



January 16, 2022 E-Newsletter Celebrating 10 Years of the RI ARA E-Newsletter

In an unprecedented move, HHS asks officials to consider lowering this year's Medicare premiums

WASHINGTON — The nation's top health official Monday directed Medicare to consider lowering the premium for the part of the program that covers visits to the doctor and other care outside hospitals. It marked the first time the vast federal health insurance system for older Americans and those with disabilities has rethought the monthly amount patients pay after a change has gone into effect.

Health and Human Services Secretary Xavier Becerra gave the instructions to the Centers for Medicare and Medicare Services, the agency that oversees the program, saying a review of the Part B premium is needed because of a price drop in a controversial Alzheimer's drug that Medicare does not yet pay for but might begin covering soon.

Becerra's directive comes just

days before the agency is due to decide preliminarily whether to include the drug, Aduhelm, among the roster of medicines that Medicare covers. The Food and Drug Administration approved the drug in June, despite considerable dispute over whether there is enough evidence that it is effective.

Aduhelm's manufacturer, Biogen, set its initial price at \$56,000 — sparking an outcry from the drug's proponents and critics alike. That price tag was part of the reason that, when CMS announced the Part B premium for 2022 in November, the monthly amount consumers must pay rose from \$148.50 to \$170.10. The increase is the largest in dollar amount in the program's history, which dates to President Lyndon Johnson's Great Society of the 1960s. In percentage terms, it is the fourth-



Secretary Becerra

largest hike. In November, the agency noted great uncertainty about how much the drug would weaken Medicare's already fragile finances, if it were to be covered.

"Depending on utilization, the potential costs for this course of treatment range from negligible to very significant," the agency wrote in the Federal Register notice about this year's premiums.

If 1 million of the roughly 62 million people on Medicare used Aduhelm, spending by the program on that drug alone would be nearly \$57 billion a year, the Kaiser Family Foundation estimated several months ago. That would far exceed all other medicines combined covered through Medicare's Part B, which includes infusion therapies such as Aduhelm and other drugs

administered in doctor's offices. (Medicare has a separate Part D, with private health plans covering medicine patients take at home.)

Late last month, Biogen cut Aduhelm's price nearly in half, to \$28,200.

In a two-sentence announcement of his directive, Becerra called the price change "dramatic" and said it "is a compelling basis for CMS to reexamine" the monthly premium that began this month.

"It's unprecedented for any administration to adjust premiums up or down while they've been announced," said Tricia Neuman, a senior vice president at the health policy organization Kaiser Family Foundation who has specialized in Medicare for three decades. "I don't know of any example."...[Read More](#)

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Millions could lose Medicaid coverage just as omicron surges — if Biden doesn't act

Unless the Biden administration extends a public health emergency declaration that's set to expire in just nine days, millions of vulnerable people across the U.S.—including many children—could soon be booted off Medicaid amid a record surge in Covid-19 cases.

The Families First Coronavirus Response Act, a relief package that Congress approved in March 2020, requires states to provide "[continuous coverage](#)" to Medicaid enrollees for the duration of the federally declared public health emergency (PHE), which has been renewed

several times since the start of the pandemic. With U.S. Covid-19 infections [soaring to record levels](#) in recent days, it's abundantly clear that the public health crisis is far from over—but the PHE is nevertheless set to lapse on January 16, 2022. If the Health and Human Services Department doesn't [extend the PHE again](#), experts and advocacy groups fear that mass Medicaid disenrollment could result.

"With the Omicron variant causing the largest surge of Covid-19 cases across the country ever, now is not the time to let crucial



supports and flexibilities necessary to combat the virus end," Mark Parkinson, president and CEO of the American Health Care Association (AHCA), wrote in a [letter](#) to HHS Secretary Xavier Becerra earlier this week.

"We strongly encourage you to continue to extend the PHE declaration and maintain the related Section 1135 and Section 1812(f) waivers, enhanced Medicaid [assistance] to states, and state Medicaid policy flexibilities, such as the waiver for Medicaid determinations," he added.

Dr. Adam Gaffney, a critical

care physician at the Cambridge Health Alliance, [argued](#) Thursday that "it's because of provisions like" the continuous coverage requirement in the Families First Coronavirus Response Act that millions of people have been able to keep their insurance throughout the pandemic.

"Make no mistake: kicking people out of Medicaid will kill many," Gaffney warned, pointing to research showing that Medicaid coverage has [saved thousands of lives](#)—and that Republican-led states' refusal to expand it has been deadly....[Read More](#)

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4 Social Security Payment Quirks That No One Warns You About

Many people understand the basics of Social Security long before they retire: You pay into the program with your taxes throughout your working years, and then there'll be a nice chunk of change waiting for you afterward.

We learn as we age that things get more complicated than that. Much is written on everything from eligibility requirements for ex-spouses to [how to maximize your Social Security checks](#).

There are also certain things that would've been nice to know ahead of time, but that many folks don't realize until they start receiving benefits. Here's a quick look at some of those.

1. You are paid in arrears

Uncle Sam is very particular about your paying him on time, but of course, he isn't quite so considerate in return.

As the Social Security Administration [freely admits](#),

you can expect every Social Security check to be "paid in the month following the month for which they are due." In other words, your May check will arrive in June.

But it's not considered a late payment when the federal government does it.

2. You are paid monthly

In our working lives, many of us become accustomed to weekly, biweekly or at least twice monthly pay — and we build our budgets around that.

These pay periods describe the vast majority of American paychecks, according to the [federal Bureau of Labor Statistics](#). Three-quarters of employers pay either weekly or biweekly, while fewer than 5% of employers pay monthly. Nonetheless, Social Security operates on the unpopular monthly frequency.



3. Your payment date usually depends on your birthday

Once upon a time —

prior to 1997 — most people received their Social Security checks in the first three days of the month. This didn't work very well.

Because everyone expected their checks at the same time, it created a burden on the Social Security Administration, banks, businesses, the postal service and others.

The SSA found that services were less overwhelmed when checks were spread out throughout the month. This process is called "[payment cycling](#)," and today it works like this:

◆ If your birthday is on the 1st through the 10th:

Benefits are paid on the second Wednesday of the month.

◆ **If your birthday is on the 11th through the 20th:** Benefits are paid on the third Wednesday.

◆ **If your birthday is on the 21st through the 31st:** Benefits are paid on the fourth Wednesday.

4. If you receive SSI, your payment date is different

There is an exception to receiving Social Security based on your birth date.

If you're also receiving Supplemental Security Income (SSI) benefits — which are income supplements for people who are elderly, blind or disabled, and who have little to no income — you'll receive your Social Security payment on the [third of the month](#), just like in the good old days. Meanwhile, you'll get your SSI payment on the first.

