

Medicare Part D Enrollees Are Paying Thousands Out-of-Pocket Above the Catastrophic Threshold, Far More than Expected

A new report from the **Kaiser Family Foundation** found that 1.5 million Medicare Part D enrollees spent more than \$5,100 in 2019 for prescription drugs, four times the number of beneficiaries in that position in 2010. The increase is directly correlated to big pharmaceutical corporations increasing their prices, according to the researchers.

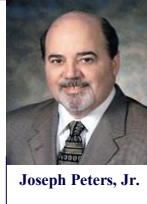
Today Medicare Part D, the

outpatient prescription drug benefit for Medicare beneficiaries, has no cap on the amount beneficiaries have to spend out-of-pocket each year at the pharmacy counter. Instead, the program has a catastrophic threshold level, above which they pay 5% of their total drug costs, unless they qualify for additional subsidies. However, there are ongoing, bipartisan efforts to introduce a hard cap on

out-of-pocket expenses.

In 2021, the catastrophic threshold is \$6,550. With no hard cap on out-of-pocket drug spending, Medicare beneficiaries without low-income subsidies who have conditions such as cancer, multiple sclerosis, rheumatoid arthritis, or hepatitis C may pay thousands of dollars in out-of-pocket costs for their medications after exceeding the catastrophic threshold.

"Congress must take action to lower drug prices now," said **Joseph Peters, Jr.**, Secretary-Treasurer of the Alliance. "Last year the House of Representatives passed legislation that would cap out-of-pocket drug spending at \$2,000, but it died in the Senate. Life-saving drugs should be affordable for all who need them."



Joseph Peters, Jr.

Staffing Shortages, High Turnover Make Finding Home Care for Older Adults Even Harder

At the start of the coronavirus pandemic, many folks feared bringing outsiders into their homes and released their caregivers, opting instead for family care. Now, as the country seeks out caregivers to rehire, there are very few available. Staffing shortages for home care were already a problem before the pandemic, but now the issue is even worse.

The Bureau of Labor Statistics

estimated job losses of 342,000 in the direct care workforce in 2020 — including nursing home and other residential care and home care staff. The losses came through layoffs and from people resigning due to health problems, fears related to Covid, lack of child care and other impediments. In addition to labor shortages, the caregiving industry is still coping with incredibly high turnover rates of

about 66% this year.

Making the problem worse, a return to workplaces means that many adult children can no longer provide elder care. With more than 800,000 older and disabled people who qualify for Medicaid on state waiting lists for home care, agencies serving private-pay clients are turning away business "Home care is a critical part of making sure that older

Americans can age gracefully and remain in a comfortable environment," said Executive Director **Fiesta**. "Staffing shortages and high turnover lower the quality of care we can provide, but we know the solution: Congress must pass the Better Care Better Jobs Act, S.2210, to solve these problems."



Rich Fiesta

Support for Medicare Drug Price Negotiation Among Voters 65 and Older

Key findings

There is overwhelming support for drug price negotiation, confirming previous polling. An 87% majority of voters over age 65 favor allowing Medicare to negotiate drug prices, including 48% who are strongly in favor.

Among Democratic seniors, 89% are in favor, as are 87% of Republican seniors and 81% of independent seniors. Voters over the age of 65 in rural areas (84%) favor the proposal with strong intensity as well.

Prescription drug prices is a politically salient, voting issue for seniors regardless of party affiliation.

If a Democratic candidate favored allowing Medicare to negotiate with prescription drug corporations to lower prescription drug prices, 51% of seniors would be more likely to vote for them, including 78% of Democrats, 35% of independents, and even 31% of Republicans. Half of Republicans (51%) say it would make no difference in their vote,



and 9% say they are unsure.

Further, if a Democratic candidate opposed allowing Medicare to negotiate with prescription drug corporations to lower drug prices, 55 percent of seniors would be less likely to vote for them, including a 60 percent majority of Democratic seniors, 53 percent of Republican seniors, and 49 percent of independent seniors.

Seniors want any savings from negotiating lower drug prices to be spent on adding vision, dental

and hearing benefits to Medicare.

Fifty-six percent of poll respondents said that savings from lower drug prices should be used to expand Medicare benefits, versus 15% who said it should be invested in public research into new treatments and cures and 9% who chose lowering Medicare's eligibility age to 60.

See a full summary of the findings from Lake Research Partners, who conducted the survey [here](#)

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Pfizer Court Fight Could Legalize Medicare Copays and Unleash ‘Gold Rush’ in Sales

Three years ago, pharma giant Pfizer paid \$24 million to settle federal **allegations** that it was paying kickbacks and inflating sales by reimbursing Medicare patients for out-of-pocket medication costs.

By making prohibitively expensive medicine essentially free for patients, the company induced them to use Pfizer drugs even as the price of one of those medicines, covered by Medicare and Medicaid, soared 44% to \$225,000 a year, the Justice Department alleged.

Now Pfizer is suing Uncle Sam to legalize essentially the same practice it was accused of three years ago — a fighting response to a federal crackdown that has resulted in a dozen drug companies being accused of similar practices.

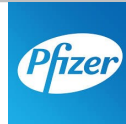
A Pfizer win could cost taxpayers billions of dollars and erase an important control on pharma marketing after decades of regulatory erosion and soaring

drug prices, say health policy analysts. A federal judge’s ruling is expected any day.

“If this is legal for Pfizer, Pfizer will not be the only pharmaceutical company to use this, and there will effectively be a gold rush,” government lawyer Jacob Lillywhite said in oral arguments last month.

Pfizer’s legal argument “is aggressive,” said Chris Robertson, a professor of health law at Boston University. “But I think they’ve got such a political tailwind behind them” because of pocketbook pain over prescription medicine — even though it’s caused by pharma manufacturers. Pfizer’s message, “‘We’re just trying to help people afford their drugs,’ is pretty attractive,” he said.

That’s not all that’s working in Pfizer’s favor. Courts and regulations have been moving pharma’s way since the Food and Drug Administration



allowed limited TV drug ads in the 1980s. Other companies of all kinds also have gained free speech rights allowing aggressive marketing and political influence that would have been unthinkable decades ago, legal scholars say.

Among other court arguments, Pfizer initially claimed that current regulation violates its speech protections under the First Amendment, essentially saying it should be allowed to communicate freely with third-party charities to direct patient assistance.

“It’s infuriating to realize that, as outlandish as they seem, these types of claims are finding a good deal of traction before many courts,” said Michelle Mello, a professor of law and medicine at Stanford University. “Drug companies are surely aware that the judicial trend has been toward more expansive recognition of commercial

speech rights.”

