



Message from Alliance for Retired Americans Leaders

Alliance Hosts Town Hall with Dr. Kilolo Kijakazi, Acting Social Security Commissioner



Robert Roach, President, ARA

Alliance members joined Dr. Kilolo Kijakazi, MSW, Ph.D., Acting Commissioner of the Social Security

Administration (SSA), on Wednesday for an Older Americans Month Retiree Town Hall webinar.



Dr. Kijakazi

The Acting Commissioner discussed why Social Security is vital to Americans of all ages, spoke about what SSA is doing to improve service, and answered some audience questions.

During the webinar, Dr. Kijakazi noted that last year, SSA employees completed about 10 million benefit claims, assisted nearly 13 million visitors at field offices and answered about 69 million phone calls. However, hiring has been limited over the past decade due to insufficient and untimely funding. If you missed the event, the Acting Commissioner's remarks are on the Alliance's YouTube channel [here](#).

Alliance Celebrates Asian American, Native Hawaiian, and Pacific Islander Heritage Month

May is not only Older Americans Month, it is also Asian American, Native Hawaiian, and Pacific Islander (AAPI) Heritage Month.

The White House has commemorated the occasion with a **proclamation**, stating in part, "Despite the immeasurable ways AA and NHPs enrich this country, we continue to see persistent racism, harassment, and hate crimes against these communities. Attacks on Asian American women and elders have left too many families afraid to leave their homes and too many loved ones traumatized."

"Alliance members join President Biden in honoring the achievements and contributions of the AAPI communities," added **Robert Roach, Jr., President of the Alliance**. "Our AAPI friends and neighbors have been key allies in advocating for labor law changes that have improved our lives, and we are a better nation when we pull together and celebrate our diversity."

Debt Ceiling Update:

Talks Continue as June 1 Deadline Approaches

President Joe Biden and Vice President Kamala Harris met with House Speaker Kevin McCarthy (R-CA), House Minority Leader Hakeem Jeffries (D-NY), Senate Majority Leader Chuck Schumer (D-NY), and Senate Minority Leader Mitch McConnell (R-KY) Tuesday to continue talks about raising the debt ceiling and prevent the nation from defaulting on its financial obligations.

Following the meeting, President Biden and Speaker McCarthy named top staff to negotiate a deal to avert an unprecedented default. Biden will also cut short an upcoming trip to



Rich Fiesta, Executive Director, ARA

Congressional Democrats strongly oppose, be passed by the Senate in conjunction with any debt ceiling increase. As written, it slashes veterans' benefits, housing and food assistance for millions of seniors. It also enacts a 22% across-the-board cut to transportation, education, and health care. That means older Americans have to wait longer to get information about their Social Security and Medicare benefits.

Without a debt limit increase, retirement savings accounts are expected to lose at least 20% of their value. Interest rates will surge, hurting businesses and increasing unemployment, and Social Security payments could be delayed or disrupted.

"Extremist GOP House members are willing to tank the economy unless they are allowed to slash essential services and programs for seniors," said **Richard Fiesta, Executive Director of the Alliance**. "These partisan shenanigans are not in the nation's best interest and we must demand that this crisis be resolved

"URGENT ACTION NEEDED:

Please make your voice heard. **Click to tell your Senators and Representative to raise the debt ceiling and vote against the House GOP budget.**

Economic Policy Institute: Almost Half of

Asia in order to close a deal before a June 1 deadline. The House GOP has demanded that its budget bill, which Biden and



Joseph Peters ARA Sec.-Trea.

released a **report** this week showing that significant numbers of Americans over 50 endure difficult working conditions, including physically taxing, dangerous and stressful jobs — jobs that often don't even pay enough to allow them to ever retire.

The report found that 54.2% of older workers are exposed to unhealthy or hazardous conditions and 46.1% of older workers have high-pressure jobs.

To ensure older workers can afford to retire when they need to, the report advises providing support for workers with caregiving responsibilities, expanding Social Security coverage and benefits, and bolstering health and safety protections in the workplace.

"Some policymakers have proposed that older Americans could delay retirement to increase their savings. However, with 50.3% of older workers enduring physically demanding jobs, proposals to delay retirement make little sense," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "We must **expand Social Security** to continue to provide retirement security for current and future generations."

Older Workers with Physically Challenging Jobs with Low Pay May Be Unable to Retire

The Economic Policy Institute

Medicare Advantage Plan Data Remains Inadequate

Significant gaps in data about Medicare Advantage (MA) plan processes and enrollee experiences make it impossible for policymakers to hold plans accountable and for beneficiaries to make informed coverage choices. This opacity has long been concerning but calls for transparency have taken on a new urgency as MA enrollment and costs escalate.

The number of MA plan members has surged in the last decade, with over half of all eligible beneficiaries now

enrolled in MA. Medicare payments to MA plans are also climbing. As a portion of total Medicare dollars, they jumped from 26% in 2010 to 45% in 2020, and may reach 54% by 2030. Per person, Medicare spending is higher and growing faster for MA beneficiaries than for those with Original Medicare (OM). This may cost Medicare \$183 billion in the coming years. In 2023 alone, Medicare will pay MA plans about 6% more than



OM for similar enrollees, translating to an extra \$27 billion.

Unless these imbalances are corrected, MA enrollment growth will continue to increase Medicare spending and lead to inappropriate plan overpayments, raising Part B premiums for everyone and worsening Medicare solvency challenges. These trajectories are additionally concerning because data gaps make it unclear what MA enrollees and taxpayers are getting in return.

A new KFF brief examines several of these transparency issues, highlighting areas where the Centers for Medicare & Medicaid Services (CMS) has the authority to require additional MA plan reporting or to make existing data collections public. Each information point would improve program transparency and help guide reforms. In the coming weeks, Medicare Rights will explore these topics in more depth...Read More

Medigap & Medicare Advantage: Which one has more benefits?

Medigap and Medicare Advantage are both healthcare plans used by people in retirement. Medigap insurance helps supplement areas like coinsurance, deductibles and copayments. Medicare Advantage, sometimes called Part C, plans are offered by private companies approved by Medicare. We'll dive into detail about the differences between Medigap and Medicare Advantage and what each is used for.

What Is Medigap?

Medigap acts as a supplement to Medicare, sometimes known as original Medicare in this

context. Because Medigap acts as a supplement to original Medicare, you must enroll in Medicare Part A and Medicare Part B to be eligible.

Medigap can help fill in certain gaps in coverage, like covering you while you are traveling. It can also fill gaps with copayments, deductibles and coinsurance. This is because choosing original Medicare with Medigap means you can see any doctor in the country who accepts Medicare. Plus, you can get coverage for healthcare in foreign countries under Medicare Part N. You will also have Medicare



Part B coinsurance, which reduces doctor's office visits to \$20 and emergency department visits to \$50.

Premiums are often higher when you have Medigap coverage, but you can reduce your out-of-pocket expenses. Thus, it may be suitable for those with health conditions that require frequent attention. However, Medigap coverage doesn't include prescription drug coverage and can't be paired with Medicare Advantage. In fact, it is illegal for anyone to sell Medigap to you if you have a Medicare Advantage

plan.

