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Message from the Alliance *for* Retired Americans Leaders

Generic Drug Manufacturer Announces Plans for Low-Cost Insulin

Rich Fiesta, Executive Director, ARA

Uninsured and underinsured Americans often pay the highest out-of-pocket costs for their medicine, forcing many to choose between purchasing the medicine they need and covering essential living expenses. However, the country's first not-for-profit generic pharmaceutical company unveiled a plan to reverse the trend of drug price-gouging that has become so rampant in the industry.

The generic drugmaker Civica Rx has announced intentions **to produce and distribute its own affordable insulin** at prices far lower than the industry average. Insulin prices have become a widely debated issue, with an estimated **one in four** Americans who suffer from diabetes choosing between rationing or skipping doses due to cost.

Civica will produce three generic insulins with a recommended price of no more than $30 per vial and no more than $55 for five pre-filled pens. The generic drugs are biologically interchangeable with the name-brand insulins that traditionally sell for over $300 a vial.

All three of Civica's insulins will be available to all Americans at one low, transparent price based on the cost of development, production and distribution. The medication will be produced at a new manufacturing facility in Virginia, with the first doses set to be available by early 2024, pending FDA approval.

In related action, Senate Democrats are also **reviving** their plans to limit the cost of insulin and other medications. Several proposed bills aim to cap insulin costs at $35 a month.

"For years, as millions of Americans struggle to pay for insulin, drug companies raked in outrageous profits," said Executive Director **Fiesta**. "We hope that the new generic vials will help make insulin affordable and available to all who need it. However, it is no substitute for real and comprehensive legislation to bring down the price of all prescription drugs."

Alliance Praises Senate Passage of Bipartisan Postal Reform Bill

Robert Roach, Jr
President, ARA

The Senate **passed the Postal Service Reform Act,** H.R. 3076, on Tuesday, repealing the Congressional mandate that the U.S. Postal Service spend billions of dollars every year to prefund retiree health care. With White House officials indicating President **Biden** intends to sign the bill into law, the Postal Service will soon pay these costs on a yearly basis, as other government agencies and corporations do, saving nearly $50 billion over 10 years.

"The **bipartisan 79-19 Senate vote** this week to pass postal reform, following the House of Representatives' vote last month, will help ensure that the Postal Service will be able to serve all Americans for years to come," said **Robert Roach, Jr.**, President of the Alliance. "Strengthening the Postal Service has been an Alliance priority for years. The activism of thousands of Alliance members who have attended demonstrations, called and written to their members of Congress has helped bring us to this moment."

"Older Americans rely on the U.S. Postal Service for timely at-home delivery of medications and important mail on weekdays and weekends," said **Richard Fiesta**, Executive Director of the Alliance. "It can trace its roots to 1775, when **Benjamin Franklin** was the first postmaster general, and it is as important today as it ever was."

Nation Celebrates One Year Since American Rescue Plan Became Law

Exactly one year ago, on March 11, 2021, President Biden signed the American Rescue Plan (ARP) into law to address the health and economic crises caused by the COVID-19 pandemic. Since then, this important legislation has been the cornerstone of the American COVID-19 recovery, providing funding for a national vaccination distribution and resources to local communities while reopening schools and creating measures to allow millions of Americans to safely get back to work. The ARP was essential to making health care more affordable. It built on the strong foundation of the Affordable Care Act (ACA) by lowering premiums, expanding coverage, and increasing access to essential health services. It made health insurance more affordable and accessible, which is more important than ever as individuals deal with mental and physical health issues from COVID-19. These measures to increase affordability also reduced racial disparities in health care access. President Biden's ARP also included something else: a provision saving multiemployer pension plans from insolvency. Thanks to the ARP, ten million Americans will receive the pensions they earned.

"The Alliance provided information and resources so that decision makers and their advisers could solve our retirement security emergency, and that led to the provision of the American Rescue Plan that solved the pension crisis," said President Roach. "The Alliance and the AFL-CIO's Retirement Security Working Group were instrumental in saving multiemployer pensions from insolvency," President Roach continued. "Former AFL-CIO President Richard Trumka started the working group, coordinated by current AFL-CIO President Liz Shuler, by bringing together all the international union presidents to find a solution."

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Biden administration bent on privatizing traditional Medicare

There appears to be little light any more between corporate health care and government health care or even between government health care-speak and corporate health care-speak. In the latest government push to privatize traditional Medicare through insurer and investor middlemen responsible for paying claims–**"ACO REACH"**–the Biden administration claims its goal is "value-based care," though there is no good evidence corporate middlemen deliver value for patients.

What's happening? The Biden administration is continuing a Trump administration experiment to pay middlemen–often entities with no meaningful medical expertise–a flat fee per patient to manage care for people in traditional Medicare. The administration just renamed the experiment –which works like Medicare Advantage–ACO REACH. It will privatize traditional Medicare by turning over "care"management read "money" management, to investors and insurers.

Who will be in the experiment? Any person with Medicare whose primary care physicians are working for a middleman that contracts with the Centers for Medicare and Medicaid Services to receive a fixed rate per patient to manage care in traditional Medicare.

What's the value to patients? If you look at the role insurer middleman play in Medicare Advantage, it is hard to see any value and easy to see huge risk for patients. Given the scant data available in Medicare Advantage, no one can demonstrate value in the care patients receive. MedPAC, the government's Medicare oversight agency, has never been able to assess care quality in Medicare Advantage because the plans have never given it complete and accurate information that would permit it to assess value.

ACO REACH will offer "care coordination, but what does that mean? The Center for Medicare and Medicaid Innovation (CMMI) claims the ACO REACH model is somehow going to ensure people in traditional Medicare have their care coordinated in ways that improve health outcomes. But, there is no evidence that people in managed care plans have better health outcomes than people in traditional Medicare. In fact, "care coordination" is often a euphemism for delayed care, less care, and referrals to low-cost providers, none of which is by definition a good thing.

Will ACO REACH promote health equity? CMMI also says it is promoting health equity through ACO REACH, but there's no evidence to support that claim. Participants will need to have health equity plans. But health equity plans are far different from results and, so long as cost is a barrier to care, it's hard to see how participants can reduce health disparities. It's also hard to imagine how CMS will ensure compliance by participants with model requirements.

How prior authorization requirements in Medicare Advantage could threaten your health

If you're in a Medicare Advantage plan and have needed any costly care, you likely know about prior authorization requirements that save corporate health insurers money but can threaten people's health and well-being. Doctors say that many of these requirements are not evidence-based. In an opinion piece for the **AMA News**, Gerald Harmon, MD, President of the AMA, describes how prior authorization "administrative hassles" could threaten your health.

