

November 7, 2021 E-Newsletter

Democrats announce deal on prescription drug pricing

Democrats on Tuesday said they had clinched a deal on a plan that aims to lower **prescription drug prices** for millions of American seniors, part of an 11th-hour blitz to fine-tune their \$1.75 trillion tax-and-spending plan in the hopes of bringing it to a vote as soon as this week.

Senate Majority Leader Charles E. Schumer (D-N.Y.) announced the agreement after a private meeting of party lawmakers, marking a potential end to a battle between some liberals and moderates over a policy priority that many Democrats had pitched over the course of the 2020 presidential election.

“Fixing prescription drug prices consistently has been a top issue for Americans year after year,” Schumer said at a news conference. “We’ve heard this from people across the country. . . . Today, we’ve taken a massive step forward in helping alleviate that problem.”

Under the deal, the U.S.

government would gain the ability to negotiate some drug prices on behalf of seniors who participate in Medicare. Such a power for the first time would give the benefit program leverage to drive down the price of medicine, allowing the federal government — along with millions of families — to save money.

At first, the Medicare negotiation powers would cover only a limited class of the 10 most expensive drugs, including medicines that help care for cancer patients, starting in 2023, according to lawmakers including Sen. Ron Wyden (D-Ore.), who helped negotiate the deal. Eventually, though, Medicare could negotiate on other drugs after they are no longer covered by certain government restrictions, which protects drugmakers from generic competition.

Democrats also plan to impose special, new caps on how much seniors would have



to pay for insulin, which would be set at \$35, seeking to help diabetes patients beset by sky-high price increases in recent

years. Additionally, seniors who participate in the Medicare drug benefits plan known as Part D would see their yearly, **out-of-pocket drug spending capped at \$2,000**, according to Wyden and other Democrats.

And their deal further includes “anti-price gouging penalties,” which Wyden explained as money paid back to the U.S. government when drug companies raise prices more than inflation. The penalties also apply to commercial health insurance plans, though the details are unclear.

“The prohibition on negotiation has almost been like a curse,” Wyden said. “There was a sense the government had its hands tied behind its back. And now a precedent is being set that, starting right out of the gate, there’s going to be negotiation on the most

expensive drugs — cancer drugs, arthritis drugs, anticoagulants.”

“Once you set a precedent . . . you are really turning an important corner,” he said.

Much is still unknown about the plan, which had not been released in full by late Tuesday afternoon. Even as Democrats championed it as an early policy win, it still marked a significant departure from the more aggressive drug-pricing reforms that the party’s House lawmakers had put forward in recent years.

Still, it presented a potential resolution to one of the thorniest fights still remaining around Democrats’ still-forming \$1.75 trillion package, which broadly aims to overhaul the country’s health care, education, climate and tax laws. Sen. Kyrsten Sinema (D-Ariz.), who had opposed an earlier version of Democrats’ drug pricing plans, joined other moderates in offering her support for the deal.

Prescription Drug Cost Reform is a Welcome Addition to “Build Back Better”

In a significant reversal and landmark win for beneficiary advocates, lawmakers this week announced an **agreement** to add prescription drug reforms to the “Build Back Better” (BBB) budget reconciliation bill. Medicare Rights applauds this development. The **negotiated deal** takes important steps to meaningfully improve prescription drug affordability for people with Medicare. Though its changes are less comprehensive than originally envisioned in the House bill **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.

Cap on Beneficiary Part D Costs. Like H.R. 3, the agreement would cap annual OOP Part D drug costs at \$2,000 and allow beneficiaries to smooth cost-sharing over the calendar year. It would also limit monthly insulin copays to \$35 for all Part D enrollees, essentially expanding the



current **Part D Senior Savings Model.**

Medicare Part D

Restructuring. Since capping OOP costs alone **would not address** the underlying issue of high drug prices, we appreciate that—also like H.R. 3—the BBB agreement seeks to do so through a Part D redesign. Both approaches would restructure Part D payment responsibilities to **better incentivize** drug plans to control costs and negotiate prices. This realignment would appropriately shift obligations away from beneficiaries and Medicare,

likely improving both individual and program finances.

Inflation-Based Penalties in Part B and Part D. As in H.R. 3, the BBB agreement would try to further control drug costs by penalizing manufacturers whose prices grow faster than inflation. However, while H.R. 3 would have benchmarked those penalties to 2016, when inflation was about 2%, the new agreement uses 2021—and its much higher 5% rate of inflation. This change would allow companies to raise prices by about 5% every year without penalty. . . . **Read More**

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Biden reconciliation framework includes Medicaid workaround, no Medicare dental or vision benefits

The White House-backed social spending framework will feature a pared-down expansion of both Medicare and Medicaid coverage as President Biden seeks to secure enough support to advance the legislation.

The framework, previewed for reporters Thursday morning ahead of Biden's meeting with House Democrats, would offer four years of subsidized private health insurance on the Affordable Care Act (ACA) exchanges for people with lower incomes living in states that did not expand Medicaid under the health care law.

According to the White House, the plan would provide \$0 premiums for 4 million people in the "coverage gap," meaning they don't earn enough to qualify

for ACA subsidies but, since they live in a nonexpansion state, also make too much to qualify for Medicaid.

The temporary plan is more industry-friendly than the proposal offered by House Democrats in September, which would have created an entirely new "Medicaid-like" government program to provide coverage in the 12 nonexpansion states.

While many Democrats backed the idea, it was opposed in recent days by Sen. Joe Manchin (D-W.Va.) and other lawmakers from states that have been paying for expanded Medicaid for years. They argued it wouldn't be fair for their constituents if the federal government paid the whole cost of the holdout states



to expand.

But at the same time, the temporary plan could be easier to set up and may avoid pushback from industry groups that worry a new federal program is a stepping stone to a larger-scale, government-run "public option."

Backers of Medicaid expansion, including House Majority Whip James Clyburn (D-S.C.) and Georgia Democratic Sens. Raphael Warnock and Jon Ossoff, wanted it to run for as long as possible.

On Medicare, the framework will expand coverage for hearing benefits, which is just one-third of what progressives were pushing for.

Sen. Bernie Sanders (I-Vt.) has drawn a line in the sand in recent

days, saying that adding dental, hearing and vision benefits to Medicare in Democrats' social spending package is "not negotiable."

Progressives have long been pushing for expanding the Medicare benefits, but dental benefits especially were some of the most expensive.

The framework does include the extension of enhanced financial assistance to help people afford premiums under the ACA, a key part of Speaker Nancy Pelosi's (D-Calif.) legacy.

According to the White House, the framework will reduce premiums for more than 9 million Americans who buy insurance through ACA exchanges by an average of \$600 per person per year.

