

Message from the Alliance *for* Retired Americans Leaders



Robert Roach, Jr.
 President, ARA

June is LGBTQ+ Pride Month
 The Alliance wishes all of our members a Happy Pride Month! More than three million lesbian, gay, bisexual and/or transgender adults over the age of 50 live in the United States.

The National Resource Center on LGBT Aging has resources available for **LGBTQ+** adults, their families and caregivers. Established in 2010 through a federal grant from the U.S. Department of Health and Human Services, it provides training, technical assistance and educational resources to LGBTQ+ organizations, care partners, community members, and the aging network.

"Pride Month is a reminder that all Americans of all ages want to live our lives with freedom and

dignity," said Robert Roach, Jr., President of the Alliance. "We are a diverse nation and that makes us stronger."

Social Security Trustees Report Shows We Can Expand Social Security



Rich Fiesta,
 Executive Director, ARA

The Trustees **reports** on the Social Security and Medicare Trust Funds were released on Thursday, showing once again that Social Security's Old-Age and Survivors Insurance (OASI) Trust Fund is strong and solvent, with enough money to cover full benefits and expenses until 2034 — an improvement of one year later than reported last year.

The Medicare Part A Trust Fund for hospital care now has sufficient funds to cover its

obligations until 2028, two years later than reported last year.

In response to the brighter outlook, the Alliance issued a **statement** saying it is time to strengthen both Social Security and Medicare for the future and expand benefits.

"Congress must act on two fronts to make that happen: lift the cap on earnings — currently \$147,000 — subject to the 6.2% payroll tax, and lower prescription drug prices to stem their rapid growth," said Richard Fiesta, Executive Director of the Alliance.

"An expansion of Social Security benefits is critical to help seniors fight inflation, and H.R. 5723, Rep. John Larson's (CT) 'Social Security 2100: A Sacred Trust,' would make that increase a reality for all beneficiaries by requiring wealthy Americans to pay payroll taxes on wages above \$400,000.

Seniors need Congress to pass this critical legislation," Fiesta added.

In addition, the Social Security Disability Insurance (DI) Trust Fund, which pays benefits to people with disabilities, is no longer projected to be depleted within the 75-year projection period, a significant improvement from last year.

Fiesta voiced his strong disapproval that despite these figures, Sen. Rick Scott (FL), who chairs the National Republican Senatorial Committee that recruits and supports Republican candidates for the U.S. Senate, has released a **plan that would sunset all federal legislation, including Social Security and Medicare**, after five years.

"No one should accept this lie, and we will not stand for any cuts to the benefits we have paid for," Fiesta concluded.

Senate Hearings Last Week on Social Security

Whether it is a coincidence or was planned knowing the Social Security Trustee's report would be released last week, the Senate Budget Committee held a hearing last Thursday, June 9th, on Social Security. Congressional Democrats and Republicans have already outlined disagreements on how to address the programs' solvency, and whether it is necessary to do so in the near term.

The hearings and the debate come at a time when key Republicans are starting to grapple with questions about what the party will do regarding Social Security should they win

back the majority in one or both houses of Congress in November.

Senator Rick Scott (R-Fla.), who is also the Chairman of the Republican Senatorial Committee, has released his legislative plan in anticipation of a Republican Senate majority next year. It includes a provision that would require *all* federal programs to expire after just five years—and he did not exempt Social Security or Medicare from that provision.

Senate Republican leader Mitch McConnell responded to the Scott plan by saying, "We will not have as part of our agenda a bill that



raises taxes on half the American people and sunsets Social Security and Medicare within five years."

Last February, House Republicans invited former Office of Management and Budget Director Mick Mulvaney to testify at a House Budget Committee. Mulvaney recommended that lawmakers attach fiscally conservative measures to the next debt limit measure, which could occur later this year or in early 2023. He specifically recommended considering changes to Social Security, saying it is "not

politically easy, but it's mathematically easy."

And Rep. Buddy Carter (R-Ga.), who is seeking the top Republican spot on the House Budget Committee has said addressing entitlement spending needs to be a priority for Republicans.

Carter said in an interview, "We've got to do something about Social Security and Medicare, and nobody wants to do that.

Alliance President Robert Roach, Jr. will speak on the WEP/GPO issue.

More in the next issue.

ADD YOUR NAME

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

AARP's Billion-Dollar Bounty

In September, AARP, the giant organization for older Americans, agreed to promote a burgeoning chain of medical clinics called Oak Street Health, which has opened more than 100 primary care outlets in nearly two dozen states.

The deal gave Oak Street exclusive rights to use the trusted AARP brand in its marketing — for which the company pays AARP an undisclosed fee.

AARP doesn't detail how this business relationship works or how companies are vetted to determine they are worthy of the group's coveted seal of approval. But its financial reports to the IRS show that AARP collects a total of about \$1 billion annually in these fees — mostly from health care-related businesses, which are eager to sell their wares to the group's nearly 38 million dues-paying members. And a paid AARP partnership comes with a lot: AARP promotes its partners in mailings and on its website, and the partners can use the familiar AARP logo for advertisements in magazines, online, or on television. AARP calls the payments "royalties."

AARP's 2020 financial

statement, the latest available, reports just over \$1 billion in royalties. That's more than three times what it collected in member dues, just over \$300 million, according to the report. Of the royalties, \$752 million were from unnamed "health products and services."

But controversy has long dogged these sorts of alliances, which have multiplied over the years, and the latest is no exception. Are the chosen partners actually a good choice for AARP's members, or are they buying the endorsement of one of the country's most respected organizations with lavish payments?

"I don't have a problem with AARP endorsing travel packages," said Marilyn Moon, a health policy analyst who worked for the group in the 1980s. But when AARP lobbies on Medicare issues while profiting off partnerships with those who are marketing to Medicare patients, "that certainly is a problem," Moon said.

There are reasons for concern about the latest partnership. Less than two months after announcing the AARP deal, Oak



Street revealed it was the subject of a Justice Department civil investigation into its marketing tactics, including

whether it violated a **federal law** that imposes penalties for filing false claims for payment to the government. Oak Street has **denied wrongdoing** and says it is cooperating with the investigation.

Companies like Oak Street, whose funders have included private equity investors, have alarmed progressive Democrats and some health policy analysts, who worry the companies may try to squeeze excessive profits from Medicare with the services they market mainly to people 65 or older. Oak Street hopes it can cut costs by keeping patients healthy and in the process turn a profit, **though it has yet to show it can do so.**

AARP has stood for decades as the dominant voice for older Americans, though people of any age can join. Members pay \$16 a year or less and enjoy discounts on hundreds of items, from cellphones to groceries to hotels. AARP also staffs a busy lobbying shop that influences government policy on a plethora

of issues that affect older people, including the future and solvency of Medicare.