Pfizer’s lawsuit, in the Southern District of New York, seeks a judge’s permission to directly reimburse patient expenses for two of its heart-failure drugs each costing \$225,000 a year. An outside administrator would use Pfizer contributions to cover Medicare copays, deductibles and coinsurance for those drugs, which otherwise would cost patients about \$13,000 a year.

Letting pharma companies put money directly into patients’ pockets to pay for their own expensive medicines “does induce people to get a specific product” instead of shopping for a cheaper or more effective alternative, said Stacie Dusetzina, an associate professor of health policy at Vanderbilt University. “It’s kind of the definition of a kickback.”...[Read More](#)

Bi-partisan Draft Legislation Addressing Medicare Advantage Care in Last Year of Life Released Last Week

On Wednesday of last week U.S. Senators Bill Cassidy, M.D. (R-La.) and Debbie Stabenow (D-Mich.) released **discussion draft legislation** following a troubling U.S. Government Accountability Office (GAO) **report** conducted at the request of the Senators. The report shows Medicare Advantage (MA) beneficiaries in the last year of life disenrolled to join Medicare fee for service (FFS), or “original Medicare,” at more than twice the rate of all other MA beneficiaries.

The report stated, “Stakeholders told GAO that,

among other reasons, beneficiaries in the last of year life may disenroll because of potential limitations accessing specialized care under MA.” It also showed that MA disenrollment in the last year of life increased overall costs to the Medicare program, estimating that FFS payments for such beneficiaries were \$490 million higher than if they would have stayed in MA in 2017.

“Medicare Advantage gives seniors better care at a lower cost,” said Dr. Cassidy. “To improve this program, we need to



make sure it best serves beneficiaries in their last year of life and does not shift costs to other parts of Medicare and taxpayers.”

“This report is alarming and raises serious questions. I’m very concerned that insurance companies may be denying seniors enrolled in Medicare Advantage plans the care they need, right when they need it the most. In addition to disrupting care, this leaves seniors and the government on the hook for higher costs. I look forward to further investigating this issue

and working with Senator Cassidy on legislation to make sure seniors get the high-quality health care they need,” said Senator Stabenow.

The discussion draft marks the beginning of a conversation to uncover the reason patients are facing these limitations and form solutions. Should this concerning trend continue, the discussion draft suggests requiring MA plans to retroactively pay for the first 90 days of FFS claims following a patient disenrolling from MA into FFS when in their last year of life.

It’s August – Congress’ Traditional Vacation Month

The House of Representatives has recessed for the month of August which means members will be going back home to their districts to meet with constituents. Many will also likely be taking some vacation time. However, they are on notice that they may be brought back in session if there is legislation to be voted on that

cannot wait until September.

This could include the infrastructure bill currently being worked on in the Senate and also an eviction moratorium bill, depending on what actions the Biden administration may take in the next few days.

The Senate continues to work



on the infrastructure bill and if they manage to pass it Senate Majority Leader Chuck Schumer (D-N.Y.) has vowed they will also pass a budget blueprint for a \$3.5 trillion social spending package. However, that legislation has no Republican support and even some Democrats are balking at it

because of its cost.

There are no committee hearings scheduled in the House of Representatives but the Senate will hold various committee hearings this week and will continue to do so until they officially recess for their August break.

Republicans have a plan to cut Social Security and Medicare

Jake Johnson reports in **Common Dreams** that Senator Lindsey Graham is using the Republicans' leverage in Congress to cut Social Security and Medicare. Only if Democrats agree to these cuts would Republicans agree to raise the federal debt ceiling.

Americans pay into Social Security and Medicare throughout their working lives. They earn these benefits. Alex Lawson, Social Security Works, explains that "Lindsey Graham and his fellow Republicans will stop at nothing to cut the

American people's earned Social Security and Medicare benefits."

It's apparently not enough that millions of retirees living in poverty or on the edge of poverty, that they are forced to go without healthcare, that they are dying prematurely. Medicare and Social Security help millions of people stay afloat. But, the Republicans want a commission to cut Social Security and Medicare as the price for raising the debt ceiling.

Meanwhile, Senate Democrats are working on a plan to raise the



debt ceiling. They should be voting to eliminate it. Either way, Republicans will try to stop this from happening. But, failure to increase or eliminate the debt ceiling could lead the federal government to **default** on its payments.

Under President Trump, Congress voted to suspend the debt limit through July 2021. With Trump out of power and a Democratic president in control, Republicans are no longer willing to support this. Senator Wyden, who chairs the Senate

Finance Committee, has said that he will not accept the Republicans' conditions for raising the debt ceiling. "Nobody is going to hold the American economy hostage, period, full stop."

Democrats could raise or eliminate the debt ceiling without Republican support, through the budget reconciliation process. To do so, they would need every Democratic Senator supporting the debt ceiling increase or elimination.

Two retirement bills would create 51 million new savers and \$6.2 trillion in savings

Lawmakers recently rolled out two new pieces of legislation that could have a game-changing impact on the number of Americans saving for retirement.

In a **Senate Finance hearing** Wednesday, the **CEO of the American Retirement Association Brian Graff testified** that passing both the Automatic IRA Act and the Encouraging Americans to Save Act would create 51 million new retirement savers and generate \$6.2 trillion in retirement savings over 10 years.

"The potential results of Congress tackling the two

biggest challenges in the retirement savings policy space—closing the retirement coverage gap and directly contributing to and incentivizing the retirement savings of moderate-income workers—are extraordinary," Graff said Wednesday.

The **Automatic IRA Act**, introduced by Sen. Sheldon Whitehouse (D-R.I.), would require employers with more than 10 workers to automatically enroll employees in a retirement plan. The bill would provide tax credits to employers to defray the costs of setting up the accounts.



The **Encouraging Americans to Save Act**, introduced last week by Senate Finance Chair Ron

Wyden (D-Ore.), would replace the **current saver's tax credit** with a government matching program that would match contributions of up to \$1,000 per year made to retirement accounts by individuals with **income up to \$32,500 and married couples with income up to \$65,000**.

This bill would make 120 million Americans eligible for the saver's match program, including gig workers and government workers like

teachers who are not traditionally provided access to matching programs, according to ARA.

Additionally, about 98% of the estimated 51 million brand new retirement savers earn less than \$100,000 and would benefit Black and Latino Americans. ARA estimated that the two legislative proposals would help 5.8 million Black Americans and 8.4 million Latino Americans become new retirement savers.

"I hope today's hearing is a launching pad for the committee to develop another bipartisan retirement package in the months ahead," Wyden said Wednesday.

