Rhode Island Alliance for Retired Americans®

RI ARA

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Message from Alliance *for* Retired Americans Leaders

Wisconsin Alliance Members Hit the Road to Save Social Security

Robert Roach, Jr President, ARA

On Tuesday the Wisconsin Alliance took its statewide "Save Social Security" tour to preserve, expand, and modernize the Social Security Administration (SSA) to **Kenosha**, bringing attention to the fight to provide hardworking SSA personnel with the resources they need to deliver for the American people. The chapter and its allies have nine stops planned over the next month.

Members and supporters of the Wisconsin Alliance and AFGE gathered at the Social Security office in Milwaukee on April 4.

During the tour, members of the Wisconsin Alliance and the American Federation of Government Employees (AFGE) are warning that staffing issues at the SSA could lead to closures of the agency's field offices across the country.

Ross Winklbauer, president of Wisconsin Alliance, told NBC's local NBC affiliate in Milwaukee, TMJ4, that the tour aims to protect and enhance Social Security as well as Medicare, while also supporting union members. "Adequately funding the SSA is crucial," said **Robert Roach, Jr., President of the Alliance**. "The American people deserve an SSA that is fully staffed so they can get faster responses to applications and questions."

Reuters: Donald Trump Considers Plan to Gut Social Security if Elected

Advisers have presented former president Donald Trump with a **plan that would** cut Social Security's dedicated funding, the federal payroll tax, if he wins a second term. A cut in the federal payroll tax would drastically reduce the Social Security trust fund and could torpedo the program. According to a staffer, Trump signaled that he is open to the idea.

At the end of his first term in office, Trump **delayed the collection of Social Security payroll taxes** paid by workers and their employers, temporarily halting the system's funding stream. He said at that time that if he is re-elected he would **make permanent cuts to the payroll tax**.

By law, Social Security can only pay benefits it has sufficient revenue to cover. Any shortfall would trigger benefit cuts.

"The very last thing we need is to cut Social Security and give millionaires and billionaires more tax cuts, but that's exactly what Donald Trump will do," said **Richard Fiesta, Executive Director of the Alliance**. "President Biden and the Democrats, on the other hand, will expand Social Security by requiring millionaires and billionaires to pay their fair share. It is a very stark contrast."

Rich Fiesta, Executive Director, ARA

House Social Security Subcommittee Holds Hearing on Social Security Provisions that Harm Public Servants and their Families

The House Ways and Means Social Security Subcommittee **heard testimony** Tuesday from Social Security experts about how the Windfall Elimination Provision (WEP) and Government Pension Offset (GPO) unfairly harm many public servants and their families. Witnesses identified how the outdated formulas used to calculate the WEP and GPO create unfair outcomes for beneficiaries affected by one or both policies.

The Alliance provided a **statement for the record**, stating that the Windfall Elimination Provision (WEP) affects over two million public sector retirees with public pensions from a job not covered by Social Security, while the Government Pension Offset (GPO) reduces by two-thirds the spousal or survivor benefits of nearly 800,000 retirees who collect a public pension from a job not covered by Social Security.

"The WEP and GPO are outdated provisions that deprive public employees of the benefits they have earned and the secure retirement they deserve," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "Moreover, the WEP and GPO disproportionately affect lower-income workers. 83% of those subject to the GPO are women. We must repeal the WEP and the GPO."

Joseph Peters, Jr. Secretary Treasurer ARA

The Alliance continues to urge Congress to pass H.R. 82, the Social Security Fairness Act introduced by Reps. Garret Graves (R-LA) and Abigail Spanberger (D-VA), and H.R. 4583, the Social Security Sacred Trust Act, introduced by Rep. John Larson (D-CT). Both of the bills repeal the WEP and the GPO.

ADD YOUR NAME

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

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Nancy Altman testifies in Congress on the importance of strengthening Social Security

Testimony of Nancy Altman before the Subcommittee on Social Security of the House Ways and Means Committee, April 16, 2024

Chairman Ferguson, Ranking Member Larson, and Members of the Subcommittee:

You should repeal WEP /GPO as one of the many ways that you should expand Social Security. [NB: The **Windfall Elimination Provision** and the **Government Pension Offset** can reduce Social Security benefits for some people.

Social Security is the nation's most universal, efficient, secure, and fair source of retirement income. It is most working families' largest source of life insurance. It is often their only disability insurance. Its one shortcoming is that its vital benefits are inadequately low even for those not subject to WEP/GPO.

Social Security benefits should be increased across the board, as the 2100 Act, the Strengthening Social Security Act, and the Social Security Expansion Act all do. In addition, Congress should repeal WEP/GPO and make the other targeted expansions that I explain in detail in my written statement and that many of you have championed. They include improvements for women, low-income workers, young people, people with disabilities, survivors, and others.

All of that is completely affordable, but there is a right way and a wrong way to cover that cost.

The right way is to require millionaires and billionaires to pay their fair share. If they contributed just on their earned and unearned income in excess of $400,000; and they contributed at simply the same rate that minimum wage workers and their employers contribute to Social Security, that raises enough revenue to restore Social Security to balance, repeal WEP/GPO, and expand benefits in other ways, as well.

The absolute wrong way is to cut the very Social Security benefits that public servants are fighting for. The Republican Study Committee budget slashes Social Security by $1.5 trillion in just the first ten years, and by $73 billion in just the first year alone. Indeed, the RSC's annual budgets will leave public servants, along with all other working families, substantially worse off — even if Congress repeals WEP/GPO.

In my written statement, I calculate the impact of just three of the RSC cuts. I take the example of a public employee who today gets a benefit of just $649. If WEP were repealed, the benefit would jump to $1,038. But, if those three RSC cuts were in effect, that $1,038 monthly benefit would be just $410 a month. That is $7,500 a year less. And it is nearly $3,000 a year less than the employee gets today, with WEP!

Instead of repeal, if you simply modify WEP/GPO, you should not do so in a way that results in some public employees worse off, as the Equal Treatment of Public Servants Act does. Once fully phased in, that bill would cut the benefits of millions of public servants whose benefits are not affected at all by current law. For those public employees affected by current law, one-third of them would get lower benefits under the new, modified WEP.

If Republicans are going to continue to advance these devastating cuts, they should at least have the courage of their convictions. Instead, Speaker Johnson and Budget Committee Chairman Arrington are pushing for the creation of a commission with essentially the power to enact these unpopular cuts behind closed doors.

This is a thinly veiled effort to avoid political accountability. President Biden accurately labeled the commission a "death panel" for Social Security. The Ways and Means Committee, not a closed-door commission, is the right forum for Social Security legislation.