To qualify for Medigap, you generally must be 65 years of age or older. Unlike Medicare Advantage, Medigap doesn't have an open enrollment period. However, if you know you want Medigap, it's usually best to enroll immediately after you enroll in Medicare Part A and Medicare Part B. This helps ensure that there won't be extensive underwriting, which could lower your approval odds...Read More

A Covid Test Medicare Scam May Be a Trial Run for Further Fraud

Medicare coverage for at-home covid-19 tests ended last week, but the scams spawned by the temporary pandemic benefit could have lingering consequences for seniors.

Medicare advocates around the country who track fraud noticed an eleventh-hour rise in complaints from beneficiaries who received tests — sometimes by the dozen — that they never requested. It's a signal that someone may have been using, and could continue to use, seniors' Medicare information to improperly bill the federal government.

The U.S. Department of Health and Human Services' Office of Inspector General has received complaints from around the country about unsolicited tests being billed to Medicare, said a top investigator. Earlier this year, the office posted a fraud

warning on its website, urging consumers to report this and other covid-related scams.

"Unfortunately, most of these schemes are the result of bad actors receiving stolen Medicare beneficiary information," Scott Lampert, assistant inspector general for investigations, told KFF Health News.

Being targeted once can mean a person is vulnerable to future scams. A stolen Medicare number can be used repeatedly to get payment for all kinds of things or sold to other fraudsters, said María Alvarez, who oversees New York state's Senior Medicare Patrol. The organization helps identify and educate beneficiaries about Medicare fraud throughout the country.

"If you have someone's Medicare number, you can bill



Medicare for procedures, tests, drugs, services, and durable medical equipment," Alvarez said.

"On the dark web, Medicare numbers are more valuable than credit card or Social Security numbers."

One beneficiary in Indiana suspected something was amiss after receiving 32 unrequested tests over a 10-day period, said Nancy Moore, the Senior Medicare Patrol program director for Indiana. None of the people who submitted a complaint recalled giving out their Medicare number, she said.

In another variation of the problem, Medicare paid for tests for some Ohio beneficiaries who never received them, said Lisa Dalga, project manager for Ohio's Senior Medicare Patrol.

"Information is the commodity of the 21st century," said Moore,

who said she urges beneficiaries to guard their Medicare numbers.

It is possible that some unwanted packages were a mistake, after pharmacies or other suppliers turned a one-time request into a continuing monthly order, a switch allowed under the program's rules that beneficiaries were responsible for correcting.

Along with those from New York, Indiana, and Ohio, Senior Medicare Patrol directors in Tennessee, Texas, and Utah told KFF Health News they noted a rise in complaints about the unwanted tests as the benefit's cutoff date approached.

Alvarez said lately test suppliers had "gotten more aggressive," calling and emailing seniors — something legitimate Medicare representatives do not do — as well as running misleading internet ads...Read More

Cost-of-Living Adjustment for 2024 Could Be 3.1%

Research on the buying power of Social Security benefits by The Senior Citizens League (TSCL) confirms that inflation is moderating. But a lower inflation rate has not necessarily meant that prices have come down. This year the study found that the oldest adults, especially those (age 85 and older) who retired before 2000, have lost 36 percent of their buying power. These retirees would need an extra \$516.70 per month (\$6,200 in 2023) *to maintain the same level of buying power as in 2000*. This study confirms that the prices older consumers are paying simply are not growing as fast as a year ago, but many prices on key items through February 2023 remain stubbornly high.

The declining rate of inflation points to a significantly lower COLA for next year, after the 8.7% COLA in 2023 — the highest in four decades. “The

2024 COLA could be around 3.1%,” says The Senior Citizens League’s Social Security and Medicare policy analyst, Mary Johnson.

The buying power of Social Security benefits can erode when the annual cost of living adjustment (COLA) fails to keep pace with rising costs. But in some years, buying power can improve modestly when inflation moderates. One year ago, this study found that Social Security benefits lost 40% of buying power since 2000. That was the deepest loss in buying power since the start of this study in 2010. This year the study found that the loss of buying power slightly improved — by four percentage points — to 36%. However, that is still one of the deepest losses recorded by this study, exceeded only by the loss in 2022.



Nothing beats eggs! This study compares the growth in the COLA since 2000 with increases in the price of 38 goods and services typically used by retirees over the same period. This year buying power was most impacted by sharp increases in food items, electricity, rental housing, repair and maintenance costs of motor vehicles, and a 16% increase in the cost of dental care. (Medicare does not cover routine dental services.) Topping our list of fastest-growing items? Eggs. No other spending item on the list grew faster during the survey reference period, which compared the average price change from February 2022 to February 2023. (See Tables 1 & 2).

Without an accurate cost of living adjustment (COLA) that keeps pace with rising costs, beneficiaries lose purchasing power, especially throughout a

retirement that could last 25 to 30 years. This loss is cumulative and grows deeper as retirees age. It can cause significant hardships, including more rapid depletion of savings than expected, growing debt, and worse health outcomes. In short, a significant deterioration in an older household’s standard of living,

Between January 2000 and February 2023, Social Security COLAs increased benefits by 78 percent, averaging 3.4 percent annually. But the cost of goods and services purchased by typical retirees rose by 141.4 percent averaging about 6.2 percent annually over the same period. For every \$100 a retired household spent on groceries in 2000, that household can only buy about \$64 worth today....[Read More](#)

Experts Propose Tax Cap as Social Security Solution — Which Americans Would Be Most Affected?

If nothing is done to change course, Americans on Social Security may see their monthly benefits drop by 25% in the years ahead. That’s because the Social Security trust fund reserves could become insolvent within the next decade. Some experts say raising the Social Security payroll tax cap could help solve the problem.

Currently, workers pay 6.2% of

their wages, and their employers match that contribution. However, any earnings over the income cap of \$160,200 are exempt from the tax (a limit that roughly 6% of wage earners hit).

Currently, those earning over the cap pay an effective Social Security payroll tax rate of 1% or less. However, those earning under the cap get stuck footing a



bill that’s six times higher.

Other Potential Solutions Not all experts and lawmakers agree that increasing the Social Security payroll tax cap is the best way to solve the problem.

Other proposed solutions include:

- ◆ Raising the full retirement age

to 70 (now 66 to 67).

- ◆ Increasing the payroll tax rate to 15.6% (from 12.4%).
- ◆ Privatizing Social Security.
- ◆ Imposing a Social Security tax on business and investment income (currently exempt).

Large corporate entities drive major generic drug shortages

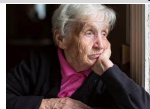
Yes, we are facing drug shortages in the United States, the wealthiest country in the world. The result is that many Americans with cancer and other deadly diseases are not able to receive treatment, reports Christina Jewett for The New York Times. Three large corporate entities likely are responsible for the drug shortages but are not accountable.