As Medicare and Medicaid turn 56, let's remember younger adults will need them in the future

Younger adults no doubt have other things to think about besides today's 56th anniversary of Medicare and Medicaid.

Earning a living wage, buying a home, raising children - or even pursuing adventure and self-exploration - naturally may be more front of mind. Indeed, today's younger adults were decades away from being born when **President Lyndon Johnson** signed both landmark social programs into law on July 30, 1965.

"Medicare isn't really on my radar at all," says Charlotte, a 27-year-old youth educator from Dallas, whose unfamiliarity with the nation's largest federal health care program may be typical of many young adults. "I'm just trying to think about the next few

years. I only recently learned what a 401K is!"

But that doesn't make Medicare - or Medicaid - any less relevant to younger people, because they most certainly will need at least one of those programs during the course of their lives, most likely in older age. In fact, Medicare and Medicaid were built to last - to provide health security for generations of Americans to come.

Millennials with aging parents may already be aware of the crucial role that these programs play. Behnam, 36, a digital media specialist from McLean, Va., says Medicare was there for his 78 year-old father when he needed a pacemaker. "Medicare paid most of his hospital bills.



Without it, the cost to my parents would have been crazy. Now, I have a better appreciation of what Medicare does."

For 56 years, Medicare has provided health insurance to Americans 65 and older. It was enacted because private insurers typically **wouldn't cover older people at a reasonable price**, leaving too many seniors desperately lacking health care. Its sister program, Medicaid, was created to provide health insurance to lower-income Americans who **couldn't afford private insurance**. Medicaid also covers long-term care for lower-income seniors - like nursing homes and, more recently, home and community-based care (a healthier and safer

alternative). In fact, Medicaid pays **more than 60 percent** of long-term care costs in America today.

By 2050, there will be **81 million** people over age 65 in America. Seniors will make up **nearly 20 percent** of the population. With the adequacy of retirement savings in doubt and health care costs ever-rising, these future seniors most certainly will rely on Medicare and Medicaid even more than the current generation does. (Medicare will have some **30 million more** beneficiaries by the time older Millennials become eligible.).....**Read More**

Retirees: Social Security Benefits Are Replacing Less Income

Social Security benefits aren't an adequate source of retirement income without additional savings to support you. There's a simple reason for that: They replace a pretty small percentage of your pre-retirement earnings.

Unfortunately, that percentage is rapidly shrinking. According to the **Center for Retirement Research**, Social Security replaced about 41% of pre-retirement income in 1995 after accounting for Medicare premiums and taxation of benefits. But by 2035, that number will be down to just 29%.

Below, you'll learn about three factors that are contributing to what could be a disastrous reduction in retirement income for those who rely on Social Security.

Full retirement age is changing

The amount of Social Security retirees receive depends on when they first start getting checks. Seniors must start benefits at full retirement age (FRA) if they want their standard benefit. And FRA is gradually getting later.

For those born in 1955, it is 66 and 2 months. But those born in 1956 have an FRA of 66 and four months. It will move ahead by two months each year until everyone born in 1960 or later ends up with an FRA of 67.

This change to FRA ends up resulting in an effective benefits cut for future retirees. That's because early filing penalties reduce benefits for each month someone claims before FRA. Someone with a later full retirement age must either wait longer to get their full benefit (giving up income in the interim) or accept a smaller monthly check.

A later FRA also means fewer opportunities to receive delayed retirement credits, which raise monthly checks for each month a retiree delays the start of them between FRA and age 70. With retirees forced to wait longer to claim benefits or to accept a smaller check, it's no wonder Social Security won't replace as much of their pre-retirement earnings.

Medicare premiums are rising
Medicare premiums are rising



due to healthcare inflation. These premiums are typically deducted from people's Social Security checks, reducing the net value of their retirement benefits.

Social Security retirees get periodic cost of living increases, which are supposed to protect them from a reduced buying power due to inflation. But the Cost of Living Adjustments (COLAs) are calculated based on a measurement of inflation that underestimates the percentage of income seniors devote to medical care.

The result: Medicare premiums are going to take an increasingly big bite out of Social Security checks, eating up a large portion of a retiree's COLAs and resulting in benefits not replacing as large a percentage of income once the costs of Medicare are deducted.

More benefits will be taxed

Finally, a growing number of retirees will be subject to federal tax on Social Security, which also reduces the net value of their benefits. That's because the thresholds at which benefits are taxed are set in stone and don't

change each year to reflect wage growth.

People, on average, typically earn a little bit more each year as wages go up over time. Since Social Security benefits are based on average wages, the average benefit also goes up a little bit each year. So, since the dollar amount above which benefits are taxed *doesn't* change, more people cross over the threshold and end up owing money to the IRS.

Of course, if more Social Security benefits are being sent to Uncle Sam to pay a tax bill, the amount left over will replace less income.

Sadly, there's little seniors can do to stop any of these three changes. But future retirees *can* and must plan for their benefits to reduce a smaller percentage of their take-home pay. This means retirees need to **save extra cash for their later years** so retirement investments provide more supplementary income to make up for the reduced role Social Security will play in their support.

The Stealth Way Social Security Has Been Robbing Seniors of Their Benefits for Years



Social Security is a critical income source for millions of seniors, and while you'll often hear that it's not advisable to live on those benefits alone, the reality is that many seniors do. But some people do a good job of saving for retirement and securing other income streams. As such, their benefits represent just a portion of their total senior income.

That's really a more ideal situation. But seniors with outside income take one big risk -- getting taxed on their Social Security benefits. And worse yet, the rules regarding those taxes haven't changed in years, and seniors often feel the pain because of that.

An outdated set of guidelines
Seniors who don't have income outside of Social

Security can generally avoid taxes on their benefits. But those with additional income often get penalized in the form of taxes.

The taxation of benefits hinges on a calculation known as provisional income, which is a senior's non-Social Security income plus half of his or her annual benefit.

Seniors face taxes on up to 50% of their benefits once their provisional income exceeds \$25,000 for singles and \$32,000 for married couples. They then face taxes on up to 85% of their benefits once their provisional income exceeds \$34,000 and \$44,000, respectively.

Meanwhile, the cost of living has risen substantially since then -- yet the income thresholds for Social Security taxes haven't. And that leaves seniors in a



pretty bad spot. Avoiding taxes on benefits

Seniors who save for retirement strategically may be able to avoid getting slammed with taxes on their Social Security benefits. And one of the easiest ways to make that happen is to save in a **Roth IRA**.