People in traditional Medicare do not have to deal with prior authorization requirements in order to get the care they need. In stark contrast, Medicare Advantage plans impose prior authorization requirements in a variety of situations, **often harming patient health**. AMA doctors surveyed reported incidents of preventable "hospitalization, disability and permanent bodily damage, or death" for patients they care for as a result of prior authorization requirements.

Dr. Harmon writes about his attempt to get prior authorization for his 92-year old mother, which kept her from getting important drugs for an unknown period of time. He spent an hour trying to expedite approval of his mom's prescriptions with no success. After trying to get help from a variety of folks, he turned to his mom's doctor who took over the effort to get his mom the drugs she needed.

Even with help from his mom's doctor, there was no guarantee his mom's insurer would authorize her drugs for several days. In turn, Dr. Harmon was deeply concerned about the deleterious effects on his mom's health of not having the medications. Note: Dr. Harmon was not concerned about drug copays–another enormous barrier to care–that leads to **thousands of unnecessary deaths** of people with Medicare each year.

The AMA has an initiative to "fix" prior authorization requirements. For sure, prior authorization should either be eliminated or restricted to specific evidence-based situations when certain treatments might not be warranted. They should never prevent patients from getting timely access to needed care.

The AMA supports bi-partisan legislation in Congress that would help people in Medicare Advantage plans, the Improving Seniors' Timely Access to Care Act of 2021 (H.R. 3173/S.3018). It wouldn't eliminate prior authorization, but it would simplify and standardize it.

If you have stories about how prior authorization in Medicare Advantage kept you or someone you love from getting needed care, please send them to info@justcareusa.org.

VA recommends closing three medical centers, opening others as part of overhaul

The Department of Veterans Affairs (VA) recommended on Monday the closure of three hospitals but the opening of dozens of other facilities as it looks to overhaul a system that serves roughly 9 million veteran enrollees nationwide.

A report on Monday from the VA said that medical centers in Massachusetts, New York and Ohio would close along with other facilities. It added that hundreds of new points of care were set to be opened, increasing access to primary care, mental health treatment and other specialty care, according to **USA Today**.

The report cited changing demographics of veterans, including younger, more diverse populations, as one of the reasons for change, USA Today reported.

"VA came to these recommendations by asking ourselves one question above all else: what's best for the Veterans we serve?" VA Secretary Denis McDonough said in **a statement.**

"We've spent the last several weeks and months communicating about this with VA employees, union partners, state partners, Veteran service organizations, Congress, and more. I'm continuing to consult with our unions, and will do so moving forward, because I so appreciate the strong partnership we have with them," McDonough added**….Read More**

Senior Citizens League Update for Week Ending February 26, 2022

Efforts to Lower Prescription Drug Prices Continue

Although Congress has so far failed to pass legislation to lower prescription drug prices, they have not given up trying to do so.

This Wednesday, the Senate Finance Committee will hold a hearing entitled "Prescription Drug Inflation: an urgent need to lower prescription drug prices in medicines."

In addition, leaders in both houses have said they will continue to work on legislation that can gain enough support to pass. As we've reported in the past, the Democratic majority has been unable to agree among themselves on legislation to lower drug prices and Republicans have said they will not vote for any drug-lowering legislation the Democrats have come up with so far.

Because of the impasse in Congress, the Biden administration has been looking for ways to lower drug prices either through executive orders or through administrative rule-making.

An example of the latter is a Medicare proposal aimed at lowering out-of-pocket drug costs. It is complicated measure but that's because the manner in which drug prices are set is very complicated and not at all transparent.

Very briefly, this new rule mandates that Medicare Part D plans apply all "price concessions" they receive from pharmacies to the final sale price.

However, it wouldn't ensure the rebates that manufacturers pay to insurers and pharmacy middlemen also apply at the point of sale. Critics argue those rebates are shrouded in secrecy and have ultimately led to higher initial list prices. The Centers for Medicare & Medicaid Services (CMS) said in January that the proposed rule would reduce costs of prescriptions for those who need them, and improve transparency and competition in the Part D program.

However, Pharmacy Benefit Managers (PBMs) argue that the proposal would limit its function to bring lower drug costs to consumers. PBMs have repeatedly argued that drug manufacturer price setting is the root cause of high drug costs.

PBMs are something no one outside of the prescription drug world had ever heard of until the drive-in recent years to lower drug prices. They are pitted against the big drug manufacturing companies in the battle, with each accusing the other of being the reason for the outrageously high prescription prices Americans are paying and each are pouring millions of dollars into lobbying efforts to try and defeat any proposed legislation that might harm their profits.

As we said, it's very complicated.

In all of this, TSCL's goal remains the same: prescription drug prices are too high, and we need government action to lower them. A drug that will cure or control a medical condition does no good if the person who needs the drug can't afford it.

Read More on……..

- **Congress Finally Acts - Government Will Not Shut Down**
- **Mail Order Drugs and the Post Office**

Medicare Rights Supports Important Proposals for Medicare Advantage and Part D Plans

This week, Medicare Rights submitted **comments** on a proposed rule that would make some important changes to Medicare Advantage (MA) and Part D plans. If finalized, **this rule** would alter how MA plans can use third parties to market to consumers; require plans to communicate with enrollees in multiple languages; change how Part D plans determine negotiated drug prices; and improve aspects of Dual Eligible Special Needs Plans (D-SNPs)—special types of MA plans that enroll only people who are eligible for both Medicare and Medicaid.

On Medicare Rights Center's national helpline, we have seen nearly a 200% increase in calls and questions around inappropriate marketing in recent years. In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) reports that complaints to the agency about marketing have also more than doubled, and points to third-party marketing as a major reason why. These third-party marketing organizations (TPMOs) advertise heavily, **often on TV**, and make big claims for what people can receive if they switch to an MA plan. In the proposed rule, CMS notes that "beneficiaries are confused by these TPMOs, including confusion regarding who they are speaking to, what plans the TPMOs represent, and that the beneficiary may be unaware that they are enrolling into a new plan during these phone conversations."

Because of these issues, CMS's proposed rule notes that plans "must not engage in activities that could mislead or confuse Medicare beneficiaries," and third parties hired by MA plans must be held to the same standard. If finalized, the rule would make MA plans responsible for enforcing the same requirements of third parties as the plans themselves must meet. In addition, it would require TPMOs to disclose that they are not offering information on every plan in the area.

CMS also highlights the need for accessible, understandable plan materials. The rule would reinstate an important previous requirement for MA and Part D plans to include a multi-language insert in communications to inform enrollees—in the top fifteen languages used in the U.S.—that interpreter services are available for free.

