

September 18, 2022 E-Newsletter

Message from the Alliance *for* Retired Americans Leaders



Alliance and Allies Highlight the Benefits of Inflation Reduction Act for Retirees

The Alliance joined Rep. Jan Schakowsky (IL) at a virtual press conference Wednesday to discuss how **millions of seniors** will benefit from the Inflation Reduction Act's prescription drug savings.

The speakers discussed how the historic legislation works to drive down health and drug costs for families nationwide, and Doug Hart, former President of the Arizona Alliance and national Alliance executive board member, detailed how he personally will save at least \$4,500 each year. "I have Medicare but the amount I currently still have to pay out of pocket for my prescriptions keeps going up - right now it's \$6,500 per year," said Mr. Hart. "I am one of the 49 million Medicare Part D beneficiaries who will see relief by having out-of-pocket costs for prescription drugs capped at \$2,000 per year beginning in 2025."

Many of the IRA benefits will begin in 2023, including:

- ◆ Insulin co-pays capped at \$35 per month;
- ◆ All recommended adult vaccines free for Medicare beneficiaries;
- ◆ Corporations that raise the price of drugs sold to

Medicare faster than inflation have to pay rebates back to Medicare; and

- ◆ U.S. Department of Health and Human Services must identify the 100 highest-priced drugs and select the first 10 for negotiation

All Medicare beneficiaries will save money thanks to the law, and those who take the most drugs will save **thousands of dollars each year.**

SSA Adds Safety Measures to Protect People Facing Long Wait Times, Adverse Conditions

When the Social Security Administration (SSA) reopened its offices for in-person appointments many beneficiaries and applicants faced long waits outside in the summer heat. Over the past several weeks, the agency has **taken several steps** to implement safety upgrades to address the problems.

For offices where outside lines are necessary, Social Security is providing access to bathrooms, water fountains and, in some cases, fans and outdoor canopies. The agency is rearranging its waiting areas to allow more people to wait in its air-conditioned offices. In addition,



Robert Roach, Jr.
 President, ARA

SSA is expanding the use of mobile check-ins for appointments, allowing people to wait in their cars or other places nearby.

SSA is also referring customers for quick express interviews or for same-day or future appointments; checking to make sure visitors have the necessary information and documents; providing drop boxes for documents; giving workload assignments to offices with less walk-in traffic; assigning volunteers to busier offices; rehiring retired employees; and increasing overtime for busy offices.

The SSA office locations which have had the most people having to wait outside include Orlando, Carrollwood, Perrine and South Miami in Florida; the Twin Cities in Minnesota; Southwest and northwest Houston and Pasadena in Texas; and Las Vegas.

"SSA personnel are doing all they can despite very challenging circumstances with inadequate resources," said Robert Roach, Jr., President of the Alliance. "Additional funding for SSA would also go a long way in addressing these dangerous situations."

Fiesta Addresses Colorado Alliance Members

Alliance Executive Director Richard Fiesta was in Denver on



Rich Fiesta,
 Executive Director, ARA

Thursday to address 70 Colorado Alliance Conference attendees. Elected to office at the gathering were: Ed Augden, President; Carolyn Boller, Executive Vice President; Allen Weisheit, Treasurer; and Bob Knapp, Secretary. Ten state representatives and 2 state senators were also in attendance.

During his presentation, Fiesta discussed the senior vote in the 2022 midterm elections and the Alliance's activities to protect and expand Medicare and Social Security. He also spoke about the many pro-retiree actions taken by Congress and the Biden Administration, including the Inflation Reduction Act, Infrastructure Bill and American Rescue Plan.

"The IRA is just the latest bill benefiting seniors that President Biden has signed into law," said Fiesta. "And he overcame strong opposition: both the IRA and the American Rescue Plan, which provided \$94 billion for 3 million Americans in troubled multi-employer pension plans, were signed without ANY Republican support on Capitol Hill."

We did it 100,000 + WEP/GPO Petition Signers

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

Why Social Security Retirees Should Mark Oct. 13 On Their Calendars

Social Security benefits have become a key source of income for many retired Americans, and for those with disabilities.

In fact, the Social Security Administration (SSA) has found that among participants in the program, more than one-third of both men and women receive roughly half of their income from Social Security benefits. For more than 10% of both men and women in the program, Social Security benefits account for 90% of their income.

Needless to say, Social Security is a centerpiece of many Americans' financial lives, which is why those in the program should monitor changes and updates carefully. One day that Social Security recipients will want to mark on their calendars is Oct. 13. Here's why.

Inflation plays a big role in Social Security

In 1975, Congress implemented the cost-of-living adjustment (COLA) into Social Security, ensuring that when inflation went up, Social Security benefits would follow suit. After all, if

consumer prices are rising at a high rate, then people receiving the same amount of Social Security would see their purchasing power decline.

As you've probably seen, inflation has been at a 40-year high all year. The Consumer Price Index, which tracks the prices on a basket of daily consumer goods and services, rose 9.1% in June on a year-over-year basis. The prices on everything from gas to rent and food have skyrocketed this year. The SSA **calculates the COLA** by looking at the growth in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) in the third quarter of each year, which comprises the months of July to September. The SSA averages the CPI-W in each of these three months and then compares it to the same period of the prior year. For instance, the average monthly CPI-W in the third quarter of 2021 was 268.421. In 2020, the average monthly CPI-W was 253.412. That means the CPI-



W **rose by 5.9%**, which is how the SSA arrived at its COLA increase for 2021. The COLA is then applied to a retiree's primary insurance amount (PIA), which is the amount a person would get if they start collecting Social Security at their normal retirement age. The PIA is calculated through a fairly complex formula.

While we don't yet know what the CPI-W will be for August and September of this year, the CPI-W in July came in at 292.219, which is roughly 9.1% higher than in July of 2021. Inflation may have already peaked, but there really is not enough data to confirm that yet.

The non-partisan Senior Citizens League is predicting the Social Security COLA adjustment could come in at 9.6% when everything is said and done, although past reports have suggested the COLA adjustment could be as high as 10.5%. Regardless, this would mark Social Security's largest COLA adjustment since 1981.

Make sure to tune in While it could vary by a day or two, the SSA is expected to announce this COLA adjustment on Oct. 13. Even if the adjustment was just 9.1%, that would still be 3.2 percentage points higher than last year's COLA, which was the largest COLA adjustment since at least 2009. The average monthly **Social Security** check program-wide in July was \$1,544.70, which means a 9.6% COLA adjustment would increase the average payment by more than \$148.

Additionally, the new Social Security COLA adjustment could end up leading to more of your Social Security benefits **being taxed**, so there are more implications than just increased benefits. That's why Social Security participants will certainly want to tune in on Oct. 13 to hear about the new COLA adjustment right away, so they can prepare accordingly.

Dear Marci: What is Fall Open Enrollment?