Date for Vote on Health Care Legislation Still Uncertain

As we have been reporting, the changes in Medicare will be part of an overall infrastructure bill that President Biden has proposed and that both the House and the Senate have been working on for weeks.

The uncertainty and difficulty of getting it passed is because of the close divisions within both bodies of Congress. The fighting is among the Democratic

majorities because the Republicans have made it clear they will not be supporting anything. And, as we've already said, the big drug companies have poured millions into trying to stop any legislation that would affect their profits.

As a result, Democrats have imposed their own deadlines



regarding getting the legislation passed and so far, they've not been able to meet those deadlines. The hope in the House is that they might be able to have a final vote on the bill by the end of this week, but that remains to be seen.

Once the House is able to pass a bill, it will go to the Senate

where there continue to be struggles within the Democratic majority.

So, while we will not get all that we want, it appears progress will be made in improving some aspects of Medicare in providing health care for seniors. You can be assured that TSCL will never stop in its fight for seniors to get the kind of health care they need and deserve.

Medicare Advantage Plans: More Choices, More "Extras," Maybe More Confusion

This week, the Kaiser Family Foundation (KFF) released a **report** analyzing the Medicare Advantage (MA) plan landscape for 2022. The report found that, for 2022, the average Medicare beneficiary has access to 39 MA plans—more than double the number available in 2017. About six in ten plans offered in 2022 are HMOs, 37% are local PPOs, and the balance are regional PPOs and a declining number of private fee-for-service plans. In 2022, almost 90% of available plans will include prescription coverage, and 59% of those plans charge no premium (beneficiaries still must pay their Part B premiums). Beneficiaries

in Alaska and Wyoming will not have access to plans with no additional MA monthly premium, but 98% of beneficiaries have access to at least one such plan.

The large number of available plans can cause **problems for beneficiaries**. More plans, more (and varied) extra benefits, and more special plans means more choices, but more choice is not always better. Especially when plans are remarkably similar, benefits have a lot of fine print, and costs associated with narrow networks or other restrictions can be hard to determine, more choices can be



overwhelming and impede good decision-making.

In addition to considering premiums, drug coverage, and plan networks, beneficiaries must also consider what additional or extra benefits are offered by different plans. Recent changes to Medicare laws and rules have expanded the supplemental benefits that Medicare Advantage plans can offer. These benefits, however, continue to vary in the "scope of specific services." The KFF report notes that "a dental benefit may include cleanings only or more comprehensive coverage, often subject to an annual cap on

the amount covered." Other extra benefits that are frequently offered in 2022 include meal benefits, transportation benefits, and over the counter supplies like bandages. Less frequently, plans cover bathroom safety devices, telemonitoring, or caregiver respite supports. Medicare Rights encourages people with Medicare **to compare MA and Part D plans each year** before the deadline and to reach out to our helpline or to local **State Health Insurance Assistance Programs (SHIPs)** for unbiased, personalized help in choosing 2022 Medicare coverage.

[Read the KFF report.](#)

Planning to Work During Retirement? Here's How It Will Affect Your Social Security Benefits



It's becoming more and more challenging to save for retirement, and many older Americans plan to continue working during their senior years. In fact, 72% of workers expect to work for pay after they retire, according to a 2021 survey from the Employee Benefit Research Institute.

While working during retirement can be a smart way to **boost your income** and decrease your reliance on your savings, it could also affect your Social Security benefits. Depending on how much you're earning, continuing to work after you've claimed benefits could result in reduced checks -- or even your benefits being withheld altogether.

If you plan to work even part-time after you retire, here's what you need to know about how it

will impact your Social Security checks.

How your earnings could affect your benefits

The age at which you file for Social Security will affect not only the size of your checks, but also whether your earnings will result in smaller payments. You can begin claiming benefits at age 62 or anytime thereafter.

But if you claim before your **full retirement age** (FRA) - which is age 67 for anyone born in 1960 or later, and either 66 or 66 and a few months for those born before 1960 -- you'll receive less money per month. In addition, if you claim Social Security early, your checks could be reduced if your income from your job exceeds a certain limit.

If you *won't* reach your FRA in 2022, your checks will be reduced by \$1 for every \$2 you earn over \$19,560 per year. If you earn less than that from



working, your checks won't be reduced.

If you *will* reach your FRA in 2022, your earnings are subject to a different limit. During the months leading up to the date you reach your FRA, your benefits will be reduced by \$1 for every \$3 you earn over \$51,960 per year.

For example, say you're currently age 62 with an FRA of 67 years old and you're earning \$30,000 per year by working. That's \$10,440 over the \$19,560 limit, which means your checks will be reduced by \$5,220 per year, or \$435 per month.

How to earn that money back

If your Social Security benefits are going to be withheld due to your income, it may seem like a better idea to avoid working or limit your earnings to keep more of your checks. However, even if your checks are reduced, that money isn't gone forever. Once you reach your FRA, the Social

Security Administration will recalculate your benefit amount to account for any benefits that were withheld due to your income.

In addition, your income from your job will be subject to Social Security taxes, which means it could affect the amount you're entitled to receive in benefits. Depending on how much you're earning, you could increase your benefit amount even further by continuing to work.

Keep in mind, too, that once you reach your FRA, your wages will no longer affect your benefits -- regardless of how much you're earning.

Working during retirement can be a wise strategy, but be sure you've considered how it could impact your Social Security benefits. By accounting for any potential benefit reductions, you can head into retirement as prepared as possible.

Manchin's means-testing proposal builds back worse

President Joe Biden's Build Back Better legislation would bring the United States into the 21st century, finally enacting programs that other industrialized nations have had for a very long time. These include children's allowances in the form of tax credits, paid family and medical leave, free post-secondary education, expanded Medicare, home and community-based services, and so much more.

If Manchin forces work requirements and intrusive, demeaning means tests, it will be substantially easier for Republicans to drown Biden's legacy in the bathtub once they are back in control.

The bill would be among the most transformative in American history. It would cement Biden's legacy alongside Presidents Franklin Roosevelt and Lyndon Johnson. But not if Senator Joe Manchin (D-WV), who **claims** that the bill would promote a so-called "entitlement society," forces work requirements and means-testing.

Manchin's demands for work requirements and means-testing would save money largely by making federal programs inaccessible to many who need them, including those who need them the most. Those most in need often have the most trouble navigating complicated and burdensome eligibility requirements, because they generally lack the necessary time, resources, and family support. Experience teaches that much of the money saved on benefits would be spent on wasteful and intrusive administration.