Overwhelming majorities of your constituents — Republicans, independents, and Democrats – vehemently oppose all benefit cuts and strongly support expanding Social Security, paid for by the wealthy. You can act with confidence in the open – if you act in accordance with the will of the people. If you expand Social Security's benefits, including repealing WEP-GPO, and you pay for it by requiring the uber-wealthy to pay their fair share, you will receive widespread praise and the gratitude of the nation.

Thank you.

Reflections on the April 16, 2024 Subcommittee on Social Security "Hearing on the Windfall Elimination Provision (WEP) and Government Pension Offset (GPO)"

Synopsis of the hearing

- **Focus on Reform vs Repeal of WEP & GPO:** The recent hearing focused on the need for Social Security reform rather than solely repealing the WEP and GPO.
- **Hearing Room:** The selection of a small hearing room limited attendees to 17 unreserved seats. Over 50 people were unable to get into the room. Why did members avoid the crowd by entering through other doors?
- **Addressing Penalties:** The penalties imposed by the WEP and GPO must be recognized as unjustly withholding earned benefits.
- **Acknowledging Unfairness:** All subcommittee members acknowledged the inherent unfairness of the WEP and GPO.
- **Financial Implications:** Social Security estimates the annual cost of repealing the WEP and GPO to be approximately $15 billion. It's crucial to understand that this is the money collected from penalties.
- **Impact on Beneficiaries:** The government dismisses the impact by citing a low percentage affected—less than 3 million out of the 68 million Social Security beneficiaries. Penalizing public employees' earned benefits for revenue is justified to sustain the fund and ensure its continuation without significant disruptions or losses. The bottom line is that the government is justifying

taking our earned benefits to sustain Social Security.

- **Reform Without Penalization:** Alternative avenues for reform must be explored to ensure fairness without penalizing beneficiaries.
- **Not Genuine Engagement:** Many questions and comments during the hearing seemed more like grandstanding than genuine inquiries, underlining the need for productive dialogue.
- **Bipartisan Support:** The bipartisan backing of reform, evidenced by 318 cosponsors, is significant and should not be ignored.
- **THE TIME IS NOW:** Please Figure it Out Over 72% of the House have spoken to eliminate the WEP and GPO, and the Committee on Ways & Means can and must effectuate change to correct this injustice.
- Complexity in the Decision-Making Process If WEP and GPO repeal were easy, the penalties would have been eliminated long ago, and we are not naïve about the complexity of legislating Social Security law, which is also related to many other governing areas. However, eliminating the unjust burden on retired Americans requires bipartisanship and fairness—treatment without discrimination—to do otherwise is un-American and defies the governance expectations shared by all of our citizens.
- **Hear from WEP/GPO Affected Americans**

Is long-term care insurance worth it for seniors in their 70s? Experts weigh in

The cost of nursing homes, assisted living and at-home care is pretty pricy these days. In fact, data shows the average nursing home facility runs seniors anywhere **from $8,600 to $9,700 per month**. Unless you have **long-term care insurance**, those costs can eat into your retirement funds and nest egg quickly.

"Long-term care insurance helps cover the exorbitant costs of in-home care, assisted living, or nursing home stays, which can easily run $50,000 or more per year," says Neal Shah, founder of caregiving platform CareYaya. "With a good long-term care policy in place, seniors can preserve their assets and ensure they have access to the care they need without going bankrupt." But while long-term care insurance **can help cover the costs** of this type of care, long-term care policy premiums also increase as you age, so at what point is buying a policy no longer worth it? Once you hit 70, do the benefits still outweigh the cost? Let's find out.

Is long-term care insurance worth it for seniors in their 70s? Experts weigh in

Here's when experts say a long-term care insurance policy might work out for seniors in their 70s.

When long-term care insurance can be worth it for seniors in their 70s

Long-term care insurance **might be worth it** if you're still in good health, as these policies require medical underwriting. They also may be worth it if you're looking to protect your loved ones financially as you age.

"Over 50% of aging adults will likely need caregiving support," says Larry Nisenson, chief growth officer at Assured Allies. "A long-term care insurance policy can help ease the family's financial and emotional burden by providing a source of income to cover professional caregivers."

If you **rely solely on Medicare** to cover the costs of your care, then buying a long-term care insurance policy can also be smart, says Esther Cromwell, founder of Avendelle Assisted Living.

"With Medicare covering limited aspects of long-term care, this insurance is critical in securing a stable and worry-free future," Cromwell says. "It protects both the seniors and their families from financial burdens."

When long-term care insurance isn't worth it for seniors in their 70s

Long-term care insurance premiums increase as you age, so getting a policy in your 70s will likely cost you more than it would have years earlier.

"Long-term care insurance can be quite expensive," Shah says, "especially for those purchasing it later in life."

If you have plenty of cash available to cover the costs of future care, then long-term care insurance may not be worth the price. According to Bill Bunting, COO of Avendelle Assisted Living, seniors at his facility use a wide variety of income sources to pay for their care — Social Security payments, pension plans, investment and retirement accounts, savings, 401(k)s, and more. Many seniors also use proceeds from selling their properties or businesses to fund long-term care.

"The aging senior population has prepared for retirement," Bunting says.

If you have loved ones who have the cash to care for you or can care for you physically themselves, you may also be able to skip the long-term care policy. In fact, you might have to if you're already in poor health or have a life-threatening illness.

"When someone gets a dire diagnosis that could lead to long-term care needs, it is almost always too late to purchase the insurance," says Mark Baron, owner of Baron Long Term Care Insurance.

The bottom line

If you want to minimize those high costs, shop around and compare several **long-term care insurance companies** before taking out your policy. There are also other ways to protect against long-term healthcare costs you might want to explore. For one, many life insurance policies offer long-term care benefits or riders. These cover your long-term care costs or, if you don't end up needing long-term care, pay out those benefits to your heirs once you pass away. Some annuities offer similar perks.

If you're considering one of these alternatives, you'll want to explore them before applying for any long-term care policy. According to the American Association for Long-term Care Insurance, nearly half of all applicants 70 to 74 **are denied long-term care insurance policies**. These denials can make it impossible to get approved for other products, like life insurance or annuities, Baron says.

"If someone gets declined, they may have lost a chance for other products," Baron says. "Some plans are an automatic decline for at least a full year if someone was declined for long-term care coverage elsewhere.

Social Security Update Expands Benefits Nationwide

Some Social Security recipients nationwide may soon get more money in their pockets after a change to eligibility criteria, the Social Security Administration (SSA) has announced.

The government agency has announced it is expanding its rental subsidy policy for those who claim Supplemental Security Income (SSI) payments. Under the new rule, published last week, rental assistance, such as renting at a discounted rate, will become less likely to affect a person's SSI eligibility or payment amount.

SSI gives monthly payments to adults and children with a disability or blindness, as well as to adults aged 65 and older who have limited income and resources. Often, these payments are intended to boost the income of those who claim Old-Age, Survivors, and Disability Insurance (OASDI) payments that may fall short of providing for basic needs. In January 2023, 7.4 million individuals received monthly SSI payments averaging $654, according to an SSA report.