Roth IRA withdrawals are not taxable income and also don't count toward provisional income. As such, a single tax filer who collects \$18,000 a year in Social Security and also takes \$24,000 a year in Roth IRA withdrawals would not have to pay taxes on benefits, despite having a total income of \$42,000 and a provisional income of \$33,000.

While higher earners aren't allowed to contribute to a Roth IRA directly, there's always the

option to fund a traditional IRA and then **convert it to a Roth account** afterward. It's a move worth making, considering that Roth IRAs offer other benefits in retirement outside of helping seniors avoid taxes on Social Security. For example, Roth IRAs are the only tax-advantaged retirement plan to not impose **required minimum distributions**.

It's bad enough that seniors face taxes on their Social Security income. But what makes the problem worse is the fact that the income thresholds that determine that haven't changed in multiple decades.

There's already pressure on lawmakers to **change the way Social Security raises are calculated**. Senior advocates should consider encouraging lawmakers to revisit these tax rules, as well.

Will My Husband's Income Hurt My Social Security Check?

Welcome to our "Social Security Q&A" series. You ask a question about Social Security, and a guest expert answers it. **Today's question comes from Rhonda:**

"I have not worked out of the home in over 10 years. I will turn 62 in a couple of months. At that time, I plan to apply for my Social Security retirement benefits and a spousal supplement. My husband started his benefits two years ago at age 65. For a year, his benefit was

reduced by the Social Security earnings limit. Since he has now surpassed his full retirement age, the earnings test no longer applies to him. Since I have no earned income, will my benefits be subjected to the earnings test, since my husband continues to earn well above the earnings limit?"

How the Social Security earnings test works

Rhonda, first let me briefly explain the Social Security



earnings test. It applies to Social Security recipients who have earned income and who are less than their full retirement age (FRA).

For 2021, the **annual earnings limit** is typically \$18,960. (An exception: For those reaching their FRA in 2021, the limit is \$50,520.) For every \$2 of earnings above \$18,960, Social Security benefits are reduced by \$1. (For those reaching their FRA in 2021, the reduction is \$1 for every \$3 in earnings.)

The earnings penalty applies both to an income earner's own retirement benefits and any spousal benefits arising from that recipient's record.

For example, suppose a 64-year-old husband has annual retirement benefits of \$20,000 and his wife is receiving \$5,000 as a spousal supplement on his record. If he earns \$2,000 above the limit of \$18,960, total benefits on his record are reduced by \$1,000....**[Read More](#)**

Dear Marci: What is an Annual Notice of Change?

Dear Marci,
Last year I received an Annual Notice of Change, or ANOC. Should I expect another one this year? What should I do with an ANOC?
-John (Nashville, TN)

Dear John,

The Annual Notice of Change, or ANOC, is the notice you receive from your Medicare Advantage or Part D plan in late September. So yes, you should expect to receive another one this year!

The ANOC gives a summary of any changes in your plan's costs and coverage that will take effect January 1 of the next year. The ANOC is typically mailed with the plan's Evidence of Coverage (EOC), which is a more comprehensive list of the plan's costs and benefits for the upcoming year. You should

review these notices to see if your plan will continue to meet your health care needs in the following year. If you are dissatisfied with any upcoming changes, you can make changes to your coverage during **Fall Open Enrollment**.

Here are three types of changes to look for:

Find out what you can expect to pay for services in 2022. Costs such as deductibles and copayments can change each year. For example, your plan may not have had a deductible in 2021, but it could have one in 2022. A deductible is the amount of money you owe out-of-pocket before your plan begins to cover your care. Another example is that your plan may increase the copayments you owe for visits to your primary care provider or



Dear Marci

specialists.

Check to see if your doctors, hospitals,

and other health care providers and pharmacies will still be in network for 2022. Plan networks

can change each year, which means your doctor may not be in your plan's network for 2022. You have the lowest out-of-pocket costs if you go to providers and pharmacies that are in your plan's network. If you see an out-of-network provider, your plan may not cover any of the cost of your care, leaving you to pay the cost out-of-pocket. You should also contact your providers directly to confirm that they will still be accepting your plan in the coming year.

Look through the plan's formulary. The formulary is the list of drugs the plan covers. Formulary changes can happen from year to year, meaning your

drug may not be covered in 2022 even though it was covered in 2021. Make sure your drugs will still be covered next year. If they are not, then you may want to **select a different drug plan** that covers all of your drugs. If the formulary is incomplete, or you do not see your drug(s) on the list, contact the plan directly to learn more.

If you have not received an ANOC by the end of September, you should contact your Medicare Advantage Plan or Part D plan to request it. This notice can be very helpful in determining whether you should make any changes to your coverage during Fall Open Enrollment. Reading your ANOC should also prevent any surprises about your coverage in the new year!

-Marci

Restoring a Sense of Belonging: The Unsung Importance of Casual Relationships for Older Adults

In May, Vincent Keenan traveled from Chicago to Charlottesville, Virginia, for a wedding — his first trip out of town since the start of the pandemic.

"Hi there!" he called out to customers at a gas station where he'd stopped on his way to the airport. "How's your day going?" he said he asked the Transportation Security Administration agent who checked his ID. "Isn't this wonderful?" he exclaimed to guests at the wedding, most of

whom were strangers.

"I was striking up conversations with people I didn't know everywhere I went," said Keenan, 65, who retired in December as chief executive officer of the Illinois Academy of Family Physicians. "Even if they just grunted at me, it was a great day."

It wasn't only close friends Keenan missed seeing during 15 months of staying home and trying to avoid covid-19. It was also dozens of casual acquaintances and people he ran



into at social events, restaurants, church and other venues.

These relationships with people we hardly know or know only superficially are called "weak ties" — a broad and amorphous group that can include anyone from your neighbors or your pharmacist to members of your book group or fellow volunteers at a school.

Like Keenan, who admitted he's an unabashed extrovert, many older adults are renewing these connections with pleasure

after losing touch during the pandemic.

Casual relationships have **several benefits**, according to researchers who've studied them. These ties can cultivate a sense of belonging, provide bursts of positive energy, motivate us to engage in activities, and expose us to new information and opportunities — all without the emotional challenges that often attend close relationships with family and friends....**[Read More](#)**

Do you have A-fib and what to do about it?

Jane Brody reports for [The New York Times](#) on "A-fib" or "atrial fibrillation," a relatively common heart condition that many people do not realize they have. If you get tired walking uphill or otherwise feel breathless, you could have A-fib, which causes an abnormality in your heart rhythm.