Moreover, limiting eligibility to a small group who must prove to the rest of us that they really deserve the benefits will make those programs far more politically vulnerable. Knowingly, the late Wilbur Cohen, known as the father of Social Security and Medicare, **remarked**, "a program that is only for the poor—one that has nothing in it for the middle income and the



upper income—is, in the long run, a program the American public won't support." For all these reasons, Cohen understood, as he often succinctly phrased it, "Programs for the poor make poor programs."

At first glance, Manchin's demands for stringent means-testing and work requirements may seem like a responsible effort to target limited resources. But a close look at the history of social welfare policy reveals that the restrictions are the latest chapter in an ugly history of treating some as less deserving than others.

While our Declaration of Independence, as well as virtually every religion, asserts that all of us are created equal, that has not been the view of some of the most powerful among us. **Andrew Carnegie** and **John D. Rockefeller**, two of the richest men in human history, believed in what was called Social Darwinism, where some people

are inherently worthier than others, due to "better" genes. They saw themselves as the fittest, and the poor as inherently unworthy and lazy people who needed their "betters" to push them to make something of their lives.

Throughout American history, some people, whether simply down on their luck or different from the majority, have been stereotyped as immoral, lazy, shiftless—in short, undeserving. Carnegie stated that "It were better for mankind that the millions of the rich were thrown into the sea than so spent as to encourage the slothful, the drunken, the unworthy."

Nor is that simply the view of a few wealthy and powerful individuals. The notion that some people are undeserving is a strong undercurrent of conservative, anti-government thinking. It is embodied in government action and inaction whenever conservatives have their way....**Read More**

Medicare Punishes 2,499 Hospitals for High Readmissions

The federal government's effort to penalize hospitals for excessive patient readmissions is ending its first decade with Medicare cutting payments to nearly half the nation's hospitals.

In its 10th annual round of penalties, Medicare is reducing its payments to 2,499 hospitals, or 47% of all facilities. The average penalty is a 0.64% reduction in payment for each Medicare patient stay from the start of this month through September 2022. The fines can be heavy, averaging \$217,000 for a hospital in 2018, according to Congress' Medicare Payment Advisory Commission, or MedPAC. Medicare estimates the penalties over the next fiscal year will save the government \$521 million. Thirty-nine hospitals received the maximum 3% reduction, and 547 hospitals had so few returning patients that they escaped any penalty.

An additional 2,216 hospitals

are exempt from the program because they specialize in children, psychiatric patients or veterans. Rehabilitation and long-term care hospitals are also excluded from the program, as are critical access hospitals, which are treated differently because they are the only inpatient facility in an area. Of the 3,046 hospitals for which Medicare evaluated readmission rates, 82% received some penalty, nearly the same share as were punished last year.

The **Hospital Readmissions Reduction Program (HRRP)** was created by the 2010 Affordable Care Act and began in October 2012 as an effort to make hospitals pay more attention to patients after they leave. Readmissions occurred with regularity — for instance, nearly a quarter of Medicare heart failure patients ended up back in the hospital within 30 days in 2008 — and



policy-makers wanted to counteract the financial incentives hospitals had in getting more business from these boomerang

visits.

MedPAC has found readmission rates declined from 2008 to 2017 after the overall health conditions of patients were taken into account. Heart failure patient readmission rates dropped from 24.8% to 20.5%, heart attack patient rates dropped from 19.7% to 15.5%, and pneumonia patient rates decreased from 20% to 15.8%, according to the **most recent MedPAC analysis**. Readmission rates for chronic obstructive pulmonary disease, hip and knee replacements, and conditions that are not tracked and penalized in the penalty program also decreased.

“The HRRP has been successful in reducing readmissions, without causing an adverse effect on beneficiary

mortality,” MedPAC wrote. The commission added that untangling the exact causes of the readmission rates was complicated by changes in how hospitals recorded patient characteristics in billing Medicare and an increase in patients being treated in outpatient settings. Those factors made it difficult to determine the magnitude of the readmission rate drop due to the penalty program, MedPAC said.

The current penalties are calculated by tracking Medicare patients who were discharged between July 1, 2017, and Dec. 1, 2019. Typically, the penalties are based on three years of patients, but the Centers for Medicare & Medicaid Services excluded the final six months in the period because of the chaos caused by the pandemic as hospitals scrambled to handle an influx of covid-19 patients.

Congress must reduce out-of-pocket costs for people with Medicare

Earlier this month, “the Medicare team” inside the federal government sent an email inviting millions of us to mark our calendars for the Oct. 15 start of a 54-day period to enroll in Medicare health plans.

At the end of the email, Medicare makes a suggestion we felt should be far more prominent and noticeable, one that is akin to what the Surgeon General requires tobacco companies to plaster on a pack of cigarettes: “A plan with the lowest premium might not always provide the lowest total cost to you.”

Yes, even older adults and people with disabilities who are eligible for Medicare need to worry about high out-of-pocket costs. Whether they are in traditional Medicare, administered directly by the government, a Medicare prescription drug plan or a Medicare Advantage plan, both of which are administered by private health insurers, costs—deductibles, coinsurance and copays—have been rising. Traditional Medicare and the bewildering array of prescription

drug plans have no out-of-pocket maximums, and Medicare Advantage plans have a cap that can be as high as \$7,550 a year for in-network care alone. According to the **Kaiser Family Foundation**, millions of people with Medicare, particularly people with modest incomes in poor health, are facing cost-related barriers to care.

Many members of Congress recognize that health care costs jeopardize health care access and want the reconciliation bill to broaden Medicare benefits to include dental, hearing and vision services. As worthy as that is, capping Medicare out-of-pockets at an affordable level could be even more beneficial for cash-strapped seniors. Because there is no reasonable cap, people with Medicare too often are forced to go deep into debt to get needed care. Many others forgo this care because of the cost.

Both Traditional Medicare and Medicare Advantage cover hospital and medical care under Parts A and B. If you've worked



and paid into Social Security, you qualify for these hospital and medical benefits at relatively low cost. But as health care costs have risen, so has the expectation that even

people with Medicare need to put more “skin in the game.”

Out-of-pocket requirements encompass deductibles, coinsurance and copayments. Deductibles for Medicare hospital and medical coverage are **relatively low** compared to what workers with private insurance pay these days. Coinsurance is an entirely different story: Traditional Medicare only covers 80 percent of its approved rate for medical services. That means people with Medicare, whose average annual income **is less than \$30,000**, can face thousands of dollars in additional medical bills unless they can afford supplemental coverage, which picks up those costs and protects them financially.

Medicare Advantage (Part C), the alternative to Traditional Medicare, claims to fill that void,

offering an out-of-pocket cap for medical and hospital services and additional benefits. Many Medicare Advantage plans even offer \$0 monthly premiums. What could be more enticing to people on retirement incomes?