Perhaps not as well known: that AARP depends on royalty income to help "serve the needs of those 50-plus through education, programs and advocacy," said Jason Young, a former AARP senior vice president.

"Since our founding, AARP has engaged with the private sector to help advance our nonprofit social mission, including by licensing our brand to vetted companies that are meeting the needs of people as they age," Young told KHN in an email before leaving his AARP position last month.

For years, AARP has drawn intermittent scrutiny for its longtime partnership with UnitedHealthcare, which uses the AARP seal of approval to market products that fill gaps in the traditional Medicare program — gaps filled by private insurers.

The arrangement has brought in hundreds of millions of dollars in annual royalties, according to court records.....[Read More](#)

2022 Trustees' report on Social Security and Medicare shows slight improvements in their finances

The 2022 **Social Security and Medicare Trustees' report** shows slight improvements in the finances of both Medicare and Social Security.

According to Dean Baker, senior economist at the **Center for Economic and Policy Research**, the Affordable Care Act helped Medicare's finances. He says: "This is hugely important, and little appreciated. The reduced payments to private [Medicare Advantage] plans operating within the Medicare program are attributed to the Affordable Care Act (ACA) reining in health care cost growth.

Baker finds that the current estimated shortfall for Social Security is not much greater than the projected savings to Medicare as a result of the Affordable Care Act.

Social Security is seeing small improvements because fewer

people are receiving disability benefits and the US recovered quickly from the recession caused by the COVID-19 pandemic. Consequently, Social Security's shortfall over the next 75 years dropped to 3.42 percent of payroll from 3.54 percent of payroll.

That said, we know that the Trump administration made it harder for people to receive Social Security disability benefits. So, Social Security's better financial footing might stem from fewer people receiving disability benefits than should.

Medicare's financial footing improved in part because its spending declined. Its premiums rose substantially because the government factored in payment for an expensive Alzheimer's drug that it ultimately decided not to cover, except in the most limited situations. The premium hike underscores the power of the



pharmaceutical industry to set sky high prices at the expense of taxpayers and people with Medicare.

According to the Trustees, the federal government is seeing higher tax income, which also helps the financial condition of Social Security and Medicare. Social Security reserves are expected to last until 2035—a year longer than projected last year—as of now. Medicare's Part A Hospital Insurance (HI) trust fund reserves are expected to last until 2028. That's two years later than previously projected. Medicare's long-term financial situation also improved slight, with a 75-year shortfall in the Hospital Insurance Trust Fund now at .70 percent of taxable payroll, down from .77 percent.

Even with all reserves depleted, both Medicare and Social Security will continue. Social Security could pay about

80 percent of benefits with its annual income from payroll contributions. Medicare Part A could pay about 90 percent of benefits. Medicare Parts B and D costs in addition to premiums are paid for with general revenue.

In its 2022 budget, the Biden Administration proposed closing a tax loophole that would strengthen the Medicare Part A trust fund for a long time. It would require high-income taxpayers with pass-through business income to pay the Medicare tax on self-employment income and the net investment income tax on unearned income. This additional tax money would go to the Part A trust fund.

We now need Congress to slow down Medicare spending. It could do so through allowing Medicare to negotiate drug prices. It could also do so by **ending overpayments to Medicare Advantage plans.**

Medicare Rights Trends Report Highlights Medicare Advantage and Part D Coverage Denials

This second installment in our **helpline trends report series** examines another worrying theme: erroneous Medicare Advantage (MA) and Part D denials. In 2020-2021, this issue accounted for nearly one-third of all calls to Medicare Rights' helpline. Of those, 65% were about how to appeal a plan's decision.

Many callers did not understand the web of appeal rules and timelines, or even how to begin the process. Navigating these intricacies can be particularly overwhelming in times of significant stress or medical need, and the system is not built to adapt quickly. During the pandemic, for example, callers frequently expressed frustration in their inability to comply with strict deadlines, given that many providers' offices were temporarily closed or operating with reduced hours.

In the best of circumstances,

appealing a denial can be difficult and time-consuming; it's an outdated, taxing process that often leads to delays in care. Troublingly, some MA and Part D plans engage in behaviors that force enrollees into this broken system. Among the most egregious are instances in which plans deny coverage for insufficient or incorrect reasons, requiring beneficiaries to then appeal those bad decisions and go without needed, appropriate care in the interim.

A **recent report** from the Department of Health and Human Services Office of Inspector General (OIG) found inappropriate denials to be widespread. **Previous OIG analysis** reached similar conclusions and found that although only 1% of beneficiaries appeal, 75% of those appeals are successful.

Importantly, even reversals



come at a cost. The most significant risks are care delays and the resulting negative health outcomes.

But appeals processes are also burdensome for beneficiary and provider alike, creating strain, expense, and extra work. Low appeal rates suggest that many beneficiaries abandon the process altogether, along with the care they need. And when plans systematically and inappropriately deny claims, it may have a chilling effect on providers' willingness to prescribe or provide a treatment or cause providers to spend additional time and resources "over proving" claims to avoid denials.

Medicare Rights urges policymakers to address the well-documented problem of inappropriate plan denials. Without intervention and deterrence, these harmful practices and the risks they pose

will only proliferate, **especially as MA plans grow in popularity**. As OIG notes: "A central concern about the capitated payment model used in Medicare Advantage is the potential incentive for Medicare Advantage Organizations (MAOs) to deny beneficiary access to services and deny payments to providers in an attempt to increase profits."

People with Medicare must be able to access the care they need, when they need it, and plans must not be permitted to gain financially by denying that care. To that end, Medicare Rights supports a stepping up of federal plan oversight, including audits of coverage denials and more significant sanctions for patterns of inappropriate coverage decisions. We also support notifying beneficiaries and the public about plan violations and offering enrollment relief where needed.

How Biden Is Impacting Social Security in 2022

President Joe Biden inherited an underfunded, overextended Social Security program that was already crowded with aging baby boomers as dwindling funds dried up before the pandemic stressed the system even further.

The Social Security Administration (SSA), the agency tasked with running the program, was anemic after a decade of budgetary neglect when the virus shuttered its offices, thinned its staff, gobbled up its budget and swelled its rolls. Then, the rising inflation that followed the pandemic forced Social Security recipients to stretch their benefits until they couldn't stretch them anymore.

Naturally, Biden had to act. His actions have by no means been universally applauded, but the president has certainly left his mark on the program that represents the bedrock of America's social safety net — and **2022 is shaping up to be the most consequential year of all**.

Some of Last Year's Changes Have Already Taken Effect
Social Security recipients started 2022 with the biggest boost to their benefits since 1982. To help retirees cope with the highest inflation rate in 40 years,

Biden oversaw a cost of living adjustment (COLA) of 5.9%, which boosted the average recipient's check by \$92 from \$1,565 per month to \$1,657 per month.