The new rule has already been implemented in seven states: Connecticut, Illinois, Indiana, New York, Texas, Vermont and Wisconsin. This is because of local judicial decisions, but the upcoming change will apply to all 50 U.S. states.

For all other claimants nationwide, the change will not be immediate, but will come into force on September 30 this year.

The change will not affect how much the government agency pays per month, which runs to a maximum of $943 in 2024. However, it may increase amounts for current SSI recipients and expand eligibility to others, the government agency said in its April 17 press release. *Newsweek* has contacted the SSA for additional comment via email outside of normal working hours.

"Our mission is to continue to help people access crucial benefits, including SSI," said Martin O'Malley, commissioner of Social Security. "Simplifying and expanding our rental subsidy policy nationwide is another common-sense solution that will improve program equality and will reduce agency time spent calculating and administering rental subsidy."

The rental subsidy change is the **second made to SSI benefits in recent months**. In February, the SSA announced it would no longer include food in its In-Kind Support and Maintenance calculations. In-Kind Support and Maintenance calculates the amount of informal food assistance an SSI applicant or claimant received from friends, family and community support networks.

The SSA said the calculation changes mean applicants and recipients would be required to report less information to the government agency, and that it would reduce month-to-month variability in payment amounts and **payment errors, which have been widely reported by Social Security recipients in recent months.**

Caring for older Americans' teeth and gums is essential, but Medicare generally doesn't cover that cost

C. Everett Koop, the avuncular doctor with a fluffy white beard who served as the U.S. surgeon general during the Reagan administration, was famous for his work as an innovative pediatric surgeon and the attention he paid to the HIV-AIDS crisis.

As **dentistry scholars**, we believe Koop also deserves credit for something else. To help make the medical profession pay more attention to the **importance of healthy teeth and gums,** he'd often say: "You are not healthy without good oral health."

Yet, more than three decades after Koop's surgeon general stint ended in 1989, **millions of Americans don't get even the most basic dental** services, such as checkups, tooth cleanings and fillings.

Americans who **rely on the traditional Medicare program** for their health insurance **get no help from that program with paying their dental bills** aside from some narrow exceptions. This group **includes some 24 million people over 65** – about half of all the people who rely on Medicare for their health insurance.

'Medically necessary' exceptions

When the Medicare program was established in 1965, **almost all dental services were excluded** due to the expense and vigorous opposition from associations that represent dentists out of fear that reimbursement rates would be markedly low compared to traditional insurance plans or out-of-pocket payment.

However, interest **in including dental benefits in Medicare is on the rise** at the Centers for Medicare and Medicaid Services, the federal agency responsible for the Medicare program, as well as many organizations that seek to provide dental benefits to all members of society.

The Biden administration initially considered the addition of comprehensive Medicare dental coverage as part of its **proposed Build Back Better legislation**, a broad US$1.8 trillion legislative package designed to fix problems ranging from child care costs to climate change, but failed to get enough support in Congress….**Read More**

Oncologists' meetings with drug reps don't help cancer patients live longer

Pharmaceutical company reps have been visiting doctors for decades to tell them about the latest drugs. But how does the practice affect patients? A group of economists tried to answer that question.

When drug company reps visit doctors, it usually includes lunch or dinner and a conversation about a new drug. These direct-to-physician marketing interactions are tracked as payments in a public database, and a new study shows the meetings work. That is, doctors prescribe about five percent more oncology drugs following a visit from a pharmaceutical representative, according to a **new study published by the National Bureau of Economic Research this month.**

But the researchers also found that the practice doesn't make cancer patients live longer.

"It does not seem that this payment induces physicians to switch to drugs with a mortality benefit relative to the drug the patient would have gotten otherwise," says **study author Colleen Carey**, an assistant professor of economics and public policy at Cornell University.

For their research, she and her colleagues used Medicare claims data and the **Open Payments database**, which tracks drug company payments to doctors.

While the patients being prescribed these new cancer drugs didn't live longer, Carey also points out that they didn't live shorter lives either. It was about equal.

The pharmaceutical industry trade group, which is known as PhRMA, has a code of conduct for how sales reps should interact with doctors. The code was most recently updated in 2022, says **Jocelyn Ulrich, the group's vice president of policy and research.**

"We're ensuring that there is a constant attention from the industry and ensuring that these are very meaningful and important interactions and that they're compliant," she explains….**Read More**

Will insulin ever be affordable in the US?

The pharmaceutical industry is all too powerful in the US. Not only does it spend a lot of money contributing to policymakers' political campaigns and lobbying them to ensure pharmaceutical companies keep their monopoly drug pricing power, they employ huge numbers of Americans. Not surprisingly, no one in Congress has proposed opening our borders to prescription drug imports–the easiest way to bring drug prices down quickly for everyone in the US. And, Senate Majority Leader Chuck Schumer can't even make good on his promise to lower insulin copays for everyone in the US, reports Rachel Cohrs Zang for **Stat News**.

Two years ago, Senator Schumer announced to a crowd that he was going to ensure the Senate voted to limit insulin costs for every insured American to $35 a month. Since then, he has said it was a "**high priority**." But, he has not yet acted.

Importantly, the Inflation Reduction Act does lower these costs for people with Medicare, but only for people with Medicare. Ideally, federal legislation would protect everyone from high drug costs, including people without health insurance. And, it would require the government to negotiate drug prices. Protecting insured Americans from high insulin costs is a toe in the door, at best, and still it would be a major feat for the Democrats.

Senator Schumer's office was unwilling to speak to a reporter about why the Senator has not yet held a vote on legislation that would limit the cost of insulin for insured Americans. Notably half of states have laws limiting these costs. And, pharmaceutical companies have said that they are making it easier to qualify for **their programs that help pay for insulin costs**.

Better access to lower cost insulin for more Americans might explain Schumer's reluctance to move forward with legislation to cover everyone, but it's not a compelling reason. As recently as August 2022, **one in seven diabetics were struggling to pay for their insulin**. For sure, hundreds of thousands, if not millions, of Americans are still struggling to pay for insulin. More likely, Schumer doesn't want to take on the opposing forces or propose legislation that undercuts other legislation to lower insulin costs that his fellow Senators are proposing.

Politically, Schumer has good reason to take on the insulin issue. Six states that the Democrats would like to win in November –Ohio, Pennsylvania, Michigan, Wisconsin, Nevada, and Arizona–do not provide residents with low-cost access to insulin. And, low-copay insulin could be a winning issue for the Democrats. Pharmaceutical companies don't mind low copays as they would not affect insulin prices.

But, the forces opposing low-copay insulin are mighty. Republicans, for one. Patient advocates, for two, because Schumer's proposal would not lower the cost of insulin, only make it more affordable, shifting costs, and not help people without health insurance.