Dear Marci,

I just enrolled in Medicare a few months ago, and now I am hearing about Fall Open Enrollment coming up. What is Fall Open Enrollment, and what should I do during this time? -Patty (Providence Forge, VA)

Dear Patty,

What an important question! **Fall Open Enrollment** begins October 15 and ends December 7 each year. (You also might hear it be called Medicare's Open Enrollment Period or Annual Election Period.) During this time, you can make changes to your health insurance coverage, including adding, dropping, or changing your Medicare Advantage and Part D coverage for next year. Even if you are happy with your current health and drug coverage, Fall Open Enrollment is the time to review what you have, compare it with other options, and make sure that your current coverage will meet your needs for the coming year.

You can make as many changes as you need to your Medicare

coverage during Fall Open Enrollment.

The changes you can make include:

Joining a new **Medicare Advantage Plan**

Joining a new **Part D prescription drug plan**

1. Switching from Original Medicare to a Medicare Advantage Plan
Switching from a Medicare Advantage Plan to Original Medicare (with or without a Part D plan)

You should consider:

- ◆ Your access to health care providers you want to see
- ◆ Your access to preferred pharmacies
- ◆ Your access to benefits and services you need

The total costs for insurance premiums, deductibles, and cost-sharing amounts

If you have Original Medicare, visit www.medicare.gov or read the 2023 *Medicare & You* handbook to learn about Medicare's benefits for the upcoming year. You should



Dear Marci

review any increases to Original Medicare premiums,

deductibles, and coinsurance charges.

If you have a Medicare Advantage Plan or a stand-alone Part D plan, read your plan's Annual Notice of Change (ANOC) and/or Evidence of Coverage (EOC). If you do not receive these notices by the end of September, contact your plan to request them. Review these notices for any changes in:

- ◆ The plan's costs
- ◆ The plan's benefits and coverage rules

The plan's formulary (list of drugs your plan covers)

Additionally, make sure that your drugs will still be covered next year and that your providers and pharmacies are still in the plan's network. If you are unhappy with any of your plan's changes, you can enroll in a new plan. If you want assistance reviewing your options, contact your **State Health Insurance Assistance Program (SHIP)** for

unbiased counseling.

Even if you are happy with your current Medicare coverage, consider other Medicare health and drug plan options in your area. For example, even if you do not plan to change your Medicare Advantage or Part D plan, you should check to see if there is another plan in your area that will offer you better health and/or drug coverage at a more affordable price. Research shows that people with Medicare prescription drug coverage could lower their costs by shopping among plans each year; there could be another Part D plan in your area that covers the drugs you take with fewer restrictions and/or lower prices. You can use **Medicare's Plan Finder tool** to compare your options and call your SHIP for assistance. Best of luck to you this Fall Open Enrollment Period! Following the advice above, you can make sure your health coverage will meet your needs in 2023.

-Marci

Washington Wants to Make 2 Huge Changes to Social Security for Retirees

It's no secret that Social Security is in dire need of reform. Inflation has become a particularly relevant issue for retirees of late, as the rising cost of food, energy, and medical care has eaten away at the buying power of benefits this year. But the problem actually started long ago. In fact, **cost-of-living adjustments (COLAs) have failed to keep pace with inflation for the last two decades.**

At the same time, seniors represent a larger portion of the population each year because birth rates have been in decline for decades. That trend is not sustainable. In fact, the Social Security Administration (SSA) says taxes will only cover 80% of scheduled benefits by 2035.

President Joe Biden addressed those issues during his campaign, and federal lawmakers have introduced legislation aimed at tackling the problems. Here's what you should know.

A better way to measure inflation

COLAs are supposed to **protect the buying power of Social Security** benefits by ensuring the payout rises at the same rate as

inflation. Currently, the Social Security Administration uses the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) to approximate inflation and calculate COLAs. But there is a big problem with that strategy.

CPI-W is based on purchases made by hourly wage earners and office workers, but the spending patterns of those individuals can differ dramatically from the spending patterns of retirees and seniors. For instance, individuals in the workforce are more likely to spend money on apparel, education, and consumer electronics, while retirees and seniors will probably spend more on household energy and medical care.

How big is the impact? Social Security benefits have increased 64% due to COLAs since 2000, but the expenses of a typical senior have grown more than twice as fast. As a result, Social Security has lost 40% of its buying power over that time period, according to The Senior Citizens League.

President Biden and many experts believe they have an



answer: The Consumer Price Index for the Elderly (CPI-E) should be used to calculate Social Security COLAs. CPI-E is based on purchases made by individuals 62 years of age and older, so it more accurately tracks the spending patterns of seniors. In fact, the average senior would have received nearly \$14,000 more in benefits over the past 30 years if COLAs had been based on the CPI-E, according to The Senior Citizens League.

To that end, several pieces of legislation that aim to revise the way COLAs are calculated have been brought before Congress, including the CPI-E Act of 2017 and the Social Security Expansion Act. But no changes have yet been made.

A higher threshold for taxable income

The amount of income subject to Social Security tax increases each year based on the national average wage index. For instance, the 12.4% payroll tax will be applied to earnings up to \$147,000 this year, while any earnings that exceed that limit will not be taxed. Many government officials believe that

threshold is too low.

For instance, President Biden would extend the 12.4% payroll tax to earnings above \$400,000 as well. In theory, that would fix the solvency issues that threaten the Social Security program, ensuring that full benefits can be paid out in 2035 and beyond. But some government officials are seeking more aggressive changes. Rep. Peter DeFazio (D-Ore.) and Sen. Bernie Sanders (I-Vt.) introduced the Social Security Expansion Act earlier this year. Among other changes, that piece of legislation would apply the 12.4% payroll tax to all earnings above \$250,000.

Should seniors be worried? No. The Social Security program will have enough money to fund full benefits for many years, meaning there is plenty of time for lawmakers to find a solution. That said, future retirees should do what they can to minimize their dependence on Social Security. That means understanding the **basics of the program**, knowing **how much money it takes to retire**, and having other **retirement plans** in place.

While Inflation Takes a Toll on Seniors, Billions of Dollars in Benefits Go Unused

Millions of older adults are having trouble making ends meet, especially during these inflationary times. Yet many don't realize help is available, and some notable programs that offer financial assistance are underused. A few examples: **Nearly 14 million adults** age 60 or older qualify for aid from the federal Supplemental Nutrition Assistance Program (also known as food stamps) but haven't signed up, according to recent estimates. Also, more than 3 million adults 65 or older are eligible but not enrolled in **Medicare Savings Programs**, which pay for Medicare premiums and cost sharing. And 30% to 45% of seniors may be missing out on help from the **Medicare Part D Low-Income Subsidy** program, which covers plan premiums and cost sharing and lowers the cost of prescription drugs.