But the biggest raise that beneficiaries have received in four decades isn't the only change to Social Security that the Biden administration made in 2021 that took effect in 2022.

Social Security recipients who haven't yet reached full retirement age can collect their full benefits while still earning income up to a certain threshold — and this year, that income threshold went up.

In 2021, recipients could earn \$18,960 before the SSA began temporarily withholding \$1 for every \$2 in earned income. In 2022, that threshold went up to \$19,560. If you reach full retirement age in 2022, you can earn as much as \$51,960 before the SSA starts pulling \$1 from your check from every \$3 you earn, compared to \$50,520 last year.

It's known as the income test, and it never applies to beneficiaries who have already reached full retirement age.



A Big Boost for SSA in 2023?

Biden's proposed 2023 budget includes an added \$1.8 billion in discretionary funding for the SSA, which administers benefits to 70 million Americans. That would be a 14% increase over the funding levels enacted in 2021 to bring the total to \$14.8 billion.

Nearly all of the new funding — \$1.6 billion out of \$1.8 billion, which also happens to be an increase of 14% over 2021 — would go to improving services for the more than 6 million retirement, survivor and Medicare claims the SSA processes each year, as well as 2 million disability and SSI claims.

The money would be spread around to field offices, teleservice centers for retirees and state disability determination services, while funding investments in things like:

- ◆ Decreasing customer wait times
- ◆ Better outreach to people who are hard to locate
- ◆ A simplified application processes
- ◆ Modernized information technology systems

- ◆ Improved 800-number access
- ◆ Improvements to online services

The remaining \$224 million goes to program integrity, responsible spending initiatives and the investigation and prosecution of fraud

Neither Side Was Fully Satisfied

According to CNBC, some groups thought that Biden's proposed increases to FFA funding didn't go far enough. The National Committee to Preserve Social Security and Medicare, for example, expressed disappointment that the 2023 budget proposals didn't increase benefits and adjust the payroll wage cap so that the wealthy would pay more into the system. Currently, wages over \$147,000 are not taxed for Social Security purposes.

The Committee for a Responsible Federal Budget, on the other hand, took issue with the fact that Biden's budget proposals didn't address the program's trust funds, which will be depleted in 2034 and able to pay only 78% of promised benefits...**Read More**

Biden administration says Part B premiums will drop in 2023

People with Medicare are now paying about \$11 in extra premiums this year but, next year, everyone with Medicare should see lower Part B premiums according to [HealthCareFinanceNews](#). After factoring the cost of covering Aduhelm, a new Alzheimer's drug, into this year's Part B premium, the Biden administration determined that Medicare would not cover the drug, except in limited circumstances. While it is not lowering the Part B premium this year, it will do so next year.

Medicare's projected spending on Aduhelm is responsible for \$11 in Part B premiums this year

based on the manufacturer's \$56,000 a year launch price and an assumption that Medicare would cover it. Since the Part B premium was calculated, however, Biogen, the manufacturer cut the launch price in half, and Medicare said it would only cover the drug for people in clinical trials.

The Biden Administration claims it cannot lower the Part B premium this year because of administrative and legal obstacles. Secretary of Health and Human Services, Xavier Becerra said that "After receiving CMS's report reevaluating the 2022 Medicare Part B premiums,



we have determined that we can put cost-savings directly back into the pockets of people enrolled in Medicare in 2023." "We had hoped to achieve this sooner, but CMS explains that the options to accomplish this would not be feasible."

Fierce Healthcare [reports](#) that a CMS report goes further: CMS "does not have sufficient authority to send premium refunds directly to beneficiaries unless there is excess payment relative to the established premium." If CMS had not considered the cost of Aduhelm in its Part B premium calculation this year, the premium would

have been \$160.40.

Because the Centers for Medicare and Medicaid Services factored the cost of Aduhelm into the Part B premium, the 2022 Part B premium is \$21.60 higher than it was last year, a 14.5 percent increase.

Aduhelm has been found to have serious and sometimes even [deadly side effects and no clear benefits](#). The manufacturers of Aduhelm ended two clinical trials because the drug was not helping people. At any price, the drug is likely ill-advised based on the clinical evidence to date. At \$27,000, it's insane.

2023 Part B Premium to Incorporate Aduhelm Coverage and Pricing Decisions

Last week, the Centers for Medicare & Medicaid Services (CMS) [released](#) an [analysis](#) of Medicare's 2022 Part B premium, factoring in [mid-year changes](#) that are likely to keep Medicare spending lower than was expected when the premium was first announced. The report, done at the [direction](#) of Department of Health and Human Services Secretary Xavier Becerra, recommends against doing a full-scale redetermination of 2022 premiums to account for these shifts and recommends instead that any cost savings be incorporated into the 2023 Part B premium calculation.

The Medicare Part B standard monthly premium jumped by 15% (\$21.60) in 2022. A sizable portion of this was due to potential Medicare coverage of

the controversial Alzheimer's drug Aduhelm, based on that drug's exorbitant initial list price of \$56,000 per year. Since then, Aduhelm's price has been reduced by half, and CMS decided to limit coverage [to people who are enrolled in qualifying clinical trials](#), likely lowering Medicare spending on the drug.

The CMS analysis finds that although the price change and narrower coverage criteria may reduce Medicare spending on Aduhelm, increased spending elsewhere in Part B could mitigate those savings. The yearly Part B premium determination reflects a variety of likely expenses. Those actual costs aren't yet known and could end up being higher than projected—



making a premium adjustment now premature. The report also flags that a redetermination in the middle of the year may not be feasible because CMS lacks the authority to send such refunds directly to beneficiaries. While Medicare Rights supported this reassessment of the 2022 Part B premium, we accept that revising the premium mid-year causes significant administrative problems and faces legal hurdles. We also reiterate our concern that a single drug could trigger such a premium jump. This points to the need to do more to rein in drug prices in Part B, as well as in Part D, the prescription drug benefit. High and rising drug prices burden millions of people with Medicare, the Medicare program,

and taxpayers. Aduhelm spending may be lower than expected, but future drugs could also overwhelm the system while still being unavailable for many because of exorbitant cost sharing. We urge policymakers to pursue [meaningful solutions](#) like allowing Medicare to negotiate drug prices in [Part B and Part D](#), limiting annual price hikes and out-of-pocket costs, and realigning financial incentives. In addition, we strongly support making Medicare's low-income assistance programs—the Medicare Savings Programs (MSPs) and the Part D Low-Income Subsidy (LIS)—[more available and accessible](#). Together, these reforms would allow Medicare to best fulfill its promise of affordable coverage and care.