The devil is in the details. Medicare Advantage plans drive profits for their corporate parents by charging high and often sudden out-of-pocket costs **that are tied to sickness**. These costs are often prohibitive, leading people to skip critical care or, as the **GAO found** in a recent study, disenroll from their Medicare Advantage plans and return to Traditional Medicare when they get sicker.

Insurers profit at taxpayer expense when that happens. Not only can Medicare Advantage plans consequently avoid covering expensive care, but they can also benefit from the upfront payments the government pays them that they don't spend. Uncle Sam's generosity to health insurers explains why many of them are reporting record profits... **Read More**

Here's How Much the Average Retired Couple Will Get From Social Security in 2022



For many retired couples, Social Security is an important income source for the household. With both partners getting benefits, the money coming from the Social Security Administration (SSA) can cover some essentials. And unlike most retirement income, these benefits are guaranteed for life.

But just how much will the typical senior couple get in retirement benefits from Social Security?

The average couple's benefit in 2022

According to the SSA, the average benefit for a couple when both will be receiving benefits will be \$2,753 in 2022. This is an increase from \$2,559 in 2021. It means that the typical senior couple will have an annual income from the SSA of \$33,036 in 2022.

The fact that this amount is so low for a couple might come as a surprise, especially since

the average benefit for all individual retirees is \$1,657 next year. But often, one person in a relationship makes more than the other or claims retirement benefits at an earlier age. The lower earner or early claimer might get less than the overall average among all retirees. Unfortunately, the annual income a couple receives from Social Security is low enough that it would be difficult for two people to live on. That's especially true given that the Bureau of Labor Statistics reports average annual consumer expenditures among households 65 and older were \$47,579 in 2020.

The combined household income a couple has from Social Security just isn't enough to cover expenses because these benefits are designed only to *supplement* other income sources, not be the sole source of funds retirees rely on. Seniors will need additional savings so



they can cover their essential costs.

How can married couples maximize their combined benefits?

While seniors can't rely on Social Security alone, they still can take steps to maximize their benefits. For couples, this often means coordinating to decide on the most effective claiming strategy.

In some cases, the ideal is for both spouses to wait until age 70 to file for benefits. This is a good strategy when both spouses qualify for Social Security on their own work records and have similar incomes. They can each maximize their benefit by earning the maximum delayed retirement credits, thus earning the largest combined household income from Social Security.

But there are other techniques as well. Sometimes, lower-earning spouses should claim benefits early to enable higher-earning spouses to delay as long as possible. Once the higher-

earning spouses start getting checks, the lower earners can switch over to getting spousal benefits if they're higher than the amount based on their own earnings history.

You can't collect both your own benefit and your spousal benefit at the same time, though. Nor can you file for spousal benefits and delay getting your own checks until your full retirement age, as you're considered to be filing for all benefits you're eligible for once you request that your checks start.

Married couples should work together to discuss the best approach for each person to claim benefits in order to maximize lifetime retirement income from Social Security. While they'll still need additional savings, choosing the right Social Security claiming strategy goes a long way toward helping them bolster their financial security.

We've Been Here Before: How Polio Vaccine Rollout Saved Millions of Young Lives

An infection that can disable and kill stalks the land, but a brand-new vaccine offers hope that almost everyone, kids included, can evade it. After scientific testing, a nationwide rollout of the vaccine begins.

Sound familiar?

As the U.S. government gears up to offer COVID-19 shots to about 28 million 5- to 11-year-olds, high levels of vaccine hesitancy in some corners may make the campaign a tough sell.

But it's not the first time a nationwide effort has sought to shield American kids from a dire infectious health threat, and history offers a successful how-to.

Back in the mid-1950s, polio stalked the United States every summer, with random outbreaks occurring in one community or the next.

The killed-virus polio vaccine developed by Dr. Jonas Salk was seen as a godsend, and in 1954, frantic parents volunteered more than 1.8 million children to serve as test subjects in a yearlong field trial of the vaccine's effectiveness.

Of those kids, 600,000 would

be randomly injected with three doses of the experimental polio vaccine or a placebo.

The picture contrasts starkly with today, with a large number of parents hesitating to inoculate either themselves or their children with COVID-19 vaccines that have been safely administered to more than 221 million people in the United States and nearly 3.9 billion worldwide.

"That's a really sad thing that we've gotten to in this society, that people have gotten to that level of mistrust around government and the medical field in general," said Dr. Peter Salk, Jonas Salk's son and president of the Jonas Salk Legacy Foundation.

Cutting-edge technology

Today's COVID-19 vaccines were developed at breakneck pace, with drug companies handed billions in government funding, using cutting-edge technology to craft the jabs and then test them in streamlined clinical trials.

The U.S. Food and Drug



Administration last week approved a reduced-dose COVID vaccine for 5- to 11-year-olds based on a clinical trial involving about 4,700 kids. The U.S. Centers for Disease Control and Prevention is expected to consider the pediatric COVID vaccine this week.

"With advances in modern science and technology, we're able to get to some of these solutions much more quickly," said Stacey Stewart, president and CEO of the March of Dimes. "Clinical trials are done very differently today that still get us to the same place, being able to validate safety and efficacy of vaccines."

By contrast, polio had been a perennial and petrifying threat for decades by the time Jonas Salk had his vaccine ready for widespread testing.

"These epidemics had been going on for years and people were terrified," his son said. "There was no way of knowing when an epidemic was going to strike near you, if it was going to hit your child or someone else's

child."

There was "total fear," Peter Salk said.

"And when kids were infected, they could end up paralyzed for life," he said. "They could end up in an iron lung for either a short period of time until their breathing muscles recovered or for the rest of their lives, or they could die."

Once the Salk vaccine had been proven safe in early trials involving 5,320 people -- including Salk himself, his wife and three sons -- the drums began beating hard for a massive clinical trial to test its effectiveness.

The National Foundation for Infantile Paralysis -- forerunner of the March of Dimes -- spent \$7.5 million in private donations to initiate, organize and run the vaccine trial, with little participation from the federal government. That's more than \$76 million in today's dollars....[Read More](#)

Where Does My Money Go When I Pay for a Nursing Home?

Room, board and caregiving are major nursing home costs.

Nursing homes are expensive and becoming more so. A private room in a nursing home facility costs \$290 per day on average nationwide, according to the 2020 Cost of Care Survey conducted by **Genworth**. A semi-private room carries a rate of \$255 per day. As a **nursing home** resident or the responsible family member, what exactly are you paying for?