57% of Future Retirees Risk Forfeiting Social Security Unless They Know This Rule

Social Security can help to support you in retirement. But there are confusing rules surrounding the benefits you'll receive.

Unfortunately, many future retirees are unaware of one particular regulation related to the amount of money they'll get in their later years -- and as many as 57% of workers could be at risk of losing some of their benefits because of it.

To make sure you don't inadvertently reduce the Social Security income you end up with, it's important you know the truth about this particular regulation and how it can affect your future plans.

Could you be at risk of losing Social Security?

A recent study from the [TransAmerica Center for Retirement Studies](#) found 57% of current workers intend to work either full time or part time after they've officially retired. As a result, they're potentially at risk of losing some of their Social Security checks.

It's not necessarily a bad idea to keep doing some work to bring in some extra income as a senior. But you can run into trouble if

you don't understand how Social Security's rules relate to your earnings. If you're collecting benefits and haven't yet reached your [full retirement age](#) (FRA), working can result in losing some or all of your [Social Security income](#).

Eventually, you can get back the money the Social Security Administration withheld due to your earnings. But it can take a very long time, and you may not live long enough to do it. Furthermore, the loss of those Social Security checks while you're working could end up blowing a hole in your budget if you intended to have both retirement benefits *and* earnings from an employer at the same time.

When do you lose Social Security benefits due to working?

To determine if working could lead to forfeiting your Social Security checks, you first need to know your full retirement age, which is based on birth year:

- 66 and four months if you were born in 1956
- 66 and six months if you



were born in 1957

- 66 and eight months if you were born in 1958
- 66 and 10 months if

you were born in 1959
67 if you were born in 1960 or after

If you've already reached your designated FRA, you're free to earn as much money as you want without losing any Social Security income. But if you're below that age, part or all of your benefit could disappear once you earn too much. Here's when you could lose benefits:

If you won't reach FRA at any time during the year, you forfeit \$1 in benefits for every \$2 earned above \$19,560 [in 2022](#).

If you'll hit FRA later in the year but haven't yet, you forfeit \$1 in benefits for every \$3 earned above \$51,960 during the part of 2022 before you reach FRA.

The Social Security Administration doesn't just take a little money out of each check. They withhold entire checks based on the amount you forfeit. If your earnings will cause you to lose \$3,000 in benefits in 2022 and your monthly checks are for

\$1,500, you'll miss two entire checks.

Once you finally reach FRA, the Social Security Administration figures out how many months you missed payments. You're credited back the [early filing penalties](#) that would've otherwise applied for those months. So your benefit check goes up a bit.

Over the years, the slightly higher checks you get after FRA make up for the forfeited funds. But this won't help you financially for a while, and if you pass away soon after your check amount is recalculated, you may not break even.

You need to be aware of the risk of losing your Social Security if you're among the majority of Americans who plan to work in retirement so you can plan accordingly. In many cases, you may decide it's not worth claiming benefits at all before FRA so you can work as much as you want and raise your future Social Security in the process.

Social Security: We answer your questions on survivor benefits, earnings test, payroll taxes

Question: I understand that if I claim Social Security before full retirement age or FRA and continue to work, my benefit will be reduced according to something called the earnings test.

In 2022, my understanding is that Social Security will **withhold \$1 for every \$2 I earn above the annual limit of \$19,560** in the years prior to FRA and **withhold \$1 for every \$3 I earn above \$51,960 in the year I reach FRA**. Do I also have to pay income tax on 50% to 85% of my Social Security benefits?

Answer: You are correct about the 2022 retirement earnings test exempt amounts, says [David Freitag](#), a financial planning consultant and Social Security expert for MassMutual.

But it's worth noting, too, the earnings test offset is not a tax. "It is qualification measurement to encourage workers to wait until full retirement age or later to start collecting benefits," notes Freitag. "Also, remember that benefits withheld because of the earnings test are gradually paid back over your life expectancy when either you stop working or at full retirement age. Once you reach full retirement age, the earnings test no longer applies."

As for paying taxes on your Social Security benefits, the short answer is yes, says Freitag. In general, if you are working no matter what age, you pay three

common types of taxes:

The **payroll tax that supports Social Security at 6.2% of your earnings**, which

is matched by your employer.

The **payroll tax that pays for Medicare at 1.45%**, which is also matched by your employer. The **income tax on the received Social Security benefit**, based on your combined income for that year.

"However, it is important to remember that when it comes to income tax, Social Security always has a big advantage over money in a tax-qualified retirement savings account," said Freitag. "The maximum amount of Social Security income that is reported is capped at 85%. There is no cap on income reported from tax-qualified retirement accounts."

It is also important to remember, said Freitag, that if you are paying into the Social Security system, you could be increasing your 35-year earnings average calculation. "When that average goes up, the monthly benefit will also go up," he said.

Q: I plan to work as an independent contractor in the year I turn full retirement age, but I won't claim Social Security until FRA. My plan is to not invoice my employer until after I turn FRA so as to avoid the earnings test. Will this plan work?

Answer: The rules for self-



employed contractors are different from employees who work for someone else, according to Freitag.

First, the self-employed contractors only need to report their net, after-business-expense income. And two, self-employed contractors report the income when it's received, not when it is earned. "So, this strategy to invoice the employer after FRA should work just fine," said Freitag.

This booklet, published by the Social Security Administration, may help workers understand the earnings test.

Q: My spouse, who was collecting Social Security, recently died and I am presently not receiving any Social Security benefits. Should I apply for survivor's benefits and are those benefits retroactive to the date of his death?

Answer: You didn't give your age, but this is a crucial part of your strategy, said [Elaine Floyd](#), director of retirement and life planning at [Horseshoeth](#).

If you are full retirement age or older, Floyd recommends calling the Social Security Administration at 800-772-1213 and applying for your survivor's benefit as soon as possible. "Ask for retroactive benefits back to the date of his death, or back six months if he died more than six months ago," she suggests.

If you are over age 60 but not

yet full retirement age, and if you apply for your survivors benefit now, **it will be permanently reduced**.

"If you have a long life expectancy or just want longevity insurance in case you do live a long time, you would do well to maximize your survivors benefit by waiting until your full retirement age to apply for it," says Floyd. "If you are 62 or older and also qualify for a retirement benefit based on your own work record, you could start that benefit now and **switch to the survivor benefit when you turn full retirement age**."

However, Floyd notes, if your own retirement benefit is higher – that is, if you were to apply for it at age 70 it would exceed the maximum survivor benefit – you should not apply for your retirement benefit now. "In this case, you could start the reduced survivors benefit now and switch to your own maximum benefit at 70," she said.

Note: If you are under full retirement age and working, all benefits are subject to the earnings test: \$1 in benefits will be withheld for every \$2 earned over the threshold, which is \$19,560 in 2022.