Most Medicare Advantage plans will see lower star-ratings

Robert King writes for [Fierce Healthcare](#) about a change to Medicare's star-rating system for Medicare Advantage plans that could mean the overwhelming majority of them will face lower star-ratings. As it is, the stars are no way to gauge whether a Medicare Advantage plan will cover your care from physicians you trust when you need it. From the perspective of people with Medicare, [the stars are a farce](#) because the Medicare Advantage plans have been able

to game them.

According to the analysis, nearly 50 percent of Medicare Advantage plans would lose one star. The loss of a star speaks to the difficulty that enrollees are increasingly facing getting prescription drugs in their Medicare Advantage plans. More Medicare Advantage enrollees are unsatisfied with their ability to fill their prescriptions at a reasonable out-of-pocket cost. CMS is also raising the bar for



getting stars. From the Medicare Advantage plans' perspective, losing a star or two means loss of significant revenues, often millions and sometimes billions of dollars. Without that money, Medicare Advantage plans might not be willing to offer as generous benefits. It will also be harder for them to retain enrollees.

The analysis also found that more than four in ten (44 percent)

Medicare Advantage plans could lose a star because their enrollees are less satisfied with customer service and care coordination.

Press Ganey performed the analysis in early 2022, based on data from 446 Medicare Advantage plans.

CMS will change how it calculates star ratings in 2023. It will be giving double the weight it has to customer service, accessing prescription drugs, care coordination and health care quality...[Read More](#)

Despite a First-Ever 'Right-to-Repair' Law, There's No Easy Fix for Wheelchair Users

Robin Bolduc isn't the type of person who takes "no" for an answer — particularly when it comes to fixing her husband's wheelchair

Her husband, Bruce Goguen, 69, is paralyzed from multiple sclerosis. And without his chair, he would be stuck in bed, at risk of developing pneumonia or pressure sores that could lead to sepsis and death.

When components of the chair wear out or break down, the road to repair is littered with obstacles. Recently, the Broomfield, Colorado, residents had to replace a button that Goguen presses with his head to control his wheelchair. They considered going through his wheelchair supplier for the repairs.

"If we did that, he would literally be in bed for months," said Bolduc, who, along with her husband, is a member of the

Colorado Cross-Disability Coalition, an advocacy group. "There's a quality-of-life issue — he could be lying in bed staring at the ceiling. He has no movement without his wheelchair."

But, instead, Bolduc tracked down the manufacturer, ordered several buttons online for \$20 each, and discovered that replacing the part herself was simple.

"It's a plug," she explained. "It's like charging your cellphone."

The multibillion-dollar power-wheelchair market is dominated by two national suppliers, **Numotion** and **National Seating and Mobility**. Both are owned by private equity firms that seek to increase profits and cut spending. One way they do that is by limiting what they



spend on technicians and repairs, which, when combined with insurance and regulatory obstacles, frustrates wheelchair users seeking timely fixes.

The \$70 billion durable medical equipment market has been an attractive target for private equity investment because of the aging U.S. population, the increasing prevalence of chronic conditions, and a growing preference for older adults to be treated at home, **according to** the investment banking firm Provident Healthcare Partners. Medicare's use of competitive bidding favors large companies that can achieve economies of scale in manufacturing and administrative costs, often at the price of quality and customer service.

Regulations set by Medicare and adopted by most Medicaid

and commercial health plans have led to lower-quality products, no coverage for preventive maintenance, and enough red tape to bring wheelchairs to a halt

Power wheelchair users have long been fighting for the right to repair their wheelchairs themselves or through independent repair shops. Medicare and most insurance companies will replace complex wheelchairs only every five years. The wheelchair suppliers that have contracts with public and private health insurance plans restrict access to parts, tools, and service manuals. They usually keep a limited inventory of parts on hand and wait until health plans approve repair claims before ordering parts. **[Read More](#)**

How to Pick a Medigap Plan

A Medigap plan, also known as a Medicare supplement plan, picks up the slack for health care expenses not covered by original Medicare, such as copayments, deductibles and coinsurance.

Individuals who choose original Medicare (rather than a Medicare Advantage plan) often choose to purchase an additional, separate Medigap policy. Also known as a supplemental plan, these insurance plans cover the "gaps" in original Medicare, including copayments, coinsurance and deductibles.

In most states, Medigap plans are named by letters like plan G or plan K. These lettered plans

offer the same health benefits, regardless of which **Medigap** company you purchase them from. People with Medicare Advantage plans, offered through a private insurance company as an alternative to original **Medicare**, are not eligible for Medigap insurance.

Although **Medicare Advantage** plans often cost less in premiums than original Medicare, the network for a Medicare Advantage plan is usually smaller and you might need prior authorization or a referral to see a **specialist**.

What Medigap Covers



All Medigap plans cover:

- ◆ 100% of **Medicare Part A**: hospitals, skilled nursing facility care, hospice care coinsurance or copayment and **home health** care and hospital costs.
 - ◆ Some or all of **Medicare Part B**: services from doctors and other medical professionals coinsurance or copayments.
 - ◆ Blood for transfusions (the first three pints).
- However, only some **types of Medigap plans** cover:
- ◆ All or part of the skilled

nursing facility care coinsurance.

- ◆ Part A and Part B deductibles.
- ◆ Foreign travel emergency costs.

Recently, **a small number of Medigap plans** have begun to cover additional services and items, including:

- ◆ **Long-term care**.
- ◆ Dental care.
- ◆ **Vision** care.
- ◆ **Hearing aids**.
- ◆ Private-duty nursing.... **[Read More](#)**

Medicare vs. Medicaid: What Is the Difference?

Although they were created at the same time, **Medicare** and Medicaid are not identical twins. And even though they've been around for almost 60 years, many people still confuse these two government-backed health care programs.

Many people don't realize that about 20% of Medicare beneficiaries are eligible for both Medicare and Medicaid. These people are commonly referred to as "dual eligibles" and are afforded special benefits and

lower out-of-pocket costs

Difference Between Medicare and Medicaid

On July 30, 1965, President Lyndon Johnson signed the laws that created Medicare and Medicaid as part of his Great Society programs to address poverty, inequality, hunger and education issues.

Both offer health care coverage

Both Medicare and Medicaid offer health care coverage, but they do so in different ways:

- ◆ Medicare is a federal



program that provides health care coverage for people aged 65 or older, and younger people with disabilities, **amyotrophic lateral sclerosis** or end-stage **renal disease**, regardless of the person's income.

- ◆ Medicaid is a combined state and federal program that provides health coverage to those who have low incomes, regardless of the person's age.

Some people may be eligible for both Medicare and Medicaid, known as dually eligible, and can qualify for both programs. The two programs provide health coverage and lower costs for the people enrolled in the programs. Although Medicare and Medicaid are both health insurance programs administered by the government, there are differences in the services they cover and their costs.... **[Read More, Medicare Defined, Medicaid Defined and The Fine Print](#)**

RI ARA HealthLink Wellness News

Will Medicare continue to cover telehealth mental health services?

