Rhode Island Alliance for Retired Americans®

RI ARA

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Message from Alliance *for* Retired Americans Leaders

41 Prescription Drugs Are Now Eligible for Medicare Part B Savings

Robert Roach, Jr
President, ARA

The U.S. Department of Health and Human Services **announced** that 41 prescription drugs will have reduced Medicare Part B coinsurance rates between April 1 and June 30, 2024. More than 700,000 seniors take at least one of the selected drugs, and depending on coverage, they could save up to $3,575 per dose.

The lower rates are a result of the Inflation Reduction Act which penalizes drug corporations that raise prices faster than inflation. The penalty payments will be deposited into the Medicare Trust Fund.

The Inflation Reduction Act has **already led** to previous significant savings for Medicare beneficiaries by allowing Medicare to negotiate lower prices, capping annual out-of-pocket drug costs at $2,000 and insulin copays at $35 a month, and expanding eligibility for Medicare's Low-Income Subsidy "Extra Help" program.

"This action is just another way the Biden administration is delivering lower drug prices and more affordable health care for seniors," said **Robert Roach, Jr., President of the Alliance**. "Meanwhile, 80 percent of House Republicans released a budget proposal last week that would actually repeal the Affordable Care Act, raise the retirement age, and cut Social Security and Medicare."

Key Senator Urges Postal Service to Suspend Agency Overhaul

Sen. Gary Peters (D-Michigan), who chairs the committee that oversees USPS matters in Congress, **criticized** controversial changes that have taken effect under Postmaster General Louis DeJoy and urged leadership to pause them in a letter issued last week.

The changes are part of DeJoy's 10-year "Delivering for America" plan, which he claims will make the agency more efficient. However, prices for stamps and package shipment are increasing while on-time delivery rates have plummeted. A recent industry study confirmed that routine price hikes implemented since December 2020 have backfired by **driving bigger customers away**.

"Seniors rely on USPS for home delivery of critical mail, including lifesaving medicine," said **Richard Fiesta, Executive Director of the Alliance**. "Lawmakers are right to demand that the agency provide on-time service for these critical deliveries." The Postal Service acknowledged that the overhaul has tended to produce lower quality service instead of increasing efficiency, conceding that some regions that piloted the updates have reached an "unacceptable level of service."

Rich Fiesta, Executive Director, ARA

April is Medicaid Awareness Month

The Medicaid program provides health care for 93.4 million Americans with limited income. This includes 42 million children who are insured through the Children's Health Insurance Program (CHIP), 33.9 million adults, 4.8 million people with disabilities, and 7.2 million seniors. Medicaid is the largest payer for long term care.

The Affordable Care Act provided incentives to expand Medicaid to provide insurance for more Americans, but **10 states** have opted out leaving millions who would be eligible if they lived in other states.

"Medicaid is the primary funder of long-term and nursing care in this country helping millions of vulnerable patients get the care they need," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "The Alliance will continue to fight for the ten holdout states to expand Medicaid and to ensure that the program is there for seniors who need it."

Joseph Peters, Jr.
Secretary
Treasurer ARA

GOP faces internal battle over raising age for Social Security

Republicans are battling among themselves over whether to push reforms to reduce Social Security spending, with some conservatives rallying around the idea of raising the retirement age.

Republicans pushing reforms to Social Security argue that raising the retirement age would not cut benefits and would be phased in slowly so as not to affect people near retirement age.

But others in the party warn that talking about delaying Social Security benefits in an election year is political malpractice and would give Democrats a golden opportunity to accuse GOP candidates of wanting to cut Social Security.

"Horrible idea. Totally opposed to this," Sen. **Josh Hawley** (R-Mo.) said of raising the retirement age, even for people who don't plan to retire soon….**Read More**

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After 14 Years, ACA Protections Remain Crucial for Older Adults

The Affordable Care Act (ACA), passed 14 years ago this week, strengthened Medicare and Medicaid and created important coverage guarantees and consumer protections for people of all ages.

From expanding access to affordable care to preventing discrimination based on health status, as well as improving Medicare's financial status, the ACA made significant improvements to the nation's health care infrastructure. These advances are especially important for older adults, who are more likely than younger adults to have health problems that cause them to rely on the ACA's consumer protections.