The rule would also make significant changes to the Part D prescription drug program. Currently, plans negotiate a price for drugs and base enrollee costs on that negotiated price. Then, in many cases, the plans recoup some of their costs from pharmacies in the form of "pharmacy concessions" without lowering the cost for enrollees. The rule would require plans to pass through the savings from pharmacy concessions to beneficiaries at the point of sale, which may lower drug costs for some enrollees. While this may not have a significant effect on out-of-pocket costs for all beneficiaries, it would greatly increase transparency in Part D and better show true drug costs.

In by far the longest section of the rule, CMS proposes to make changes to Dual Eligible Special Needs Plans (D-SNPs). These specialized MA plans are supposed to help beneficiaries who are eligible for both Medicare and Medicaid access their benefits by integrating some of their care. Unfortunately, D-SNPs have historically not lived up to this promise and many enrollees are still left with a jumble of coverage that they can struggle to navigate. The proposed rule would make important changes and clarifications to address this, including requiring plans to create enrollee advisory committees and ask questions about social risk factors to better understand enrollee needs; to merge appeals and grievances processes for more plans; and to redefine some plan terminology so that potential enrollees can better understand what a given plan may offer.

We are encouraged by this rule as a whole. While more work must be done to ensure MA and Part D plans work better for beneficiaries, each of these proposals would be an important step toward that goal. We will **continue to urge CMS** to conduct more rigorous oversight of all plans and to rein in MA overpayments, strengthening the program for all beneficiaries.

Biden again emphasizes help for veterans

President Joe Biden on Tuesday traveled to Fort Worth, Texas, to advocate for veterans — an issue that hits close to home.

The president, speaking at the Tarrant County Resource Connection, met with veterans and their caregivers and called for better health care for service members who face health problems potentially linked to burn pits, which were used during the Iraq and Afghanistan wars to dispose of war wastes, including things like metals and jet fuel.

Veterans Affairs Secretary Denis McDonough accompanied Biden on the trip, in which the president called on Congress to send him a bill that protects veterans facing health ailments after burn pit exposure.

"Veterans are used to always giving, you don't think you have the right to ask," Biden said in the state with the second-largest veteran population. "Tell us what your [health care] needs are … we owe you."

The trip comes after Biden's State of the Union speech, where he outlined his new unity agenda that includes combating the opioid epidemic, addressing mental health, supporting veterans and ending cancer. In his March 1 speech, he discussed the potential connection between the toxic chemicals from burn pits and the death of his son.

"One of those soldiers was my son Major Beau Biden," Biden said on March 1, talking about his late son who was deployed to Iraq in 2008. The two-term Delaware attorney general died in 2015 at age 46, after being diagnosed with brain cancer in 2013.

Biden on Tuesday cited the debate that emerged after the Vietnam War, when veterans for decades were denied health benefits for illnesses caused by exposure to Agent Orange. As a senator in 1991, Biden co-sponsored the Agent Orange Act, which declared the defoliant chemical used in the Vietnam

war likely caused at least a dozen illnesses in those who served.

"I refuse to repeat the mistake when it comes to veterans of our Iraq and Afghan wars," Biden said, noting that it took too long after the Vietnam War to take action. The Agent Orange Act came 16 years after the war ended.

There was movement last week after Biden's speech. The House passed a bill that would expand health benefits for Iraq and Afghanistan veterans exposed to burn pits. And the Department of Veterans Affairs announced that it would propose a rule to add nine rare respiratory cancer as service-connected disabilities for veterans who served in "the Southwest Asia theater of operations."

The president talked about Beau Biden again Tuesday, saying his administration is "committed" supporting research that will shed light on how burn pits are connected to diseases like the one that killed his son.

"When the evidence doesn't give a clear answer, one way or the other, the decision we should favor is caring for our veterans while we continue to learn more. Not waiting. Not waiting," Biden said to loud applause.

Biden's voice grew louder as he talked about the 9/11 generation of soldiers who were deployed multiple times.

"This is an incredible generation, the 9/11 generation that fought," Biden said. "They're right up there with the Greatest Generation."

Unlike his State of the Union Speech, where Rep. Lauren Boebert (R-Colo.) heckled the president as he mentioned burn pits and the death of his son, Tuesday's travels showed a glimmer of bipartisanship. Republican Rep. Jake Ellzey of Texas traveled with Biden aboard Air Force One, and Biden had kind words for the lawmaker, a former military officer.

"Jake's a Republican, but I like the hell out of him," Biden said at the beginning of his remarks. "This guy's the real deal."

Drug Prices Already Rising in 2022

A new **analysis** from the AARP Public Policy Institute finds drug companies have increased prices for many brand name Part D drugs in 2022, contributing to affordability challenges for people with Medicare.

According to the report, 75 of the 100 brand name drugs with the highest Medicare Part D spending in 2020 saw their list prices increase in January 2022; none experienced a decrease. The average increase was 5%, with some drug prices (12 of 75) growing by nearly 8%. In 2020, these 75 drugs were used by more than 19 million Part D enrollees and accounted for nearly half of all Medicare Part D prescription drug spending ($93.2 billion out of $198.7 billion).

These price hikes will have a cumulative impact, as they are building on those in prior years. For example, the typical cost of a brand name medication in 2020 was $6,600–**$3,700** more than it would have been, had drug prices not grown faster than inflation **every year since 2006**. For Medicare beneficiaries, who take an average of **four to five** prescription drugs per month and have a median annual income of **just under $30,000**, this can be a significant burden.

Prescription drug price hikes also affect Medicare's financing. The Medicare Payment Advisory Commission (MedPAC) has consistently cited high prices as a key reason for growth in Medicare Part D spending. From 2013 to 2018 alone, Part D spending on prescription drugs **increased** by 26%. The commissioners **attributed** "nearly all of the growth . . . to higher prices rather than an increase in the number of prescriptions filled by beneficiaries."

And the consequences don't stop there. As AARP notes, "High and growing prescription drug prices will eventually affect all

Americans in some way . . . those with private health insurance **will pay higher** cost sharing and premiums. Increased government spending **driven by drug price increases** will lead to higher taxes and/or less spending for other priorities. Equally important, high drug prices and related costs will prompt more older Americans to **stop taking necessary medications**."

Immediate action is needed to reform the nation's drug pricing system in ways that will strengthen Medicare and improve beneficiary well-being. Absent such interventions, prices and unaffordability will continue to rise, as will risks to the program. An ever-growing number of Americans could be priced out of needed **medications** and **coverage**, leading to worse health outcomes and higher costs in the future. At the same time, policymakers could seek to control government spending through Medicare changes that threaten beneficiary health and financial security.