Senate Finance Committee Chair Ron Wyden (D.Ore.) and others on his committee would like Medicare to continue to cover telehealth mental health services after the public health emergency ends, according to [HealthcareFinanceNews](#). Since the Covid-19 pandemic, Medicare has covered a wide array of [telehealth services](#) for the first time, and it has worked well for millions of people with Medicare. But, unless Congress acts swiftly, after the public health emergency ends, Medicare coverage for almost all telehealth services will also end.

Under federal law, Medicare's coverage of telehealth services will end 151 days after the Covid

public health emergency ends. As of now, the public health emergency will end mid-July, but President Biden is expected to extend it at least another 90 days to mid-October and, more likely, through the end of the year. In that event, Medicare coverage of telehealth services would end around July 2023.

There appears to be bi-partisan support on the Senate Finance Committee for Medicare coverage of audio mental health services, in which case an in-person visit is no longer required. A Finance Committee [discussion draft](#) clarifies that, if legislation were enacted, everyone with Medicare would be eligible for



audio-only or video telehealth mental health services.

The goal is to help increase mental health parity in Medicare, by making it easier to get mental health care. If this policy were to become law, Medicare costs would go up and Congress would need to find an offset to pay for the increased cost.

A recent poll shows a wide range of Americans, including people over 65, are more concerned with mental health issues and getting care to treat these issues. During the pandemic, people used telehealth services in large part to treat mental and behavioral issues.

Logic and reason would dictate that a move for Medicare to cover mental health telehealth services would allow more people with Medicare to benefit from mental health care. However, outreach would be critical to ensure that not only better-educated and more affluent individuals benefited. There's some evidence from a [recent study of cancer patients](#) that coverage of telehealth services for mental health care could widen health disparities. In the study of cancer patients, Black and uninsured individuals and people who live in rural areas and had lower incomes were less likely to use telehealth services.

U.S. Spends More on Cancer Than Any Other Country. Why Are Survival Rates Low?

The United States spends far more on cancer care than other wealthy nations, but it's not seeing a return on that investment in terms of lives saved, a new study shows.

Compared with the average high-income country, [researchers found](#) the U.S. spends twice as much on cancer care -- more than \$200 billion a year. Yet the nation's cancer death rates remain just about average.

Experts said the findings -- published May 27 in the

journal [JAMA Health Forum](#) -- are not entirely surprising. It's well known that the U.S. pays much more for cancer drugs, for example, so the heavy spending on cancer treatment was expected.

"But it was disappointing to see that despite that, our outcomes aren't at the top of the pack," said senior researcher Dr. Cary Gross, a professor at Yale School of Medicine.

Why is all that spending not reaping bigger rewards?



Gross said those high drug prices are likely a big factor: If the U.S. is paying more for the same treatments, that could go a long way in explaining why its [cancer death rates](#) are no lower than many other countries'.

When it comes to approving new drugs, Gross said, "most other countries are a little more dubious than we are."

The U.S. tends to approve more new cancer treatments more quickly than other countries

-- often without evidence they improve patients' long-term survival.

Unlike the U.S., other countries consider [costs](#) when making decisions on new drug approvals, and also negotiate prices of those drugs. In contrast, new cancer drugs typically have a higher starting price in the U.S., and that price tag usually grows over time, Gross and his colleagues point out....[Read More](#)

Experimental Therapy May Be New Tool Against Pancreatic Cancer

In what could turn out to be a potential breakthrough in the treatment of [pancreatic cancer](#), a new report suggests a key component of a patient's immune system can be rewired to assassinate tumor cells.

The experimental approach has already shown promise in one patient.

Kathy Wilkes, 71, had been struggling with advanced pancreatic cancer that had spread to other organs and proven largely unresponsive to complicated and painful treatments since her diagnosis at age 67.

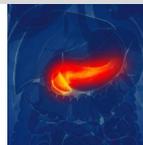
"I just went through with it. I certainly wasn't ready to die," the

Florida resident told the *New York Times*. "I had this voice inside saying, 'You can best this one.'"

In 2021, she was treated with the new therapy.

The novel approach, described in the June 2 issue of the [New England Journal of Medicine](#), focused on a particular type of white blood cell known as T-cells, which naturally fight infections.

Wilkes received a single treatment, which involved several days of infusion with the re-engineered killer [T-cells](#). Eleven days later, she was discharged. Within a month, cancerous



tumors in her lungs had diminished by upwards of 67%.

Wilkes continues to fare well a year later, according

to the study team led by oncologist Dr. Rom Leidner, of the Earle A. Chiles Research Institute in the Providence Cancer Institute in Portland, Ore. "We are cautiously optimistic," Wilkes told the *Times*.

During a Wednesday briefing by the journal on Wilkes' case, *NEJM* Editor-in-Chief Dr. Eric Rubin noted that an extremely complex rejiggering process showed that "we can also take those [T-cells] and engineer them so they can kill tumor

cells."

In essence, it's a "very specific kind of immunotherapy," he explained. [Immunotherapy](#) typically involves treating patients with targeted medicines that prompt the patient's immune system to attack and kill cancer cells.

Rubin described the achievement as both "encouraging" and "a big step" forward. In theory, he said, it could point the way towards markedly improved treatments both for pancreatic cancer and "other diseases that are relatively recalcitrant to therapy."...[Read More](#)

Men Think They're Healthier Than They Are, Don't Need Checkups: Survey

It's a classic case of male machismo jeopardizing health: A new survey finds many American men believe they're healthier than other men and don't bother with annual checkups, even though a yearly exam can catch health problems in the early stages.

The online survey of nearly 900 U.S. men 18 and older was conducted in May by The Harris Poll on behalf of Orlando Health and found that 65% of men view themselves as healthier than others and 33% consider **annual health screening** to be unnecessary.

"It is statistically impossible for the majority of men to be healthier than the majority of men," said Dr. Thomas Kelley, family medicine specialist at Orlando Health Physician

Associates.

"Even if you think you're healthy and you're not experiencing any symptoms, there can be developing issues that often go unnoticed and can also be life-threatening if left unchecked," Kelley said in a health system news release. "Some of those include rising blood pressure that can be a ticking time bomb for a **heart attack or stroke**, as well as **colon cancer**, which is one of the most deadly yet preventable cancers that exist."

The survey also found that 38% of respondents often get health advice from social media, which can be risky if they're not using reputable sources.

Fear is a major reason why men don't see a doctor, according to Kelley.



"If you're a man and you haven't been to the doctor in a while, you don't really know what to expect," he said.

"One of the big things that makes it less scary is having that great relationship with a primary care physician, and most men find the process to be easier than they thought," Kelley said. "It takes about half an hour and by the end of the appointment you have the big picture about where you stand, what you're at risk for and what you need to do for your health in the future."