What is A-fib? It is a condition in which the upper chambers or atria of your heart do not beat in sync with the lower chambers or ventricles. The ventricles circulate blood through your body. If the upper and lower heart chambers are out of sync, then the lower chambers might not be able to pump all the blood your body needs.

What are the symptoms of A-fib? Your heart might beat irregularly and quickly for several minutes. Or, you might feel shortness of breath and dizziness from an activity that

normally would not cause these symptoms. Some people feel these symptoms on occasion. Others experience them regularly. You should not dismiss these symptoms, even if they disappear soon after you experience them.

What can trigger A-fib? Coffee and alcohol are two triggers.

How common is A-fib? Fairly common. You have a one in five chance of getting A-fib during your lifetime. About 3 million Americans have this condition. And, the number is on the rise. People with diabetes and high blood pressure are more likely to have it, as are people who are seriously overweight.

Will I know if I have A-fib? You might not. But, it's important you do. With timely and appropriate treatment, you can extend your life. Without



treatment, you increase your risk of having a stroke significantly. You also increase your risk of heart failure.

And, it could lead to dementia because of lack of blood in your brain.

Is A-fib a condition that can kill me? Yes. The evidence suggests that more than 150,000 people die of A-fib each year, either directly or indirectly.

How do I get tested for A-fib? Talk to your doctor. The doctor can test for it in a number of ways, often through a heart monitor. The doctor might also do an EKG or have you take a treadmill test.

Can A-fib be cured? Most people are prescribed treatment. Beta blockers and calcium blockers help to keep your heart beating regularly. You might also get an anticoagulant so that your blood doesn't clot.

Sometimes the doctor will do an electrical cardioversion, which uses paddles to the chest to shock your heart back to a standard beat.

Sometimes people receive ablation, an alternative to drug treatment, by which a catheter passes through a vein into your upper heart chamber in order to burn or freeze cells that are causing your heart to beat rapidly and irregularly. Ablation treatment has been found to be quite effective, although it generally takes several weeks to work. In the interim your heart can beat out of sync.

Warning: Sometimes prescription drugs stop working and you might need a change of treatment. So, if you have A-fib, you should be sure to see your doctor regularly.

CDC reverses indoor mask policy, saying fully vaccinated people and kids should wear them indoors

The Centers for Disease Control and Prevention recommended Tuesday that fully vaccinated people begin wearing masks indoors again in places with [high Covid-19 transmission rates](#). The agency is also recommending kids wear masks in schools this fall.

Federal health officials still believe fully vaccinated individuals represent a very small amount of transmission. Still, some vaccinated people could be carrying higher levels of the virus than previously understood and potentially transmit it to others.

"This pandemic continues to pose a serious threat to the health of all Americans," CDC Director Rochelle Walensky told reporters on a call. "Today, we have new science related to the delta variant that requires us to update the guidance regarding what you can do when you are fully vaccinated."

The updated guidance comes ahead of the fall season, when the highly contagious delta variant is

expected to [cause another surge](#) in new [coronavirus](#) cases and many large employers plan to bring workers back to the office. In mid-May, the CDC said fully vaccinated people didn't need to wear masks in most settings, whether indoors or outdoors.

"In areas with substantial and high transmission, CDC recommends fully vaccinated people wear masks in public, indoor settings to help prevent the spread of the delta variant, and protect others. This includes schools," Walensky said. The CDC recommends that everyone in grade schools wear masks indoors, "including teachers, staff, students and visitors, regardless of vaccination status."

Walensky said new data shows the variant behaves "uniquely differently from past strains of the virus," indicating that some vaccinated people infected with the delta variant "may be contagious and spread the virus



to others." White House chief medical advisor [Dr. Anthony Fauci](#) said Sunday that the CDC

was considering whether to revise mask guidance for vaccinated Americans, saying it was "under active consideration."

"It's a dynamic situation. It's a work in progress, it evolves like in so many other areas of the pandemic," Fauci, also the director of the National Institute of Allergy and Infectious Diseases, told CNN. "You've got to look at the data."

The CDC's guidance is only a recommendation, leaving it up to states and local officials on whether to reintroduce their mask rules for certain people. But even before the CDC's anticipated guidance Tuesday, [some regions were reintroducing](#) mask mandates and advisories as Covid cases began to spike again.

Walensky said a majority of the hospitalizations and deaths in the U.S. are occurring among

unvaccinated people, pointing to vaccines she said worked well in protecting against severe illness and death. "But the big concern is that the next variant that might emerge, we're just a few mutations potentially away where it could potentially evade our vaccines," she said.

President Joe Biden said the CDC's updated guidance was necessary to defeat the virus, and that he will lay out "next steps" to get more Americans vaccinated on Thursday.

"Although most U.S. adults are vaccinated, too many are not. While we have seen an increase in vaccinations in recent days, we still need to do better," he said in a statement. "More vaccinations and mask wearing in the areas most impacted by the Delta variant will enable us to avoid the kind of lockdowns, shutdowns, school closures, and disruptions we faced in 2020..." [Read More](#)

Want to Avoid Dementia? Add Some Color to Your Plate

(HealthDay News) -- Something as simple as having a glass of orange juice in the morning or an apple at lunch could be one of the keys to protecting your brain health.

People who consumed just a half serving a day of foods high in a naturally occurring compound called flavonoids had a 20% lower risk of mental decline, according to a new study.

"We think it may have important public health implications because based on what you're seeing in the current study, it could be that just by

making some simple changes to your diet, that is, by adding these flavonoid-rich foods into your diet, you could potentially help prevent cognitive decline," said study co-author Dr. Tian-Shin Yeh, a research fellow at Harvard T.H. Chan School of Public Health.

Besides bananas, apples, pears and sweet peppers, the list of flavonoid-rich foods includes celery, citrus fruits, cherries and berries. Flavonoids are a type of antioxidant, the researchers said.

In the absence of effective treatments for dementia, the



impact of risk factors that people can control, such as changing their diets and building in regular exercise, is getting more attention. Cognitive, or mental, decline is caused by a combination of genetic, lifestyle and environmental factors, Yeh said.

Researchers examined the diets and perception of subjective cognitive decline in about 77,000 U.S. adults enrolled in the Nurses' Health Study or the Health Professionals Follow-up Study. The women had an average age

of 48 and the men an average age of 51 at the start.

Participants completed several questionnaires over 20 years of follow-up that asked how often they ate certain foods. Researchers calculated their flavonoid intake.