Survey Shows LGBT Adults Face Discrimination in Daily Life, Health Settings

.As a companion to its **report on race and discrimination**, KFF released a **new report** and survey on the experiences of Lesbian, Gay, Bisexual, and Transgender (LGBT) adults. The survey asked both LGBT and non-LGBT adults about many scenarios and situations, including in daily life and health care settings.

A majority of LGBT respondents reported experiences with discrimination in the previous year. LGBT people with incomes below $40,000 per year reported more discrimination in their daily lives than LGBT people above that income. People who identify as White or Hispanic LGBT adults reported higher levels of discrimination than White or Hispanic non-LGBT adults. For Black adults, the reported levels of discrimination were roughly equal for LGBT and non-LGBT respondents. Rates were also higher for women than men, and for younger adults than older adults.

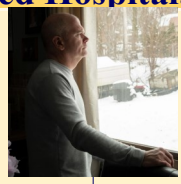
In health care settings, LGBT adults were more likely to report unfair or disrespectful treatment than their non-LGBT peers (33% to 15%, respectively). The numbers were especially high for people with lower income (41%) and those between the ages of 18 and 29 (37%). Over 60% of LGBT respondents reported at least one negative experience with a health care provider over the previous three years, with lower income people being the most likely to cite such experiences, at 70%.

Six in ten LGBT respondents said they had to prepare carefully for appointments, including by dressing well or steeling themselves for insults. And these negative experiences with health care providers led to adverse consequences for many of the respondents, with 39% of LGBT adults saying it made them less likely to seek care, 46% saying it made them less likely to seek mental health care, and 24% reporting that it made their health worse.

More LGBT adults report their mental health or emotional well-being as poor or fair (39%) compared to non-LGBT adults (16%), and younger LGBT adults and those with lower incomes did so at even higher rates. The survey also asked about social networks and support systems, daily stressors, and homelessness, and the results contain important findings illuminating the damaging impacts of discrimination on the LGBT community.

At Medicare Rights, we continue to urge greater efforts on the part of providers, policymakers, and stakeholders to find ways to eliminate discrimination against LGBTQ+ individuals and to mitigate its effects. This is especially vital in health care settings, to avoid creating or exacerbating disparities in treatment and outcomes and to adequately treat and address the health-related consequences of discrimination in society at large. It must also be done comprehensively, to fully address the range of barriers and their causes. All people deserve to be treated respectfully and competently, and to have access to health care that prioritizes their physical and mental well-being.

He Thinks His Wife Died in an Understaffed Hospital. Now He's Trying to Change the Industry.



For the past year, police Detective Tim Lillard has spent most of his waking hours unofficially investigating his wife's death.

The question has never been exactly how Ann Picha-Lillard died on Nov. 19, 2022: She succumbed to respiratory failure after an infection put too much strain on her weakened lungs. She was 65.

For Tim Lillard, the question has been why.

Lillard had been in the hospital with his wife every day for a month. Nurses in the intensive care unit had told him they were short-staffed, and were constantly rushing from one patient to the next.

Lillard tried to pitch in where he could: brushing Ann's shoulder-length blonde hair or flagging down help when her tracheostomy tube gurgled — a sign of possible respiratory distress.

So the day he walked into the ICU and saw staff members huddled in Ann's room, he knew it was serious. He called the couple's adult children: "It's Mom," he told them. "Come now."

All he could do then was sit on Ann's bed and hold her hand, watching as staff members performed chest compressions, desperately trying to save her life.

A minute ticked by. Then another. Lillard's not sure how long the CPR continued — long enough for the couple's son to arrive and take a seat on the other side of Ann's bed, holding her other hand.

Finally, the intensive care doctor called it and the team stopped CPR. Time of death: 12:37 p.m.

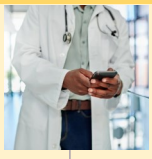
Lillard didn't know what to do in a world without Ann. They had been married almost 25 years. "We were best friends," he said.

Just days before her death, nurses had told Lillard that Ann could be discharged to a rehabilitation center as soon as the end of the week. Then, suddenly, she was gone. Lillard didn't understand what had happened.

Lillard said he now believes that overwhelmed, understaffed nurses hadn't been able to respond in time as Ann's condition deteriorated. And he has made it his mission to fight for change, joining some nursing unions in a push for mandatory ratios that would limit the number of patients in a nurse's care. "I without a doubt believe 100% Ann would still be here today if they had staffing levels, mandatory staffing levels, especially in ICU," Lillard said….**Read More**

Read Special Edition on Nurseing Home Understaffing

Medicare's Push To Improve Chronic Care Attracts Businesses, but Not Many Doctors



Carrie Lester looks forward to the phone call every Thursday from her doctors' medical assistant, who asks how she's doing and if she needs prescription refills. The assistant counsels her on dealing with anxiety and her other health issues.

Lester credits the chats for keeping her out of the hospital and reducing the need for clinic visits to manage chronic conditions including depression, fibromyalgia, and hypertension.

"Just knowing someone is going to check on me is comforting," said Lester, 73, who lives with her dogs, Sophie and Dolly, in Independence, Kansas.

At least two-thirds of Medicare enrollees have two or more chronic health conditions, **federal data shows.** That makes them eligible for a federal program that, since 2015, has rewarded doctors for doing more to manage their health outside office visits.

But while **early research found** the service, called Chronic Care Management, reduced emergency room and in-patient hospital visits and lowered total health spending, uptake has been sluggish.

Federal data from 2019 shows just 4% of potentially eligible enrollees participated in the program, a figure that appears to have held steady through 2023, according to a Mathematica analysis. About 12,000 physicians billed Medicare under the CCM mantle in 2021, according to the latest Medicare data analyzed by KFF Health News. (The Medicare data includes doctors who have annually billed CCM at least a dozen times.)

By comparison, federal data shows about 1 million providers participate in Medicare….**Read More**

Medicare Rights Joins Advocates in Urging Medicare Advantage Reforms

This week, Medicare Rights joined 47 organizations representing people with Medicare, families, advocates, and providers **in a letter** thanking the U.S. Department of Health and Human Services (HHS) for the advancements in the 2025 Medicare Advantage (MA) **rate announcement** and urging additional action to further improve plan accountability and payment methodology.

The 2025 rate announcement, and in particular its continued phase-in of **planned changes** to the MA risk adjustment model, is a critical step forward. Once fully in place, those modifications will better align MA with current health care practices and yield more accurate plan payments. Yet, important reform opportunities remain. For example, the letter notes that persistent, harmful plan practices—including inappropriate denials, aggressive utilization management, predatory marketing, and coding abuses—drive **billions of dollars** in overpayments each year and **raise serious questions** about MA care quality, equity, and value. Other MA-prevalent features, like the **lack of** meaningful plan transparency and oversight, an ineffective **quality program**, and growing evidence of **adverse selection**, only compound these concerns.