This article originally appeared on [USA TODAY: Social Security: We answer your questions on survivor benefits, earnings test, payroll taxes](#)

Report: Too Few Beneficiaries Receiving Needed Opioid Treatment Through Medicare

A recent report from the U.S. Department of Health and Human Services Office of Inspector General (OIG) shows that many people with Medicare are not receiving needed prescription medications and therapy to treat their Opioid Use Disorder (OUD). These findings come during a surge in opioid-related overdose deaths nationally.

Around one million people with Medicare had a diagnosed OUD in 2020. OIG defines an OUD as "a problematic pattern of opioid use that leads to clinically significant impairment or distress and is sometimes

referred to as opioid addiction. It is a chronic disease that may cause people to seek opioids compulsively or in ways that they find difficult to control despite harmful consequences." Despite the prevalence, only 16% of beneficiaries with OUDs received recommended medication to treat their opioid use disorder. These medications work to decrease illicit opioid use and opioid-related overdose deaths.

Of the 16% who received medication for OUD, only half received the recommended behavioral therapy that should



accompany that treatment.

As with many coverage issues, there is an equity component to this missing OUD treatment. Beneficiaries who are older, Asian and Pacific Islander, Hispanic, or Black were less likely to receive medication than younger or white beneficiaries.

These data show continuing issues in coverage for OUD and other substance use disorders through Medicare. **Limited numbers of providers, coupled with gaps in coverage**, lead to missing treatment for a significant portion of people with OUDs and Medicare.

OIG recommends that the Biden Administration do more to ensure appropriate OUD treatment for beneficiaries, including through outreach to beneficiaries, increasing the number of providers for OUD, improving utilization of behavioral therapy, and better data collection to track issues.

At Medicare Rights, we concur with these recommendations and urge the Biden Administration and Congress to do more to increase OUD treatment options for all beneficiaries.

No Surprises Act Goes into Effect, Expanding Patient Protections

The No Surprises Act, a federal law that protects people who are covered under group and individual health insurance policies from receiving surprise bills in many circumstances, went into effect at the beginning of the year. The law also establishes an independent mechanism to resolve disputes between plans and providers as well as between uninsured patients and providers when they have received a good faith estimate from a provider.

Many Americans fear getting **unexpected medical bills**, and this law was passed after years of outrage over surprise bills following emergency procedures. The law covers surprise bills resulting from care from out-of-network providers and facilities in

emergency and some non-emergency situations, and when out-of-network practitioners provide care at in-network facilities. It also requires providers and facilities to provide easy-to-understand notices explaining billing protections and practices. These changes do not directly apply to people with public health insurance like Medicare, Medicaid, TRICARE, the Indian Health Service, or VA benefits, because these people are already protected from balance billing and these types of surprise bills. Since 1997, people with Original Medicare have been protected against surprise billing from **opt-out providers** under financial liability rules, and such providers must enter into a private contract



with the patient in advance of providing care that explains fully that Medicare will not pay for the services. Providers who do not **accept assignment** may charge more than the Medicare-approved amount but are still limited in the amount above that rate they may charge and are always required to submit the bill to Medicare.

People with Medicare Advantage plans that have networks are also **protected** from out-of-network surprise and balance billing in several ways—enrollees may not be charged more than in-network cost-sharing for emergency and urgently needed services, including stabilization, medically necessary dialysis when the

enrollee is outside of the plan's service area, or services provided by an in-network provider who works with out-of-network providers, or where an in-network provider has referred or received prior authorization for the referral to an out-of-network provider.

At Medicare Rights, we support these needed limitations on surprise billing and are glad to see protections extended to people with group and individual coverage. We will continue to urge Congress to extend the reach of surprise billing prohibitions to cover ambulance services and other care that was not covered by the No Surprises Act.

[Read the CMS fact sheet about the No Surprise Act.](#)

What Will the Fed's 2022 Taper Plans Mean for Social Security?



Social Security's Trust Funds currently have just over \$2.8 trillion in assets in them, yet those funds are expected to run dry by 2034, which would cut benefits by nearly a quarter. A key reason for the trust funds' challenges comes from the way they're designed. They only hold U.S. Treasury debt, which right now pays the program a weighted interest rate below 2.4%.

When that interest rate is compared with the **whopping 5.9% increase in per recipient benefits** Social Security has to pay out this year due to inflation, it's no wonder the trust funds are in trouble. They simply can't earn enough to keep up with the increases that the program has to pay out.

Still, some hope may very well be on the horizon. While the stock market has gotten a bit nervous when it comes to the Federal Reserve's plans to start **tapering its bond purchase program**, that news may very well mean good things for Social Security. Indeed, it could help both increase Social Security's return on its investments *and* reduce the amount the program needs to pay out over time.

How tapering can help Social Security's return on investment

Because the Fed has the authority to print legal currency, it has the ability to pay any price it chooses for the assets (typically bonds) that it buys. That is largely how it influences interest rates. If it wants rates to go down, it buys more bonds. If it wants rates to go up, it slows or stops its purchases -- that's what "tapering" means -- and it could even sell some of the bonds it owns.

When the Fed buys less, it means that *other* people and institutions -- ones who can't print legal money -- need to step up to buy the supply of bonds that the Fed is no longer purchasing. Given a consistent *supply* of bonds, but lowered *demand* for bonds given the Fed's tapering decision, prices will naturally drop to a lower level. A lower price for a bond means the buyer gets a higher net expected return on that investment -- in effect, higher interest rates.

Since Social Security can *only* buy U.S. Treasury bonds, higher interest rates mean that when it purchases new bonds for its trust funds, it gets a higher return on its investment than it would with lower rates. That



could potentially help extend the life of the trust funds, but it won't be by all that much. The reason is that now that Social Security's trust funds are expected to start shrinking, Social Security won't be a net buyer of new bonds. Thus, it won't benefit as much as if it were still building its trust funds.

How tapering can help lower Social Security's expenses

The Fed's taper should help Social Security, but it won't be enough

Because Social Security's income could increase from higher interest rates and its expense pressures could reduce from lower inflation, **Social Security** could be a big winner from the Fed's taper. Even with that boost, however, it doesn't change the fundamental trajectory that Social Security is on.

Even under more optimistic assumptions than its base case, Social Security's modeling projects a 95% probability that if nothing changes in how it operates, its trust funds will empty by 2041. While that does indicate there's a chance that its trust funds could last beyond the current 2034 baseline projection, it at best buys a few years before benefits are at risk of being

slashed.

Regardless of when it happens, you need to recognize that there are really only a handful of tools that Congress can use to protect Social Security for the longer term. It can raise taxes, it can cut benefits in a more controlled way than simply letting the trust funds empty, or it can change the way those trust funds are invested. All three of those options involve a different set of trade-offs and risks, and they all will impact most Americans as taxpayers, as recipients, or both.

