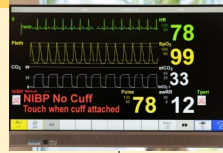
A growing number of hospitals are offering people both hospital emergency room services and urgent care at one site, reports Philip Galewitz for [KFF Health News](#). This model could be a financial winner for Intuitive Health, which is offering it in partnership with hospitals. Patients have little say over whether the care is billed as ER or urgent care or the cost.

The doctors at the Intuitive Health facilities decide whether patients receive ER care or urgent care. And, they have every financial incentive to choose hospital ER care. If the doctors decide the wound treatment is ER

care, the cost could be thousands of dollars more than if urgent care.

There's no bright line between what services are urgent and what services are emergency. Often care received in a hospital ER could have been gotten at an urgent care facility, such as ultrasounds and blood work. Physicians notify patients when the physicians determine the care needed is emergency care. While patients can choose not to receive ER care, the facilities can still charge them a triage fee.

The value proposition for Intuitive Health—backed by



Altamont Capital Partners, a private equity firm—is even greater than being able to bill for ER care for services that need not be treated as ER care. Intuitive Health can build a large patient base that leads to more medical tests, more physician and hospital services and more revenue.

Patients using the Intuitive Health facility in Florida had short waits for care. They appear to like having access to both emergency and urgent care services at one location. Intuitive is responsible for administrative activities, such as collecting

payment; their hospital partners provide the physicians and do the billing.

Medicare pays for these services because of the hospital affiliation, as do most other insurers. But, what patients pay varies considerably. If patients pay the “all-inclusive” fee out of pocket, it's \$250. With insurance, their copays could be higher than that, depending upon what the facility charges their insurers.

Patients with commercial insurance have **no federal protection from surprise medical bills**, since the protections do not cover urgent care facilities.

FDA Approves First Nasal Spray to Curb Anaphylaxis, An Alternative to Injections

People who are nervous about administering a rescue shot for anaphylaxis finally have a new alternative in a nasal spray. The U.S. Food and Drug Administration on Friday announced that it has approved neffy, the first non-injected treatment for life-threatening allergic reactions.

The epinephrine nasal spray is for use by adults and children who weigh more than 66 pounds, the agency said.

"Anaphylaxis is life-threatening and some people, particularly children, may delay or avoid

treatment due to fear of injections," Dr. Kelly Stone, associate director of the Division of Pulmonology, Allergy and Critical Care in the FDA's Center for Drug Evaluation and Research, said in an **agency statement**. "The availability of epinephrine nasal spray may reduce barriers to rapid treatment of anaphylaxis. As a result, neffy provides an important treatment option and addresses an unmet need." People with **allergies** can experience a sudden, frightening



reaction to allergens -- often certain foods, medications or insect stings.

Until now, epinephrine has been the only rescue medication when such incidents occur, and it's only been administered via a needle.

Neffy, made by ARS Pharmaceuticals, is delivered as a spray spritzed into one nostril, the FDA said. If the first dose doesn't ease symptoms, the agency urges giving a second dose (from a new dispenser) into the same nostril. Monitor patients closely after

epinephrine is used, in case further treatment, including emergency medical help, is needed.

"Neffy's approval is based on four studies in 175 healthy adults, without anaphylaxis, that measured the epinephrine concentrations in the blood following administration of neffy or approved epinephrine injection products," the FDA said. "Results from these studies showed comparable epinephrine blood concentrations between neffy and approved epinephrine injection products." ...**Read More**

How to prevent falls and their sometimes horrific consequences

According to the **National Institutes of Health (NIH)**, **more than one in four people over 65 fall each year**, and around **three million end up in the emergency room or as a hospital inpatient**. Falls are increasing, even though they are preventable. Falls are also costly. In the period between 2016 and 2018, the **average annual cost of falls** among older adults was **\$80 billion**.

For older adults, the consequences of a fall can be particularly horrific, restricting people's activities, if not robbing them of their independence. According to the CDC, **falls are the leading cause of injury and injury death** among people 65 and older.

How to prevent falls?

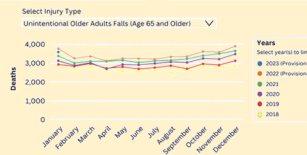
1. Talk to your doctor about the

side effects of the medications you're taking, both prescription and over-the-counter

drugs. Some medicines can make you dizzy and more prone to falls.

2. Make your home safer. Remove any loose rugs or tack them to the floor. Install grab bars in the bathroom. Use night lights.
3. Stand up slowly after sitting to avoid light-headedness.
4. Have your eyesight and hearing checked each year.
5. Use a cane or walker for stability.
6. Do balance and strength exercises.

Here are five exercises to



improve balance that the NIH recommends:

1. **Standing on one foot.** Place a chair in front of

you and hold on to it with one hand. Then raise one leg and hold it up for 10 seconds.

Then do it again with the other leg. Repeat this exercise three times on each leg.

2. **Walking heel to toe.** Place the heel of one foot in front of the toe of the other. Now take a step with your back foot and move it so that the heel is just touching the toe of your other foot. Repeat 18 more times. Focus your gaze on a spot in front of you to steady yourself. You can also hold your arms out on either side

of you for balance.

3. **Back leg raises.** Place a chair in front of you and hold on to it with one hand. Breathe in. Lift one leg back as you breathe out. Keep the leg you stand on slightly bent. Repeat 10-15 times on each leg.

4. **Side leg raises.** Place a chair in front of you and hold on to it with one hand. Breathe in. Lift one leg to the side as you breathe out. Keep the leg you stand on slightly bent. Repeat 10-15 times on each leg.

Balance walk. Walk in a straight line for 20 steps lifting one knee up and then the other. You can hold your arms out on either side of you for balance. You can also focus your gaze on a spot in front of you.