As the rate announcement makes changes only to payment policies and guidelines, some of these problems are beyond its scope and will require separate intervention. Others, **such as upcoding**—when plans record 'paper-only' diagnoses without providing additional care—are well within its purview and overdue for correction. Through these manipulated diagnoses, plans raise their own payments and payment inaccuracy system-wide, **as well as costs** for beneficiaries, taxpayers, and Medicare.

Coding exploitation is well documented, and HHS has more tools to curtail it. The letter recommends the agency do so in the following ways:

As Medicare Rights noted in **our comments**, we are disappointed that HHS will again apply the statutory minimum coding adjustment in 2025, rather than a higher and more effective rate. Unchanged since 2018, this minimum amount is **not keeping pace** with coding intensity or the resulting excess plan payments. We strongly recommend that HHS apply a more appropriate adjustment in future years. A tiered approach could target MA plans that engage in upcoding to the greatest extent, removing their unfair and ill-gotten financial advantage over other, more rule-abiding plans.

- **Independent experts agree that** in-home chart reviews and health risk assessments (HRAs) are easily manipulated and represent a significant portion of coding -related overpayments. To help deter plans from using these encounters as hunting grounds for sham diagnoses, we recommend excluding information collected exclusively during these visits from MA risk score and payment calculations.
- Once upcoding occurs, it is blended with other payment factors and hard to disentangle, therefore distorting both current and future payments. Updating MA payment methodology to counter this could help disincentivize upcoding and reduce overpayments. Specifically, using **two years** of Original Medicare and MA data to calculate MA risk-adjusted payments could better limit the impact of erroneous diagnoses from one particular year.

Medicare Rights applauds HHS for finalizing 2025 payment rules that recognize beneficiary priorities and respond to flaws in MA financing. We strongly urge policymakers to build upon these changes to improve payment accuracy, insurer accountability, and access more fully to care.

Medicare Part D drug coverage stunts are rampant

When it comes to Medicare Part D prescription drug coverage, one thing's for sure: Medicare Part D coverage stunts will continue without an overhaul. Insurers have way too much room to drive up drug costs for enrollees in order to profit handsomely. Cheryl Clark reports for **MedPage Today** that Medicare Payment Advisory Commission (MedPac) Commissioners are surprised by the huge variation in generic drug prices and availability among different Part D drug plans. It's no surprise, it's the "free market" run amok.

Commissioners considered why one generic drug can cost someone with Part D coverage $1.06 at one pharmacy and $102 at a different pharmacy, sometimes even the same pharmacy chain. **What goes into generic drug pricing?** Lots of unknown factors in addition to the cost of manufacturing and dispensing the drug and the pharmacy's costs. (But, you can be sure it's all about insurer profits.)

About 20 percent of Medicare spending on prescription drugs is for generics, and generics represent about 90 percent of the drugs that Part D plans fill. Generics are costing more and more.

Some basic generic drugs, including cardiovascular drugs, are just plain "out of stock." The big PBMs can't even say when they will have these drugs in stock. Is it a supply chain issue? (Editor's note: A David Dayen story in **TAP** reveals that 323 drugs are in short supply, many more than in the past, endangering people's health and lives.)

MedPac Commissioners want to know more about Medicare Part D, as if we need to know more to fix a multi-headed drug cost problem. The biggest players have so much power that they can keep drugs off the market if that helps them

financially. A while back, I reported on a story about **CVS not selling certain generic drugs** because they profited more from only making the brand-name alternatives available.

"Tying arrangements" are another cog in the pharmaceutical supply and price wheel. These agreements allow drug wholesalers and pharmacies to set the amount of a brand-name drug discount to the amount of generic drugs a pharmacy buys and the price it pays. Wholesalers can then charge more for generic drugs and give bigger discounts on brand-name drugs.

In addition, bigger pharmacy chains can bargain for lower costs than independent pharmacies. They can also pay less for the same drug from wholesalers. The manufacturers might be charging the same price for a drug, but the wholesalers do not.

And, the Part D the insurers don't help matters, designing formularies that benefit their bottom lines and often cost their enrollees more. For more on the challenges of getting your drugs covered through Part D, check out **this post from last week**.

Bottom line: You cannot assume that you are getting your drugs at the lowest cost through your Part D drug plan. You need to shop around. Too often you can pay a lot less without using your insurance. One MedPac Commissioner explained that with "irrational drug prices … beneficiaries in the know have to strategize multiple means to access their meds. GoodRx over here and a mail order for Mark Cuban over there, a patient assistance program over there, and the many other methods that … bypass the local pharmacist." Of course, those not in the know, often the most vulnerable, pay more than they should…..**Read More**

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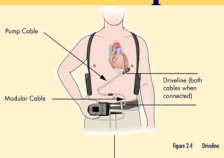
FDA Announces Recall of Heart Pumps Linked to Deaths and Injuries

A pair of heart devices linked to hundreds of injuries and at least 14 deaths has received the FDA's most serious recall, the agency **announced Monday**.

The recall comes years after surgeons say they first noticed problems with the HeartMate II and HeartMate 3, manufactured by Thoratec Corp., a subsidiary of Abbott Laboratories. The devices are not currently being removed from the market. In an emailed response, Abbott said it had communicated the risk to customers this year.

The delayed action raises questions for some safety advocates about how and when issues with approved medical devices should be reported. The heart devices in question have been associated with thousands of reports of patients' injuries and deaths, as described in a **KFF Health News investigation late last year**.



"Why doesn't the public know?" said **Sanket Dhruva**, a cardiologist and an expert in medical device safety and regulation at the University of California-San Francisco. Though some surgeons may have been aware of issues, others, particularly those who do not implant the device frequently, may have been in the dark. "And their patients are suffering adverse events," he said.

The recall involves a pair of mechanical pumps that help the heart pump blood when it can't do so on its own. The devices, small enough to fit in the palm of a hand, are implanted in patients with end-stage heart failure who are waiting for a transplant or as a permanent solution when a transplant is not an option. The recall affects nearly 14,000 devices.

Amanda Hils, an FDA press officer, said the agency is working with Abbott to investigate the reported injuries and deaths and determine if further action is needed.

"To date, the number of deaths reported appears consistent with the **adverse events observed in the initial clinical trial,**" Hils said in an email.

According to the FDA's recall notice, the devices can cause buildup of "biological material" that reduces their ability to help the heart circulate blood and keep patients alive. The buildup accumulates gradually and can appear two years or more after a device is implanted in a patient's chest.