There are literally hundreds of prescription and over-the-counter drugs that Americans cannot get, including drugs that treat strep throat, lung cancer, breast cancer and ovarian cancer. The drugs are generic, meaning that they generally do not command the prices that pharmaceutical companies charge for brand-name drugs. It seems likely that

somehow the goal of maximizing profits is behind the generic drug shortage.

One possible immediate solution to the generic drug shortage would be for the US to open its borders to the importation of these drugs from verified pharmacies abroad. While today these imports are not legal, no one has ever been prosecuted for purchasing them for personal use. But, that solution does not appear on the table.

Instead, Congress is considering handing pharmaceutical companies more money through lower taxes as a carrot to manufacture the drugs we need. I would imagine that would only induce them to keep



making limited supplies of generics so the tax benefits continue. Congress might be better off having

government take control of the prescription drug supply-chain to ensure that supplies are adequate.

The Food and Drug Administration (FDA) wants the White House to focus on the economic challenges facing generic drug manufacturers. Today, almost all generic drug purchases come from just three entities. Those entities, such as Red Oak Sourcing and Clarus ONE, include big retailers such as CVS Health and Walmart. You can bet they are doing what they can to maximize their profits.

One academic expert, Dr. Kevin Schulman, who teaches at Stanford Medicine, argues that

these entities use their leverage to demand super low prices from the generic drug manufacturers. When the manufacturers don’t deliver, it’s not their problem. They are not accountable. Rather, they profit off of the brand-name drugs they sell, and it’s the patients who suffer because their generic drugs are not available.

One big manufacturer of generics, Akorn, closed down. It had made 100 generic drugs, including albuterol and a drug that treated lead poisoning. There is at least one promising domestic solution, Civica Rx, a non-profit that manufactures prescription drugs, which you can read about on Just Care here. Civica was started to ensure a robust supply of critical generic drugs.

Appeals Court Ruling Keeps Obamacare Preventive Health Care Coverage in Place for Now

Americans will continue to be able to get free preventive health care services -- at least for now.

The U.S. Court of Appeals for the Fifth Circuit in New Orleans temporarily blocked a lower court decision on Monday, pausing a ruling that challenged an Affordable Care Act provision that all health plans cover certain care, the *New York Times* reported.

The earlier ruling in March, by Judge **Reed O'Connor** of the Federal District Court for the Northern District of Texas, would

have immediately eliminated access to a long list of free preventive services mandated under the ACA since 2010. This was one of the most popular provisions of "Obamacare," as the ACA is commonly called.

This includes depression screening for teens and drugs that prevent HIV transmission for about 150 million Americans enrolled in private employer-sponsored health insurance or through the ACA marketplaces, *The Times* noted.



O'Connor maintained that the U.S. Preventive Services Task Force, which recommends the list of services, was not appointed by Congress. He ruled that the group did not have the constitutional authority to make a decision about health care services.

The USPSTF is an independent group of experts that makes evidence-based recommendations on effective ways to prevent disease and prolong life.

This isn't O'Connor's only

ruling on Obamacare provisions. He ruled in 2018 that the ACA was unconstitutional, a ruling that was later overturned by the U.S. Supreme Court.

O'Connor also ruled last September that the ACA mandate requiring coverage of an HIV prevention pill violated a company's religious freedom, according to the news report.

Americans will keep this free preventive health care while the case works its way through the appeals process. It could end up in the Supreme Court.

Health insurers increasingly deny coverage for critical care

Elisabeth Rosenthal writes for **The Washington Post** on the rising rate of health insurance denials. High denial rates are not surprising given that health insurers generate greater revenues on each claim they deny. Consequently, they often use proprietary computer algorithms to deny claims in a systematic fashion, with no regard for people's medical needs.

Since the Affordable Care Act, health insurers can no longer refuse to cover people with pre-existing conditions in many instances. Instead, to maximize profits, they find ways to deny care. Rosenthal highlights how one insurance company literally has as a job title "**denial nurse**."

Although the US Department of Health and Human Services is charged with **overseeing insurance company denials**, it has not undertaken its oversight responsibilities in a meaningful way. Rather, too often, patients are faced with care denials and the obligation to pay for their

care themselves or skip getting care altogether.

The Kaiser Family Foundation (KFF) recently **reported** that, in 2021, one in six claims for in-network care in the state health insurance exchanges were denied, 17 percent. In one case, the insurer denied half of all claims, 49 percent! Worse still, another insurer denied four in five claims, 80 percent. And, while insurers reverse the majority of denials when people appeal, patient appeal rates are extremely low—one in 500.

At times, denials are not only medically incomprehensible but nonsensical. For example, one patient with arrhythmia had his insurer's approval for a heart procedure, but he was denied coverage "for injections into nerves in your spine," which he had not received. The insurer had not paid the claim many months later, notwithstanding endless attempts to fix the error.

In another instance, the insurer wrote a newborn to let the baby



know that his neonatal care was denied because the baby could drink from a bottle and breathe on his own. Of course, the baby could not read

the denial! And, an insurer denied coverage for epinephrine and steroids received in the emergency room to treat a young man with a deadly anaphylactic allergic reaction, which the insurers claimed was medically unnecessary. Though the patient's mother has appealed, she still has not gotten the insurance to cover the services.

Increases in insurer denial rates are likely a product of a computer system, PXDX, which I wrote about **here**, that allows insurers' medical claims-review staff to deny 50 claims in ten seconds. This system saves insurers billions of dollars a year, at the expense of the health and well-being of their enrollees.

To add insult to injury, claims can be denied because an insurer does not have a contract with a particular drug or device

manufacturer. It doesn't matter that the patient needs the treatment.

Of course, these **denials are also happening in Medicare Advantage plans**. And, the Centers for Medicare and Medicaid Services (CMS) is not reporting plan denial rates to enable people to avoid plans with high denial rates. In fact, most likely, those plans are getting **four and five-star ratings**, because the rating system is such a farce! (You can read about why the Medicare Advantage star-ratings are a farce **here**.)

The Affordable Care Act gives health insurer oversight responsibilities to HHS and requires HHS to collect and publicly report denial rates among corporate health insurers in the state health exchanges. But, HHS has not undertaken this data collection and reporting, as required. So, after more than a decade of failed government oversight, the insurers continue to deny claims with impunity.

Senator Sanders pushes for greater investment in community health centers

Daniel Payne and Burgess Everett report for **Politico** on Bernie Sanders latest big push on the health care front. As Chair of the Senate HELP committee, Sanders is moving to put \$190 billion more into our health care system over five years. The money is sorely needed.

Senator Sanders' plan includes \$130 billion for the **federally qualified health centers**

(**FOHCs**), often referred to as community health centers. You can find these community health centers throughout the country. If you are not familiar with FQHCs, they offer free and low-cost primary care services, sometimes even vision and dental services. And, FQHCs are known for their high quality care.

Sanders would put another \$60



billion into expanding our health care workforce, including \$15 billion for graduate medical education initiatives. His goal is to increase access to primary care.