The majority of U.S. nursing home residents – somewhere between 65% and 70% – pay under the Medicaid system, says Bob Lane, president and CEO of the American College of Health Care Administrators. "But for private pay, room and board is the main thing," Lane says.

Standard Nursing Home Costs

Your monthly bill won't spell

out most of these items, which are folded into the daily rate. However, standard costs, which are detailed on the admission agreement when a resident moves into a nursing home, typically include these basic care services:

- ◆ **Room with functional furniture.** A bed, bedside table and dresser are basic furniture pieces, along with some closet space for the resident's belongings.
- ◆ **Dietary services.** Menu planning and meal preparation to meet the resident's individual dietary needs and restrictions, with three daily meals, beverages and snacks all falling under room and board.
- ◆ **Personal care services and supervision.** Certified nursing



assistants provide day-to-day care such as helping residents with their hygiene, dressing, toileting, transferring and walking as needed around the clock.

- ◆ **Nursing services.** Licensed practical or licensed vocational nurses provide higher-level care such as monitoring vital signs, administering medications and wound care. Registered nurses develop residents' treatment plans, and are responsible for advanced care such as starting intravenous infusions, monitoring blood glucose levels, giving oxygen, collaborating with physicians and supervising other nursing staff.
- ◆ **Activities.** Recreational, spiritual and other group and individual programs are standard nursing home

activities.

- ◆ **Bedding and linens.** Sheets, pillow cases, towels, washcloths and gowns are all provided.
- ◆ **Housekeeping.** The residence provides room and facility cleaning and sanitation services.
- ◆ **Personal hygiene items.** Nursing homes stock routine items such as hand soap, bath soap, shampoo, toothbrushes and toothpaste.
- ◆ **In-house laundry.** Residents' personal clothing items are laundered as needed.
- ◆ **Prescription drug administration.** Medication management and administration are essential nursing home services....[Read More](#)

People with long Covid struggle to get disability benefits

Amanda Morris writes for the **New York Times** on the difficulty people with long-term side effects of Covid are facing getting disability benefits. People with "long Covid" can have serious health issues and might not be able to work. They need disability benefits, including health care and housing.

The issue is that the Social Security Administration wants proof of long-term disability in order to award benefits. But, the side effects of long Covid are not

easy to prove. Often lab tests show that things look normal. People do not have specific medical evidence to support their claims for disability benefits.

President Biden, for his part, has promised "to make sure Americans with long Covid who have a disability have access to the rights and resources that are due under the disability law." But, how is long Covid diagnosed without medical evidence? Moreover, to qualify for Social



Security disability benefits you need to be able to show that you cannot work for at least a year.

An estimated three to ten million Americans could have long Covid, according to the American Academy of Physical Medicine and Rehabilitation. These people are still getting care for several different medical conditions long after they were diagnosed with Covid-19.

To date, about 16,000 Americans have been able to

prove that they have long Covid to the Social Security Administration. It's early days, since it takes about five months for Social Security to make a disability determination. To make matters worse, the Trump Administration underfunded the Social Security Administration. President Biden has proposed that Congress allocate \$1.3 billion additional dollars to it....[Read More](#)

Open Enrollment: You could save big money on drugs

It's Medicare open enrollment season, and if you're smart you'll take an hour or two to review your options. While it is not possible to choose a Medicare Advantage plan that is **right for you**—there are too many unknowns—you should be able to avoid choosing a **Medicare Advantage plan** that is wrong for you. And, you could save big money on drugs.

Paula Span reports for **The New York Times** on one woman who saw hundreds of dollars in savings by choosing a particular **Part D prescription drug plan** and using that plan's pharmacies. Especially if you are

taking multiple medications, using the Medicare Part D Plan Finder can direct you to Part D plans that cover the drugs you are currently taking at the lowest cost. Of course, if you are prescribed new expensive medicines after you sign up with a Part D plan, all bets are off.

What should you do to lower your drug costs? First, make a list of all the medicines you are taking and your current copays. Then, go to the Medicare Part D Plan Finder to figure out which Part D plans offer you the least expensive coverage from



pharmacies that you can easily use. Keep in mind that each Part D plan has different rules about where you can fill your prescriptions.

What if you're in a Medicare Advantage plan? The same rules apply. Each Medicare Advantage plan has its own formulary—list of covered drugs and copays—along with where you can fill your prescriptions. You want to check that the Medicare Advantage plan you choose will cover the drugs you use, in addition to your doctors and hospital, at a low price. If you are on multiple medications,

to save money, you should look carefully at your drug costs in different Medicare Advantage plans.

Can I get help choosing a Part D plan or a Medicare Advantage plan? Yes, free help is available through your local State Health Insurance assistance Program or SHIP. Call 877-839-2675 for information on your state's SHIP. Do not rely exclusively on the **advice of an insurance agent**. Agents are paid more to steer you towards particular plans and might not direct you to the best plan for you.

RI ARA HealthLink Wellness News

Use of Ritalin, Other Stimulants Can Raise Heart Risks for Older Adults

ADHD medications are increasingly being prescribed to older adults, and they may cause a short-term spike in the risk of heart attack, stroke and arrhythmias, a large new study suggests.

Stimulant medications, such as Ritalin, Concerta and Adderall, are commonly used to treat attention deficit hyperactivity disorder (ADHD). But they are also increasingly being prescribed "off-label" to older adults, to combat conditions such as severe drowsiness, appetite loss and depression.

The new findings add to evidence that the drugs can pose heart risks.

Researchers found that on average, older adults starting on a stimulant showed a 40% increase in their risk of heart attack, stroke or ventricular arrhythmia within 30 days.

Ventricular arrhythmias are rhythm disturbances in the heart's lower chambers, and some can be fatal.

In the study, stimulant users had double the risk of dying within a month of starting a stimulant, compared to older adults who were similar in terms



of health but not using a stimulant.

The absolute risks were relatively small, said lead researcher Mina

Tadrous, an assistant professor of pharmacy at the University of Toronto.

Over one year, 5 out of 100 stimulant users had a heart "event," the study found. That compared with between 3 and 4 of every 100 non-users.

And the increased risk appeared limited to the first 30 days of use, Tadrous said. Over the longer term -- six months and one year -- stimulant users

were not at greater risk of heart trouble.

Why? It's not clear, but Tadrous said it may be because of monitoring.

Doctors have long known that stimulant medications can raise blood pressure and heart rate. In fact, the drugs carry warnings about those effects, particularly for people with established heart disease.

So doctors and patients are likely checking for red flags -- a spike in blood pressure or symptoms like chest palpitations -- and if they come up, the drug may be stopped, Tadrous explained....[Read More](#)

More Lung Cancer Patients Are Surviving, Thriving

Mike Smith is beating the odds.