Doctors were advised to watch out for "low-flow alarms" on the devices and, if they do diagnose the obstruction, to either monitor the patient or perform surgery to implant a stent, release the blockage, or replace the pump. "Rates of outflow obstruction are low," Abbott spokesperson Justin Paquette said in an email, adding that patients whose devices are functioning normally "have no reason for concern."...**Read More**

What Folks Consider 'Old Age' Is Getting Older

People's idea of "old age" is aging itself, with middle-aged folks and seniors believing that old age starts later in life than did peers from decades ago, a new study finds.

The study revolves around the question "At what age would you describe someone as old?"

Decades ago, folks born in 1911 set the beginning of old age at 71 when they were asked that question at age 65, researchers report April 22 in the journal *Psychology and Aging*.

But folks born in 1956 said old age begins at 74 when asked at age 65, researchers found.

It's not clear why people these days are setting a later date for the start of old age, said researcher **Markus Wettstein,** a psychologist with Humboldt University in Berlin, Germany.

"Life expectancy has increased, which might contribute to a later perceived onset of old age," Wettstein said in a university news release.

"Also, some aspects of health have improved over time, so that people of a certain age who were regarded as old in the past may no longer be considered old nowadays," Wettstein added.

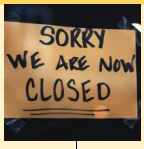
For the study, researchers examined data from more than 14,000 participants in the German Aging Study, which includes people born there between 1911 and 1974.

Participants responded to surveys up to eight times over 25 years, and one question specifically asked the age at which someone could be considered old.…**Read More**

Half of rural hospitals are losing money, closing units

Jazmin Orozco Rodriguez reports for **Kaiser Health News** on the failing finances of half of rural hospitals. They are losing money. A big part of the reason are the insurers offering Medicare Advantage plans who don't pay these hospitals the money they are due.

"The rapid growth of **rural enrollment in Medicare Advantage plans,** which do not reimburse hospitals at the same rate as traditional Medicare, has had a particularly profound effect." Insurers don't profit as much from rural enrollees, so they do not pay rural hospitals adequately, which our government unforgivably allows them to do. (Most people don't appreciate that government payments to Medicare Advantage plans are based on the payment rates in traditional Medicare.)



What's happening? In many cases, rural hospitals are closing their operating rooms and obstetrics units. Hundreds of hospitals have stopped providing chemotherapy. Expenses are greater than revenue. Hospitals cannot find enough workers. And, administrative challenges are large.

Where are the hospital closures happening? All over the US, particularly in small communities. **Chartis** describes that, in the last year alone, one in two rural hospitals operated in the red. That's nearly a ten percent increase from the year before.

How many hospitals are at risk? Chartis found that 418 rural hospitals were at risk of closing. Of note, those rural hospitals in states with expanded Medicaid coverage were in better shape financially than those in states that did not opt to expand Medicaid.

Medicaid expansion to low-income adults has helped ensure access to care health care in those states a lot: In Montana, for example, as a result of Medicaid expansion, there are half as many uninsured residents as there had been. Access to care for Montanans has improved. And, rural facilities are still operating. No hospitals have closed in the last nine years.

The future looks grim for rural hospitals and the people who live in their communities, according to Chartis. Even non-profit hospitals can't survive financially in rural America. The hospitals have no profit margin. Rural residents tend to live on low incomes, to be older and in poorer health. Overall, they have shorter life expectancies than Americans living in other areas.

Alan Morgan, CEO of the National Rural Health Association notes that Congress needs to do more: "It's just bad public policy. And bad policy for the local communities."

Relationship With Partner Affects Outcomes for Breast Cancer Survivors

A strong relationship can help a breast cancer survivor thrive in the aftermath of their terrible ordeal, a new study finds.

Diagnosis and treatment of **breast cancer** places tremendous stress on the women and their partners, researchers said.

Those women in a solid relationship with their partner tend to have less depression and fatigue following their treatment, as well as better physical functioning, the study results show.

For example, they were better able to carry groceries, walk around the block and perform other typical day-to-day tasks, researchers found.

On the other hand, weaker relationships were associated with poor emotional and physical outcomes for breast cancer survivors.

"How the breast cancer survivor and partner communicated and handled stressful events, particularly those related to breast cancer, were linked to emotional and physical health for the survivor, with better agreement related to better outcomes," said lead study author **Eric Vachon.** He's a research scientist with the Regenstrief Institute and Indiana University School of Nursing.

However, part of the strength of a relationship rests on a shared understanding between the partners, the study also found.

Couples where one person rated the relationship more highly than their partner tended to reap worse outcomes, results show.

"Interestingly, breast cancer survivors who rated their relationship satisfaction as high did not necessarily have better agreement with their partner or better well-being than those survivors who viewed their relationship less positively," Vachon said. "It's the communication and relationship between the survivor and partner that are determinant."

For the study, researchers analyzed survey data from 387 couples, including 220 couples with a breast cancer survivor and 167 with no breast cancer. The average age of study participants was mid-40s.

"We knew from the literature that breast cancer survivors' rating of their relationship satisfaction is linked with some poor physical and emotional outcomes," Vachon said in an institute news release…**Read More**

Urine Test Might Spot Head-and-Neck Cancers Early

A newly developed at-home urine test could potentially help doctors catch head and neck cancers **earlier**, a new study suggests.

The test looks for tiny DNA fragments sloughed off by tumor cells, which pass from the bloodstream into urine through the kidneys, researchers said.

These fragments are too small to be caught by current urine or blood tests that look for cancer DNA circulating in the body, researchers reported recently in the journal ***JCI Insight.***

"Conventional assays do not detect ultrashort fragments found in urine, since they are designed to target longer DNA fragments," explained lead researcher **Chandan Bhambhani**, a research lab specialist with the University of Michigan Rogel Cancer Center.

Early detection of head and neck cancers is critical because tumors are easier to treat and potentially cure when they're at an early stage, researchers noted.

Using genetic analysis, researchers showed that the DNA fragments released by head and neck cancers are very short, and thus likely to be overlooked by current tests.

The researchers then created a mail-in urine test that would detect these fragments. The test has been distributed for research purposes to patients located relatively near the University of Michigan.

"One of the most remarkable outcomes of this study is that the test that has been developed has detected cancer recurrences far earlier than would typically happen based on clinical imaging," said co-senior study author **Chad Brenner**, an associate professor of otolaryngology-head and neck surgery at the University of Michigan.

"As such, these promising results have given us the confidence to broaden the scope of the study, seeking to expanding distribution even further," Brenner added in a university news release.

The test also can be tweaked to look for small DNA fragments from other cancers as well, like leukemia and breast cancer, the researchers added.

"Many people are not aware that urine carries information about many different cancer types, although it is made in the kidneys," Bhambhani said.

Urine tests are also easier for patients to gather themselves and send in for analysis, compared to blood tests, Bhambhani added.

Two-Drug Combo Curbs Drinking for People Battling Severe Alcoholism

A combo of an allergy drug and a blood pressure med appears to lower daily drinking in folks battling severe alcoholism, French researchers report.