Of late, FQHCs have not had adequate funding. And the health care workforce has been shrinking to the point where there are staff shortages throughout the country.

The question is whether

Bernie Sanders can bring along other Democrats and Republicans to address health care inadequacies in the US, especially the shortage of primary care providers, dentists and nurses. Unfortunately, it's not likely in this Congress. Other Sanders' priorities include lowering the price of prescription drugs and increasing the minimum wage.... **Read More**

Medicare Advantage could be the death of Medicare

Ady Barkan, co-director of Be a Hero, makes the compelling case that Medicare Advantage, the part of Medicare administered by private health insurers, could be the death of Medicare. It could also be the death of guaranteed affordable health care for all in the US. Senator Bernie Sanders, Representative Pramila Jayapal, and Representative Debbie Dingell are trying to prevent that and breathing continued life into Medicare through their recent introduction of the Medicare for All Act in Congress, legislation that would keep corporate health insurers out of Medicare.

Several times in the last 70 or so years, progressive policymakers have tried to ensure everyone in the US has guaranteed access to affordable health care. And, several times, their efforts failed. Most recently, advocates on the ground and in the Congress pushed for a public health insurance option, like Medicare, for all Americans. Instead, we got the Affordable Care Act, health insurance through corporate health insurers.

During his campaign for the presidency, Senator Bernie Sanders brought to national attention the value of Medicare for All, guaranteed, government-administered, affordable health insurance. He called for an improved and expanded version of traditional Medicare that the US guaranteed everyone, with dental, vision and hearing benefits, and without premiums, deductibles and copays.

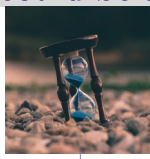
Ady Barkan testified in the US

House of Representatives on the value of Medicare for All. He understood its value full well. At 35, he was diagnosed with ALS. He explained how everyone will need health care at some point.

“Our time on this earth is the most precious resource we have,” were his words. “A Medicare for All system will save all of us tremendous time. For doctors and nurses and providers, it will mean more time giving high quality care. And for patients and our families, it will mean less time dealing with a broken health care system and more time doing the things we love, together.”

Barkan interviewed all the presidential candidates on Medicare for All and then sat down with President Biden to discuss health care. At the time, Barkan supported Medicare for All but did not appreciate that corporate health insurers had sunk their teeth into Medicare through the Medicare Advantage program. Now, he recognizes that if corporate health insurers take full hold of Medicare, it is not likely we will get government-administered Medicare back.

The argument for Medicare Advantage when Congress debated it in the early 2000’s was that it would improve quality and save money through “managed care.” But, 20 years later, Medicare Advantage has always cost more per enrollee than traditional Medicare. And, several analyses show that quality of care, particularly for people



with costly and complex conditions tends to be worse in Medicare Advantage than in traditional Medicare.

Because the federal government pays corporate health insurers upfront for the care they provide, regardless of the amount they spend on care, the insurers do what they can to spend as little of that money on people’s care as possible. The less they spend, the more they profit. The consequence for enrollees can be deadly—delayed and denied care, lack of access to top quality specialists and specialty hospitals and unaffordable out-of-pocket costs.

Medicare Advantage has become big business. Every business wants in and wants more. The insurance companies offering Medicare Advantage are buying up primary care providers in order to help control the care that people receive. To be sure, in the best of hands, this could be great. But, in the hands of corporate executives who are looking to return as much money to shareholders as possible, you can imagine the danger.

The corporate health insurer execs are likely dreaming of a time when Congress passes Medicare Advantage for All, a time when they control the full Medicare market and the hundreds of billions of dollars that come with it. Americans should be extremely concerned.

Without traditional Medicare in the mix, putting competitive pressure on the Medicare

Advantage plans, without the tens of billions in excess payments to the Medicare Advantage plans, and without any freedom for enrollees to disenroll from Medicare Advantage, all bets are off on health care costs and coverage for older adults and people with disabilities, all bets are off on their health and well-being.

Fortunately, members of Congress are beginning to understand the fundamental differences between traditional Medicare and Medicare Advantage. They are holding hearings focused on abuses in Medicare Advantage—overpayments, inappropriate delays and denials, misleading marketing and ghost networks, among others. And, the Biden administration is passing regulations in an attempt to rein in the bad actor Medicare Advantage plans.

Unfortunately, the regulations are only as good as the government’s ability to enforce them. And, enforcement has been lax, to put it mildly. As of now, the Medicare Advantage plans that are engaged in keeping their enrollees from getting costly care can continue to do so, with impunity.

If we are going to guarantee Medicare for All, free or low-cost access to good care in the US, we must keep the corporate health insurers from taking over Medicare.

Dear Marci: Does Medicare cover substance use disorder treatment?

Dear Marci,
I'm helping my father set up his treatment for substance use disorder. Does Medicare cover this kind of care?

-Saul (Arlington, VA)

Dear Saul,

Yes, Medicare should cover alcoholism and substance use disorder treatment for your father if:

- ◆ His provider states that the services are medically necessary
- ◆ He receives services from a Medicare-approved provider or facility

- ◆ And, his provider sets up his plan of care

Medicare covers treatment in both **inpatient** and **outpatient** settings. Here are just a few examples of the services that Medicare covers:

- ◆ Psychotherapy
 - ◆ **Opioid treatment program (OTP)** services
 - ◆ Patient education regarding diagnosis and treatment
 - ◆ Post-hospitalization follow-up
- Part A should cover his care if he is hospitalized and needs substance use disorder treatment.



Dear Marci

If he is in an inpatient psychiatric hospital, keep in mind that

Medicare only covers a total of 190 lifetime days. Once this limit has been reached, though, Medicare may cover care at a general hospital. A plan’s cost-sharing rules for an inpatient hospital stay should apply. Part B should cover outpatient substance use disorder care he receives from a clinic, hospital outpatient department, or opioid treatment program. Original Medicare covers these services at 80% of the Medicare-approved amount. As long as he receives

the service from a **participating provider**, he will pay a 20% coinsurance after meeting his Part B deductible. Visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to find participating providers. If he is enrolled in a Medicare Advantage Plan, contact his plan for information about costs, coverage, and in-network providers for substance use disorder treatment.

I hope this information is helpful to you and your father. Wishing him well on his recovery.

-Marci

Lawyer Fees Draw Scrutiny as Camp Lejeune Claims Stack Up

David and Adair Keller started their married life together in 1977 at Camp Lejeune, a military training base on the Atlantic Coast in Jacksonville, North Carolina. David was a Marine Corps field artillery officer then, and they lived together on the base for about six months.

But that sojourn had an outsize impact on their lives.

Forty years later, in January 2018, Adair was diagnosed with acute myeloid leukemia. She died six months later at age 68. There's a chance her illness was caused by toxic chemicals that seeped into the water military families at the base drank, cooked with, and washed with for decades.