"Tens of billions of dollars of

benefits are going unused every year" because seniors don't know about them, find applications too difficult to complete, or feel conflicted about asking for help, said **Josh Hodges**, chief customer officer at the National Council on Aging, an advocacy group for older Americans that runs the National Center for Benefits Outreach and Enrollment.

Many programs target seniors with extremely low incomes and minimal assets. But that isn't always the case: Programs funded by the Older Americans Act, such as home-delivered meals and legal assistance for seniors facing home foreclosures or eviction, don't require a means test, although people with low incomes are often prioritized. And some local programs, such as property tax breaks for homeowners, are available to anyone 65 or older.

Even a few hundred dollars in assistance monthly can make a



world of difference to older adults living on limited incomes that make it difficult to afford

basics such as food, housing, transportation, and health care. But people often don't know how to find out about benefits and whether they qualify. And older adults are often reluctant to seek help, especially if they've never done so before.

"You've earned these benefits," Hodges said, and seniors should think of them "like their Medicare, like their Social Security."

Here's how to get started and some information about a few programs.

Getting help. In every community, Area Agencies on Aging, organizations devoted to aiding seniors, perform benefits assessments or can refer you to other organizations that conduct these evaluations. (To get contact information for your local Area Agency on Aging, use

the **Eldercare Locator**, a service of the federal Administration on Aging, or call 800-677-1116 on weekdays during business hours.)

Assessments identify which federal, state, and local programs can assist with various needs — food, housing, transportation, health care, utility costs, and other essential items. Often, staffers at the agency will help seniors fill out application forms and gather necessary documentation.

A common mistake is waiting until a crisis hits and there's no food in the refrigerator or the power company is about to turn off the electricity.

"It's a much better idea to be prepared," said **Sandy Markwood**, chief executive officer of US Aging, a national organization that represents Area Agencies on Aging. "Come in, sit down with somebody, and put all your options on the table."...**Read More**

States plan to ensure access to top cancer care providers

Kara Hartnett writes for **Modern Healthcare** on two states that plan to ensure access to top cancer providers for their low-income residents. To date, Medicaid and state health insurance exchange plans, not unlike a lot of Medicare Advantage plans, do not include National Cancer Institute providers in their networks. New York and California are putting an end to this health inequity.

Under new laws in both New York and California, insurance companies will have to work out a payment arrangement with National Cancer Institute Cancer Centers. The New York law went into effect in April. The California law is expected to go into effect in January 2023.

What does this mean? If you live in New York City and your insurance is through Medicaid or a NY state health insurance exchange plan, you will be covered for care from Memorial Sloan-Kettering Cancer Center.

These two state laws will help promote health equity for people with low incomes, people of color, and other people who otherwise would not have access to care from a cancer center of excellence. And, they make sense. Why should insurers be allowed to contract with low-value providers and not be required to contract with high-value providers?

Insurers should not be allowed to keep enrollees from getting



their care from centers of excellence. To date, Medicare Advantage plans have had free rein to

restrict access to these centers for their enrollees. It's how they save money—while likely jeopardizing the health and well-being of their enrollees.

The federal government should step in to stop insurers from designing their own provider networks, particularly in Medicare and Medicaid, where the government negotiates provider rates. Networks make no sense in Medicare Advantage, as Medicare Advantage plans can piggyback off of traditional Medicare provider rates. They don't need a network to bring down provider rates. The only

purpose the network serves is to keep people with complex conditions from getting care from the specialists they need to see.

What's worse for people in Medicare Advantage plans is that the federal government has no way to ensure that network providers are adequate to meet enrollee needs. While there are Medicare Advantage rules in place regarding time and distance, the rules do not include provider availability. That aside, for years, the Medicare Advantage plans issue provider directories filled with misleading information, and the federal government has not held them accountable for misleading their enrollees.

Can You Collect Social Security and Be Eligible for Food Stamps?

More than 70 million Americans collect **Social Security**, Supplemental Security Income (SSI), or both, according to the Social Security Administration (SSA). The vast majority are people age 65 and older collecting Social Security retirement benefits alone.

The Supplemental Nutrition Assistance Program (**SNAP**) is the country's largest anti-hunger initiative. Formerly known as

food stamps, the program supports nearly 42 million beneficiaries who rely on SNAP to buy groceries and other food.

Both programs help tens of millions of people avoid poverty and food insecurity, but are the two mutually exclusive? Can Social Security recipients also collect food stamp benefits?

Despite much misinformation and an unfortunate number of



eligible people who do not, the answer is yes — **food stamps can go to seniors and others on**

Social Security.

SNAP and Social Security Not only can older Americans receive SNAP benefits while they collect Social Security, but there are special rules for people age 60 and up that make it easier to qualify for food stamps. For example, a standard household

can have up to \$2,500 in countable resources — things like cash or money in the bank — and still qualify for SNAP.

If a household includes a disabled individual or a senior, however, the countable resource limit increases to \$3,750.

SNAP Treats Social Security Like Any Other Income....**Read More**

Patient Satisfaction Surveys Earn a Zero on Tracking Whether Hospitals Deliver Culturally Competent Care

Each day, thousands of patients get a call or letter after being discharged from U.S. hospitals. How did their stay go? How clean and quiet was the room? How often did nurses and doctors treat them with courtesy and respect? The questions focus on what might be termed the standard **customer satisfaction aspects** of a medical stay, as hospitals increasingly view patients as consumers who can take their business elsewhere.

But other crucial questions are absent from these ubiquitous surveys, whose results influence how much hospitals get paid by insurers: They do not poll patients on whether they've experienced discrimination during their treatment, a common complaint of diverse patient populations. Likewise, they fail to ask diverse groups of patients whether they've received

culturally competent care.

And some researchers say that's a major oversight.

Kevin Nguyen, a health services researcher at Brown University School of Public Health, who parsed data collected from the government-mandated national surveys in new ways, found that — underneath the surface — they spoke to racial and ethnic inequities in care.

Digging deep, Nguyen studied whether patients in one Medicaid managed-care plan from ethnic minority groups received the same care as their white peers. He examined four areas: access to needed care, access to a personal doctor, timely access to a checkup or routine care, and timely access to specialty care.

"This was pretty universal across races. So Black



beneficiaries; Asian American, Native Hawaiian, and Pacific Islander beneficiaries; and Hispanic or Latino or Latinx/Latine beneficiaries

reported worse experiences across the four measures," he said.

Nguyen said that the Consumer Assessment of Healthcare Providers and Systems surveys commonly used by hospitals could be far more useful if they were able to go one layer deeper — for example, asking *why* it was more difficult to get timely care, or *why* they don't have a personal doctor — and if the Centers for Medicare & Medicaid Services publicly posted not just the aggregate patient experience scores, but also showed how those scores varied by respondents' race, ethnicity, and preferred language. Such data can

help discover whether a hospital or health insurance plan is meeting the needs of all versus only some patients.