The two generic drugs are the antihistamine cyproheptadine and prazosin, which treats high blood pressure and urinary urgency, noted a team led by **Henri-Jean Aubin**, of the Université Paris-Saclay in Villejuif.

Aubin's group thought the drug duo might work against alcohol use disorder because cyproheptadine works on brain cell receptors linked to impulsive behaviors, while prazosin targets receptors associated with cravings.

Speaking in an American Psychiatric Association news release, Aubin noted that current medications for alcohol use disorder offer only "limited-to-moderate" effectiveness, so any additional treatment options are welcome.

The new study was published recently in the journal ***Addiction.***

The research involved 154 adults diagnosed with severe alcoholism. That means they drank at least 60 grams of alcohol per day for men or 40 grams per day for women (at least three or four drinks daily). A standard bottle of beer, glass of wine, or shot of liquor contain 14 grams of alcohol.

Participants were divided into three groups: They received daily doses of dummy placebo pills; a "high dose" combo of prazosin plus cyproheptadine; or a "low dose" combo of prazosin plus cyproheptadine for 12 weeks.

Everyone also received support in terms of advice on adhering to the drug therapy and reducing their alcohol intake.

Aubin's team focused at alcohol intake reduction as their goal, not total abstinence.

Folks taking the two-drug regimen did see their alcohol intake decline compared to those on placebo, and the higher the dosage, the bigger the decline.

For example, people taking low-dose prazosin/cyproheptadine experienced an average 18.4 gram reduction in daily alcohol intake (compared to placebo), while those on the higher dose experienced an average 23.6 gram reduction.

The regimen was also tested among a subgroup of people with alcohol used disorder who drank a lot -- more than 100 grams of alcohol (at least 7 drinks) for men and 60 grams per day for women

In this group, taking high-dose prazosin/cyproheptadine cut daily intake by almost 30 grams of alcohol daily, the study found.

As for side effects, the drugs appeared to be "well tolerated," the researchers said.

"The promising efficacy of the combination of prazosin and cyproheptadine warrants prolonging this work with phase 3 trials," they concluded.

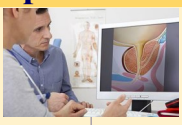
Urine Test Might Help Men Skip Prostate Biopsies

When prostate cancer strikes, one question is paramount: Is it aggressive and requiring immediate treatment, or slow-growing and worthy of monitoring only?

Right now, an invasive biopsy is the only way to answer that query, but researchers say they've developed a urine test that could do the job instead.

The test, called MyProstateScore2.0 (MPS2), was developed by researchers at the University of Michigan, who reported their findings April 18 in the journal ***JAMA Oncology***.

"If you're negative on this test, it's almost certain that you don't have aggressive prostate cancer," said **Dr. Arul Chinnaiyan,** a professor of pathology and urology at Michigan Medicine.



The approach to prostate cancer care has changed radically over the past few decades, noted study co-senior author Dr. John Wei.

"Twenty years ago, we were looking for any kind of [prostate] cancer," said Wei, a professor of urology at the university. "Now, we realize that slow-growing cancer doesn't need to be treated. All of a sudden, the game changed. We went from having to find any cancer to finding only significant cancer."

In decades past, the prostate-specific antigen (PSA) blood test was used routinely to help spot cancers. But its inefficiency in differentiating between aggressive and slow-growing tumors led to over-treatment, and the test is now used much less frequently.

Almost 10 years ago, University of Michigan researchers developed the first generation MyProstateScore test. It tracked two genes, TMPRSS2::ERG, that fuse together to cause prostate cancer, along with another cancer marker called PCA3.

That test was good, but maybe not quite good enough, Chinnaiyan said.

"There was still an unmet need with the MyProstateScore test and other commercial tests currently available," he explained. "They were detecting prostate cancer, but in general they were not doing as good a job in detecting high-grade, or clinically significant, prostate cancer. The impetus for this new test is to address this unmet need."

In the latest-generation test, the Ann Arbor team added analyses of 54 more genes -- all linked to aggressive prostate tumors -- into the mix. Further testing narrowed that list of genes down to 16, which are now included into MyProstateScore2.0.

Prostate cancers' level of aggression is measured on what's called the Gleason score, with tumors scoring as Gleason Grade Group 2 (GG2) or higher more likely to grow and spread than those rated Grade Group 1 (GG1), which may remain "indolent" for years….**Read More**

Big Health Care Disparities Persist Across the U.S., New Report Finds

Deep-seated racial and ethnic disparities persist in health care across the United States, even in states considered the most progressive, a new report shows.

For example, California received a score of 45 for the care its health system provides Hispanic Americans. The Commonwealth Fund report gives each state a 0-to-100 score for each population group living there.

That's better than Florida's health system, which received a 37 for care provided to Hispanic Americans there.

But it's far worse than California's treatment of white patients, which received a score of 87.

The report "offers a comprehensive analysis of the way health care systems are functioning for people in every state, evaluating disparities in health and health care across racial and ethnic groups, both within and between states," the report authors said.

Researchers used 25 measures to evaluate states on health care access, quality, service use and health outcomes for different racial and ethnic populations.

They found that disparities exist even in states well-known for their high-performing health systems.

For example, Massachusetts, Minnesota and Connecticut stand out for their relatively high performance in treating all patients, but those states still had considerable health disparities between white and non-white residents, researchers found.

Across the country, premature deaths from preventable and treatable causes occur at a higher rate among Black and American Indian people overall, compared to other groups, the report found.

Further, in several southwestern and Mountain states premature death rates for Hispanics are higher than elsewhere in the United States, where Hispanic rates align more closely to those of white residents. These states include New Mexico, Arizona, Colorado, Oklahoma, Texas and Wyoming.

However, preventable deaths are higher for both Black and white residents in several southern and south-central states, including Arkansas, Mississippi, Louisiana, Tennessee, Kentucky and Missouri.

The report's authors suggest pursuing four broad policy goals to create an equitable health system:

- Make sure affordable, comprehensive and equitable health insurance is available for everyone
- Improve primary care
- Reduce paperwork for patients and providers
- Invest in social services

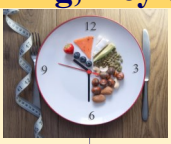
"Since disparities and health inequities vary across states, there are also opportunities for state programs to tailor interventions that address communities' unique needs," the researchers added.

Calories, Not Meal Timing, Key to Weight Loss: Study

A head-to-head trial of obese, pre-diabetic people who ate the same amount of daily calories -- with one group following a fasting schedule and the other eating freely -- found no difference in weight loss or other health indicators.

So, despite the fact that fasting diets are all the rage, if you simply cut your daily caloric intake, **weight loss** will occur no matter *when* you eat, the study authors concluded.