So take the opportunity that you have *now* to prepare for the changes that will take place to Social Security in the not too distant future. Based on the trajectory it is on, it's not a matter of *if* the program will change, it's a matter of *how* it will change. The better prepared you are in advance, the easier it will be for you to manage through those changes, regardless of what that ultimately look like.

With a little more than a decade until the trust funds are expected to empty, you still have time to put a plan in place for yourself, but the longer you wait, the tougher any disruption will likely be. So get started now, and be all that much more ready for whatever comes down the pike for Social Security.

A New Paradigm Is Needed: Top Experts Question the Value of Advance Care Planning

For decades, Americans have been urged to fill out documents specifying their end-of-life wishes before becoming terminally ill — living wills, do-not-resuscitate orders, and other written materials expressing treatment preferences.

Now, a group of prominent experts is saying those efforts should stop because they haven't improved end-of-life care.

"Decades of research demonstrate advance care planning doesn't work. We need a new paradigm," said Dr. R. Sean Morrison, chair of geriatrics and palliative medicine at the Icahn School of Medicine at Mount Sinai in New York and a co-author of a [recent opinion piece](#) advancing this argument in JAMA.

"A great deal of time, effort, money, blood, sweat and tears

have gone into increasing the prevalence of advance care planning, but the evidence is clear: It doesn't achieve the results that we hoped it would," said Dr. Diane Meier, founder of the Center to Advance Palliative Care, a professor at Mount Sinai and co-author of the opinion piece. Notably, advance care planning has not been shown to ensure that people receive care consistent with their stated preferences — a major objective.

"We're saying stop trying to anticipate the care you might want in hypothetical future scenarios," said Dr. James Tulsky, who is chair of the department of psychosocial oncology and palliative care at the Dana-Farber Cancer Institute in Boston and collaborated on the



article. "Many highly educated people think documents prepared years in advance will protect them if they become incapacitated. They won't."

The reasons are varied and documented in dozens of research studies: People's preferences change as their health status shifts; forms offer vague and sometimes conflicting goals for end-of-life care; families, surrogates and clinicians often disagree with a patient's stated preferences; documents aren't readily available when decisions need to be made; and services that could support a patient's wishes — such as receiving treatment at home — simply aren't available.

But this critique of advance care planning is highly

controversial and has received considerable pushback.

Advance care planning has evolved significantly in the past decade and the focus today is on conversations between patients and clinicians about patients' goals and values, not about completing documents, said Dr. Rebecca Sudore, a professor of geriatrics and director of the Innovation and Implementation Center in Aging and Palliative Care at the University of California-San Francisco. This progress shouldn't be discounted, she said.

Also, anticipating what people want at the end of their lives is no longer the primary objective. Instead, helping people make complicated decisions when they become seriously ill has become an increasingly important priority...[Read More](#)

DCE "experiment" could mean total privatization of Medicare

In 2020, the Trump administration launched a plan to hand traditional Medicare over to [Wall Street](#). Inexplicably, the Biden administration is playing along.

The overwhelming evidence demonstrates that the plan will drive up healthcare costs, inhibiting people from getting needed care. So-called Direct Contracting Entities, DCEs, must pay for the care of the people assigned to them. Here's the sweet part for Wall Street: In addition to the normal profits from providing services, these firms can keep as much as 40 percent of the money they don't spend on care. Talk about a financial incentive to deny treatments.

In addition, a [new safe harbor rule](#) lets DCEs owned by the same investors shuffle money between them without risking civil or criminal penalties for

paying kickbacks. That's the kind of system that makes profiteering easy.

In phase one of this healthcare experiment, the Centers for Medicare and Medicaid Services, CMS, pays 53 DCEs. They receive a fixed amount of money to cover care for each traditional Medicare enrollee whose primary care doctor signs up with that DCE. The government already auto-assigned hundreds of thousands of people to DCEs.

Since people in traditional Medicare did not sign up for this, they likely do not know or understand what's in store.

Yes, they should have received written notice of their new status. But CMS treats the change as if it does not affect the quality of care provided to these older and disabled people.

Astonishingly, CMS does not require DCEs to tell people that



they have the right to opt out, let alone alert them that there is good reason to do so.

Anyone enrolled in a DCE should worry that their primary care doctors will limit their access to costly necessary care. The DCEs are likely paying these doctors more to keep patients away from specialty care or providing them with guidance to delay and withhold care. We have seen this profit maximizing before, and it isn't pretty.

With Medicare Advantage, which corporate health insurers administer, the Office of the Inspector General found [widespread and persistent inappropriate delays and denials of care and coverage](#).

The Biden administration continues to [mislead people](#) about Medicare Advantage or Part C of Medicare

with information claiming it offers people more than traditional Medicare without explaining its risks, including considerable [financial](#) and [administrative](#) barriers to care.

Conflicts of Interest Abound

These business models mean that [providing quality health care](#) and abiding by their [legal obligations](#) is at odds with profiting handsomely, reports by government agencies and independent researchers have shown again and again.

Private equity firms and corporations that own or operate [dialysis centers, hospice programs, long-term care programs](#) and even [dermatology practices](#) put their own interests first, to the detriment of their patients, government watchdogs found...[Read More](#)

How to Get Social Security Questions Answered

The Social Security Administration (SSA) has released a new [flyer](#) explaining how Americans can get help and information while the pandemic continues. It stresses that the best way for most people to find the

information they need is on its website, [www.SSA.gov](#).

People can also reach SSA by calling 800-772-1213 or contacting a local Social Security office.

Local Social Security offices are open by appointment only.



All visitors must wear a mask, regardless of vaccination status. Visitors are asked to be prepared to wait outdoors when ability to follow physical distancing requirements is limited indoors and to come alone unless they require help

with their visit. If you need help, only one person is allowed to accompany you.

A recent [report](#) by the SSA's Office of Inspector General found that there was a sixty-five percent increase in calls to the SSA during the pandemic.

Ask Rusty – I Have Medicare Advantage – Why Is a Medicare Premium Deducted from my Social Security?

Dear Rusty: My wife and I have a Medicare Advantage Plan, and we do not use Medicare for our claims. However, we still have the Medicare premium deducted from our Social Security checks. Is this correct? Signed: Wondering

Dear Wondering: If, after age 65, you choose to take Medicare outpatient coverage of any kind you must pay that Part B premium, even if you decide to acquire a Medicare Advantage plan instead of using “original Medicare” to administer your healthcare claims.

Medicare Advantage plans (often referred to as Medicare “Part C”) are healthcare plans offered by private insurers who will administer your healthcare claims instead of the Federal

Government. But you cannot get a Medicare Advantage plan without first being enrolled in Medicare Part A (inpatient hospitalization coverage) and Part B (coverage for outpatient services) and paying any associated Part B (and perhaps Part A) premium.