Nguyen did not study responses of LGBTQ+ individuals or, for example, whether people received worse care because they were obese. The CAHPS Hospital Survey, known as HCAHPS, has been around for more than 15 years. The results are **publicly reported** by CMS to give patients a way to compare hospitals, and to give hospitals incentive to improve care and services. Patient experience is just one thing the federal government publicly measures; **readmissions and deaths** from conditions including heart attacks and treatable surgery complications are among the others....**Read More**

How Many Hours Can You Work and Still Collect Social Security?

As the name would imply, **Social Security retirement benefits** were meant to be paid out to beneficiaries after they stop working.

You can continue to work as long as you want, and you can still collect Social Security benefits. However, you should be aware that continuing to work after claiming Social Security benefits could reduce the amount that you receive, particularly if you have not yet reached full retirement age.

Working Before Full Retirement Age

From the perspective of the Social Security Administration, full retirement age for those born in 1960 or later is 67. If you continue to draw income before you reach full retirement age, the SSA considers you a worker rather than a retiree. As such, some of your benefits may be held back.

Specifically, for every \$2 you earn above a certain limit, the SSA will withhold \$1 of your earnings. For 2022, the earnings limit is \$19,560. Thus, if you are under full retirement age and you

earn \$39,560 in 2022, your Social Security benefits will be reduced by \$10,000.

As to how many hours you can work and still collect Social Security, this will obviously depend on your hourly wage. For example, if you earn \$20 per hour, you can work 978 hours per year before your Social Security benefits are reduced, assuming you haven't yet reached full retirement age. At 40 hours per work week, that means you can work just over 24 weeks before hitting the earnings limit. If your salary is higher, that number obviously will be adjusted downward.

Working the Year You Reach Full Retirement Age

Things change the year you reach full retirement age. At this point, the amount you can earn before any benefits get withheld is \$51,960, as of 2022. Further, benefits are reduced by just \$1 for every \$3 you earn above the earnings limit. For example, if you're earning \$50,000 the year you reach full retirement age, you won't see any reduction in your



benefits at all. But if you earn \$60,960, your annual benefit will be reduced by \$3,000. Note that this reduction ends in the month that you reach full retirement age.

Working After Full Retirement Age

For some people, working after full retirement age is not the definition of "retirement." But for others, working after age 67 can be a joy — or a requirement.

Regardless of the reasons you might have, the good news is that once you reach full retirement age, you'll no longer suffer any penalties for working. You'll be entitled to your full monthly Social Security benefit regardless of how many hours you work. Even if you decide to work full time or run a business, you'll get to keep your earnings and all of your Social Security payments.

You'll Always Be Made Whole
Losing Social Security benefits because you might have to work can be a tough choice to make. But the good news is that ultimately it's not an either-or proposition. If you lose Social

Security benefits because you are working, they are never actually "lost." Rather, they are simply suspended. The SSA will always make you whole for any suspended benefits.

Once you reach full retirement age, the Social Security Administration will recalculate your monthly payout and increase your payments to make up for your deferred benefits.

What Is Considered Income?

There is one final way you can still "work" and collect all of your Social Security at the time you expect it, rather than as deferred payments. Essentially, if all of your income is passive, you can earn as much as you'd like and it won't have any ramifications on your Social Security earnings. Specifically, the SSA counts only wages or salary from a job, or the net profit from self-employment, as earnings. Investment income, pensions, veterans benefits, annuities, interest and government or military benefits are not counted.

WEP/GPO Petition Surpasses 100,000 + Signers

On Sunday, September 11, 2022 the MoveOn Repeal the WEP/GPO surpassed 100,000 signatures. **Thank you to all that signed.**

Why is this important?

To urge all Americans their families, friends or everyone subject to the GPO/WEP to increase their efforts to make sure the Congress of the United States enacts legislation to repeal the Government Pension Offset and the Windfall Elimination Provision from Social Security Act.

H. R. 82 by Congressman Rodney Davis. (R) (IL) and Rep. Abigail Spanberger (D) (VA) will be introducing legislation this week for the full repeal. There's 298 bipartisan co-sponsors.

Some quotes from people that have signed the petition:

Tom B. 09-08-2022

"I earned my piece of Social Security before I became a police officer and I should be paid what I earned."

Neal O. 09-09-2022

26 years of paying into SSA,

then have about 30% taken away due to 12 years of other work. NO other retirement system does this."

Madelaine B. 09-08-2022

"Unfair that other states have this provision and Massachusetts is eliminated."

Charles K. 09-09-2022

"I am entitled to receive my own earned benefits of \$1,264 a month minus the Windfall Elimination Provision (GPO/WEP) I will now receive \$762.00 a month. I am not able to collect spouses survivor's benefits. We currently purchased a life insurance policy for my spouse to add to my income upon his passing. This policy will only cover lost income for three years. Cost of this insurance is \$4,800 a year."

Gregory J. 09-08-2022

"When & if I die, my wife will receive none of my social security benefits that I've worked all my life to earn. Without them,



she will have to depend on our children for assistance."

Karen Hall 09/10/2022

"My story is quite sad. You see, I'm a second generation victim of Wep. Both mom and dad had their pension reduced by sixty percent as do I. With inflation I'm struggling on my pension. I'd work. I'm unable for medical reasons. Please repeal the Wep. I did everything correct to be retired, until I discovered the Wep penalty. Help me. Please repeal this disaster."

Kenneth D. 09-08-2022

"My wife put into Social Security for years and now she can't collect her fair share or my SS when I pass. This is causing us more of a financial strain to live in our retirement."

Karen R. 09-02-2022

"I have worked since I was 16 years old, paying into social security all these 38 years. I'm no longer physically able to work

in nursing, due to disability. I've looked into becoming a teacher as a second career, but WEP is discouraging me from becoming a teacher and impacting the lives of our youth."

These are but a few of the thousands of stories that pertain to the egregious Windfall Elimination Provision and Government Pension Offset parts of the Social Security Act that affects teachers, police officers, firefighters, state and city municipal employees, certain government workers and foreign retirees.

For many years there has been a push for the repeal. However, because of different politics nothing has been done.

This year the Repeal Coalition to Repeal the WEP/GPO made up of different organizations across the USA believes we have the best chance to get legislation passed.

Please keep signing the petition on the front page because we're not done yet.Stay tuned

Hospitals find a lot wrong with Medicare Advantage

August 31 was the deadline for filing responses to the government's request for information on Medicare Advantage. Thousands of individuals and organizations filed comments, including **Just Care**, and we are still poring over them. Of particular note, the **American Hospital Association's comments** reveal that hospitals find a lot wrong with Medicare Advantage. The government, along with anyone thinking of joining a Medicare Advantage plan, should give its 43-pages of comments close attention.