When the **PACT Act** passed last August, David asked a neighbor who worked at a personal injury law firm in Greenville, South Carolina, if he thought he might have a case. Now Keller is filing a wrongful death claim against the federal government under a section of that measure that allows veterans, their family members, and others who spent at least 30 days at Camp Lejeune between Aug. 1, 1953, and the end of 1987 to seek damages against the government for **harm caused by exposure to the toxic**

water.

The **Camp Lejeune Justice Act** didn't attract the spotlight as the aspects of PACT that deal with the harms soldiers experienced from burn pit fumes overseas did. But for veterans who served at this North Carolina post, it is the realization of a decades-long effort to hold the government accountable.

As cases begin to proceed through the legal system, some veterans' advocates worry that families who have already suffered from toxic exposure may get shortchanged by a process that's supposed to provide them with a measure of closure and financial relief. They **support limiting lawyers' fees**, some of which may exceed half of a veteran's award.

The government estimates as many as a million people were exposed to Camp Lejeune's contaminated water during the 34-year period covered by the law. Personal injury lawyers have taken notice. In recent months, **TV ads** trying to drum up business have been impossible to ignore: "If you or a loved one were stationed at Camp Lejeune between 1953 and 1987 and developed cancer, call



now. You may be entitled to significant compensation."

During the year that ended in March, TV ads soliciting Camp Lejeune claims reached an estimated \$123 million, according to **X Ante**, a company that tracks mass tort litigation advertising. Camp Lejeune TV ads currently rank third among the top targets for mass tort claims since 2012, behind only asbestos and mesothelioma (\$619 million) and Roundup weed killer (\$132 million).

"The attorneys have calculated out that they stand to make a pot of money," said Autrey James, chairman of the American Legion's Veterans Affairs & Rehabilitation Commission. "We need Congress to put caps on how much these attorneys can charge."

For Keller, a 73-year-old former workers' compensation lawyer, it's a matter of accountability. Because of his experience, he came out of retirement last year to represent Camp Lejeune victims. He is now working part time at the Greenville law firm he spoke with originally and that now represents his late wife. It

currently has roughly 65 Camp Lejeune cases.

Under the law, veterans must first file an administrative claim with the Judge Advocate General of the Navy's Tort Claims Unit. If, after six months, the Navy hasn't settled the claim, or if it denies the claim, veterans can file suit in the U.S. District Court for the Eastern District of North Carolina.

So far, approximately 23,000 claims have been filed with the Navy, none of which have been fully adjudicated, said Patricia Babb, a spokesperson for the Judge Advocate General's office.

This legal remedy has been a long time coming. In the early 1980s, the Marine Corps learned that three of Camp Lejeune's water distribution systems were contaminated with industrial chemicals that had seeped into the water from leaking underground storage tanks, industrial spills, and waste disposal sites. The Corps shut them down in the mid-1980s and the area was **declared a hazardous waste site** in 1989 under the Environmental Protection Agency's Superfund law.... **Read More**

4 times when your Social Security benefit can be garnished for old debts

For most retirees, Social Security accounts for more than half of their income, according to the **Census Bureau** —and for some, it makes up most or almost all, of their income.

What happens when people receiving Social Security benefits have unpaid debt? Can those Social Security benefits be withheld, or garnished, to settle those debts?

Section 459 of the Social Security Act allows Social Security to attach income for some delinquent debts that you owe — but it depends on the type of debt.

"Federal law generally prohibits garnishing Social Security benefits, but they can be garnished under certain circumstances," explains Leslie H. Tayne, financial attorney and managing director of Tayne Law Group in New York.

Social Security benefits cannot

be confiscated to pay down credit card debt or a car loan, Tayne says. But they can be seized if you owe:

- ◆ back taxes to the government,
- ◆ alimony to a former spouse,
- ◆ support to dependent children, or restitution to a victim of a crime you committed.

The amount that can be withheld from your benefits depends on which of those obligations you are responsible for, which we outline below:

Alimony or spousal support and child support "The most common phenomenon since 1990 is **'gray divorce' (divorce after 50)** and it often occurs between two Social Security recipients (or one) and the court can order spousal support be paid from



Social Security benefits," says Derek Jacques, attorney at The Mitten Law Firm in Southgate, Michigan, who specializes in personal bankruptcy/debt relief, divorce and family law.

"The maximum amount that can be garnished for child support and alimony is 50% to 65%, depending on the circumstances," Tayne says. While the number of ex-spouses you have doesn't affect the rate at which your wages are attached, she says the amount that can be withheld does change depending on whether you currently support a family.

"If you don't currently support another child or spouse, up to 60% of your benefits can be garnished," she says. But, for example, if you got remarried and had another child, up to 50% of your benefits can be

garnished. "In either case, if you're more than 12 weeks behind on payments, an additional 5% can be withheld."

Child support payments are another scenario in which Social Security benefits can be garnished. "The Debt Collection Improvement Act, passed in 1996, gives the Treasury Department the authorization to withhold Social Security for certain debt — and one of them is child support debt," Jacques explains. "This has actually been instrumental in collecting back child support from now-retired delinquent fathers."

Regarding how much, Tayne says the maximum amount that can be garnished for child support is between 50% and 65%, depending on the circumstances.... **Read More**

White House wants to improve access to opioid overdose reversal medication

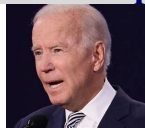
President Joe Biden's administration is seeking to meet with the makers of the life-saving medication naloxone used to reverse opioid overdoses, in an effort to increase access and reduce cost, a spokesperson for the White House Office of National Drug Control Policy said.

ONDCP Director Dr. Rahul Gupta "plans to have conversations with manufacturers to share his key principle moving forward: the easier it is for people to access naloxone, the more lives

we can save," the spokesperson said.

The planned meeting is part of the administration's efforts "to ensure naloxone is both accessible and affordable to everyone who may need it," they added in a statement.

Opioid abuse has plagued the country for more than two decades and killed more than a half million Americans, according to federal data — turning the highly addictive pain medications into a public health crisis.



Naloxone is seen as a key tool to help someone survive an opioid overdose. U.S. health regulators approved an over-the-counter version of Emergent BioSolutions Inc's ([EBS.N](#)) Narcan earlier this year aimed at making it easier to access without a prescription. The Food and Drug Administration approved the first generic version of the medication in 2021 sold by Israeli drugmaker Teva Pharmaceuticals ([TEVA.TA](#)). Other drugmakers also sell

various versions of the product.

"We welcome the opportunity to discuss the true out of pocket costs for patients, including how Medicare and private insurers will cover Narcan as an over the counter product. We encourage the ONDCP to include all stakeholders — manufacturers, retailers, insurers — in this conversation," Emergent said in a statement.

It was not immediately clear which pharmaceutical makers the White House had planned to invite to the meeting.

Study Shows Powerful New Target to Saving Lives From COPD

Researchers may have found a new target in chronic obstructive pulmonary disease (COPD) symptoms that could potentially save more lives.

The study focused on mucus plugs, which clog airways in the lungs of many patients with the respiratory disease.