As you know, you pay a low premium (or perhaps no premium) for your Medicare Advantage plan. That’s because the Part B premium you are now paying from your Social Security is actually going to your Medicare Advantage plan provider, enabling them to offer you equivalent coverage at little or no additional cost. Some Medicare Advantage plans even provide added coverage which Medicare Part B doesn’t, such as



dental and vision and, sometimes, prescription drug coverage. If that all sounds enticing, remember that Medicare Advantage

plans usually also include restrictions on which medical service providers you can use, unlike “original Medicare” which permits you to use any medical service provider who accepts Medicare (nearly all).

So, when you see or hear a Medicare Advantage provider advertising “no cost” or “very low cost” coverage, recognize that they can offer that only because the government pays them a fixed amount for your care from the Medicare Part B premium taken from your Social Security. The Part B premium you are paying from your Social Security benefit is why your

Medicare Advantage plan premium is as low as it is.

Many people like the cost efficiency and extra coverage provided by Medicare Advantage plans and are comfortable with the restriction to use “in-network” providers. Many others choose “original Medicare” because of the inherent flexibility to use just about any healthcare service provider they wish. You should always carefully evaluate which type of healthcare coverage is right for you personally.

This article originally appeared on Devils Lake Journal: Ask Rusty – I Have Medicare Advantage - Why Is a Medicare Premium Deducted

THE WEP/GPO LAWS WITH FLAWS!

One of the reasons we are fighting so hard for the repeal of the WEP/GPO from the Social Security Act

The Technical Reasons Why the Government Pension Offset and Windfall Elimination Provision Should Be Eliminated The formulas are wrong.

Representative Kevin Brady (R-TX) has shown for years that the WEP formula is an incorrect way of doing what it purports to do.

1. Social Security allotments are calculated using both the amount of money contributed to FICA and the number of years a person contributes. But the Government Pension Offset considers only the dollar amount of the public pension. It ignores

the number of years a spouse has been married and was truly dependent, fully-qualifying for spousal or survivor benefits.

2. The GPO gets worse every year. The Government Pension Offset penalty increases every time that a retiree gets a cost-of-living raise in their public pension. If the public pension increases by \$30 a month, the GPO cuts the spousal or survivor Social Security benefit that a person receives by \$20 a month. The WEP penalty stays the same even when the retiree receives a cost-of-living raise in their public pension.

3. Taxes are different in every state. Workers contribute to



Social Security Fairness

pensions differently and are taxed differently in different states. Applying the same formulas against earned public pensions nationwide is unavoidably unfair.

4. The offsets cut lower-income and women retirees more. Both offsets affect lower-income retirees more than those with a bigger pension. In addition, both offsets together affect more women than men, and since women usually have smaller pensions than men, women lose a larger percentage of their retirement income to the offsets.

5. Most people never knew. Neither the Social Security Administration nor affected

public agencies have ever done an adequate job informing employees how their pensions would affect their Social Security benefits, leaving many retirees without the financial support they have counted on. Since the requirement to inform new public employees was finally made mandatory in 2005, the effects of the WEP/GPO penalties have become better known to prospective teachers and other public servants. Learning about these punitive laws can discourage many qualified prospective candidates from taking the jobs that our society needs....More information at [**ssfairness**](#)

Help for Seniors: Your Guide to Assistance Programs & Services

Did you know there are literally thousands of programs that provide help for seniors in America? Whether you are struggling with the cost of housing or home repairs, looking for ways to save on prescriptions or hearing aids, or seeking affordable legal guidance, you can probably find senior citizens assistance programs that are designed to address needs like yours. In fact, the range of available services is so vast that

the biggest challenge might be identifying the options that work best for your particular situation.

A good starting point in any search for senior assistance options is to check with your local Area Agency on Aging or use the online [**Eldercare Locator**](#) provided by the U.S. Administration on Aging. Either method can direct you to a host of services for older adults in



your area. The [**directory of resources**](#) at the end of this article includes many more sites that can help you find the benefits and programs that are most applicable to you.

The following sections provide information on the many different resources that are available to help older adults meet their needs and improve their quality of life. Check out specific information about 11

different topics, or use the directory of resources to track down additional assistance.

Contents Help related to:
[**Income and taxes**](#) • [**Medicare and prescriptions**](#) • [**Hearing aids**](#) • [**Mobility aids**](#) • [**Dental care**](#) • [**Housing an rent**](#) • [**Mortgages**](#) • [**Home repairs, improvements, and modifications**](#) • [**In-home care**](#) • [**Downsizing**](#) • [**Legal matters**](#) • [**Technology**](#) • [**An essential directory of helpful resources**](#)



The War on Cancer at 50: The Origin Story Begins With a Socialite Citizen-Lobbyist

The roots of the National Cancer Act can be traced to a small home in Watertown, Wisconsin. In the early 1900s, a girl named Mary tagged along when her mother went to visit their laundress, Mrs. Belter, who had breast cancer.

When they arrived, the woman was in bed, her seven children around her. She was terribly sick. That day, Mary was only around 4 years old, but she remembered it for the rest of her life.

"When I stood in the room and saw this miserable sight, with her children crowding around her, I was absolutely infuriated, indignant that this woman should suffer so and that there should be no help for her," **she recalled** decades later, in 1962.

That girl grew up to be Mary Lasker, who transformed her outrage into action. Lasker

became an activist, philanthropist and strategist focused on supporting medical research.

Belter, who'd had her breasts removed, survived.

"I'll never forget my anger at hearing about this disease that caused such suffering and mutilation and my thinking that something should be done about this," Lasker recounted.

In the first half of the 20th century, cancer was misunderstood. It was widely considered a death sentence, and some people believed it was contagious and something to be ashamed of.

"It was a disease diagnosis that was whispered about and kept secret," said **Ned Sharpless**, director of the National Cancer Institute. Sharpless said that to protect a



Mary Lasker

person's dignity, doctors commonly fibbed about someone's condition or said that "the patient died of old age."

Decades of advocacy — and scientific breakthroughs — have dramatically changed that. The U.S. government has spent **more money** on the fight against cancer than any other disease, and many cancers are far less deadly than they once were.

A crucial moment in this evolution was the president's signing of the National Cancer Act into law 50 years ago, on Dec. 23, 1971.

Launching a Crusade

For years, Mrs. Belter's illness remained vivid in Mary Lasker's mind. About 40 years later, in 1943, her cook also fell ill with cancer. As Lasker — a person with wealth and status — helped

her employee navigate the health care system, she was shocked to discover that cancer care had not advanced much.

So Lasker started a crusade. In the 1940s, broadcasters wouldn't say "cancer" on the radio.