Nearly 2 in 5 men (38%) in the survey admitted that they tend to focus on their pet's health more than their own, which doesn't surprise Kelley.

"Men tend to put their health last after their family, and

apparently even after their dog or their cat," he said. "But in order to take care of others in your life, you first have to take care of yourself, and that includes making that yearly appointment with your primary care doctor."

Combining annual exams with regular exercise, healthy eating, drinking plenty of water and reducing stress can make a big difference in your overall health.

"It's much easier to go to the doctor once a year for a wellness checkup and make certain that you're not developing diabetes, high blood pressure or a heart problem, than to find yourself in an intensive care unit needing heart bypass surgery because you didn't look into those things," Kelley said.

Your Liver Is Just 3 Years Old

No matter how old you are, your liver is always roughly less than three years old, according to a new study.

That's because the liver is constantly renewing itself and replaces its cells equally well in young and old people, the German **study** explained.

The liver clears toxins from our bodies, putting it at risk of regular injury. To overcome this problem, it has a unique ability to regenerate itself after damage. But it was unclear if **the liver's** capacity to renew itself diminished with age.

"Some studies pointed to the possibility that liver cells are long-lived while others showed a

constant turnover. It was clear to us that if we want to know what happens in humans, we need to find a way to directly assess the age of human liver cells," said researcher Dr. Olaf Bergmann of the Center for Regenerative Therapies Dresden, in Germany.

For the study, Bergmann and his team used a technique called retrospective radiocarbon birth dating to determine the age of livers in a number of people who died between the ages of 20 and 84. In all of them, liver cells were more or less the same age, according to findings published online May 31 in the journal **Cell Systems**.



"No matter if you are 20 or 84, your liver stays on average just under three years old," Bergmann said. Not all liver cells are that young, however. A fraction of cells can live up to 10 years before renewing themselves. These cells carry more DNA than typical liver cells and could be protective, the researchers said.

"Most of our cells have two sets of chromosomes, but some cells accumulate more DNA as they age. In the end, such cells can carry four, eight, or even more sets of chromosomes," Bergmann said in a news release from the Technical Institute

Dresden.

When his team compared typical liver cells with those richer in DNA, they found fundamental differences in renewal.

"Typical cells renew approximately once a year, while the cells richer in DNA can reside in the liver for up to a decade," Bergmann said.

"As this fraction gradually increases with age, this could be a protective mechanism that safeguards us from accumulating harmful mutations," he added. "We need to find out if there are similar mechanisms in chronic **liver disease**, which in some cases can turn into cancer."

Is Slowed Walking a Sign Dementia Is Near?

If you're a senior and walking to the mailbox takes longer than it used to, new research suggests you might want to ask your doctor to check your thinking skills.

The study included nearly 17,000 adults over 65 and found those who walk about 5% slower or more each year and also had memory declines were the most likely to develop **dementia**.

The findings were published May 31 in the journal **JAMA**

Network Open.

"These results highlight the importance of gait in dementia risk assessment," corresponding study author Taya Collyer, a research fellow at Peninsula Clinical School at Monash University in Victoria, Australia, told **CNN**.

The findings echo those of a **2020 study** of nearly 9,000 U.S. adults that found an association between slowed walking speed and memory decline and future risk of



dementia. Research suggests the link between walking speed and decreasing mental function may be due to shrinking in the right hippocampus, a part of the brain that handles learning, memories and the ability to find your way around, **CNN** reported.

At the same time, previous studies have also found that aerobic exercise such as brisk walking, running, swimming, cycling and dancing can enlarge

the hippocampus and improve some areas of memory.

And just because someone has what's called **mild cognitive impairment** (MCI) doesn't mean they'll go on to develop dementia. Only 10% to 20% of those 65 and older with MCI develop dementia within a year, according to the U.S. National Institute on Aging, which also states that in "many cases, the symptoms of MCI may stay the same or even improve."

Why Treatment Helps Some Asthma Patients More Than Others

New research reveals why popular treatments for asthma attacks are often ineffective.

Corticosteroids are used as an emergency treatment during asthma attacks to decrease airway swelling and irritation. While effective in people with moderate asthma, they often fail to help those with severe asthma.

"Our study has uncovered a potential mechanism to explain why patients with severe asthma are unresponsive to conventional therapy," said study co-author author Reynold Panettieri Jr., vice chancellor of Clinical and Translational Science at Rutgers University in New Brunswick,

N.J. "If we could uncover new approaches to treatment that directly affect that mechanism, we may be able to restore a sensitivity to the steroid and improve outcomes."

He and his colleagues found that two naturally occurring growth factors -- natural substances that stimulate cell proliferation -- activate in the airway-lining cells of severe asthma patients when they inhale corticosteroids and block the medications from working.

The two growth factors are fibroblast growth factor (FGF) and granulocytic colony forming



growth factor (G-CSF), according to findings recently published in the journal *Science Translational Medicine*.

"We believe this response explains why patients with severe asthma are unresponsive to such conventional therapy," Panettieri said in a Rutgers' news release.

Of the more than 25 million people in the United States with **asthma**, an estimated 5% to 10% have severe asthma, according to the American Lung Association.

The new findings suggest different cellular pathways are at work in the airway lining cells of

patients with severe asthma, particularly those involved in inflammation, researchers said.

They said these results could point the way to new therapies for people with severe asthma.

Tests in mice showed that when researchers blocked release of chemicals that trigger secretion of the two growth factors, corticosteroids were able to reverse airway inflammation and also prevented tissue scarring. Research done in animals often produces different results in humans.

Pandemic Caused Millions of U.S. Women to Skip Cancer Screenings

(HealthDay News) -- Millions of U.S. women missed breast, cervical and colon cancer screenings due to the COVID-19 pandemic, according to a new study.

It found that compared to 2018, the number of women in 2020 who said they had **breast cancer screening** in the past year fell by 2.13 million (6%). The number of women who said they had **cervical cancer screening** in the past year fell by 4.47 million (11%).

Over the same period, **colonoscopies** for colon cancer detection dropped by 16% for both men and women.

"COVID-19 pandemic had an immediate impact in March and

April of 2020, as screenings initially dropped by close to 80%," said senior author Dr. Ahmedin Jemal, a senior vice president at the American Cancer Society.

"Many people caught up on screenings later in 2020, but overall, the COVID-19 pandemic kept screenings down over the course of the entire year," he said in a society news release. "As we move forward, it's crucial to get people back into their doctor's offices to **get screened**."

Hispanic women and those in lower-income brackets had larger fall-offs in breast and cervical cancer screening, the study found. Asian/Pacific Islander



women had a 27% drop in past-year breast cancer screening, the largest for any race. Meanwhile, Hispanic women had a 17% decline in past-year cervical cancer screening.