"As a chronic disease, COPD can't be cured, but our findings suggest that using therapies to break up these mucus plugs could help improve outcomes for COPD patients, which is the next best thing," said corresponding author [Dr. Alejandro Diaz](#), an associate scientist in the Division of Pulmonary and Critical Care Medicine at Brigham and

Women's Hospital in Boston.

"Mucus is something that we already know a lot about from a basic science standpoint, and there are also a lot of mucus-targeting therapies that either already exist or are in development for other diseases, so it's an extremely promising target," Diaz said in a hospital news release.

The researchers used data from the Genetic Epidemiology of COPD (COPDGene) study, which included more than 10,000 people recruited between 2007 and 2011. They had COPD at different stages.

Narrowing that to data from



more than 4,000 of these patients, researchers analyzed chest CT scans taken at their first clinic visit in search of mucus

plugs.

"Creating mucus is a normal part of the body's immune response, but usually we cough it up as we're getting better," Diaz said. "COPD causes the body to produce too much mucus and makes it harder to clear out, so you end up with these mucus plugs that aren't strongly correlated with any specific symptoms and can go undetected."

Researchers found that the death rate for COPD patients

with no detectable mucus plugs was 34%. For those with mucus plugs in up to two lung segments, the death rate jumped to 46.7%. Patients with plugs in three or more lung segments had a death rate of 54.1%.

"The data show a compelling association between the accumulation of these mucus plugs and overall mortality, but we don't know anything about what's driving it yet," Diaz said.

COPD is the fourth-leading cause of death in the United States. It affects 15.9 million Americans... [Read More](#)

FDA Approves First Pill to Treat Moderate-to-Severe Crohn's Disease

Patients with Crohn's disease have a new treatment option, following U.S. Food and Drug Administration approval of a pill called Rinvoq (upadacitinib).

Rinvoq is meant to treat adults with moderately to severely active Crohn's disease who have not had success with TNF (tumor necrosis factor) blockers. The daily pill is the first oral treatment for this group of patients.

Crohn's is a chronic inflammatory bowel disease. It causes inflammation in any part of the digestive tract, typically affecting the small intestine and the beginning of the large intestine. Common symptoms include diarrhea, cramping,

stomach pain and weight loss.

The medication was previously approved for several other conditions, including eczema, rheumatoid arthritis, psoriatic arthritis and ulcerative colitis, according to the website of pharmaceutical company AbbVie.

Researchers evaluated its safety and effectiveness in two randomized trials in 857 patients with the disease. Participants received either 45 mg of Rinvoq or a placebo daily for 12 weeks.

More patients treated with the medication achieved remission than those treated with the placebo, the FDA said in a news release. Also, more people treated



with the medication had improvement in intestinal inflammation, which was assessed with a colonoscopy.

The FDA also assessed Rinvoq as a maintenance treatment, evaluating 343 patients who had responded to the 12 weeks of medication. This group received 15 mg or 30 mg once daily or a placebo for a year. More of those on the maintenance treatment achieved remission and reduced intestinal inflammation than those on the placebo.

Side effects of the medication were upper respiratory tract infections, anemia, fever, acne, herpes zoster and headache.

The drug is not recommended

for use with other Janus kinase (JAK) inhibitors, biological therapies for Crohn's disease or with strong immunosuppressants including azathioprine and cyclosporine.

Among the risks are serious infections, death, cancer, major adverse cardiovascular events and thrombosis (blood clot).

Patients should take 45 mg of Rinvoq once daily for 12 weeks and then start a 15 mg maintenance dose. A higher 30 mg maintenance dose can be considered for patients with refractory, severe or extensive Crohn's disease, according to the FDA.

Drug May Offer New Approach Against Rheumatoid Arthritis

An investigational drug may hit the reset button on a faulty immune system for some people with rheumatoid arthritis.

Rheumatoid arthritis, or RA, is an autoimmune disease that occurs when the body misfires against its own joints and tissues, causing joint pain, stiffness, fatigue and other symptoms. The drug, peresolimab, is a monoclonal antibody that stimulates human programmed cell death protein 1 (PD-1), which serves as the brakes on the immune system, said study author **Dr. Ajay Nirula**. He's vice president of immunology for Lilly Research Laboratories in San Diego, which is developing peresolimab. It funded the new research, which was published May 17 in the *New England Journal of Medicine*.

PD-1 is a protein found on T cells that helps keep the body's

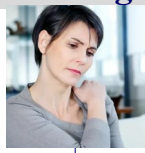
immune responses in check.

"Some autoimmune disease like RA could be caused by an inability to push the normal brakes on the immune system," Nirula said. The new drug hits this brake by stimulating PD-1. "We are trying to turn down the immune system by replacing a missing signal," he added.

And so far, so good, the researchers report.

The new study included 98 people with difficult-to-treat RA. They received 700 mg of peresolimab, 300 mg of peresolimab, or a placebo intravenously once every four weeks.

Compared to folks who got a placebo, participants who took the higher dose of peresolimab had significantly less joint pain, swelling, tenderness and



inflammation at 12 weeks as measured on a standard scale assessing RA symptom severity. The safety profiles were similar across all groups in the study.

"We saw a level of efficacy that was intriguing," Nirula said.

"In the past, steroids were effective in alleviating symptoms of RA, but chronic steroid use has its toxicities, so we moved to different types of drugs that suppress the immune system," he said.

Then came biologics such as tumor necrosis factor (TNF) alpha-blockers. These drugs target specific proteins, such as TNF, that play a role in stirring the inflammatory cascade, Nirula said.

The new study included people who had not done well on traditional immune-suppressing drugs or existing biologics.

"We saw good responses in both patient populations, and we are looking for medications that work in RA patients who have failed multiple therapeutics," Nirula said.

PD-1 is also a target of some current cancer drugs, but in cancer, the goal is to shut this pathway down, not stimulate it. Longer studies are needed to see if peresolimab increases cancer risk in people with RA, Nirula noted.

The drug is still a few years away from the bedside, assuming further research pans out and no new safety signals emerge. Results of a phase 2 study are expected next year. If they are positive, it could set the stage for phase 3 clinical trials, which would take two to three years to complete....[Read More](#)

AHA News: The Brain Isn't the Only Place a Stroke Can Occur

Sudden, painless loss of vision. Burning back pain. Achy legs. Incontinence.

People might not recognize these as signs of a stroke, because some are not the symptoms of a stroke in the brain, where most strokes occur. But strokes can happen in other parts of the body, too, said Dr. Matthew Schrag, an assistant professor of neurology and vascular neurologist at Vanderbilt University Medical Center in Nashville, Tennessee.

Sudden, total vision loss in one eye may signal a stroke in the eye. Back pain, aching legs and incontinence, along with paralysis, weakness and loss of

pain or the ability to feel temperature, signal a stroke in the spine.

Though rare, these strokes, just like those in the brain, are serious and require immediate medical attention, Schrag said.

"They present special challenges and can be harder to recognize, but are theoretically treatable," he said.