She **worked to change that**, with the help of her husband, Albert Lasker, an advertising executive. The couple persuaded Reader's Digest to do a series of articles about cancer. And Lasker persuaded her friend behind the Ann Landers advice column to write about it.

Lasker, who **died in 1994** at age 93, didn't just focus on changing the popular perceptions of cancer. She wanted to cure cancer, and that demanded a real investment in medical research.

..Read More

Even Symptom-Free, People With Omicron Much More Likely to Spread COVID: Studies

(Healthday News)

Researchers say they've uncovered a clue to why the Omicron variant spreads COVID-19 so much more rapidly than its predecessors.

People who are infected but have no symptoms are still far more likely to infect others than they would have been with earlier variants, the data shows.

"As we witness the quick, global spread of **Omicron**, it is clear that we urgently need a better understanding of the transmission dynamics of this variant," said senior study author Dr. Lawrence Corey. He is principal investigator of the Fred Hutchinson Cancer Research Center-based operations center of the COVID-19 Prevention Network.

"Since so many people may be asymptomatic, we can't always know who is carrying the virus, but we do know what we can do to protect ourselves and to help prevent further spread: Wear a mask; wash your hands; avoid large, indoor gatherings; and get fully vaccinated as soon as possible," he added in a network

news release.

Both of the **new studies** were done in Africa.

The Sisonke study used **PCR** testing from mid-November 2021 to Dec. 7, 2021, in asymptomatic people. It found the carriage rate was 16%.

The larger Ubuntu study found 31% asymptomatic carriage, or in 71 out of 230 samples between Dec. 2 and Dec. 17, 2021. All the samples available for sequencing analysis were verified to be Omicron.

Past studies on ancestral, Beta and Delta variants had asymptomatic transmission rates of between 1% and 2.6%, seven to 12 times less than with the Omicron samples, the researchers said.

The Ubuntu study began in early December with the goal of evaluating the effectiveness of Moderna's COVID-19 vaccine in people living with HIV.

The **Sisonke research** was a sub-study of a larger study that evaluated the effectiveness of a single dose of the Johnson &



Johnson COVID-19 vaccine. The sub-study evaluated immune responses and breakthrough infections in 1,200 health care workers, including those who are pregnant or breastfeeding or who have HIV. The study included 577 people vaccinated with Johnson & Johnson's COVID-19 vaccine, with results suggesting a high carriage rate even in those known to be vaccinated.

"The larger studies were designed to analyze data at the intersection of COVID-19, vaccines and people living with HIV, but they also are giving us useful information about Omicron and how its spread differs from those of previous variants of concern," Dr. Glenda Gray, president of the South African Medical Research Council (SAMRC), said in an SAMRC news release.

Sub-Saharan Africa has been hit hard by both **HIV** and the COVID-19 pandemic, said Dr. Nigel Garrett, head of Vaccine and HIV Pathogenesis Research at the Center for the AIDS

Program of Research in South Africa.

"Ubuntu and Sisonke will provide important data on safety, dosage and effectiveness of vaccines, but they already are helping us better understand the way this virus can change and how those changes affect transmission and severity. It is critical that we know how Omicron and other variants spread among those who are immunocompromised as well as those who are not," Garrett said.

Preliminary findings on both studies were published on the preprint server *medRxiv*, and have not been peer-reviewed.

"We are not yet able to determine how vaccination affects asymptomatic infection and spread," said Linda-Gail Bekker, director of the Desmond Tutu HIV Centre at the University of Cape Town. "We further need to devise strategies for rapid detection of asymptomatic carriage, particularly in long-term care facilities and hospitals, where transmission to high-risk populations may occur."

Unhealthy Heart May Be Bigger Threat to Women's Brains Than Men's

What's good for the heart is good for the brain, and a new study suggests that connection might be especially critical for women.

The study, of more than 1,800 adults in their 50s and 60s, found that those with heart disease, or risk factors for it, generally showed a greater decline in their memory and thinking skills over time.

That was not a surprise, since past studies have revealed an **association between heart health and mental acuity**. But it turned out that the link was especially strong among women, researchers found.

"It's extremely important for both women and men to have

their cardiovascular risk factors treated and well-controlled," said study author Michelle Mielke, a professor at Mayo Clinic in Rochester, Minn.

But, she added, these findings suggest that could be especially critical for women's cognitive function.

The study, published Jan. 5 in the journal *Neurology*, is the latest to highlight the connection between heart and brain health.

Like the heart, the brain relies on healthy blood vessels to supply its cells with oxygen and nutrients. Research over the years has found that many of the risk factors for heart disease and stroke are also tied to a quicker



decline in cognitive abilities as people age - and possibly a heightened risk of dementia.

Those risk factors include high blood pressure, high cholesterol, diabetes, smoking and obesity. On the flip side, research suggests that some **heart-healthy practices**, such as physical exercise and a diet rich in fish, vegetables and "good" fats, may help shield the aging brain. And a 2019 clinical trial found that aggressively lowering **high blood pressure** in older adults reduced the risk of mild cognitive impairment.

That refers to subtle but noticeable declines in memory

and thinking that in some cases progress to dementia.

According to Mielke, it's not clear why poorer cardiovascular health might be tougher on women's cognition.

It's natural to speculate that menopause and hormonal changes could play a role, she said. But, Mielke added, there are many other possibilities, too.

For one, heart disease in women and men can be different. Women are more likely than men to have dysfunction throughout smaller blood vessels in the body, versus blockages in larger ones feeding the heart. It's possible that could contribute to cognitive decline...**Read More**

Some At-Home Tests May Miss Omicron in Early Stages of Infection

The Abbott BinaxNOW and Quidel QuickVue -- two widely used rapid at-home COVID tests -- may sometimes fail to spot evidence of the Omicron variant in the first days after infection, even when people are carrying substantial levels of the virus, preliminary research suggests. The researchers focused on 30 people infected with COVID at five workplaces that experienced what were most likely outbreaks of the **Omicron variant** last month. The people received both saliva-based PCR tests (the gold standard) and rapid antigen-

based tests involving nasal swabs.

It took three days, on average, for people to test positive on the two rapid antigen tests after their first positive PCR result, researchers reported. In four cases, people transmitted the virus to others after a negative result, according to the **study**, which hasn't yet been peer-reviewed.

It is not yet clear whether the infections were missed because the antigen tests are inherently less sensitive to Omicron or because saliva tests may be



better at detecting the new variant, *The New York Times* reported.

One possible explanation? Omicron may replicate faster or earlier in the throat and mouth than in the nose, experts said.

"While we'll have to wait to see if the science bears out, that might be an indicator that that's where the virus is growing first," Gigi Gronvall, an immunologist and testing expert at Johns Hopkins Bloomberg School of Public Health, told the *Times*. "So if you're going to look for

the virus, which is what the tests do, then you may find more of it faster in the throat swab over the nose."