Diagnosed with stage 4 lung cancer back in 2016, the 56-year-old South Carolina resident says there are a lot of reasons to be optimistic as the "narrative of lung cancer changes from being a horrific, terminal disease to a chronic disease and, ultimately, to a cure."

Still, he remains clear-eyed about the challenges he faces.

"I'm at war," he said bluntly. "It's been a roller-coaster ride. I'm fighting on all fronts. I've had radiation. I've had a

craniotomy [brain skull surgery] to have a tumor removed. I've had three different targeted therapies. So I'm fighting drug tolerance, because targeted therapy drugs do not last forever. And I'm fighting the stigma that people have about cancer, and lung cancer in particular. And I'm fighting financially," despite having good insurance through his Fortune 500 financial services employer.

And as a late-stage patient, Smith knows that he's also



fighting long odds. "I have stage 4 lung cancer. And the five-year survival rate is just 3% to 7%," he noted.

"So why are you still here?"; I get that question a lot," said Smith. "And I don't have a good answer. All I can say is that medical innovation has improved. A lot. And I'm stubborn. I follow the directions of my doctor. I go to check-ups. I go to follow-ups. I eat healthy. And I'm physically active."

Patients like Smith are becoming the norm, according

to the American Lung Association. Significant improvements in both screening and treatment have meant that, over the last decade, the chance that a new patient will survive at least five years following a lung cancer diagnosis has shot up by a remarkable 33%.

Much of that is due to the development of personalized targeted treatments and immunotherapies that hone in on the particulars of each patient's cancer....[Read More](#)

More Evidence COVID Shots Less Effective for People With Weak Immune Systems

Transplant patients and certain other folks may need four shots of COVID-19 vaccine for optimal protection, new research suggests.

People with weakened immune systems who've received both doses of two-dose COVID-19 vaccines aren't adequately protected against severe illness. They should be given a third shot plus a booster, according to the study.

"These findings indicate that while two doses of mRNA COVID-19 vaccines are beneficial in immunocompromised individuals, they are significantly less protected from

severe disease than people with normal immune systems," said study lead author Dr.

Peter Embi. He is president of the Regenstrief Institute in Indianapolis and associate dean for informatics and health services research at Indiana University School of Medicine.

"Since they are less protected after a two-dose series, those who are immunocompromised should receive an additional dose and a booster, take additional precautions like masking when in public, and, if they get infected, they should seek treatment with proven therapies that can protect against



progression to severe disease and the need for hospitalization," Embi said in a university news release.

In general, people who are immunocompromised have an increased risk for severe COVID-19 outcomes.

The researchers analyzed data on more than 89,000 hospitalizations in nine U.S. states and found that the two-dose mRNA vaccines from Pfizer and Moderna were 90% effective at protecting against COVID-related hospitalization in people with healthy immune systems, but only 77% effective who had weakened immunity

due to a range of health conditions.

The investigators also found that the vaccines' effectiveness varied significantly between subgroups of immunocompromised people.

For example, the vaccines were less effective in organ or stem cell transplant patients. However, they were more protective in people with rheumatologic or inflammatory disorders, according to the findings.

The differences between those with healthy immune systems and those with weakened immune systems were similar across age groups.

Tingling, Burning in Your Feet? Common Condition May Be the Cause

The number of people experiencing numbness, pins and needles, and burning pain in their feet and toes seems to be on the rise, new research suggests, and some of these folks may be at increased risk for heart trouble.

Exactly why there has been an uptick in "small fiber neuropathy" is not fully understood yet, but it could be due to the ongoing diabetes and obesity epidemic as both conditions raise the risk for small fiber neuropathy and heart disease, explained study author Dr. Christopher Klein, a professor of neurology at the Mayo Clinic in Rochester, Minn.

"There is something diabolic about small fiber neuropathy in that it has a very strong association with heart disease and heart attacks," Klein said.

Often caused by an underlying condition such as diabetes, small fiber neuropathy occurs when the small fibers of the peripheral nervous system become

damaged. It can sometimes progress to large fiber neuropathy, which results in weakness, balance issues and lack of coordination.

"The pain is quite bad, but the good news is that for most folks, the average worsening per year was nominal, and they don't develop any major disability," Klein said. Despite this, some people with small fiber neuropathy are at risk for heart problems.

Diabetes does increase the risk for heart attack, but there's likely more to the story, he said. It could be an underlying inflammation or high levels of dangerous blood fats called triglycerides that increase heart risks in these folks.

For the study, the researchers compared medical records from 94 people with the condition and 282 people without it. The investigators followed these individuals for about six years to



learn as much as they could about small fiber neuropathy and how it progresses.

Small fiber neuropathy occurs in 13.3 of every 100,000 people, and the rate increased during the study period. These individuals were also more likely to have insomnia and/or take opioids to relieve their burning pain.

Folks with small fiber neuropathy are more likely to be obese than their counterparts without this condition, and about 50% of people with neuropathy had diabetes, compared to 22% of those without it, the findings showed.

People with the nerve condition were also more likely to have heart attacks, the study found. Close to 50% of people with small fiber neuropathy had a heart attack during the study period.

Given this increased risk, some of these individuals may need

more aggressive screening for heart disease, Klein said.

The study was published online Oct. 27 in *Neurology*.

"Doctors, and especially neurologists, are more aware of this condition than they were 10 years ago," said Dr. Brian Callaghan, an associate professor of neurology at the University of Michigan Medical School in Ann Arbor. Callaghan co-wrote an editorial accompanying the new study.

Still, "doctors often forget to ask about these symptoms, so patients should definitely make their doctors aware," he said. If the small fiber neuropathy is linked to diabetes or obesity, treating these conditions will make a difference in overall health and well-being.

"We can treat the underlying cause in some cases and the pain," Callaghan said. Neuropathic pain treatments include medications, topicals and behavioral interventions.

Will an Early-Stage Breast Cancer Spread? New Analysis Offers Some Answers

It's a life-and-death prediction: How likely is early-stage breast cancer to spread throughout the rest of a patient's body?

A new analysis that tried to make that call easier for doctors to predict found that a younger age at diagnosis was a strong indicator of spreading ("metastatic") cancer.

To come to that conclusion, the researchers analyzed data from tens of thousands of women who took part in more than 400

studies in North and South America, Europe, Africa, Asia and Oceania.

For most patients, the risk of localized breast cancer spreading to other parts of the body was between 6% and 22%.

However, the risk was about 13% to 38% among women first diagnosed before age 35, while the risk was about 4% to 29% among women aged 50 or older, according to the study presented



online Tuesday at the Advanced Breast Cancer Sixth International Consensus Conference.