Decreases were nearly twice as high among people with less than a high school education, compared to college graduates. Rates among those without a high school diploma fell 11% for breast cancer screening and 17.7% for cervical cancer screening, compared to 6.1% and 9.5%, respectively, for college graduates.

Meanwhile, while colonoscopy screening for colon cancer fell for both women and men, **stool**

testing was up 7%. Researchers said this suggests at-home testing may help maintain screening rates during major health care disruptions.

The American Cancer Society-led study was published June 3 in *JAMA Network Open*.

"The impact of these drops on stage at diagnosis and survival is not yet known, but it is something we need to monitor closely," Jemal said. "It is imperative that we understand the impact of lower screening rates on cancer outcomes among people of color and people of lower socioeconomic standing and also work to improve access to health care and cancer screenings for everyone."

What People With Early-Onset Dementia Want You to Know

An elevator encounter that happened to Laurie Waters highlights the daily plight faced by early-onset **Alzheimer's** patients like her.

Waters, 57, was stuck in an elevator at an Alzheimer's convention with other folks who were growing loud and excited -- and the situation was getting to her.

"I was starting to get panic-stricken, being in that enclosed space. And one gentleman was like, 'Well, what's the matter with you?'" Waters recalled. "I said, 'I'm actually living with Alzheimer's.' And this woman next to him said, 'You know,

that's really mean to say that.'"

June is Alzheimer's & Brain Awareness Month, and people like Waters are taking the opportunity to share what they'd like others to know about what it's like to live with a dementia.

Her elevator tale illustrates two important lessons -- younger people can have dementia and people with this disease would really rather *not* debate their diagnosis or be told they don't look like they have Alzheimer's.

"I look young, and people even in the Alzheimer's community who are around it still don't recognize younger-onset," said



Waters, who lives in Clover, S.C. "It's everywhere. I've had doctors who have sat there, who haven't met me before, just look at me and be like, 'Are you sure you're diagnosed with Alzheimer's?'"

The frustration for Deborah Jobe comes from folks who talk about her as though she isn't there.

"My husband and I will be in a room and people will ask him, you know, 'She looks pretty good, how is she doing?'" said Jobe, 55, of St. Louis, who has an early-onset form of dementia called **posterior cortical atrophy**.

"I'm like, 'Hello! Right here! You can ask me. It's OK. I don't mind,'" Jobe said, laughing. "I'm still here. I'm still human. Please address to me and if I can't answer, I'm sure he'll step in and help."

The upshot from Waters and Jobe -- people with Alzheimer's are still people.

"One of the common themes I hear over and over again is that how the diagnosis does not define who they are," said Monica Moreno, senior director of care and support with the Alzheimer's Association, who works with early-stage families in the wake of their diagnosis.... **Read More**

Race Matters in Stroke Survival, Study Finds

Racial disparities in health outcomes persist in the United States, with Black and Hispanic Americans more likely to die within a month after a bleeding stroke than white Americans, a new study shows.

"We've known that there are disparities in death from stroke among racial and ethnic groups in the U.S. due to **higher stroke rates**, higher burden of risk factors for stroke, socioeconomic inequality and structural racism, but we have needed more information breaking these differences down by type of stroke," said study co-author Dr. Hugo Aparicio, of Boston University School of Medicine.

For the study, the researchers analyzed U.S. Veterans Health

Administration data on nearly 38,000 patients hospitalized for stroke over a 10-year period. Men accounted for 98% of the patients.

Nearly nine in 10 (89%) of the strokes were caused by a blood clot (ischemic stroke). Nine percent were intracerebral hemorrhage strokes and 2% were subarachnoid hemorrhage strokes, both caused by **bleeding in the brain**.

After adjusting for factors that could affect the risk of death after stroke — such as smoking, diabetes and heart disease — the researchers concluded that Hispanics who had subarachnoid hemorrhage strokes had a 30% increased risk of death within a



month, compared with a 20% increased risk among white patients.

Black patients who had intracerebral hemorrhage strokes had a 30% increased risk of death within a month, compared with a 27% increased risk among white patients, according to the study.

The report was published online June 1 in the journal *Neurology*.

"These results will help us to better understand the nature of this health inequity," Aparicio explained in a journal news release.

"Differences in mortality by race or ethnicity varied substantially when considering specific types of stroke,

especially the different types of hemorrhagic stroke," Aparicio said.

When all types of stroke are considered together as one disease, it may mask underlying racial or ethnic disparities, he added. "Given these differences in stroke mortality by race and ethnicity, it is clear that more research is also needed in Native American, Alaska Native, Native Hawaiian and Asian American groups," he said.

Because nearly all of the study participants were male veterans, the findings may not apply to women or the general population, the researchers noted.

A Cancer Trial's Unexpected Result: Remission in Every Patient

It was a small trial, just 18 rectal cancer patients, every one of whom took the same drug.

But the results were astonishing. The cancer vanished in every single patient, undetectable by physical exam; endoscopy; positron emission tomography, or PET scans; or MRI scans.

Dr. Luis A. Diaz Jr. of Memorial Sloan Kettering Cancer Center, an author of a paper published Sunday in the *New England Journal of Medicine* describing the results, which were sponsored by drug company GlaxoSmithKline, said he knew of no other study in

which a treatment completely obliterated a cancer in every patient.

"I believe this is the first time this has happened in the history of cancer," Diaz said.

Dr. Alan P. Venook, a colorectal cancer specialist at the University of California, San Francisco, who was not involved with the study, said he also thought this was a first.

A complete remission in every single patient is "unheard-of," he said.

These rectal cancer patients had faced grueling treatments — chemotherapy, radiation and,



most likely, life-altering surgery that could result in bowel, urinary and sexual dysfunction. Some would need colostomy bags.

They entered the study thinking that, when it was over, they would have to undergo those procedures because no one really expected their tumors to disappear.

But they got a surprise: No further treatment was necessary.

"There were a lot of happy tears," said Dr. Andrea Cercek, an oncologist at Memorial Sloan Kettering Cancer Center and a co-author of the paper, which was

presented Sunday at the annual meeting of the American Society of Clinical Oncology.

Another surprise, Venook added, was that none of the patients had clinically significant complications

On average, 1 in 5 patients have some sort of adverse reaction to drugs like the one the patients took, dostarlimab, known as checkpoint inhibitors. The medication was given every three weeks for six months and cost about \$11,000 per dose. It unmasks cancer cells, allowing the immune system to identify and destroy them ... [Read More](#)

Gruesome Warnings on Cigarette Packs Have Smokers Hiding Them, but not Quitting

(HealthDay News) -- Graphic images on cigarette packs of diseased body parts and other smoking horrors may not have the desired effect on smokers themselves, a new study finds.

Many smokers kept cigarette packs with gruesome warning images hidden, but the images didn't have a lasting effect on their smoking habits, researchers discovered after presenting thousands of specially designed cigarette packs to smokers in California.