Medicare Rights supports comprehensive efforts to lower prescription drug prices, including as outlined in the House-passed budget reconciliation **bill**. Though its changes are less comprehensive than originally envisioned in **H.R. 3,** it retains that bill's core elements by capping beneficiary out-of-pocket (OOP) drug costs; realigning Part D financial obligations; penalizing drug manufacturers for price hikes that outpace inflation; and allowing Medicare to negotiate drug prices. Together, these policies would achieve historic coverage and affordability gains, better ensuring that all people with Medicare have meaningful access to care.

Read the report, **Prices for Most Top Medicare Part D Drugs Have Already Increased in 2022**

Does Social Security have a healthy future?

Data from the Social Security Administration shows that last year more than 65 million people received payments from one of the support programmes offered by the agency.

That figure has **grown every single year since 1982 and has risen from just 50 million in 2008.** The changing demographics of the United States, with people typically living longer and the birth rate decreasing, means that the population is getting older and more people are eligible for Social Security support.

However this trend could have severe consequences for the fate of Social Security. A report from **Social Security Trustees** found that the current funding system will become unable to cover the programme's payments by 2034**,** meaning that recipients may start to receive a reduced benefit.

The report estimates that retirees will only be able to receive 78% of their full entitlement by then. There has been no major Social Security legislation passed since the early 1980s but change is now needed to ensure that vulnerable Americans are not left without sufficient support.

Funding concerns for Social Security programmes

Funding for the SSA's programmes comes from payroll tax deductions from working people in the US. The payroll tax rate for Social Security is 6.2%**,** meaning that both the employee and the employer must contribute 6.2% of the worker's salary to the SSA to fund the programmes. If you're self-employed you have to cover the whole 12.4%.

The system is designed to run with a rolling surplus in the Social Security Trust Fund, a reserve of money that ensures that the payments can continue through fluctuations in the labour market. However in recent years that excess has been drained by the growing number of Social Security claimants and it is now projected to run dry in just 12 years.

Kathleen Romig, senior policy analyst from the Center on Budget and Policy Priorities, explains: "You want to have the worker to beneficiary ratio at a sort of healthy level where you don't have too few [working] people paying for too many beneficiaries."

She adds: "People are having fewer children and because the birth rate is declining you just have fewer workers paying for beneficiaries."

Much has changed since the first **#SocialSecuity** check went out 82 years ago, but one thing has not: the program's benefits remain a critical lifeline helping millions of Americans make ends meet.

I'm proud to support **@RepJohnLarson's** Social Security 2100: A Sacred Trust Act.

— James E. Clyburn (@WhipClyburn) **January 31, 2022**

There are efforts in place to secure the future of Social Security payments but they are yet to get much traction in Congress. Rep. John Larson of Connecticut has proposed a package known as **Social Security 2100: A Sacred Trust**, which aims to expand upon and boost the funding of Social Security.

In announcing the proposals in a Congressional hearing, Larson said: "Nobody understands better than the president of the United States that Social Security is a sacred trust between the people and its government."

Legislative intervention will be vital to ensuring that vulnerable Americans are not hit with a sudden loss of income when the programme's fund becomes insolvent, but it remains to be seen if Larson's bill will have the votes to pass the Senate.

Despite Seniors' Strong Desire to Age in Place, the Village Model Remains a Boutique Option

Twenty years ago, a group of pioneering older adults in Boston created an innovative organization for people committed to aging in place: Beacon Hill Village, an all-in-one social club, volunteer collective, activity center, peer-to-peer support group, and network for various services.

Its message of "we want to age our way in our homes and our community" was groundbreaking at the time and commanded widespread attention. Villages would mobilize neighbors to serve neighbors, anchor older adults in their communities, and become an essential part of the infrastructure for aging in place in America, **experts predicted**.

Today, there are 268 such villages with more than 40,000 members in the U.S., and an additional 70 are in development — a significant accomplishment, considering how hard it is to get these organizations off the ground. But those numbers are a drop in the bucket given the needs of the nation's 54 million older adults. And villages remain a boutique, not a mass-market, option for aging in place.

Now, people invested in the village movement are asking tough questions about its future. Can these grassroots organizations be seeded far more widely in communities across the country as baby boomers age? Can they move beyond their white, middle-class roots and attract a broader, more diverse membership? Can they forge partnerships that put them on a more stable operational and financial footing?

Villages share common features, although each is unique. Despite their name, physical structures are not part of villages. Instead, they're membership organizations created by and for older adults whose purpose is to help people live independently while staying in their own homes. Typically, villages help arrange services for members: a handyman to fix a broken faucet, a drive to and from a doctor's appointment, someone to clean up the yard or shovel the snow. Volunteers do most of the work.

Also, villages connect members to one another, hosting discussion groups, sponsoring outings, offering classes, and organizing social events. "I've lived here a long time, but I really didn't know a lot of people living in my neighborhood," said Nancy Serventi, 72, a retired trial lawyer who joined Beacon Hill Village nearly five years ago. "Now, because of the village, I almost always meet people on the street who I can stop and say hello to."

In principle, this model of neighbors helping neighbors can work in all kinds of communities, adapted for particular needs. **Andrew Scharlach**, an emeritus professor of aging at the University of California-Berkeley and a leading researcher on villages, believes the potential for growth is considerable — a view shared by several other aging experts. **His work** has found that village members have more confidence about aging in place because they expect support will be there when they need it.

In practice, however, the fierce "we'll do it our way" independence of villages, their reliance on a patchwork of funding (membership dues, small grants, and donations), and the difficulty of keeping volunteers and members engaged have been significant obstacles to growth.

"Villages' long-term sustainability requires more institutional support and connection, whether from local or state governments, or Older American[s] Act programs, or partnerships with health care providers," Scharlach told me.

"We have been brilliant about creating a sense of community and giving people a sense of belonging and being cared for," said **Susan McWhinney-Morse**, 88, a co-founder of Beacon Hill Village. "But can what we do be scaled broadly? That's the critical question."...**Read More**

UnitedHealth could force nearly 3,000 patients to forgo care or find new physicians

Because the US Congress leaves it to corporate health insurers to negotiate health care provider rates and agreements, our health care costs are far higher than they should be. In addition, access to health care is often far more difficult than it should be. In Vermont, **Valley News** reports that UnitedHealth's negotiations with doctors at the University of Vermont Medical Center might fail and cut ties with physicians for nearly 3,000 patients, forcing them to forgo care or find new physicians.

Health insurers are legally obligated to think first and foremost about their own profits. The effects of their administrative, financial and other activities on patient care do not seem top of mind. So, it's no surprise that UnitedHealth's failure to reach agreement with physicians providing in-network care at UVM Medical Center could leave its members without a treating physician. If fewer members are getting in-network care, it would increase profits further for UnitedHealth.