Reports have also surfaced that some people who initially tested negative on antigen tests when they swabbed inside their noses went on to receive a positive result when they swabbed the back of their throats.

"There's a lot of chatter around this," Nathan Grubaugh, a virologist at the Yale School of Public Health, told the *Times*. "Obviously, that warrants further investigation..."**Read More**

Aduhelm: Will Medicare Cover the Controversial Alzheimer's Drug?

Following a months-long and unprecedented review, Medicare officials expect to announce within the next couple of weeks whether the program will cover the controversial Alzheimer's drug Aduhelm. The drug's benefits are in question and its annual price tag tops \$28,000.

The U.S. Centers for Medicare and Medicaid Services (CMS) tend to cover with little fanfare most drugs approved by its sister agency, the U.S. Food and Drug Administration.

However, the **FDA's approval of Aduhelm** (aducanumab) in June sparked a firestorm of criticism because clinical trials showed no clear improvement in brain function, plus a host of safety concerns.

Proponents such as the Alzheimer's Association argue that Aduhelm's success could pave the way for even better treatments for the degenerative brain disease. It's the first drug ever approved to treat Alzheimer's.

"It's always been a progression from first treatments that weren't by any means all that we hoped for, but were an important first step leading to progressive advances treatment by treatment as we learned more and we had further research and development," said Robert Egge, chief policy officer for the Alzheimer's Association. "That's the path we see before us for Alzheimer's disease."

Critics say CMS has



essentially been put in the awkward position of rectifying a grave error made by the FDA when it approved Aduhelm based on shaky evidence.

"The drug, given the available evidence, provides false hope to Alzheimer's disease patients and their families," said Dr. Michael Carome, director of Public Citizen's Health Research Group. "The right decision for CMS is to not cover the drug until there's sufficient evidence that the drug works."

Asked to comment, a CMS spokesperson simply said that the agency "expects to release more information regarding the National Coverage Determination (NCD) analysis

for monoclonal antibodies targeting amyloid for the treatment of Alzheimer's disease by mid-January 2022."

Cost and equity issues

Medicare coverage could throw a lifeline to Aduhelm, which has been struggling to find its place in the pharmaceutical market.

A number of major health systems -- the U.S. Department of Veterans Affairs, Cleveland Clinic, Mount Sinai and Mass General -- have already said they will not offer Aduhelm to patients. Following weak sales, the drug's maker, Biogen, slashed its annual cost in half -- from \$56,000 to \$28,200 last month...**Read More**

Breakthrough COVID Cases Overwhelmingly Mild for Vaccinated People: Study

A review of cases from 465 U.S. hospitals underscores the protection provided by COVID-19 vaccines.

The **new review** -- by researchers at the U.S. National Institutes of Health -- found that vaccinated adults who got breakthrough infections rarely got severely ill. Respiratory failure, the need for treatment in an intensive care unit, and death were also very rare.

"Vaccines are highly effective and greatly reduce the risk of severe outcomes from COVID-19," said senior researcher Dr. Sameer Kadri, head of clinical epidemiology in the NIH Clinical Center's Department of Critical Care Medicine in Bethesda, Md.

The data covered a stretch between March 2020 and October 2021 when the severe Delta variant of SARS-CoV-2 became widespread in the United States.

Omicron, a variant that is better at evading immunity but tends to produce less severe illness, had not yet emerged.

The review included data from 1.2 million people who were fully vaccinated against COVID.

Those at highest risk for severe disease or death included people 65 and older, as well as folks with compromised immune systems or chronic illnesses, such as those affecting the kidney, heart, lungs, liver or nervous system, the study found.



For every 10,000 vaccinated patients who developed COVID, 1.5 died, and 18 had severe outcomes, according to the study. All of those who had worse outcomes had at least one risk factor leaving them vulnerable to severe COVID, and almost 8 in 10 of those who died had four or more.

In addition to getting two doses of the Pfizer or Moderna vaccine or one Johnson & Johnson vaccine, booster shots offer further protection, researchers pointed out.

The U.S. Centers for Disease Control and Prevention recommends Moderna and J&J boosters for people 18 and

older and the Pfizer booster for everyone 12 and up.

"Increasing COVID-19 vaccination coverage is a public health priority," Kadri said, adding that vaccines may not only slow spread of the virus but also help prevent new variants from emerging.

For vaccinated folks with **breakthrough COVID**, treatment with monoclonal antibodies can effectively limit the severity of the infection, researchers said.

As new variants of the virus appear, it will be important to develop new treatments for those already vaccinated, especially for those at risk for severe disease, they added....[Read More](#)

White House Finalizes Plan to Send Americans Free COVID Rapid Tests

(HealthDay News) -- The final touches are being put on the White House's plan to deliver 500 million free coronavirus rapid at-home test kits to households across America.

The administration will launch a website where people can request the **rapid tests**, said four people familiar with the plan who spoke on the condition of anonymity, the *Washington Post* reported. With the help of the U.S. Postal Service (USPS), officials hope to start sending out testing kits by mid-January.

Test makers and distributors seeking to provide a share of the 500 million tests have already submitted proposals to the government, and the first contract was awarded Thursday evening, said a person with knowledge of the plan. A formal

announcement on the specifics of the plan could come next week, the *Post* reported.

Meanwhile, the USPS is negotiating with its four labor unions to extend the seasonal workforce — the roughly 40,000 people brought in each year to help the agency work through a glut of holiday packages and mail, the *Post* reported.

A White House representative would not comment on the plan, and USPS representatives did not respond to requests for comment.

President Biden first **announced the test kit plan** right before Christmas.

In recent weeks, demand for the tests has soared past supply as millions of Americans traveled during the holiday season while



the highly contagious **Omicron variant** raged. Across the country, Americans

stood in long lines at pharmacies, community centers and local government buildings, desperate for tests that would tell them whether they could visit loved ones over the holidays.

White House coronavirus response coordinator Jeffrey Zients told reporters Wednesday that manufacturers would begin delivering tests to the federal government "over the next week or so." He added those kits would "not disrupt or in any way cannibalize the tests that are on pharmacy shelves and on websites and used in other settings," the *Post* reported. Since the Omicron variant first surfaced in South Africa in

November, the wily variant has spread across America at a breakneck pace and now accounts for 95% of all U.S. COVID cases, the latest **data** from the U.S. Centers for Disease Control and Prevention shows.

The USPS almost played a part in a similar partnership with the Trump administration back at the beginning of the pandemic. The idea was to ship 650 million reusable cloth **masks** to every U.S. household as early as April 2020, but former President Donald Trump nixed the plan over a running feud with USPS leadership and a concern that sending the masks "might create concern or panic," a Trump administration official told the *Post*.