Here's an excerpt from the opening:

"In this context, we are writing to share several serious concerns about the negative effects of Medicare Advantage Organization (MAO) practices and policies, which impede patient access to health care services, create inequities in coverage between Medicare beneficiaries enrolled in MA versus those enrolled in Traditional Medicare, and in some cases, even directly harm Medicare beneficiaries through unnecessary delays in care or outright denial of covered services.

As enumerated below, such practices include abuse of utilization management programs, inappropriate denial of medically necessary services that would be covered by Traditional Medicare, requirements for unreasonable levels of documentation to demonstrate clinical appropriateness, inadequate provider networks to ensure patient access, and unilateral restrictions in health plan coverage in the middle of a contract year, among others. These practices add billions of wasted dollars to the health care system, are a major driver of health care worker burnout, and worst of all, harm the health of Medicare beneficiaries."

The AHA goes on to explain that MA plans are failing to pay the hospitals hundreds of millions of dollars they are due. There's no collection agency that will go after the MA plans for payment.

"Insurer practices that deny and delay payment for services appropriately rendered to patients exacerbate these financial challenges and destabilize providers of critical health care services. For



example, in our most recent survey, 50% of hospitals and health systems reported having more than \$100 million in accounts receivable for health insurance claims that are older than six months. This amounts to \$6.4 billion in delayed or potentially unpaid claims that are six months old or more among the 772 reporting hospitals, leaving providers with untenable financial liability. In MA specifically, one-third of hospitals reported having \$50 million or more in accounts receivable that are six months or older, suggesting that MA plans make up a significant portion of the problem."

MA horror stories are not uncommon for patients needing inpatient hospital care:

"Our most recent AHA survey data shows that health plans serving public programs are more likely to deny inpatient prior authorization requests, and specifically that MA plans have the highest inpatient prior authorization denial rate across all payers, followed by Medicaid managed care and then commercial products. These rates vary despite physicians following the same clinical

guidelines and regardless of a patient's type of coverage, suggesting that the denials are linked to financial, not clinical, considerations. Further, these survey data reflect that MA plans are aggressively and systematically denying nearly 20% of all inpatient prior authorization claims off the bat, most of which are later overturned."

The Texas Hospital Association submitted its own comments and told this story:

"Misuse of utilization management practices directly jeopardizes lifesaving care. One hospital in rural Texas shared a story of a patient over age 90 on blood thinners, who presented after falling and hitting their head. The MA plan denied authorization for a CT scan to check for a suspected brain bleed, stating it was not medically necessary. The hospital performed the CT scan anyway, confirming a brain bleed requiring transfer to a higher level of care. That night, the patient was flown to another facility and received treatment that saved their life. If the local hospital had abided by the CT scan denial from the MA plan, this patient would not have survived."

Assisted Living Will Become Financially Out of Reach for Many Middle-Class Americans

America's middle-income seniors could face a time of financial reckoning within the next decade, with the rising costs of health care and assisted living overwhelming their meager savings, a new study reports.

The number of middle-income seniors in the United States is expected to nearly double by 2033, with 16 million people 75 or older making too much to qualify for government assistance but too little to afford comfortable living, according to an **analysis** by NORC at the University of Chicago.

Three-quarters of seniors in the "Forgotten Middle" — 11.5 million seniors — won't be able to pay for private assisted living unless they have a house to sell, the study concludes.

And nearly 40% of those with a house won't be able to afford assisted living anyway, the

researchers added.

"Not everyone is going to want assisted living, but middle-income seniors may not be able to pay for even many of the other paid intensive caregiving services" that could help keep them in their homes, said report lead author Caroline Pearson, senior vice president at NORC.

"We really have no long-term care system in this country that is going to appropriately support middle-income older adults," Pearson said. "And so particularly as the baby boomers begin to age and have more health needs, we're going to see a growing number of folks that aren't able to live fully independently and may not have the financial resources to pay for the housing or care that they need."

The new study in *Health*



Affairs is an update of the 2019 "Forgotten Middle" report that drew attention to the squeeze that middle-income seniors will face as they enter what should be their golden years. That first report projected out to 2029, while this new study projects to 2033.

For the new report, researchers at NORC looked at people aged 60 and older in 2018, since they will be 75 or older in 2033. The researchers assessed that group's expected health problems and financial resources, to characterize the challenges they might face as they age.

Who is 'middle income'?

Middle-income seniors are characterized as having an annual income between \$26,500 and \$79,000 in 2018 dollars for those 75 to 84, including assets. For those 85 or older, the income range is \$26,000 and \$101,000 a

year.

Between 53% and 55% of middle-income seniors are expected to have three or more chronic health problems by 2033, while between 50% and 68% will have mobility limitations, the researchers project. Between 27% and 40% will be suffering some form of cognitive impairment.

These are the folks for whom assisted living could be desirable, but they'll need an average \$65,000 annually to pay for it, Pearson said. The average Social Security benefit currently is just over \$19,000 a year.

"Now that's actually 2018 dollars, so it probably gets closer to \$70,000 by the time we get to 2033," Pearson said, "but that's \$65,000 a year just to sort of get the housing and health care required." ...**Read More**

Another Reason to Get the Flu Shot: Lowered Risk for Stroke

(HealthDay News) -- As flu season approaches, a new study is pointing to a possible bonus from vaccination: a lower risk of stroke.

Researchers in Spain found that among nearly 86,000 middle-aged and older adults, those who got their annual flu shot were less likely to suffer an ischemic stroke over the next year.

Ischemic strokes, which account for most strokes, are caused by a blood clot that diminishes blood flow to the brain.

The risk reduction linked to the **flu shot** was not huge: On average, vaccinated people were 12% less likely to suffer a stroke compared to their unvaccinated counterparts.

But senior researcher Dr. Francisco Jose de Abajo pointed to the bigger context: A huge number of people worldwide suffer a stroke each year, and a huge number get -- or could get -- a flu shot.

So even a modest protective effect from vaccination could translate into a substantial number of strokes averted, said de Abajo, a professor at the University of Alcalá in Madrid.

That assumes, however, that the flu shot does directly lower stroke risk.

The new findings, published Sept. 7 in the

journal *Neurology*, do not prove that. They show only an association between flu vaccination and lower stroke risk.

It's difficult, de Abajo said, to account for all the differences between people who get a yearly flu shot and those who do not. People who get the recommended vaccinations are likely, for example, to be health-conscious in many ways -- eating healthier, exercising or taking medications to get conditions like high blood pressure or high cholesterol under control.

But researchers accounted for the differences they could, including body weight, smoking and chronic health conditions. And the link between flu vaccination and lower stroke risk held up.

They also looked at whether people who received another recommended vaccination -- the **pneumococcal vaccine** against pneumonia -- had a lower stroke risk. It turned out they did not.

That's one of the strengths of the study, said Dr. Mitchell Elkind, a professor of neurology at Columbia University in New York City. He co-authored an editorial published with the study.