UnitedHealth's members will all have to find new providers if United does not reach agreement with the providers at UVM. But, that means that some members in the midst of cancer treatment could be without treatment as of April 1. Notably, people in Medicare Advantage are not affected by these negotiations, likely because the government negotiates provider rates for people with Medicare, and Medicare Advantage plans can piggyback off those rates for their Medicare members.

UnitedHealth claims UVM provider rates are rising too much. UVM, in turn, says that it is facing rising staffing and other costs and needs higher rates to survive. It adds that administrative and other operational barriers United imposes keeps patients from getting the care they need in a timely fashion. "Despite our best efforts to resolve these issues, patients continue to experience unnecessary delays in and restrictions on approvals for common tests, imaging, treatments and medications, among other challenges, due to United's own policies and reimbursement practices."

UnitedHealth told one cancer patient currently getting treatment at UVM Medical Center to get her chemotherapy from a hospital 95 miles away. Really? If Congress does not yet deem it appropriate to step in and guarantee everyone access to care, it's hard to imagine what it will take to move policymakers

House Passes $1.5 Trillion Spending Bill With $14 Billion For Ukraine Aid—But No Covid Relief

With the government set to run out of funding in days, the House on Wednesday passed a $1.5 trillion omnibus spending bill that will shore up funding for the rest of the fiscal year upon Senate approval, while also doling out cash for Ukraine in its fight against Russia, additional student aid, cybersecurity and more.

The massive spending package, which would appropriate funds for the government until September 30, passed the House on Wednesday evening in largely bipartisan votes of 361 to 69 for the defense portion of the bill and 260 to 171 for non-defense spending.

Headlining the **2,741-page** bill, about $730 billion is allocated for military spending under the Defense Department, while an additional $125 billion has been allocated to the Department of Veterans Affairs.

In addition to funding day-to-day government **operations**, the bill appropriates about $13.6 billion in emergency aid for Ukraine as it **fights** off a Russian invasion, with $4 billion to help displaced refugees, $6.5 billion for military assistance and $1.8 billion for any macroeconomic needs, **according** to the House Committee on Appropriations.

It also grants agency requests for a number of new provisions, including a $400 increase to the maximum Pell Grant award, and nearly $7 billion to establish an agency under the National Institutes of Health **tasked** with building "high-risk, high-reward" technologies for disease research. Among other provisions are the **reauthorization** of the Violence Against Women Act, which expired in 1994 and provided funds to help prosecute violent crimes against women; a measure to give the Food and Drug Administration **regulatory** autho rity over synthetic nicotine; and cybersecurity **protections** to help curb the risk of infrastructure attacks.

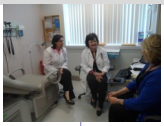
What didn't make the cut? About $16 billion for Covid relief, including tests, vaccines and treatments, was **stripped** from the bill following last-minute disagreements over how to fund the provision—a move House Speaker Nancy Pelosi (D-Calif.) called "heartbreaking" on Wednesday as she pledged "to fight for urgently needed Covid assistance" in separate legislation slated for a vote next week.

The spending bill now heads to the Senate, where Majority Leader Chuck Schumer (D-N.Y.) said he hopes to pass the legislation before Friday, when funds were previously set to run out. In case the upper chamber needs more time, the House unanimously passed a continuing resolution Wednesday to extend stopgap funding for an additional four days, until Tuesday. The measure would still need to be approved in the Senate to prevent a government shutdown

For help in the hospital, contact a patient advocate

Tara Parker-Pope writes for the **New York Times** about how she was able to help her family members receiving hospital inpatient care. As you likely know, it can be extremely difficult and stressful to try to help a loved one who is hospitalized. What you might not know is that you can reach out to a patient advocate to come to the rescue.

Patient advocates serve as quarterbacks when you're trying to get non-medical problems solved in the hospital. In Parker-Pope's case, she wanted her dad, who was hospitalized for pneumonia, to be able to spend time with her step-mom, who was dying of Covid and also hospitalized. The patient advocate managed to get them into the same hospital room.



Patient advocates can help with treatment plans and visitation issues. They can help arrange for a loved one to stay with a patient overnight, a virtual Zoom visit or a visit from a pet. They also can sometimes follow up with the medical care team to understand and explain to family members what is going on and the status of a loved one's hospital care.

If there's anything you need that is not billing-related or treatment-related, ask to speak to a patient advocate. Patient advocates are employed by the hospital, so there are limits to what they will do for you. There are also advocates you can hire, who are independent, but they tend to cost quite a bit.

How do you find the patient advocate at the hospital? Ask your patient's nurse. Or, ask the hospital operator to direct you to the advocate. Sometimes, the advocate is a hospital social worker.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Lymphedema in Legs Strikes 1 in 3 Female Cancer Survivors

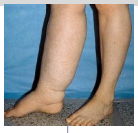
After surviving cancer, many older women suffer severe leg swelling that interferes with everyday life, a new study finds.

About one-third of older women develop this chronic condition — called lymphedema — after treatment for colon, uterine or ovarian cancer, according to **the study**.

"Older cancer survivors who experience lower extremity lymphedema are at risk for decreases in physical functioning and ability to perform activities of daily living," said senior researcher Electra Paskett. She is a professor of cancer research at Ohio State University in Columbus.

The condition can affect cancer survivors' quality of life and it has implications for overall death rates, Paskett added.

Lymphedema is a **chronic condition** that causes swelling, heaviness, pain, discomfort and decreased mobility in legs and arms. It is a common side effect of cancer treatment.



The disorder affects a person's ability to walk or stand for long periods or to lift heavy objects. It can also cause persistent infections in the arms, hips or legs that, in severe cases, can result in loss of a limb.

Dr. Susan Maltser, director of cancer rehabilitation at Northwell Health in New Hyde Park, N.Y., said lymphedema can happen when some cancer treatments disrupt the body's lymph system, which helps maintain fluid levels in the body.

"When a patient has surgery for cancer, lymph nodes are frequently taken out in order to prevent the cancer from spreading," Maltser said. "In addition, many patients have radiation therapy, which can target lymph nodes as well."

When lymph nodes are either removed or affected by radiation therapy, it creates a backup of lymphatic fluid, which causes swelling, said Maltser, who had no part in the study.

Men, too, can develop lymphedema after cancer treatment, she added. Early detection and treatment are keys to **managing lymphedema**.

Paskett suggested that "older cancer survivors need to be screened for lower extremity lymphedema, and if there is swelling, they should be promptly referred to physical therapy for treatment and impact on physical functioning."

For the study, her team collected data on 900 postmenopausal women (average age: 79) with endometrial, colon or ovarian cancer. On average, their cancer had been diagnosed nine years earlier.

Compared with women who did not suffer from lymphedema in their legs, those who did reported significantly impaired physical function, the researchers found.