"Consuming most calories earlier in the day during 10-hour time-restricted eating did not decrease weight more than consuming them later in the day," wrote a team led by **Dr. Nisa Maruthur**, an associate professor of medicine at Johns Hopkins Medicine in Baltimore.



Her team presented its findings Friday at the annual meeting of the American College of Physicians (ACP) in Boston. The study was published simultaneously in the ***Annals of Internal Medicine***.

Intermittent fasting has become very popular among weight-conscious Americans in recent years.

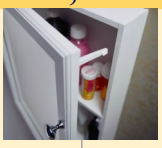
In an ACP news release, the researchers noted that "evidence shows that when adults with obesity limit their eating window to 4 to 10 hours, they naturally reduce caloric intake by approximately 200-550 calories per day and lose weight over 2-12 months."

But what if people simply cut their daily calories by the same amount, without shifting their eating schedules?

The new trial involved 41 people with obesity and pre-diabetes, mostly Black women averaging 59 years of age. Participants were assigned to one of two eating regimens.

Twenty-one of them engaged in time-restricted eating, where they ate only between the hours of 8 a.m. to 6 p.m. and consumed most of their calories before 1 p.m.…**Read More**

Many Seniors Are Overmedicated, But ChatGPT Might Prevent That



AI could help doctors cut back on the bewildering variety of medications that seniors frequently are prescribed, a new study suggests.

More than 40% of seniors are prescribed five or more meds, and this increases a person's risk of adverse **drug** interactions, researchers said.

When asked to evaluate faux medication lists of seniors, the OpenAI program ChatGPT consistently recommended dropping potentially unnecessary drugs, according to findings published April 18 in the ***Journal of Medical Systems.***

"Our findings suggest that AI-based tools can play an important role in ensuring safe medication practices for older adults," said lead researcher **Arya Rao**, a student at Harvard Medical School. "It is imperative that we continue to refine these tools to account for the complexities of medical decision-making."

For the study, researchers asked AI to analyze different clinical scenarios featuring the same elderly patient taking a mixture of medications. The scenarios included variations in history of heart disease and the degree to which people are impaired in performing activities of daily living.

The AI was more cautious when the scenario included heart disease, and was more likely to not request changes to the patient's medication list. However, a patient's daily impairment did not seem to affect the AI's recommendations, researchers added.

The AI did have a tendency to disregard a patient's pain, and favored dropping pain meds over other drug types like statins or blood pressure medications, researchers found.

It's become increasingly tough for doctors to keep track of patients' prescriptions, researchers noted. The rate of seniors on Medicare seeing more specialists has increased, leaving primary care docs the task of overseeing medication management.

"While caution should be taken to increase accuracy of such models, AI-assisted [medication] management could help alleviate the increasing burden on general practitioners," said senior researcher **Dr. Marc Succi**, associate chair of innovation and commercialization at Mass General Brigham Radiology in Boston.

"Further research with specifically trained AI tools may significantly enhance the care of aging patients," Succi added in a hospital news release.

A-Fib Is Strong Precursor to Heart Failure

The dangerous **heart rhythm disorder** known as atrial fibrillation is mainly known for increasing people's risk of stroke.

But people with A-Fib actually have a much higher risk of developing heart failure than suffering a stroke, a new study shows.

In fact, the risk of heart failure associated with A-Fib is "twice as large as the lifetime risk of stroke," concluded the research team led by **Dr. Nicklas Vinter**, a postdoctoral researcher with the Danish Center for Health Services Research at Aalborg University in Denmark.

Two out of five A-Fib patients (42%) will develop heart failure, compared to one in five (20%) who will suffer a stroke and one in 10 (10%) who will have a heart attack, according to results published April 17 in the ***BMJ***.

"Although atrial fibrillation guidelines principally focus on stroke prevention, our findings indicate that heart failure was the major complication," the researchers concluded in a journal news release.

The study also found that a growing number of people are developing A-Fib, increasing their risk of heart failure and stroke.

It used to be that one in four people would develop A-Fib at some point in their lives, researchers said.

That number has now gone up to one in three people, an increase in lifetime A-Fib risk from 25% to 31% between the 2000s and the 2010s.

A-Fib is known to increase stroke risk because the quivering, irregular heartbeat allows blood to pool and clot in the upper chambers of the heart, the American Heart Association (AHA) says. But A-Fib can also contribute to heart failure, which occurs when the heart can't pump out enough blood to meet the body's needs, the AHA says.

A-Fib can cause the heart to beat so fast it never properly fills up with blood to pump out to the body, according to the AHA.

Nearly 16 million Americans are expected to have A-Fib by 2050, researchers said in background notes.

For the new study, they analyzed health data for 3.5 million Danish adults who started with no history of A-Fib. These folks were tracked over a 23-year period, 2000 to 2022, to see whether they wound up with the heart rhythm disorder.

More than 360,000 people wound up with A-Fib, and researchers then followed them to see if they were later diagnosed with heart failure, stroke or heart attack.

Overall, men diagnosed with A-Fib had a higher risk of heart failure than women, 44% versus 33%. Men also had a higher risk of heart attack, 12% versus 10%. But women with A-Fib had a higher risk of stroke, 23% versus 21%.

Doctors currently focus on stroke risk following a diagnosis of A-Fib, prescribing blood thinners to prevent clotting. More than 85% of patients in Denmark diagnosed with A-Fib are prescribed these drugs, researchers said….**Read More**

Dietary Changes May Beat Meds in Treating IBS

The right diet may be the best medicine for easing the painful symptoms of irritable bowel syndrome (IBS), new research shows.

In the study, two different eating plans beat standard medications in treating the debilitating symptoms of the gastrointestinal disease. One diet was low in "FODMAPs," a group of sugars and carbohydrates found in dairy, wheat and certain fruits and vegetables, while the second was a low-carb regimen high in fiber but low in all other carbohydrates.

Published April 19 in the journal ***Lancet Gastroenterology and Hepatology***, the findings suggest that patients should first try dietary changes before moving to drugs for relief.

IBS is one of the most common and stubborn conditions gastroenterologists treat. It affects roughly **6 percent of Americans**, with women diagnosed more often than men.

Its symptoms are hard to ignore and life-limiting: abdominal pain, bloating, diarrhea and constipation.

Treatments often include dietary changes or taking **medications** that can include laxatives and antidiarrheals; certain antidepressants; and other prescription medications such as **linaclotide** and **lubiprostone** -- both of which increase fluid in your gut and the movements of your intestines.

Research has found that a **low-FODMAP diet** -- which involves avoiding foods like wheat products, legumes, some nuts, certain sweeteners, most dairy products and many fruits and vegetables -- can reduce IBS symptoms in most people, **Dr. William Chey**, a gastroenterologist at Michigan Medicine, told the *New York Times*.…**Read More**