If getting vaccinated against the flu is simply a marker of better health or greater health consciousness, Elkind said, then



you'd expect other vaccinations to be tied to a lower stroke risk, too. Why would a flu shot help ward off a stroke?

It's known, de Abajo said, that flu infection can temporarily raise the risk of stroke in vulnerable people. So in theory, a vaccine that helps prevent the flu would, in turn, prevent some strokes.

But there may be more going on, as well, the experts said.

The study found that stroke risk went down quickly after people were vaccinated -- within two weeks to a month. And the benefit emerged during the "pre-epidemic" period, between September and the annual flu surge. That's a time when people would be getting their flu shots, but the virus would not yet be widely circulating.

It's possible, Elkind said, that the vaccine reduces inflammation or has other beneficial effects on the blood vessels. But more research is needed to answer those questions, he said.

The findings are based on adults ages 40 to 99 whose medical records were part of a Spanish primary care database. Over 14 years, 14,322 of them suffered a first-time ischemic stroke. The researchers compared each of them with five stroke-free patients of the same age and sex.

In both patient groups, about 40% received a flu shot -- which

Elkind said shows a lot of room for improvement.

"The flu shot is not 100% effective," he said, "but it's pretty darn good."

And even if vaccination does not prevent infection entirely, Elkind noted, it can reduce the severity of the flu. People with a history of stroke, or risk factors for it, are among those at increased risk of severe flu complications.

The new findings, Elkind said, offer even more incentive to get the flu shot.

De Abajo agreed.

"We hope that studies such as ours will help to enhance public awareness of the benefits of being vaccinated," he said.

As for **COVID vaccination**, it's unclear whether it might help ward off strokes. But it's known, Elkind said, that COVID can promote blood clotting and increase the risk of stroke. Studies show that of people hospitalized with the infection, roughly 1% to 2% suffer a stroke.

One recent study from Korea did find that fully vaccinated people were less likely to suffer a stroke or heart attack if they contracted COVID-19, versus unvaccinated people.

More information

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

Blood Test Shows Promise for Quick Diagnosis of ALS

(HealthDay News) -- Patients suspected of having amyotrophic lateral sclerosis (**ALS**) may soon be able to get a diagnosis much more quickly, not wasting the precious time many have left, new research suggests.

In 2020, a blood test for ALS based on microRNA (short segments of genetic material) was developed by scientists from the company Brain Chemistry Labs, but it required precise protocols for shipping and storage of blood samples, which were maintained at -80° Celsius. That meant many doctors and neurologists couldn't use the test.

Now, researchers from the company, Dartmouth's department of neurology and the U.S. Centers for Disease Control and Prevention report they have been able to replicate the original test with blood samples that were not collected and maintained under such stringent requirements.

They did so by comparing blinded blood samples from 50 ALS patients from the **U.S. National ALS Biorepository** with 50 healthy "control" participants. The investigators found that in this new test the genetic fingerprint



of five microRNA sequences accurately discriminated between people with ALS and healthy individuals.

"We were surprised that the microRNA test worked for samples collected from a variety of investigators under differing conditions," said first author Dr. Sandra Banack.

The doctors are now verifying the new blood test, and Brain Chemistry Labs, in Wyoming, has applied for a patent on the test, according to a company news release.

ALS, also known as Lou

Gehrig's disease, is an incurable neurological disease. Currently, the lag time between when symptoms begin and diagnosis is given is over a year. An inaccurate diagnosis can occur in about 13% to 68% of cases. Unfortunately, most ALS patients die between two to five years after diagnosis.

The findings were published online Aug. 29 in the *Journal of the Neurological Sciences*.

More information

The U.S. National Institute of Neurological Disorders and Stroke has more on **ALS**

Experimental Drug Shows Promise Against Lupus

An experimental drug that has been shown to treat rashes in people with lupus may also help with lupus-related joint pain.

Affecting as many as 1.5 million people in the United States, **lupus** is an autoimmune disease in which the body's immune system misfires against its own joints, skin, brain, lungs, kidneys and blood vessels.

People with lupus who took litifilimab showed marked reductions in joint tenderness and swelling compared with people who took a placebo (or dummy medication), a **clinical trial** showed.

Given as a shot, the new drug is a **monoclonal antibody**. These are man-made molecules that target specific proteins on cells. In this case, the drug targets a protein called blood

dendritic cell antigen 2 (BDCA2). This protein is found on plasmacytoid dendritic cells (PDCs), which produce inflammatory molecules including type 1 interferons.

"There's a lot of evidence that interferon is important in lupus," said study author Dr. Richard Furie. He is chief of rheumatology at Northwell Health in New Hyde Park, N.Y., and a professor at the Feinstein Institutes for Medical Research in Manhasset, N.Y.

"The antibody binds to BDCA2, the protein is internalized, and the synthesis of type 1 interferon is shut off," he explained. "Litifilimab doesn't kill the cell: It just puts it to sleep."

The new drug also seems to



help cool other inflammatory proteins involved in lupus, but its chief effect is on type 1 interferon, Furie said.

For the study, 102 people with lupus who had at least four tender and four swollen joints received a 450 mg dose of litifilimab or a placebo for 24 weeks. The drug is given as a shot every four weeks.

Patients who took litifilimab had fewer swollen and tender joints than their counterparts who got the placebo, the investigators found.

In addition to improving joint symptoms, the new drug also improved skin rashes and had a "very robust" effect on a scale measuring overall lupus symptoms and activity, Furie said.

"This drug is very good for skin disease, and this robust response says it is good for global lupus too, not just arthritis," he said. Drug maker Biogen sponsored the new trial.

Now, the new drug moves on to larger Phase 3 trials, to test safety and effectiveness. Then, Furie said, hopefully it continues its march toward U.S. Food and Drug Administration approval.

"The future is bright," he said. "There's a lot of drug development in lupus, and we are finally seeing success."

The findings were published Sept. 8 issue in the **New England Journal of Medicine**. In July, the same journal published promising **results** for litifilimab in treating skin lupus...**Read More**

CT Lung Cancer Screening Catches More Tumors Early

(HealthDay News) -- **Lung cancer CT screening scans** can catch tumors at an earlier and more treatable stage, a new study indicates.

The number of stage 1 lung cancers detected by doctors increased 8.4% after low-dose CT screening scans were implemented across four different health care systems, according to findings published recently in the **Journal of Thoracic Oncology**.

Regular lung cancer screenings also were linked to a 6.6%

decrease in stage 4 cancers, because the tumors were caught earlier, researchers said.

The statistics were drawn from four major health systems that are part of a consortium aimed at optimizing lung cancer screenings -- Henry Ford Health System in Detroit, Kaiser Permanente Colorado, Kaiser Permanente Hawaii and the University of Pennsylvania Health System.

Researchers looked at nearly 3,700 patients diagnosed with



lung cancer at the four systems between January 2014 and September 2019, looking specifically at how advanced the cancers were when discovered.