Graphic warning labels are used on cigarette packs in more than 120 countries. They were mandated by Congress in

2009, but have been held up by legal challenges from the tobacco industry.

"Prior to the study, we found that many smokers in the U.S. were discreet and reported hiding their usual pack in public settings. The packs with graphic warning labels had their main effect on those who were least likely to hide their packs prior to the study," said study co-author David Strong, a professor at the University of California, San Diego School of Public Health.

"We found no evidence that graphic warning-labeled packs changed smoking behavior over



the year-long study," he added in a university news release.

For the study, researchers created cigarette packs with images used on cigarette packs in Australia. They showed a diseased foot, a newborn with a breathing tube or **throat cancer**.

They then had 357 smokers in San Diego buy their preferred brand of cigarette from a study website. The smokers received their cigarettes in one of three pack designs: with a graphic warning label, a blank pack or in a standard pack available in the United States. About 19,000 packs were delivered to the

participants.

Those who received cigarette packs with graphic warning labels hid their packs 38% more often, but stopped hiding them when they returned to regular packs without the graphic labels, according to the study. The findings are published in the June 2 online issue of the journal *JAMA Network Open*.

Those who received cigarettes in a standard U.S. pack or in a blank pack did not change their pack-hiding behavior.

Overall, the participants continued to smoke as often as they did before and after the study.

Diabetes drug helps patients lose never-before-seen amounts of weight, new study shows

A drug recently approved to treat type 2 diabetes is also extremely effective at reducing obesity, according to a new study.

The drug, called tirzepatide, works on two naturally-occurring hormones that help control blood sugar and are involved in sending fullness signals from the gut to the brain.

Researchers noticed that people who took the drug for their diabetes also lost weight. The new trial focused on people who have obesity without diabetes and found even more weight loss.

Those taking the highest of three studied doses lost as much as 21% of their body weight – as

many as 50-60 pounds in some cases.

Nothing has provided that kind of weight loss except surgery, said Dr. Robert Gabbay, chief scientific and medical officer for the American Diabetes Association. The full study was presented Saturday at the ADA's annual convention in New Orleans and simultaneously **published in the New England Journal of Medicine.**

Another obesity treatment approved last year called semaglutide, from Novo Nordisk, provides an average of up to about 15% weight loss. Previous generations of diet drugs cut only about 5% of



weight and many carried prohibitive side effects.

"We've not had tools like this," Gabbay said. "I think it's really exciting."

For most of the trial participants, side effects from tirzepatide were not serious, said Jeff Emmick, vice president of product development for the diabetes division of drug giant Lilly, which makes the drug.

About 15% of participants who received the active drug dropped out of the 72-week trial, about a third because of gastrointestinal side effects. Meanwhile, 26% of trial volunteers who received a placebo dropped out. Emmick said he thinks they may have

been frustrated by their lack of weight loss.

On May 13, the **Food and Drug Administration** approved **tirzepatide**, under the trade name Mounjaro, for the treatment of type 2 diabetes.

Tirzepatide is not yet available for weight loss, but Lilly hopes to have an updated timeline from the FDA later this year, Emmick said. Before approving the drug for weight loss, the regulatory agency may first want Lilly to complete other studies underway examining tirzepatide in people with obesity and diabetes and the addition of lifestyle changes to the drug regimen...**Read More**

Skin Biopsy? Here Are Tips on Wound Care

(HealthDay News) -- A skin biopsy is often used to diagnose **skin cancer** and other skin conditions.

It involves the removal of a small amount of skin, which is examined under a microscope. Afterwards, you'll need to look after the biopsy location to make sure it heals properly.

"Your dermatologist will treat the small wound from the **skin biopsy** during your visit," said dermatologist Dr. Rajiv Nijhawan, an associate professor at UT Southwestern Medical Center in Dallas.

"Continuing to care for your wound once you get home is important because it will help it

heal, reduce scarring and decrease chances of infection," he said in an American Academy of Dermatology news release.

Wash your hands before touching your wound. To care for your wound, gently wash the biopsy area with mild soap and water. Rinse thoroughly and gently pat dry with a clean wash cloth.

To keep the wound moist and help it heal faster, apply petroleum jelly from a squeeze tube to the wound. Then cover the wound with an adhesive bandage or sterile gauze and paper tape. Do this daily for as



long as your dermatologist recommends.

Do not use topical antibiotics unless advised by your dermatologist because they can cause **allergic reactions.**

Applying petroleum jelly can also help relieve itching as the wound heals. Itching can also be a sign of an allergic reaction or skin irritation. Cover the wound with a nonstick pad and paper tape instead of an adhesive bandage.

If your wound starts bleeding, apply firm and steady pressure with a sterile gauze pad for 20 minutes. Call your

dermatologist's office if your wound is still bleeding after 20 minutes.

If you have pain at the biopsy site, take acetaminophen or place an ice pack over the bandage to relieve swelling.

Reduce scarring by protecting the biopsy site from the sun. Cover it with sun-protective clothing, apply a broad-spectrum, water-resistant sunscreen with an SPF of 30 or higher, and stay in the shade when possible.

"If you have any signs of infection such as worsening pain, increased swelling, warmth or fever, contact your dermatologist," Nijhawan said.

New Treatments Battle Advanced Breast Cancers

Two "smart bomb" drugs are offering new hope to women with aggressive breast cancers, a pair of clinical trials show.

Both medications are **antibody-drug conjugates**, consisting of a chemo drug that's been wedded to an antibody that delivers the chemotherapy directly to cancer cells.

"That's a way to take the chemo right to the cancer cells and spare the rest of the body a lot of toxicity," said Dr. Shanu Modi, a medical oncologist at Memorial Sloan Kettering Cancer Center in New York

City. "The antibody takes the chemo right to the cancer cells. When the antibody finds its target, the whole complex gets internalized into the cell, and then the chemo gets released inside the cancer cell."

Modi served as lead researcher for the first drug, Enhertu (trastuzumab deruxtecan), which stalled cancer progression for nearly double the time of standard chemotherapy – 10.1 versus 5.4 months – in a select group of patients with advanced breast



cancer.

The other drug, Trodelvy (sacituzumab govitecan), also resulted in longer progression-free survival compared to standard chemotherapy in certain cancer patients, according to results presented Saturday at the American Society of Clinical Oncology (ASCO) annual meeting, in Chicago. Such research is considered preliminary until published in a peer-reviewed journal.

Both antibody-drug conjugates are already U.S.

Food and Drug Administration-approved for use in treating certain types of **breast cancer**. These new clinical trials show that they could be useful for even more patients, said ASCO Chief Medical Officer Dr. Julie Gralow.

Enhertu is already approved in more than 40 countries for the treatment of adult patients with **HER2-positive breast cancer**, the researchers said in background notes...**Read More**