The American Heart Association and American Stroke Association define stroke as an obstruction of blood supply to the brain, spinal cord or retina that causes cell death. When strokes occur in the brain, symptoms



may include numbness in the face, weakness in arms or legs, especially on one side of the body, trouble speaking or understanding speech, vision problems, lack of coordination or a sudden, severe headache.

But blood supply can be obstructed almost anywhere in the body, said Dr. Lucia Sobrin, a professor of ophthalmology at Harvard Medical School in Boston.

A stroke in the eye – known as central retinal artery occlusion, or CRAO – typically happens when plaque that has built up in a carotid artery, the main arteries

on each side of the neck that send blood to the brain and eyes, breaks loose and travels to the retina. That same plaque also could travel to the brain and cause an ischemic stroke. "It could go either way," Sobrin said.

Total vision loss in one eye typically occurs, but in some cases, a person may only lose partial vision, she said. "They may still be able to perceive light or motion."

A CRAO isn't fatal, Schrag said. But vision loss can be permanent if not treated within the first few hours....[Read More](#)

More than 1 in 6 adults have depression as rates rise to record levels in the US, survey finds

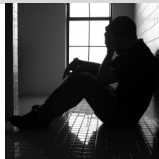
Depression is more widespread than ever in the United States, according to a [new report](#) from Gallup.

About 18% of adults – more than 1 in 6 – say they are depressed or receiving treatment for depression, a jump of more than 7 percentage points since 2015, when Gallup first started polling on the topic.

Nearly 3 in 10 adults have been clinically diagnosed with depression at some point in their lifetime, according to the

survey, which is also a record high.

The Covid-19 pandemic took an undeniable toll on mental health. Rates of clinical depression had been rising steadily in the US but "jumped notably" in recent years, the Gallup data shows. "The fact that Americans are more depressed and struggling after this time of incredible stress and isolation is perhaps not surprising," said Dr. Rebecca Brendel, president of the American Psychiatric



Association, which was not involved in the new research. "There are lingering effects on our health, especially our mental health, from the past three years that disrupted everything we knew."

But experts say that awareness around mental health has grown, which could lead to higher rates of diagnoses – and that's not a bad thing.

"We're making it easier to talk about mental health and looking at it as part of our

overall wellness just like physical health," Brendel said. "People are aware of depression, and people are seeking help for it."

Younger generations seem especially willing to open up about mental health struggles, she said. But the Covid-19 pandemic also disrupted pivotal periods of growth for young adults, which could have left them more susceptible to the drivers of depression....[Read More](#)

Even After Pandemic, Cancer Patients Prefer Telemedicine Care

During the early part of the COVID-19 pandemic, one of the only ways to see a doctor was via video or phone appointment, and it turns out many people with cancer still prefer telemedicine visits over in-person ones.

The recent end of the U.S. public health emergency will remove some of the flexibilities that were put in place during the pandemic to allow for wider use of telemedicine, and this may be unfortunate, noted study author **Dr. Krupal Patel**, an oncologist at the Moffitt Cancer Center in Tampa, Fla.

"When implemented right and offered to the right patient, telemedicine visits can be a valuable alternative to in-person appointments," Patel said. The benefits of telemedicine for people with cancer are substantial, he noted. It allows for greater flexibility with scheduling, reduces costs associated with getting to the

doctor's office or hospital, and saves travel time.

For **the study**, more than 33,300 people with cancer answered survey questions on in-person visits, and almost 6,000 on their telemedicine experiences during and after the height of the pandemic, from April 2020 through June 2021.

Almost 76% of cancer patients were highly satisfied with their access to their doctors via televisits, compared with about 63% of those who saw their doctors in person. About 91% of people who saw their doctor virtually were highly satisfied with the response and amount of concern their doctor expressed. By contrast, just over 84% of people who saw their doctor in person felt this way.

These findings held with time, including after researchers controlled for factors that may affect how a person feels about telemedicine, such as age and



insurance status.

Telemedicine isn't always appropriate. At Moffitt Cancer Center, people are triaged first to determine whether they need to be seen in person, Patel noted. "It's not an on-demand service."

Dr. Paul Fu, chief medical information officer at City of Hope, in Duarte, Calif., agreed. "A lot of the care that oncologists provide simply cannot be provided virtually," said Fu, who had no role in the study.

While City of Hope saw an increase in telehealth visits during the study period, Fu said the cancer center's own assessments "have consistently shown better performance for in-person visits than telehealth visits." Much of that has to do with the complexity and customization involved in cancer treatment, he noted.

The new study is published in the May issue of the *Journal of*

the National Comprehensive Cancer Network.

"Telemedicine has been such a fantastic experience for doctors and cancer patients," said **Dr. Richard Carvajal**. He is the deputy physician-in-chief and director of medical oncology at the Northwell Health Cancer Institute in North New Hyde Park, N.Y.

The worry was that there would be an increase in adverse events or that things may be missed virtually, but this has not proven to be the case, he said.

"We can do more remotely than we thought we could," said Carvajal, who has no ties to the new research. "If someone needs an infusion or has a potentially serious complication, they will need to see the doctor in person, but toxicity checks for people on oral or chronic therapy to treat cancer can frequently be done at home."

U.S. House and Senate Notification

From Senator Sheldon Whitehouse's (D-RI) office.

CMS Issues Final National Coverage Determination for Seat Elevation Equipment on Power Wheelchairs

Today, May 16, 2023, the Centers for Medicare & Medicaid Services (CMS) issued

a final Benefit Category Determination (BCD) and National Coverage Determination (NCD) that, for the first time, establishes power seat elevation for power wheelchairs as durable medical



equipment eligible for coverage by the Medicare program. People with Medicare who perform transfers from power wheelchairs, or reach from their chair for mobility related activities of daily living

such as dressing, grooming, toileting, feeding and bathing, can receive Medicare covered seat elevation equipment effective immediately.

The final BCD and NCD decision memorandum is available at: [click here](#)

Medicare is prohibited from paying for weight-loss drugs. These are the 3 potential ways to change that.

Older Americans hoping to get their hands on powerful weight-loss drugs such as Ozempic and Wegovy may find it impossible to access them.

That's because Medicare, the federal program that provides health coverage for people 65 and older, is strictly **prohibited** by a 2003 law from paying for weight-loss medications. Without insurance, the drugs are unaffordable, with price tags that can top more than \$1,000 a month.

A big push is underway by drugmakers and other groups to get Medicare to pay for the drugs, but the potential high costs to the program are a sticking point.

One analysis by Vanderbilt University researchers in March estimated that if just 10% of Medicare beneficiaries were

treated with Wegovy, the cost to the program would total \$26.8 billion a year and premiums for drug plans would increase.

Still, covering the drugs could provide big benefits.

Researchers at the University of Southern California wrote in an **April paper** that if all eligible Medicare beneficiaries were treated with weight-loss drugs, Medicare could save \$176 billion in medical costs over 10 years, driven by fewer hospitalizations, surgeries, doctors' visits, and other medical services. This estimate didn't account for the cost of treatment.