That impairment greatly affected colon cancer survivors. Among them, nearly 22% had significantly weakened physical function and needed help with daily activities, such as walking, standing for long periods or lifting heavy objects.

This risk was lower in survivors of endometrial or ovarian cancer.

Maltser said treatment for lymphedema has two parts and is best done by a certified lymphedema therapist, usually a physical or occupational therapist.

"The first part is specialized massage through very specific lymphatic tracts to get the lymphatic fluid out of the affected arm or leg and circulating through the body," she said.

The second part is compression. "If somebody has lymphedema in their arm, we do a compression sleeve. If they have lymphedema in their leg, it's a compression stocking. If it's in their groin, it's compression shorts," Maltser said.

Is It 'Pre-Alzheimer's' or Normal Aging? Poll Finds Many Americans Unclear

You regularly can't remember where you left your phone or your book. You keep missing appointments. You often lose your train of thought during conversation.

Many older folks shrug off these instances as so-called "senior moments" -- but experts say this isn't typically part of normal aging.

Instead, these are signs of mild cognitive impairment (MCI), a stage that exists between the expected declines associated with aging and the more serious degeneration of dementia and Alzheimer's disease.

"**Symptoms of mild cognitive impairment** can look like senior moments. It can look like you're forgetting conversations, you're misplacing items, you're having a hard time keeping your train of thought. You might lose track of how to say a certain word every now and then," said Maria Carrillo, chief science officer of the Alzheimer's Association.

"It is, in fact, rarely normal aging, and is an early stage of memory loss that can go on to be quite significant and develop into dementia," Carrillo said.

More than 4 in 5 Americans (82%) know very little about or are not familiar at all with MCI, according to a new Alzheimer's Association special report on the condition.

In fact, more than half (55%) say MCI sounds like "normal aging" when provided a description of the disorder, a survey performed for the report found.

"We found that the understanding of mild cognitive impairment is pretty low, even though when asked about it the concern is pretty high," Carrillo said.

Estimates say that 12% to 15% of people 60 or older have MCI, according to the Alzheimer's Association. The condition has very mild symptoms that are unlikely to interfere with everyday activities. "Once mild cognitive impairment starts to interfere with everyday life, that actually is moving into an early dementia stage," Carrillo said.

Nonetheless, doctors can detect mild cognitive impairment and distinguish it from normal brain aging, Carrillo said.

Even better, physicians can treat MCI much of the time.

A person's MCI might be due to a lack of sleep, poor nutrition, a mood disorder or some other medical reason unrelated to dementia or Alzheimer's, Carrillo said.

For example, vitamin B12 deficiencies can cause MCI symptoms, which are fairly well resolved with B12 injections, Carrillo said.

"There's lots of good reasons to go and check with your physician as to why this might be happening," Carrillo said.

Unfortunately, in some cases MCI is a precursor to **dementia or Alzheimer's**. About 10% to 15% of people with MCI go on to develop dementia each year, and about half of those will go on to develop Alzheimer's, Carrillo said.

For those people, early detection of MCI is even more important, Carrillo said. That's because the new Alzheimer's drug Aduhelm (aducanumab) needs to be deployed in the earliest stages of cognitive decline to have the greatest benefit.

"There's lots of other potential reasons and underlying causes of mild cognitive impairment, but if it is due to Alzheimer's disease there is now a medication for that specifically, and there are more on the horizon," Carrillo said….**Read More**

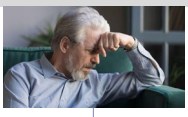
Trouble Paying Bills Could Mean Worse Outcomes After Heart Attack

A healthy bank account pays dividends after a heart attack, with new research indicating severe financial strain increases survivors' risk of death.

Researchers analyzed data from nearly 3,000 people, 75 and older, whose health was tracked after they suffered a **heart attack**.

"Our research indicates the importance of financial strain in predicting which patients will survive severe health conditions," study co-author Jason Falvey, of the University of Maryland School of Medicine, said in a school news release.

"Many of the participants in our study under severe financial strain were not living below the poverty line or enrolled in safety net options such as Medicaid," noted Falvey, an assistant professor of physical therapy and rehabilitation science. "This means we would have no way of knowing who these patients are if we do not ask this question when we take their medical history."



Within six months after leaving the hospital, nearly 17% of those who couldn't meet their monthly expenses had died, compared with 9% of those with moderate financial strain and 7% of those with no financial worries.

After adjusting for other health factors, severe financial strain increased the risk of death by 61% compared with moderate or no financial strain, according to the authors. The results were published recently in the journal ***JAMA Internal Medicine***.

The researchers did not examine why serious money struggles would increase heart attack survivors' risk of death, but suggested that a lack of access to crucial medications and difficulty getting to follow-up health care appointments could play a role.

Biological stressors, such as **elevated inflammation**, are also associated with money woes and likely an important factor in the increased risk of death, Falvey suggested.

Hospitals should consider asking about a patient's financial situation during discharge planning to help identify those who may be at risk due to money struggles, he recommended.

Social workers and other hospital staff could refer these patients to free or subsidized transit services, programs that assist with medication co-payments for low-income patients, or community organizations that can provide or loan medical equipment and devices, Falvey added.

"This is an important finding that points to the need to identify and address economic disparities in our patient population," said Dr. Albert Reece, executive vice president for medical affairs at the university.

"We see a real cost in terms of shorter lives in those patients who cannot make ends meet every month that may not be due to the limits of medical care, but to our inability to provide these patients with access to that care and the services they need," Reece said in the release.

Flu Vaccine No Match for Circulating Variants This Season

(HealthDay News) -- This season's flu shot offered virtually no protection against infection, a new government report shows.

While this latest vaccine only cut the risk of getting a mild case of flu by 16%, the agency has **noted** that flu vaccines typically reduce the risk of illness by 40% to 60%.

Still, the shot should offer some protection against more severe illness, according to the **study** from the U.S. Centers for Disease Control and Prevention.

But the findings mean the flu vaccine was "essentially ineffective," Dr. William Schaffner, an infectious diseases expert at the Vanderbilt University Medical Center in Nashville, Tenn., told *NBC News*.

The CDC study, which included data on over 3,600 Americans in seven states, confirmed research released earlier in the flu season that the dominant variants is **H3N2**, which is particularly challenging to guard against because it tends to mutate faster than other flu variants and often results in more hospitalizations and deaths, according to experts.

In October and November of 2021, the CDC investigated a **flu outbreak** at the University of Michigan and found that the vaccine did not offer much protection.

Despite the vaccine's meager level of protection, this flu season has been the second in a row to show low overall case counts. That may be because the surge of the **Omicron variant** in December and January had people wearing masks and practicing social distancing, thereby preventing the spread of the flu, Schaffner suggested.