By the end of the study, CT scan screens were catching about 20% of the lung cancer cases diagnosed at the centers, said researchers led by Dr. Anil Vachani, from the University of Pennsylvania.

In addition, the number of early-stage tumors had increased while the number of late-stage

tumors had declined -- showing that doctors were catching lung cancer when patients still had the best chance of survival.

This also showed that the screening did not result in over-diagnosis, which can cause patients to undergo unnecessary **biopsies** and other follow-up testing, the researchers said in a journal news release.

More information

The American Cancer Society has more about **lung cancer screening**.

Do Taxes on Soda Really Lower Sugar Intake?

New research suggests that good intentions may not always be enough when it comes to public health.

According to the study of the consequences of **Philadelphia's 2017 tax on sugar-sweetened drinks**, people bought more candy and cookies or did more shopping outside city limits, to both avoid the tax and satisfy their sweet tooth cravings.

"Taxes like this are associated with increases in consumption of additional sugary foods," said lead researcher Felipe Lozano-Rojas, an assistant professor of public administration and policy at the School of Public and International Affairs at the

University of Georgia.

He sees this consequence as a failure in how the tax is designed and implemented. "The offsetting forces right now are substantial, and we want to think how to make this policy more effective," he said.

Lozano-Rojas and his colleague Patrick Carlin, from the O'Neill School of Public and Environmental Affairs at the Indiana University, found that the Philadelphia tax caused a 31% drop in the sale of sugary drinks in the city, but it increased sales of other sweetened foods and promoted



shopping trips outside Philadelphia. In fact, this largely offset the decrease in sugar consumption from sodas and other sweet drinks, the researchers noted. Shopping for sodas outside the city canceled out nearly 40% of the decrease in **sugar-sweetened drink** purchases within the city.

The soda tax actually triggered about a 4% increase in purchases of other high-sugar goods in Philadelphia and neighboring towns, and additional sweetened food purchases offset an additional 40% of the decrease.

Lozano-Rojas added that the

burden of the tax falls most heavily on the poorest. Other research has shown those folks tend to spend more of their pay on sugar-sweetened drinks, so the tax burden hits them harder than people who can afford the higher price, he said.

For the study, Lozano-Rojas and Carlin used Nielsen Retail Scanner Data, which captures scanner information from stores throughout the United States. They used these data to look at more than 804 million weekly reports on purchases of sugary foods and sugar-sweetened drinks over nearly four years....**Read More**

New York Declares State of Emergency Over Growing Polio Concerns

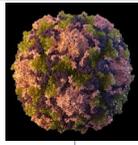
New York Governor Kathy Hochul declared a state disaster emergency Friday, after poliovirus was detected most recently in wastewater samples from Nassau County. The executive order is meant to increase the availability of resources to protect against the disease—namely by expanding the network of healthcare providers able to administer vaccines, which should allow more people to get vaccinated.

"On polio, we simply cannot roll the dice," State Health Commissioner Mary T. Bassett, MD, MPH, said in a press release. "If you or your child are unvaccinated or not up to date on your vaccinations, the risk of

paralytic disease is real. I urge New Yorkers to not accept any risk at all."

The New York State Department of Health (NYSDOH) first identified a case of paralytic polio in July in a Rockland County resident. The case launched an investigation into the wastewater in surrounding communities—since people can shed poliovirus in their stool—and additional poliovirus samples were collected from Rockland, Orange, and Sullivan counties, as well as New York City, and now Nassau County.

In Nassau—now the fifth area in New York to have poliovirus detected in the wastewater—the



sample was genetically linked to the case of paralytic polio in Rockland County, suggesting community spread.

According to the NYSDOH, all of the reported samples are considered "samples of concern," meaning they are types of poliovirus able to infect and potentially cause paralysis in humans.

An Executive Order to Increase Immunization Efforts Governor Hochul's declaration of a state disaster emergency will help to increase the availability of resources to help protect New Yorkers from poliovirus.

Emergency medical technicians (EMTs), paramedics,

and other EMS workers will be able to administer the polio vaccine, along with other healthcare professionals including midwives, and pharmacists. Physicians and certified nurse practitioners will also be able to issue non-specific standing orders for vaccines.

The executive order also requires healthcare providers to send polio vaccination data to the NYSDOH, so the state can focus vaccination efforts where they're needed and track community protection levels.

The state of emergency is set to expire on October 9...Read More

New cell-based therapy for melanoma more effective than existing treatment, trial finds

European researchers announced Saturday that a new treatment for advanced melanoma was more effective than the leading existing therapy in a Phase 3 clinical trial.

The treatment, which uses a patient's own immune cells to fight the cancer, has some similarities to another type of treatment that has proven to be highly effective for blood cancers, called CAR-T therapy. CAR-T therapy involves harvesting a patient's T cells and modifying them in the lab to turn them into cancer fighters, then infusing the cells back into the patient. The personalized treatment was first shown to be successful a decade ago in certain leukemia patients; it's now also used for lymphomas as well as multiple myeloma.

And while it's been explored for solid tumors, which make up the majority of cancers, including melanoma, these tumors present

challenges that blood cancers do not. Many blood cancers are homogeneous, meaning their cells are uniform.

This gives CAR-T therapy a clear target to latch onto and attack. But solid tumors tend to have a number of different cell types that vary largely between cancer types, said Dr. Vincent Lam, an assistant professor of oncology at Johns Hopkins Medicine, who specializes in immunotherapies.

This heterogeneity of the tumor cells makes finding a convenient and universal CAR-T target difficult in solid tumors, said Lam, who was not involved with the new research.

In the melanoma trial, doctors used an approach called TIL therapy. It involves harvesting a patient's immune cells — in this case, cells called tumor-infiltrating lymphocytes, which are taken from the tumor — but instead of modifying them in the



lab as they would with CAR-T therapy, they're simply amplified to produce billions of cells.

Those cells are then infused back into the patient's bloodstream, where they can work to kill the cancer.

"We expand them from a million cells to several billion cells," Dr. John Haanen, a medical oncologist at the Netherlands Cancer Institute, who led the new clinical trial, told NBC News.

Haanen presented the results of the trial — the first of its kind to test TIL therapy against an existing treatment — at the ESMO Congress 2022 meeting in Paris.

"This is what the field needs to really gain confidence about this emerging therapy. It's potentially practice-changing," Lam said of the results.

In the trial, 168 patients with metastatic melanoma were

randomly assigned to receive either TIL treatment or the current standard treatment, an immunotherapy drug called ipilimumab. Ipilimumab is typically used in people who don't respond to a first-line treatment called anti-PD-1 therapy; nearly all of the patients in the trial had not responded to that treatment.

The patients were followed for a median of almost three years. Compared to those who were treated with ipilimumab, patients on TIL therapy had a 50% reduction in disease progression and death.