Those who ate the most flavonoids had an average of 600 milligrams (mg) daily. Those who ate the least had 150 mg on average. To put that in context, an apple has about 113 mg of flavonoids, while there are roughly 180 mg in about two-thirds of a cup of strawberries....[Read More](#)

NIH unveils new online tool to improve Alzheimer's clinical trials recruitment

The National Institute on Aging (NIA), part of the National Institutes of Health (NIH), has launched a new online research tool to help increase participation by traditionally underrepresented populations in [clinical trials](#) on Alzheimer's disease and related dementias. Unveiled at the Alzheimer's Association International Conference (AAIC), [Outreach Pro](#) enables those involved with leading clinical research to create and customize participant recruitment communications such as websites, handouts, videos, and social media posts.

"We are facing a critical and

growing need for people living with Alzheimer's and related dementias, as well as those at higher risk, and healthy people, to participate in clinical trials," said NIA Director Richard J. Hodes M.D. "That need is especially acute for frequently underrepresented groups such as Black and Hispanic Americans, which is why Outreach Pro includes an emphasis on helping clinical trial researchers connect with these and other important communities."

Outreach Pro is an integral part of NIA's efforts to implement the [National](#)



[Strategy for Recruitment and Participation in Alzheimer's and Related Dementias Clinical Research](#)

Released in 2018, the national strategy was developed in collaboration with the Alzheimer's Association with input from government, private sector, academic, and industry stakeholders, as well as from individuals, caregivers, and study participants. The overarching goal is to engage broader segments of the public, including underrepresented populations, to participate in Alzheimer's and related dementias clinical research.

"It is critical that clinical trials have appropriate representation to ensure we have a complete understanding of how well different therapies or approaches to dementia care work in different populations," said Holly Massett, Ph.D., NIA senior advisor on clinical research recruitment and engagement, who oversees the implementation of the national strategy. "Outreach Pro was designed to provide well-tested and culturally appropriate outreach materials that resonate with diverse populations and encourage them to participate in clinical trials."...[Read More](#)

Claims That CDC's PCR Test Can't Tell Covid From Flu Are Wrong

Claim: "CDC has just announced they will revoke the emergency use authorization of the RT-PCR tests first introduced in 2/20. ... Translation: They've been adding flu cases to Covid cases when using that test."



Posts circulating on Facebook and Instagram claim the Centers for Disease Control and Prevention will stop using its covid-19 test because it cannot differentiate between the covid virus and flu viruses.

"CDC has just announced they will revoke the emergency use authorization of the RT-PCR tests first introduced in 2/20,"

reads a July 25 post, which goes on to quote from the agency's lab directive: "CDC encourages laboratories to consider adoption of a multiplexed method that can facilitate detection and differentiation of SARS CoV-2 and influenza viruses." It continues: "Translation: They've been adding flu cases to Covid cases when using that test."

Mike Huckabee, a former Fox News host who was also a Republican presidential candidate and governor of Arkansas, [similarly claimed on Facebook](#) that the CDC test cannot tell the difference between coronaviruses and flu viruses.

A July 24 [Instagram post](#) went further: "The FDA announced today that the CDC PCR test has failed its full review. Emergency Use Authorization has been REVOKED."

The [posts](#) were flagged as part of Facebook's efforts to combat false news and misinformation on its news feed. (Read more about PolitiFact's [partnership with Facebook](#).)

We wanted to know whether there was any truth to the idea that the CDC was removing its test because it is faulty and cannot tell one virus from another. So we consulted several laboratory testing experts.

The first Facebook post we referenced quoted from and linked to a [July 21 CDC laboratory alert](#) that informed labs that as of Dec. 31 the agency would withdraw its emergency use authorization request for the CDC 2019

It is standard practice for the Food and Drug Administration to issue temporary [emergency use authorizations](#) for tests and other medical products that have not yet undergone the FDA's full approval process but need to be used in an emergency to diagnose, treat or prevent serious diseases....[Read More](#)

Pfizer Says 3rd Shot of Vaccine Boosts COVID Protection

New data show that protection from both doses of the Pfizer COVID-19 vaccine decreases slightly over time, but that a third dose significantly boosts levels of antibodies against several variants of the virus, including the highly contagious Delta variant that's now dominant in the United States.

Not everyone thinks a third dose is necessary or should be prioritized, however.

The study of 42,000 volunteers in six countries found that the vaccine had an efficacy rate of about 96% against symptomatic COVID-19 for the first two months following the second dose, but that declined

by about 6% every two months after that, reaching 83.7% after six months, the *New York Times* reported.

The vaccine's efficacy against severe disease held steady at about 97%, according to the **findings** posted online July 28 on the preprint server *medRxiv*. The study ended before the rise of the Delta variant.

The vaccine's decline in efficacy is not big, "but it is noteworthy," Natalie Dean, a biostatistician at Emory University in Atlanta, told the *Times*. "Overall, they find that the vaccine is still



performing very well, at very high efficacy." Also on Wednesday, Pfizer disclosed that a third dose of its

vaccine significantly increases blood levels of antibodies against the Delta variant and other variants of the virus.

Those preliminary findings were included in an earnings statement and have not been peer-reviewed or published in a scientific journal. More conclusive results are expected in the coming weeks.

And while antibody levels are an important measure of immunity, the body has other defenses against infection,

the *Times* reported.

Pfizer has said it plans to seek U.S. approval for a third booster shot of its vaccine, but the issue has been controversial.

U.S. federal health officials have said boosters for the general population are unnecessary, and experts question whether vaccinated people should get booster shots when so many people in the United States and worldwide have yet to receive a first shot, according to the *Times*.

"There's not enough evidence right now to support that that is somehow the best use of resources," Dean said.

Deaths Related to Irregular Heart Rhythm May Be Rising, Especially Among Younger People

(American Heart Association News) -- Deaths related to atrial fibrillation appear to be on the rise, especially among younger adults, a new study suggests.

Atrial fibrillation – often called AFib – is an irregular heartbeat that sometimes leads to blood clots, stroke, heart failure and other cardiovascular complications. The condition is increasingly common, with an estimated 12.1 million people in the U.S. expected to have it in 2030.

The study, published Thursday in the *Journal of the American Heart Association*, used data from the Centers for Disease Control and Prevention.

Researchers focused on 276,373 people ages 35 to 84 who died between 2011 and 2018 from cardiovascular disease related to AFib.

After adjusting for age, researchers found about four additional AFib-related deaths per 100,000 people in the U.S. population in 2018 compared to 2011 – 22.3 deaths per 100,000 versus 18 deaths. Breaking it down by age, they learned the increase per year was greater among those 35 to 64 – 7.4% – compared to 3% among those 65 to 84.

Dr. Yoshihiro Tanaka, the study's lead author, said the



research did not prove AFib was causing more deaths, only that "it could be contributing to the increase."