He added that the latest CDC study highlights the need for better flu vaccines because "the flu is not going away. ... It will be back again next year and the year after that and the year after that."

Not only that, even a mild flu season can be deadly: The CDC has **estimated** that during the 2019-20 flu season, around 22,000 people in the country died and 400,000 were hospitalized.

A number of vaccine makers including Pfizer and Moderna, are trying to develop flu vaccines using mRNA technology, the same approach used to create some COVID-19 vaccines. But those vaccines likely won't be ready until late 2023, *NBC News* reported.

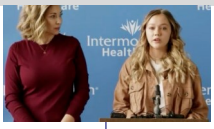
When Will Americans With Diabetes Get Relief From High Insulin Prices?

Katherine Stewart, 16, must take six to 10 insulin shots a day to properly manage her type 1 diabetes.

Her Highland, Utah, family pays $500 a month out of pocket for her insulin. Before they meet their insurance's deductible, they shell out the cash price of nearly $2,000 a month.

Now Stewart is preparing to leave the nest, and she doesn't know how she'll be able to afford it.

"Insulin is so expensive, it's already something I've started to worry about," she said at a news conference Tuesday. "If I'm already trying to pay for college and get a job, how am I supposed to get the money to also buy insulin?"



Stewart added: "At my age, having to worry about this seems like growing up too fast. I shouldn't have to worry about this."

U.S. legislators, policymakers and health care experts agree. **Several strategies** to rein in the runaway cost of insulin have been proposed in recent months, though none has yet borne fruit.

The highest-profile tack is President Joe Biden's promise in his State of the Union address to champion legislation that would cap insulin copays at $35 a month.

But other means of lowering insulin prices also are being pursued, including a plan by maverick nonprofit **Civica Rx** to start manufacturing its own insulin and selling it at $30 a vial or $55 for five insulin pens.

"The price of manufacturing insulin has not gone up -- it definitely hasn't gone up 11% a year for 20 years," Civica's board chair Dan Liljenquist said at the same media briefing where Stewart spoke. He is also chief strategy officer for Salt Lake City-based Intermountain Healthcare

"When we manufacture insulin, we're going to put it on the market at a wholesale price that only reflects how much we need to continue to manufacture. That's it," Liljenquist added….**Read More**

Drug Could Be Non-Antibiotic Alternative to Treat UTIs

Women plagued by frequent urinary tract infections often take daily antibiotics to ward them off. But an old antibiotic alternative might work just as well, a new clinical trial finds.

Researchers found that the medication, called methenamine, was comparable to standard, low-dose antibiotics in preventing women's recurrent urinary tract infections (UTIs). Either treatment curbed the infections to around one per year, on average.

Methenamine is a long-established medication that works by making the urine more acidic and stopping bacterial growth. Studies have shown that it can prevent recurrent UTIs, but it's not widely used.

It's such an "old" drug, many doctors today do not know about it, said Dr. Karyn Eilber, a urologist at Cedars-Sinai Medical Center in Los Angeles.

Eilber, who was not involved in the new study, said she reserves daily antibiotics as a last resort for preventing recurrent UTIs, favoring methenamine instead.

A concern with daily antibiotic use is feeding **antibiotic resistance**, where bacteria learn to thwart the medications used to kill them. Plus, Eilber said, it disrupts the body's normal bacterial balance.

Dr. Chris Harding, a consultant urological surgeon at Freeman Hospital in the United Kingdom, led the trial.

He said it "adds supportive evidence for the use of methenamine and will be particularly welcome to those women with recurrent UTI who want to avoid long-term antibiotic treatment."

UTIs are exceedingly common and can affect anyone, but are particularly prevalent among women. Studies suggest up to 80% of women develop a UTI at some point, and about one-quarter of those women go on to have frequent recurrences.

Some symptoms include burning during urination, and feeling a strong, persistent urge to urinate.

The new study — published online March 9 in the *BMJ* — involved 240 women with recurring UTIs. At the start, they were averaging around six UTIs per year.

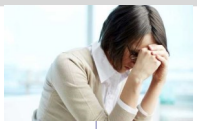
Half of the women were randomly assigned to daily low-dose antibiotic treatment, while the other half took methenamine twice a day….**Read More**

High Anxiety: Poll Finds Americans Stressed by Inflation, War

Inflation, Russia's invasion of Ukraine and continuing concerns about money and COVID-19 have Americans more stressed than ever, a new poll conducted last week reveals.

The biggest concerns: rising costs of food, energy and other everyday items due to inflation (87%); supply chain issues (81%); global uncertainty (81%); Russia's invasion of Ukraine (80%), and potential Russian cyberattacks or nuclear threats (80%).

In addition to those worries cited by the thousands of adults who participated in the American Psychological Association's **Stress in America Poll**, 63% said their lives had been forever changed by COVID-19.



"Americans have been doing their best to persevere over these past two tumultuous years, but these data suggest that we're now reaching **unprecedented levels of stress** that will challenge our ability to cope," said Arthur Evans Jr., chief executive officer of the association.

"The number of people who say they're significantly stressed about these most recent events is stunning relative to what we've seen since we began the survey in 2007," he said in an association news release.

Pollsters also found continued hardship for vulnerable groups of people, concerns about children's development among parents, and unhealthy coping habits.

Almost half of respondents (47%) said they have been less active since the pandemic's start. Fifty-eight percent said they've had unwanted weight changes and 23% said they have been drinking more.

Among respondents who gained more weight than they wanted, the average was 26 pounds. Among those who lost more weight than they wanted, the average amount was 27 pounds. (The median change in either group was 15 pounds, meaning half of respondents gained or lost more.)

The new findings add to a broader Stress in America poll conducted in February that pegged financial stress at its highest level since 2015.

A large number of adults in the new poll said separation from others and conflicts over COVID had put strains on relationships or ended them.

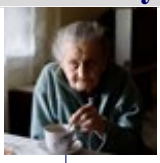
Half of respondents and 61% of essential workers said they have loved ones they have not been able to see in person in the past two years due to the pandemic. ....**Read More**

Diogenes syndrome: What you need to know

Diogenes syndrome happens when a person does not take care of themselves or their surroundings, leading to poor hygiene and possibly some health and social problems. It often occurs with other conditions, such as dementia.

People with the condition often show signs of severe self-neglect, social isolation, and hoarding. They may live in unsanitary conditions. The person does not make a conscious decision to do this.

Views on self-hygiene and safety vary can between people and cultures. As a result, many of the symptoms of Diogenes syndrome can also be difficult to assess and treat objectively.



However, a person with this condition may be at risk of harm from poor hygiene or self-neglect.

Diogenes was a **Greek philosopher** who lived in a barrel in the 4th Century.