"This may be because younger women have a more aggressive form of breast cancer or because they are being diagnosed at a later stage," said lead researcher Eileen Morgan, from the International Agency for Research on Cancer.

Her team also found that women with luminal B cancer

(which tends to grow faster) had a 4% to 35.5% risk of metastasis, while there was a 2% to nearly 12% risk in women with luminal A cancer (which tends to grow slower).

Not surprisingly, women with larger tumors at diagnosis had a higher risk of metastasis than those with smaller tumors.

Research presented at meetings should be considered preliminary until published in a peer-reviewed journal... [Read More](#)

COVID Vaccination Provides Better Protection Than Prior Infection

Think you don't need to get a COVID-19 vaccination because you've been infected by SARS-CoV-2 in the past? Think again.

A new **study** from the U.S. Centers for Disease Control and Prevention finds that "those who were unvaccinated and had a recent infection were five times more likely to have COVID-19 than those who were recently fully vaccinated and did not have a prior infection."

According to the agency, "the data demonstrate that vaccination can provide a higher, more

robust and more consistent level of immunity to protect people from hospitalization for COVID-19 than infection alone for at least 6 months."

The new findings came from data collected from 187 hospitals across nine U.S. states from January to September of 2021. In total, the data covered more than 7,300 adult patients who had COVID-19 so severe that they required hospitalization.

The take-home message:



People who'd been infected previously (between three to six months prior) and remained unvaccinated were about 5.5 times more likely to be infected again compared to people who'd been fully vaccinated with either the Pfizer or Moderna mRNA vaccines within three to six months, and who had no history of prior infection.

"We now have additional evidence that reaffirms the importance of COVID-19 vaccines, even if you have had

prior infection," CDC Director Dr. Rochelle Walensky said in an agency news release.

"This study adds more to the body of knowledge demonstrating the protection of vaccines against severe disease from COVID-19," she added. The best way to stop COVID-19, including the emergence of variants, is with widespread COVID-19 vaccination and with disease prevention actions such as mask-wearing, washing hands often, physical distancing and staying home when sick."

Cheap Antidepressant Might Help Keep COVID Patients Out of Hospital

A cheap and widely available antidepressant drug called fluvoxamine may reduce COVID-19 patients' risk of serious illness requiring hospitalization, according to a new study.

The trial included almost 1,500 unvaccinated outpatients in Brazil. All of the patients tested positive for infection with SARS-CoV-2 and were deemed to be at high risk for a severe case of illness.

Fluvoxamine was provided to 741 of the patients while another 756 received a placebo.

Over 28 days of follow-up, the overall rate of hospitalization was 32% lower in the fluvoxamine group than in the

placebo group. One patient in the fluvoxamine group died, compared to 12 deaths among those who got the placebo. **The study** was published online Oct. 27 in *The Lancet Global Health*.

The fluvoxamine trial was part of the larger TOGETHER trial launched in May 2020 to test potential out-of-hospital COVID-19 treatments. Fluvoxamine is a selective serotonin reuptake inhibitor (SSRI) medication that has been used since the 1990s for various conditions, including depression and obsessive-compulsive disorder.

Fluvoxamine was chosen because of its anti-inflammatory



powers. When COVID-19 strikes, patients' immune systems can create dangerous pro-inflammatory "cytokine storms."

"Fluvoxamine may reduce the production of inflammatory molecules called cytokines, that can be triggered by SARS-CoV-2 infection," study co-author Dr. Angela Reiersen explained in a journal news release. She's an associate professor of psychiatry at Washington University in St. Louis.

According to Edward Mills, co-principal investigator for the TOGETHER trial, "Fluvoxamine is, so far, the only treatment that if administered

early, can prevent COVID-19 from becoming a life-threatening illness. It could be one of our most powerful weapons against the virus and its effectiveness is one of the most important discoveries we have made since the pandemic began." Mills is a professor in the department of health research methods, evidence and impact at McMaster University in Canada.

"In addition, this cheap, easily accessible pill is a massive boon to public health, both in Canada and internationally, allowing hospitals to avoid expensive and sometimes risky treatments," he added in a university news release. **[Read More](#)**

New Guidelines Help Doctors Diagnose Chest Pain – But Only if You Act

Chest pain is about more than pain in the chest. But when it comes on suddenly, experts behind new guidelines on evaluating and diagnosing it don't want you pondering nuances. They want you to act. Now.

"The most important thing people need to know about chest pain is that if they experience it, they should call 911," said Dr. Phillip Levy, a professor of emergency medicine and assistant vice president for research at Wayne State University in Detroit. "People shouldn't waste time trying to self-diagnose. They should immediately go to the nearest hospital. And if they're going to go to the nearest hospital to get evaluated for chest pain, ideally, it should be by an ambulance."

Levy helped lead the

committee that wrote the new guidelines from the American Heart Association and American College of Cardiology.

The recommendations aim to help patients and health care professionals act faster, make smarter choices and communicate better about chest pain.

Part of that is spreading the word that some people may not report chest "pain" but rather chest "discomfort," which may include pressure or tightness in the chest but also in other areas, including the shoulders, arms, neck, back, upper abdomen or jaw.

The sudden onset of any of those symptoms could be a sign of reduced blood flow to the heart, said Dr. Martha Gulati, president-elect of the American



Society for Preventive Cardiology and chair of the writing committee for the guidelines published Thursday in the AHA journal *Circulation*.

Chest pain does not always mean a heart attack, which happens when blood supply to the heart is stopped, starving it of oxygen.

"The majority of chest pain is not life-threatening," Gulati said. "And in fact, the majority of chest pain is not cardiac." It may instead be due to respiratory, musculoskeletal, gastrointestinal, psychological or other causes.

"But when it is cardiac, it can be deadly," Gulati said.

That's why getting care is urgent. "We have such good treatment, but time is heart muscle," she said. "The sooner we see you, the sooner we can

treat you."

Chest pain accounts for more than 6.5 million emergency department visits annually in the United States, plus nearly 4 million outpatient visits. The guidelines, the first from the AHA and ACC dedicated solely to chest pain, outline standards to help doctors identify who is most at risk and reduce unnecessary testing in those who aren't

That involves shared decision-making. "It is a rethinking of conversations where doctors and patients are both participants in the decisions of what happens next," Levy said. That concept may sound simple, but "there is a generation of patients who are just used to the doctor saying something, and that's what happens." **[Read More](#)**

'Balance' Is the Key Word in New Dietary Guidance for Heart Health

The latest word on heart-healthy eating is "balance." A new report encourages people to think of broad eating habits instead of narrowly focusing on single foods. Rather than one-size-fits-all rules, it leaves room for personal preferences.