He said the study was limited by possible misclassifications in the cause of death and a lack of data about when people were diagnosed with AFib, how long they had it and if they were treated for it.

Still, the findings are troubling, especially the rising AFib-related death rate for younger adults ages 35-64, said Tanaka, a cardiologist and researcher at Northwestern University in Chicago.

He also pointed out a disparity

among younger Black men and women, whose AFib-related death rates accelerated at a greater pace compared to their white counterparts.

"Prevention and treatment are very important," Tanaka said, as well as more education about AFib and easier access to care "to encourage younger and vulnerable populations to get treatment, possibly for free or at discounted prices."

He'd like to conduct future studies to see if smartwatches and other wearable devices might improve early detection of AFib and reduce death rates.... [Read More](#)

CDC Now Says Vaccinated Should Be Tested After COVID Exposure, Even Without Symptoms

(HealthDay News) -- People fully vaccinated against COVID-19 should be tested for the virus if they come into contact with infected people, whether or not they have symptoms, say updated testing guidelines from the U.S. Centers for Disease Control and Prevention.

The agency previously said that fully vaccinated people did not need to be tested after exposure to the virus unless they had symptoms, *The New York Times* reported.

Fully vaccinated people should wear a mask in public indoor spaces after exposure, the agency said. Three to five days later, they should be tested. If the results are negative, they can stop wearing masks indoors. If the results are positive, they should isolate at home for 10 days, the guidance states.

The new testing advice was released Tuesday, the same day the CDC issued [new mask guidelines](#) that recommend that



the fully vaccinated wear a mask indoors if they live in a high-transmission area.

The agency also recommended that vaccinated people in close contact with unvaccinated people, including children under 12, consider wearing masks in public indoor spaces whatever the transmission rates in the local community. In a shift, the agency also recommended universal masking in schools.

"Our updated guidance recommends vaccinated people get tested upon exposure regardless of symptoms," CDC director Dr. Rochelle Walensky told the *Times*. "Testing is widely available."

Even though fully vaccinated people may still get infected, people with these "breakthrough" infections tend to have mild or no symptoms because vaccines provide strong protection, according to the *Times*.

'Moderate' Drinking May Be Heart-Healthy

(HealthDay News) -- Here's a reason to not feel guilty about drinking a glass of wine every evening: A new study suggests that people who drink moderately may have lower risks for both heart attack and stroke than teetotalers — even when they have a history of heart issues.

The researchers found that among over 48,000 people with previous cardiovascular trouble, those who drank the equivalent of a single drink per day were less likely to suffer a repeat heart attack or stroke. They also

had a lower risk of dying during the 20-year study period.

The study authors cautioned, however, that the link does not prove a cause-and-effect relationship.

"It's difficult to determine whether light-to-moderate drinking really has a protective effect," said lead researcher Chengyi Ding, of University College London, in the United Kingdom.

One reason, she explained, is that in studies, "non-drinkers" may include people who used to



drink but quit for health reasons. So, moderate drinkers may simply look healthier by comparison.

And Ding and her colleagues did find that when former drinkers were excluded from their analysis, the benefits tied to moderate drinking waned.

Still, the researchers said, the findings suggest that people with a history of heart attack or stroke do not need to give up alcohol entirely.

Limits, however, are wise, according to Ding: In the study,

only people who drank up to 15 grams of alcohol per day showed reduced risks of a future heart attack or stroke.

That is roughly equivalent to a glass of wine or a pint of beer per day.

The moderation message is a long-standing one. Guidelines from the American Heart Association (AHA), for example, suggest that if people do drink, they should restrict it to no more than one drink per day for women — and two per day for men....[Read More](#)

AHA News: Find Your Way Back to the Gym – Safely

(American Heart Association News) -- If the pandemic put your workout routine on ice, you're in good company.

Gym attendance plummeted last year, and as people slowly return, their bodies may be telling them, "Hey! It's been a while!" Even the likes of action hero Will Smith acknowledged, "I'm in the worst shape of my life" before posting a video poking fun at how much he had forgotten about working out.

If you, like Smith, are plotting a fitness comeback, experts applaud you. But, they say, you need to be careful. Here's their advice on how to do that.

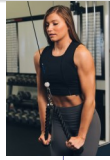
It starts with a vaccine.

The first step in a safe return

to the gym is to remember what drove people away.

"Number one, get vaccinated," said Dr. Brandee Waite, director of sports medicine at UC Davis Health in Sacramento, California. That's especially important as coronavirus variants spread.

"If you're indoors, and exercising and breathing hard, and are not vaccinated, by all means please wear a mask to protect yourself and the community that you wanted to rejoin," she said. Even fully vaccinated people should wear masks in public indoor settings in parts of the country with "substantial" or "high"



transmission rates, according to updated guidance issued Tuesday by the Centers for Disease Control and Prevention.

Masking also is a good choice for vaccinated people at increased risk for severe COVID-19 or those with high-risk or unvaccinated family members.

The CDC offers guidelines for gyms. Waite suggested checking to make sure you know what your gym is doing and are comfortable with it — so an unwelcome surprise doesn't become an excuse for not returning.

Is it safe to work out after having COVID-19?

For most people, yes, Waite

said. It depends on lingering symptoms. Anyone who had COVID-19 should get clearance from their physician before returning to exercise. Some people also might want guidance from a physical therapist or a doctor who specializes in rehabilitation.

A team of British researchers, writing in the journal *BMJ* in January, recommended waiting at least a week after symptoms clear and minimizing exertion for the first two weeks.

But overall, Waite said, "We want to get people back exercising, because we need their cardiovascular health to get better to improve their overall health."...[Read More](#)

Diabetes Drug's New Weight Loss Formula Fuels Cost-Benefit Debate

The long list of side effects that follow ads for the newer expensive drugs to treat Type 2 diabetes sometimes include an unusual warning: They might cause weight loss. That side effect is one that many people — especially those with Type 2 diabetes, which is associated with obesity — may desperately want.

So it's no surprise that some of the same drugs are being reformulated and renamed by manufacturers as a new obesity treatment. No longer limited to the crowded field of treatments for Type 2 diabetes, which [affects about 10%](#) of Americans, they join the far smaller number of drugs for

obesity, [which affects 42% of Americans](#) and is ready to be mined for profit.

One that recently hit the market — winning Food and Drug Administration approval in June — is Novo Nordisk's Wegovy, a higher-dose version of the company's injectable diabetes drug, Ozempic.