As Diogenes syndrome usually occurs with other conditions and there is little research about it, the current *Diagnostic and Statistical Manual of Mental Disorders 5th Edition, (DSM V)* does not list it as a psychiatric condition.

What is Diogenes syndrome?

Men or women of any age and socioeconomic status can have Diogenes syndrome, but it usually appears as a behavioral disorder in older people.

Research suggests that it is **most common** among people with average intelligence, who are over 60 years, and who live alone.

Around **0.05 percentTrusted Source** of people aged 60 years and older may have Diogenes syndrome. It is considered rare, but there is a lack of research about its prevalence.

Diogenes syndrome can be primary or secondary.

Primary: No other existing medical condition triggers the condition.

Secondary: The syndrome results from another **mental health** disorders.

Other names for Diogenes syndrome include senile or severe social breakdown syndrome, self-neglect syndrome, senile squalor syndrome, and messy house syndrome.

Read more on Symptoms vary, but a cluster of common features may be present, including signs of self-neglect.

Sleep Experts Call for End to Twice-a-Year Time Changes

Spring and fall time changes for daylight saving time should be scrapped because they pose health and safety risks, the American Academy of Sleep Medicine (AASM) says.

Moving clocks ahead and losing an hour of sleep presents **hazards** that include: an increase in car crashes and fatal crashes; a rise in missed medical appointments; a higher risk of stroke and hospital admissions; greater chance of mood disturbances, and a disruption of the body's internal clock that harms sleep quality and leads to sleep loss, according to the academy.

"Physicians, legislators and the general public have been talking about the health and safety benefits of eliminating seasonal time changes for years," said Erin Flynn-Evans, a sleep and circadian researcher who is a consultant to the AASM's Public Safety Committee.

"Research shows that time changes affect the body's circadian rhythm, or body clock, which makes it more difficult to achieve quality sleep and also negatively impacts health and safety," Flynn-Evans said in an academy news release.

Americans will move clocks ahead one hour on Sunday, March 13.

A U.S. House of Representatives subcommittee held a hearing this week on impacts of the seasonal time change, and a bill introduced in the U.S. Senate last year would make daylight saving time permanent nationwide. More than 40 states are considering changes to end the shifting.

A pair of experts who testified at the subcommittee hearing said the seasonal disruption is damaging to sleep and linked to significant health issues, according to the **Washington Post**.

But AASM says evidence supports the adoption of year-round standard time, rather than daylight saving time. "There is no question that putting an end to seasonal time change is best for Americans' well-being," Flynn-Evans said. "However, a shift to permanent daylight time -- which would result in more morning darkness in the winter -- would result in most people experiencing a misalignment between the body's daily rhythm and the timing of routine social obligations like work and school. Therefore, permanent year-round standard time is the best choice to most closely match the circadian sleep-wake cycle."

To help you make the adjustment when clocks move ahead an hour, AASM offers some tips:

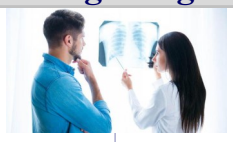
- Adults should get at least seven hours of sleep and teens should strive for eight hours each night before and after the time change.
- Go to bed 15 or 20 minutes earlier each night.
- In the hour before bedtime, dim your lights and minimize screen use.
- Adjust scheduling of other daily routines that are “time cues” for your body. For example, start eating dinner a little earlier each night.
- On Saturday night, set your clocks ahead one hour in the early evening. Then go to sleep at your normal bedtime.
- Go outside for some early morning sunlight on Sunday. That will help set your internal clock.
- Then, go to bed early enough on Sunday to get plenty of sleep before the work week begins Monday.
- "We are hopeful that seasonal time changes will be eliminated in the near future," Flynn-Evans said. "Until then, it's important to be mindful of the health and safety consequences this time change can have and to prepare for it as best as possible."

Long COVID May Bring Long-Term Lung Damage

Even after a mild case of COVID, some people suffer breathing problems that last for months. Now, a new study suggests many of them may have abnormalities in the small airways of their lungs.

Researchers found that of 100 patients with "**long COVID**" symptoms, more than half had signs of small-airway disease on CT scans. And people who'd been mildly ill at home were just as affected as those who'd been hospitalized.

"Independent of COVID severity, their airways continued to be affected months afterward," said senior researcher Dr. Alejandro Comellas, of the University of Iowa Carver College of Medicine.



Specifically, the patients showed signs of "**air trapping**" in the lungs -- where a person is able to take a full breath in with no problem, but the air is abnormally retained on the exhalation.

Air trapping occurs in diseases like asthma, emphysema and chronic bronchitis.

It's generally a sign of inflammation in smaller airways called **bronchioles**, explained Dr. Cedric "Jamie" Rutland, a pulmonologist and volunteer spokesperson for the American Lung Association.

Rutland, who was not involved in the study, said he regularly treats patients with persistent respiratory symptoms after COVID. That often involves medications that ease airway inflammation, like **prednisone** or inhaled corticosteroids, he said.

Patients vary in how long they take to recover from those symptoms, according to Rutland. And it's still unclear whether some will have ongoing lung disease.

Similarly, Comellas said, it not clear whether the airway abnormalities seen in this study will resolve, or mark the beginnings of a chronic condition.

Comellas suspects both will ultimately be true: Some patients will fully recover, while others will not.

He and his colleagues report the findings March 15 in the journal *Radiology*….**Read More**

High Blood Pressure Diagnosis Leads to Discovery of Complex Heart Issues

Childhood friends Glenda Jennings and Connie Hoffroggy were catching up. They lived in different cities and hadn't seen each other in a while.

Hoffroggy noticed Jennings was being snippy – and wondered if it could be because her friend had high blood pressure.

Jennings, who hadn't been diagnosed with high blood pressure before, admitted she had been uncharacteristically short with people lately. She remembered seeing a blood pressure kiosk at a local grocery store and went to check her numbers.

It read 250/150. (Normal blood pressure is less than 120/80.)

"I called my friend and told her I was going straight to the hospital," Jennings said.

Jennings, who lives just outside of Cincinnati in Loveland, Ohio, spent most of the day at the hospital. She was sent home with several medications and encouraged to visit a cardiologist.

Over the next few years, Jennings struggled to get her blood pressure under control, at times requiring hospitalization. Meanwhile, her cardiologist tried to uncover what was driving her health issues.

Testing offered confusing results. She would fail a stress test, pass the next one, then fail again.

Eventually, a genetic counselor solved part of the mystery: Jennings had two gene mutations that led to two blood disorders contributing to her heart issues. These were treatable. Yet even once under control, they couldn't fully explain what was happening.

Frustrated, Jennings got a second opinion….**Read More**