Should Medicare cover weight loss medication, it could also unlock access for people who



have private coverage. "A decision by Medicare to cover weight-loss drugs would put pressure on employers and other private insurers to cover weight-loss drugs too," said Tricia Neuman, a senior vice president at KFF who co-authored a **recent brief** on the subject.

There are three potential strategies that could be used to expand Medicare coverage to weight-loss drugs. Congress could pass a law allowing the program to cover the drugs; the Biden administration could set up a new payment model; and, according to Novo Nordisk, the Centers for Medicare and Medicaid Services could side-step the prohibition by reframing how it characterizes anti-obesity treatments.

The most obvious route to

Medicare coverage is to pass legislation that would allow Medicare Part D — the prescription drug benefit — to cover drugs used to treat obesity.

The leading bill that would do this, called the **Treat and Reduce Obesity Act**, has been stuck in Congress for more than a decade. It was last **proposed** in 2021 and hasn't been reintroduced in the current Congress.

Still, some champions of the bill are optimistic about its chances, as support for the legislation has grown over the years, reaching 176 co-sponsors. Drugmakers, including Novo Nordisk and Eli Lilly, as well as other healthcare companies and patient advocacy groups are **lobbying** for Congress to take action.

The Women's Health Screenings and Preventive Care Appointments You Need

Health screenings and preventive care appointments are a key to maintaining long-term health and well-being. By proactively engaging in these practices, women can identify potential health risks early on and take necessary steps.

This guide will outline the key women's health screenings and care appointments to help you prioritize your health and stay on top of your well-being.

5 high-priority health screenings for women



- ◆ Breast cancer screening
- ◆ Cervical cancer screening
- ◆ Colorectal cancer screening
- ◆ STD screening

◆ **Skin cancer screening**
By proactively engaging in these screenings, women can take charge of their health and ensure a healthier future.....[Read More on each of the above screenings](#)

When Older Parents Resist Help or Advice, Use These Tips to Cope

It was a regrettable mistake. But Kim Sylvester thought she was doing the right thing at the time.

Her 80-year-old mother, Harriet Burkel, had fallen at her home in Raleigh, North Carolina, fractured her pelvis, and gone to a rehabilitation center to recover. It was only days after the death of Burkel's 82-year-old husband, who'd moved into a memory care facility three years before.

With growing distress, Sylvester had watched her mother, who had emphysema and peripheral artery disease, become increasingly frail and isolated. "I would say, 'Can I help you?' And my mother would say, 'No, I can do this myself. I don't need anything. I can handle it,'" Sylvester told me.

Now, Sylvester had a chance to get some more information. She

let herself into her mother's home and went through all the paperwork she could find. "It was a shambles — completely disorganized, bills everywhere," she said. "It was clear things were out of control."

Sylvester sprang into action, terminating her mother's orders for anti-aging supplements, canceling two car warranty insurance policies (Burkel wasn't driving at that point), ending a yearlong contract for knee injections with a chiropractor, and throwing out donation requests from dozens of organizations. When her mother found out, she was furious.

"I was trying to save my mother, but I became someone she couldn't trust — the enemy. I really messed up," Sylvester said. Dealing with an older parent



who stubbornly resists offers of help isn't easy. But the solution isn't to make an older person feel like you're

steamrolling them and taking over their affairs. What's needed instead are respect, empathy, and appreciation of the older person's autonomy.

"It's hard when you see an older person making poor choices and decisions. But if that person is cognitively intact, you can't force them to do what you think they should do," said Anne Sansevero, president of the board of directors of the Aging Life Care Association, a national organization of care managers who work with older adults and their families. "They have a right to make choices for themselves."

That doesn't mean adult children concerned about an

older parent should step aside or agree to everything the parent proposes. Rather, a different set of skills is needed.

Cheryl Woodson, an author and retired physician based in the Chicago area, learned this firsthand when her mother — whom Woodson described as a "very powerful" woman — developed mild cognitive impairment. She started getting lost while driving and would buy things she didn't need then give them away.

Chastising her mother wasn't going to work. "You can't push people like my mother or try to take control," Woodson told me. "You don't tell them, 'No, you're wrong,' because they changed your diapers and they'll always be your mom." ...[Read More](#)

A Swallowable Gastric Balloon Helps People Shed Pounds

Combining a swallowable gastric balloon with a weight loss drug may be a way to lose significant body weight, a new study suggests.

In about eight months of combination treatment, participants lost an average of 19% of their body weight, and significantly reduced their body mass index (BMI), researchers report.

"Combination therapy gives providers much flexibility and further options in managing obesity in patients who need additional weight loss or increased durability," said lead researcher Dr. Roberta Ienca, from the Nuova Villa Claudia Clinic in Rome, Italy.

"The ease of use and low rate of adverse events make it an ideal primary weight loss therapy that can be complemented by medications or other treatments," she added.

Gastric balloons for weight loss are not new, but they haven't

been popular because they require an endoscopy for placement, the study authors said. This new swallowable balloon from Allurion Technologies eliminates the need for a medical procedure. (Ienca and her two co-authors are advisors for Allurion.)

In the noninvasive procedure, the balloon is swallowed as a capsule and is filled with liquid after it reaches the stomach. The outpatient procedure takes about 20 minutes. After about 16 weeks, the balloon is excreted naturally.

The balloon reduces the amount of food that can be ingested, which leads to weight loss. Taking the diabetes drug liraglutide (Saxenda) enhances feelings of fullness and suppresses appetite, adding to the weight loss, the researchers noted. Liraglutide is a glucagon like peptide-1 receptor agonist (GLP-1 RA).



Not all weight-loss experts believe gastric balloons are a solution to obesity, however, largely because they're temporary.

"I do not recommend a balloon to my patients unless they have a short-term need for something, say it's not safe to get a transplant or it's not safe to get a knee or hip replacement," said [Dr. Jamie Kane](#), director of Northwell Health Center for Weight Management, in Great Neck, N.Y.

According to Kane, better options for the long term include bariatric surgery, newer drugs such as Ozempic and Wegovy (semaglutide), and, of course, lifestyle changes including a healthy diet, portion control and exercise.

"You should always be thinking long term — that's the main advice," added Kane, who played no role in the research.

[Dr. Mitchell Roslin](#), director

of bariatric surgery at Northern Westchester Hospital in Mount Kisco, N.Y., isn't a fan of the gastric balloon, either.

"By putting a balloon in people they lose a lot of weight early, but ultimately the thermostat or the energy regulation center in the brain isn't going to be reset," said Roslin, who wasn't involved in the study.

The prolonged weight loss is mostly due to the medication. "If you didn't have the medication, they'd regain all of their weight after the balloon is removed," Roslin said.

"The effective tools that we have are bariatric surgical procedures and the GLP analogs," he said. "What they both share in common is they change the energy regulation center in the brain."

"Temporary devices are just that, they're temporary," Roslin added. Weight loss is a "lifetime commitment no matter what you do." ...[Read More](#)