Ozempic's peppy ads suggest that people who use it might lose weight, but also include a disclaimer: that it "is not a weight loss drug." Now — with a new name — it is. And clinical trials showed [using it leads to significant weight loss](#) for many patients.



"People who go on this medication lose more weight than with any drug we've seen, ever," said Dr. Fatima Cody

Stanford, an obesity medicine specialist at Massachusetts General Hospital and Harvard Medical School who was not involved with any of the clinical trials.

But that leaves employers and insurers in the uncomfortable position of deciding if it's worth it.

Wegovy's monthly wholesale price tag — set at \$1,349 — is about 58% more than Ozempic's, although, the company points out, the drug's injector pens

contain more than twice as much of the active ingredient. Studies so far show that patients may need to take it indefinitely to maintain weight loss, translating to a tab that could top \$323,000 over 20 years at the current price. Weight loss treatments are not universally covered by insurance policies.

The arrival of this new class of weight loss drugs — [one from Lilly](#) may soon follow — has created a thicket of issues for those who will pay for them. The decision is complicated by many unknowables concerning their long-term use and whether competition might eventually lower the price....[Read More](#)

Dementia Cases Will Nearly Triple Worldwide by 2050: Study

(HealthDay News) -- The global total of people living with dementia will rise nearly three-fold by 2050, researchers say.

Cases are projected to increase from an estimated 57.4 million in 2019 to an estimated 152.8 million in 2050, driven mainly by population growth and aging.

This "emphasizes the vital need for research focused on the discovery of disease-modifying treatments and effective low-cost interventions for the prevention or delay of dementia onset," said lead researcher Emma Nichols of the University of Washington School of Medicine.

By 2050, 16% the world's population will be people over 65. That compares with 8% in 2010, according to the U.S. National Institute on Aging.

The researchers said the

largest increases in dementia are expected to occur in eastern sub-Saharan Africa, North Africa and the Middle East.

While positive trends in education access worldwide are expected to result in 6.2 million fewer dementia cases by 2050, smoking, excess weight and high blood sugar are predicted to boost cases by 6.8 million.

The projections, covering 1999 to 2019, are based on data from the Global Burden of Disease (GBD) study, a set of worldwide health trend estimates.

The findings were presented Tuesday at a meeting of the Alzheimer's Association, held in Denver and online. Research presented at meetings is typically considered preliminary



until published in a peer-reviewed journal.

"Improvements in lifestyle in adults in developed countries and

other places -- including increasing access to education and greater attention to heart health issues -- have reduced incidence in recent years, but total numbers with dementia are still going up because of the aging of the population," said Maria Carrillo, chief science officer of the Alzheimer's Association.

"In addition, obesity, diabetes and sedentary lifestyles in younger people are rising quickly, and these are risk factors for dementia," she added in a meeting news release.

Nichols said these estimates would help policymakers and decision makers better

understand the expected increases in dementia and what's driving them.

Her team used the same data to estimate that Alzheimer's disease death rates rose 38% worldwide between 1990 and 2019. That study was published last year in *Alzheimer's & Dementia: The Journal of the Alzheimer's Association*.

Carrillo said the numbers will grow beyond 2050 without effective treatments to stop, slow or prevent Alzheimer's and all dementia. This will affect individuals, caregivers, health systems and governments.

"In addition to therapeutics, it's critical to uncover culturally tailored interventions that reduce dementia risk through lifestyle factors like education, diet and exercise," Carrillo said.

FDA OKs Automatic Use of a Cheaper Generic Insulin

(HealthDay News) -- U.S. pharmacists will now be able to automatically substitute a cheaper biosimilar for a more expensive brand-name insulin, the U.S. Food and Drug Administration announced Wednesday.

The agency's approval of an "interchangeable" biosimilar could save diabetics and health plans millions each year, the *Associated Press* reported. Until now, doctors have had to specifically prescribe a biosimilar or approve

substituting it for a more expensive brand-name insulin.

The FDA said Wednesday that the biosimilar Semglee is interchangeable with the widely used fast-acting insulin Lantus. A biosimilar is a near copy of an injected biologic medicine that's manufactured inside living cells, the *Associated Press* reported.

A typical month's supply of Semglee injector pens cost about \$150 to \$190 without insurance, compared to \$340 to \$520 for



Lantus.

Semglee is from Viartis Inc., which is seeking FDA approval of another

biosimilar of a long-lasting insulin.

From 2020 to 2024, savings from the use of biosimilars will exceed \$100 billion in the United States, health data firm IQVIA suggests.

U.S. sales of biosimilars are lower than in Europe due to factors such as red tape, lengthy patents and opposition from brand-name drug makers,

the *AP* said.

Only 20 of 29 FDA-approved biosimilars — for cancer and immune disorders like rheumatoid arthritis — are currently available in the United States, Sean McGowan, head of biosimilars at AmerisourceBergen, a leading drug wholesaler, told the *AP*.

"These products are highly similar, but much more affordable," McGowan told the *AP*.

Dangers of Life-Threatening Second Heart Attack May Be Highest Soon After the First

A first heart attack is a serious, life-changing event, although most people now survive them. But a new study underscores the importance of doing everything possible to avoid another one.

"It's like taking another hit," said Dr. Umesh Khot, a cardiologist at the Cleveland Clinic in Ohio. "One heart attack is a lot, and having another one is a big hit on the heart."

Khot is lead author of a study that examined the outcomes of patients who suffered a second heart attack — formally known as recurrent myocardial infarction — within 90 days of being discharged from the hospital

after the first heart attack. The study was published Aug. 2 in the *Journal of the American Heart Association*.

Khot's team examined the data from 6,626 admissions for heart attack at the Cleveland Clinic from 2010 through 2017. While only about 2.5% of them were readmitted within 90 days with another heart attack, nearly 50% of those people would die within five years.

"What we've done for the first time is to analyze a large population of patients to find this uncommon recurrence and describe it," he said. "It's



important for the cardiology community to understand that this phenomenon happens, and when it does it has significant implications for long-term mortality."

One surprise in the results, Khot said, was that the greatest risk of an early recurrent heart attack occurred in the first two weeks, "which means you have to really get on top of this early on in terms of treatment."

Heart disease is the leading cause of death in the United States and worldwide. About 805,000 people in the United States have a heart attack each year — one-fourth of which are

recurrent heart attacks, according to statistics from the American Heart Association.

A heart attack occurs when blood flow to the heart is blocked, damaging or destroying part of the heart muscle. Survival can depend on how much damage is done, and how quickly it can be treated with medication and surgical procedures

To prevent a recurrent heart attack, experts recommend following professional advice regarding medication and making lifestyle changes to reduce risk factors ... **Read More**