"The emphasis is on dietary patterns, not specific foods or nutrients," said Alice H. Lichtenstein, who led the writing committee for the American Heart Association scientific

statement. "And it's not just about what people shouldn't be eating. The focus is really on what people should be eating, so they can customize it to their personal preferences and lifestyles."

The guidance, last updated in 2006, was published Tuesday in the AHA journal *Circulation*. The advice is consistent with federal dietary guidelines but emphasizes the latest research on reducing the risk of heart



disease.

The report seeks to dispel the idea that a heart-healthy diet is about adding one vegetable or vitamin, said Lichtenstein, Gershoff Professor of Nutrition Science and Policy and director of the Cardiovascular Nutrition Laboratory at Tufts University in Boston. Instead, it emphasizes the importance of "the whole package" of what someone eats over the course of a day or week.

"If we increase our intake of one thing in our diets, we tend to decrease our intake of something else," she said. "And both the increase in one dietary component and decrease in another dietary component can have independent effects. What's really important is the balance of everything together that has the biggest impact on cardiovascular health." **[Read More](#)**

Right Amount of Sleep May Be Important in Early Alzheimer's

Getting the right amount of sleep — not too much and not too little — could reduce your risk of mental decline as you age, even if you have early Alzheimer's disease, a new study claims.

Poor sleep and Alzheimer's disease are both associated with thinking ("cognitive") declines, but separating out the effects of each has been a challenge.

This new study included 100 older adults whose cognitive function had been monitored for an average of 4.5 years. The participants underwent a sleep study at an average age of 75 and were tested for the high-risk Alzheimer's genetic variant APOE4 and for levels of Alzheimer's proteins in their cerebrospinal fluid.

Most of the participants (88) had no cognitive impairment, 11 had very mild impairment and one had mild impairment.

Overall, cognitive scores declined for those with less than 5.5 or more than 7.5 hours of self-reported sleep per night, while scores remained stable for those in the middle of the range.

"It was particularly interesting to see that not only those with short amounts of sleep but also those with long amounts of sleep had more cognitive decline," said co-senior study author Dr. David Holtzman. He is a professor of neurology at Washington University School of Medicine in St. Louis. "It suggests that sleep quality may be key, as opposed



to simply total sleep." This U-shaped link between sleep and mental decline held true after the researchers

adjusted for factors that can affect both sleep and cognition, such as age, sex, levels of Alzheimer's proteins, and the presence of APOE4, according to the study published Oct. 20 in the journal *Brain*.

The findings could help keep people's minds sharp as they age, the researchers suggested.

"It's been challenging to determine how sleep and different stages of Alzheimer's disease are related, but that's what you need to know to start designing interventions," said study first author Dr. Brendan Lucey, director of Washington

University's Sleep Medicine Center.

"Our study suggests that there is a middle range, or 'sweet spot,' for total sleep time, where cognitive performance was stable over time. Short and long sleep times were associated with worse cognitive performance, perhaps due to insufficient sleep or poor sleep quality," Lucey said in a university news release. "An unanswered question is if we can intervene to improve sleep, such as increasing sleep time for short sleepers by an hour or so, would that have a positive effect on their cognitive performance so they no longer decline?"

More research is needed to answer that question, Lucey said.

COVID Death Toll Tops 5 Million Worldwide

The worldwide death toll from COVID-19 surpassed 5 million on Monday, and the more than 740,000 lives lost in the United States is the most of any nation, Johns Hopkins University data show.

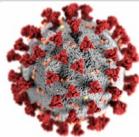
"This is a defining moment in our lifetime," Dr. Albert Ko, an infectious disease specialist at the Yale School of Public Health, told the *Associated Press*. "What do we have to do to protect ourselves so we don't get to another 5 million?"

Being a wealthy country provided little protection: The United States, Britain, Brazil and European Union account for one-eighth of the world's population,

but nearly half of all reported COVID-19 deaths since the pandemic began 22 months ago, the *AP* reported.

"What's uniquely different about this pandemic is it hit hardest the high-resource countries," Dr. Wafaa El-Sadr, director of ICAP, a global health center at Columbia University in New York City, told the *AP*. "That's the irony of COVID-19."

Wealthier nations tend to have larger numbers of older people, cancer survivors and nursing home residents, all of whom are vulnerable to COVID-19, El-Sadr noted, while poorer countries typically have larger



shares of children, teens and young adults, who are less likely to fall seriously ill from the coronavirus.

For example, despite a terrifying Delta surge that peaked in early May, India now has a much lower reported daily death rate than Russia, the United States or Britain, though there is uncertainty around its figures, the *AP* said.

But within countries, poverty still played a role: In the United States, COVID-19 has taken a bigger toll on Black and Hispanic people, who are more likely than white people to live in poverty and have less access to health care.

"When we get out our microscopes, we see that within countries, the most vulnerable have suffered most," Ko told the *AP*.

The death toll rivals the number of deaths caused by battles among nations since 1950, according to the Peace Research Institute Oslo.

COVID-19 is now the third leading cause of death worldwide, behind only heart disease and stroke. The staggering statistic is almost certainly an undercount because of limited testing and people dying at home without medical attention, especially in poor parts of the world, the *AP* said.

Vision Troubles Could Raise Midlife Depression Risk for Women

Midlife vision problems could increase women's risk of depression, new research suggests.

Rates of eye problems and depression rise during midlife, but knowledge about how vision affects depression at that time has been limited. The new study identified a significant link between impaired vision and development of depression.

"Given that the combination of visual impairment and depression has a particularly devastating effect on physical and mental health, correcting vision

problems early is important for future quality of life," said Dr. Stephanie Faubion,

medical director of the North American Menopause Society (NAMS).

The study was led by Carrie Karvonen-Gutierrez, assistant professor in the School of Public Health at the University of Michigan, Ann Arbor. Her team published their findings Oct. 27 in *Menopause*, the society's journal.

In their analysis of data from the Study of Women's Health



Across the Nation, researchers found a significant link between impaired vision and depression. The link held for mild, moderate and severe vision problems in middle-aged women.

Midlife vision problems include common and correctable ones such as refractive errors and cataracts, as well as more serious, chronic eye diseases such as glaucoma, diabetic retinopathy, hypertensive retinopathy, and macular degeneration.

Researchers noted that midlife depression can interfere with

healthy aging and lead to poor long-term health outcomes. Early identification and treatment of vision problems in middle-aged women is an important part of helping them maintain their mental and physical health, they said.

Middle-aged women have a higher rate of depression than all other age groups, and depression is more common in women than in men.

More information

The U.S. National Eye Institute has more on [**women and eye health**](#).