In the TIL therapy group, 20% saw their tumors disappear completely, compared to 7% in the ipilimumab group. The patients are still being tracked, but so far, the median overall time of survival for cancer patients who received TIL therapy was over two years,

Walking More Will Cut Your Risk of Developing Dementia

Walking between 3,800 and 9,800 steps each day can reduce your risk of mental decline, according to a new Journal of the American Medical Association study.

People between the ages of 40 and 79 who took 9,826 steps per day were 50% less likely to develop dementia within seven

years, the study found. People who walked with "purpose" -- at a pace over 40 steps a minute -- were able to cut their risk of dementia by 57% with just 6,315 steps a day. Experts describe 40 steps per minute as "a brisk walking activity," similar to a power



Joseph Peters, Jr.
Secretary
Treasurer ARA

walk.

Even people who walked approximately 3,800 steps a day at any speed cut their risk of dementia by 25%, the study found.

"If you don't have a step counter, you can count the number of steps you take in 10 seconds and then multiply it by

six to calculate steps per minute," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "However, before beginning any new exercise program, consult your doctor, and stop right away if you experience pain."

In Rare Move, FDA Panel Gives Support to Controversial ALS Drug in 2nd Review

In a rare second review, a U.S. Food and Drug Administration panel on Wednesday recommended approval for an experimental drug for **ALS** (amyotrophic lateral sclerosis).

The FDA is not obligated to follow its advisors' recommendations, though it usually does. Wednesday's vote was 7-2 for approval. The same panel **voted** 6-4 last March not to approve the drug, called Albrioza (**AMX0035**), for the deadly neurodegenerative condition that's also known as Lou Gehrig's disease.

Getting the drug approved has become a rallying cause for patients, their families and members of Congress, the *Associated Press* reported. They have contended that enough evidence exists to support

Albrioza's safety and effectiveness in patients with a disease that has no cure.

In the second review -- convened after a massive lobbying effort by the drug's supporters -- members of the FDA panel debated for hours, the *AP* said. The panelists' main focus was the strength and reliability of the one study conducted by the drug's maker, Amylyx Pharmaceuticals Inc.

In the end, a majority of panelists backed the medication. "To deprive ALS patients of a drug that might work, it's probably not something I would feel terribly comfortable with," Dr. Liana Apostolova of Indiana University's School of Medicine, who voted for approval, told the *AP*. "At the previous meeting, it wasn't that clear and it's still questionable."



One new factor encouraging a "yes" vote from panelists may have been a deal struck between Amylyx and the FDA to remove Albrioza from the market if its effectiveness is not borne out in a new large, ongoing study. Amylyx co-CEO Justin Klee said the company would voluntarily withdraw its drug should that come to pass.

"I'm somewhat assured that if an approval is issued it can be withdrawn in the future," Apostolova said.

At the opening of the Wednesday meeting, Dr. Billy Dunn, chief of neurology review at the FDA, said the data supplied by Amylyx still raised "concerns and limitations." But he also said that "we are highly sensitive to the urgent need for the development of new

treatments for ALS."

There are currently only two FDA-approved medications for ALS, which kills nerve cells and slowly robs patients of the ability to walk, talk or even swallow. Most people with ALS die within 3 to 5 years of diagnosis, usually from respiratory failure.

When regulators first reviewed the drug in March, they voted against it after finding data wasn't convincing that it would benefit those with the disease. The panel then gave the agency until Sept. 29 to review any further data the company submitted.

Canadian regulators have already **approved** the drug for ALS patients, which put the FDA in a "precarious position," bioethicist Holly Fernandez-Lynch told the *AP*. . . [Read More](#)

Are Big Breakfasts Really the Key to Weight Loss?

Dieters who believe that eating a big breakfast followed by a small dinner is the surest way to lose weight will likely be very disappointed by the findings of a new, small study.

What did the researchers discover? Eating the largest meal early in the day is unlikely to make any difference.

"The notion of timing of eating to influence health has been around for a long time," said study author Alexandra Johnstone, a registered nutritionist and professor in the school of medicine, medical sciences and nutrition with the Rowett Institute at the University of Aberdeen in Scotland.

Johnstone acknowledged that the advice to "breakfast like a king and dine like a pauper" has plenty of adherents.

And prior research has in fact "suggested that eating earlier in the day enhanced **weight loss**, affecting energy metabolism, compared to eating later in the day," she noted.

Still, "**chrono-nutrition**" — the relationship between food intake and time of day — "is a relatively young science," Johnstone cautioned.

To try to separate myth from fact, she and her colleagues decided to conduct a diet test



involving 16 men and 14 women. For a month, each participant was randomly assigned to follow a morning-heavy diet or an evening-heavy diet, the study authors explained.

All meals were based on a 30% protein, 35% carbs and 35% fat breakdown, while total daily calorie intake was fixed.

But those on the morning-heavy diet consumed 45% of their daily calories at breakfast, followed by 35% and 20% at lunch and dinner, respectively.

In contrast, those on the evening-heavy diet followed a 20%, 35% and 45% daily calorie split.

At the end of the month, all participants took a one-week break, which was then followed by a switch: for the following month all the morning-heavy eaters became evening-heavy eaters, and vice versa.

The result: "We found weight loss was similar with both diets," Johnstone said.

All participants *did* lose a notable amount of weight, with an average loss of about 7 pounds during each of the one-month periods. It's just that neither dietary pattern prompted more weight loss. . . . [Read More](#)

As Heat Continues Through Fall, Shield Yourself from UTIs

(HealthDay News) -- As summer gives way to fall, hot weather isn't likely to let up anytime soon, and that means it's important to stay hydrated to keep urinary tract infections at bay.

Getting **dehydrated** is a leading risk factor for these common, painful infections, also known as UTIs.

"Patients can experience more UTIs during the summer due to inadequate fluid intake, especially in the historic heat waves we've been experiencing,"

said Dr. Maude Carmel, associate professor of urology at UT Southwestern Medical Center in Dallas.

UTIs are common and feature burning or pain with urination, increased frequency and need to go, and blood in the urine.

While painful urination does not necessarily mean you have a UTI, that can be a cause. Diagnosing this requires a urine culture. Urinalysis or a dipstick test are not enough.



Cranberry juice is too diluted to treat UTI, despite the widespread myth that it does. Cranberry supplements can, however, reduce some infection risk, Carmel said in a center news release.

Anyone experiencing UTI symptoms should make an appointment with their primary care physician, she said. A person who has more than three UTIs diagnosed in a year may need to see a urologist. This specialist can order additional

testing and evaluate individual risk factors to narrow down the cause.

Carmel offered some tips to reduce the chance of getting a UTI: In addition to drinking at least two liters of fluid (about a half gallon) a day, urinate at least every three hours and also after **intercourse**. Avoiding constipation can also help.

More information

The U.S. Centers for Disease Control and Prevention has more on **urinary tract infections**.