Best Diets for Seniors

These extra tips can help older adults choose the best eating plan for their health and lifestyle.

When a panel of health and nutrition experts ranked 40 diets for U.S. News's **Best Diets for 2022**, they considered not only weight loss, but also whether the diets were **heart healthy**, good for **controlling diabetes** and **easy to follow**.

Now, three panel members discuss which U.S. News-ranked diets make the most sense for

seniors

Fewer Calories

For Amy Campbell, a registered dietitian and diabetes educator, the **DASH**, **Mediterranean** and **Mayo Clinic** diets stood out as smart choices for older adults because they're good for weight loss as well as controlling conditions such as diabetes and high blood pressure.

"The **MIND diet** is another consideration for older adults, as it combines the DASH and



Mediterranean diets, focusing on foods that can support and improve brain health to possibly lower the risk of mental decline, including Alzheimer's disease," Campbell adds.

As with anyone, being overweight or having obesity can be issues for seniors, Campbell says. "People are living longer, so we're seeing more of it in older adults. As we get older, our calorie needs go down. People don't need to eat

as much as they did when they were 20 or 30."

Older women generally need anywhere from 1,600 to 2,200 calories per day, depending how active they are, Campbell says, while younger women need about 1,800 to 2,200 calories daily. For older men, the range is 2,000 to 2,800 calories per day, compared with 2,200 to 3,200 calories for younger men....[Read More](#)

You Can Help Prevent Cervical Cancer

(HealthDay News) -- Cervical cancer is the only gynecologic cancer that can be prevented, yet there were more than 4,000 deaths in the United States in 2021 and nearly 14,500 new cases, the American Cancer Society says.

The best way to prevent this is to make sure you and your children get their human papillomavirus vaccines, experts noted.

Nearly all cervical cancer stems from HPV, which will first cause pre-cancer cells, said

Dr. James Aikins Jr., chief of gynecologic oncology at Rutgers Cancer Institute of New Jersey in New Brunswick.

The U.S. Centers for Disease Control and Prevention recommends children receive two doses of the **HPV vaccine** at age 11 or 12. It can be started as early as age 9.

The vaccine is also approved for adults who haven't yet had it up to age 45, but it works better when given at an earlier age.

To protect yourself, get



regular **pap tests** and testing for HPV, which can detect precancerous changes in cells that can eventually become cervical cancer. Screening is typically done for women ages 21 to 65 but can vary, Aikins said in a Rutgers news release.

Other lifestyle choices can help prevent cervical cancer, he said.

Maintain a healthy weight, be physically active, eat a healthy diet and avoid or quit smoking. Also, use a condom with any

sexual partners.

It's impossible to know whether a partner has HPV, and the cancer society says that using condoms can reduce the rate of HPV infection by about 70%.

All women should have a routine examination schedule with their doctor, Aikins said.

More information

The U.S. Centers for Disease Control and Prevention has **more on HPV**.

Know Your Thyroid Facts

(HealthDay News) -- Thyroid cancer diagnoses have spiked for U.S. women this past decade.

That's why it's essential to pay attention to this small gland at the base of your neck. The thyroid is an important part of your endocrine system, producing a hormone that helps control metabolism.

"While there is no known way to prevent **thyroid cancer**, some things that may help to maintain thyroid health are the lifestyle choices you make," said endocrine surgeons Dr. Amanda Laird and Dr. Toni Beninato, of Rutgers Cancer Institute of New

Jersey in New Brunswick.

Thyroid disorders can range from a small, harmless goiter (an enlarged gland) to cancer that may need to be treated with radioactive iodine or surgery. Laird and Beninato offered these tips for good thyroid health: Start by maintaining a healthy lifestyle. Eat nutritious foods, including a variety of fruits, vegetables, nuts and whole-grain foods. Maintain a healthy weight. Strive to be regularly physically active to improve your overall health.



Learn the signs of **thyroid cancer**, the most common of which is a painless lump or swelling in the neck. "Other symptoms only tend to occur after the condition has reached an advanced stage, which may include unexplained hoarseness or difficulty swallowing that does not go away," Laird and Beninato said in a Rutgers news release. "You may also experience a feeling of pressure at the point of the mass." If you do notice something abnormal, tell your doctor. "The best way to determine if you have a thyroid condition is to

consult your physician as soon as possible," the doctors said.

Masses in the neck should be evaluated first with a physical exam. Then your doctor can decide whether further testing is needed.

An ultrasound may be done to evaluate thyroid masses, followed by a biopsy, depending on the results.

Laird and Beninato recommended seeing a provider familiar with the latest advances in genetic counseling and testing if your family has a history of thyroid cancer.

VSED, an end-of-life choice

When it comes to health care, there seem to be fewer and fewer things that the US health care system gets right. End-of-life matters are no exception, with hospitals generally keeping people alive, even when they have asked to die, and forcing their loved ones to suffer through their slow passing. For this reason, Kevyn Burger reports for **Next Avenue** that more people are taking their deaths at the end of their lives into their own hands through voluntarily stopping eating and drinking or VSED. One way people help ensure a peaceful death is through electing **hospice care**. **Medicare** covers hospice care, usually at home, for people believed to have six months or less to live. Hospice care focuses on easing pain and

providing social and emotional supports for patients and their families. To learn more about the hospice benefit, **click here**.

At the end of their lives, some people choose to speed up their death by forgoing food and drink, an age-old process. This choice is called "voluntary stopping eating and drinking" or VSED. People typically die in 10 days.

Three quarters of Americans favor medical assistance in dying. Ten states—California, Colorado, Hawaii, Montana, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington—and Washington DC permit it. In these places, patients with six months or less to live can ask their doctors for medicines that allow them to die



in their sleep. But, in other states, where this is not an option, VSED is an option.

You need assistance with VSED to ensure your pain and other symptoms are well managed. Medicines should be available to you. It's best for patients who are in very poor health to understand the process and be committed to it. Even with help from a doctor, it is not considered assisted suicide. But, a family member who helps with VSED should have written authority through a **health care proxy document or durable medical power of attorney** that he or she is carrying out the patient's wishes if the patient cannot speak for himself or herself.

A new book! "**Voluntarily Stopping Eating and Drinking**,

A Compassionate, Widely-Available Option for Hastening Death" explains the process, including practical and ethical details. It also provides case examples.

On day one, patients can engage with their loved ones and say good goodbye. With no food or drink, they get weaker and are less able to engage. With no liquids, their organs fail. Quite quickly, they tend not to be hungry but they are thirsty. Water will extend life, so generally mists and swabs of the patient's mouth are the treatment.

With VSED, it's common for patients to become delirious and agitated right before death. They are often given tranquilizers and anti-anxiety medicines. Then, their heart stops, and they stop breathing.