Some of these benefits and protections are so important that it is hard to recall what the health insurance landscape and consumer rights were like before the ACA's passage. As a reminder, we are highlighting some of the key components of the landmark legislation.

The Benefits

Medicaid Expansion: The ACA gave states the option to expand their Medicaid programs to include coverage for low-income, non-elderly adults (ages 19-64) without dependent children. To date, 41 states (including D.C.) have **expanded Medicaid**, which studies indicate has led to historic coverage gains, improvements in access and financial security, and **economic benefits** for states and providers.

- **Age-Based Discrimination:** The ACA prevents insurers from charging older consumers more than three times what younger people pay. Prior to the ACA, there was no limit on this disparity; health insurance companies were typically free to set significantly higher and often cost-prohibitive premiums based on an individual's age, among other factors.
- **Pre-Existing Conditions, Community Rating, and Guaranteed Issue:** The ACA does not allow compliant insurance plans to deny, limit, or charge people more for coverage based on a pre-existing condition.
- **Elimination of Lifetime and Annual Limits:** The ACA prevents private insurance plans from placing annual or lifetime limits on coverage. These important reforms help protect consumers from catastrophic health expenses and medical-bill-induced bankruptcy. Before the ACA, insurers could simply stop paying for an enrollee's health care expenses after their costs reached a certain amount—often leaving the sickest patients responsible for **extremely high costs**.
- **Essential Health Benefits:** To ensure that people with ACA-compliant plans have access to comprehensive coverage, the health law requires most insurers to cover, at a minimum, a set of 10 essential health benefits (EHB). Prior to the ACA, consumers were often unable to find affordable coverage for many of these services—nearly 1 in 5 Americans lacked coverage for mental health care, and almost 1 in 10 didn't have any prescription drug coverage, despite **60% of the population needing at least one medication per year**.
- **Access to Preventive Services:** The ACA dramatically improved access to no-cost preventive services within Medicare and Medicaid and requires most private health insurance plans to cover a range of preventive health services without patient cost-sharing (co-payments, deductibles, or co-insurance). These changes, particularly when considered alongside the ACA's coverage **expansions, have increased access to clinical preventive services and improved public health**.

Medicare Rights looks forward to continuing to work with policymakers to build upon these important reforms.

Dear Marci: *What is the Part D donut hole?*

Dear Marci,

I recently got onto a Part D drug plan and am concerned about the donut hole. What should I know about it?

-Lisa (Clinton, NJ)

Dear Lisa,

The donut hole—also called the coverage gap—can be very confusing! Here's what you need to know:

There are **four phases of Part D coverage** in 2024: the deductible, initial coverage period, coverage gap (or donut hole), and catastrophic coverage. During the deductible, you are responsible for the full cost of your medications. After you spend a certain amount, set by the plan, you reach the initial coverage period, where your plan pays a portion of your drug costs, and you pay a copay or coinsurance. After your total drug costs (what you have paid and what the plan has paid) reach a certain amount (**$5,030** for most plans in 2024), you then enter the donut hole. (Note: If you have Extra Help, the following doesn't apply to you, as you won't have a donut hole.)

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Once in the donut hole, you'll be responsible for **25%** of the cost of your drugs. You may notice a difference in what you paid for your drugs during your plan's initial coverage phase and the donut hole. For example, if your drug costs $100 and you paid your plan's $15 copay while in the initial coverage period, you'll begin paying $25 for the same drug once you've entered the donut hole.

The donut hole phase ends when you've reached an out-of-pocket amount of **$8,000** for covered drugs. This will put you into the next phase, called **catastrophic coverage,** during which you'll have no cost-sharing for your drugs for the rest of the year. Out-of-pocket costs that count toward this $8,000 limit include:

- Amounts you paid during the deductible period
- What you paid during the initial coverage period
- Almost the full cost of brand-name drugs (including the manufacturer's discount) purchased during the coverage gap
- Amounts paid by others (family members, charities, and other persons on your behalf)
- Amounts paid by **State Pharmaceutical Assistance Programs (SPAPs)**, AIDS Drug Assistance Programs, and the Indian Health Service

Some costs **do not** count towards the $8,000 limit. These include:

- Monthly premiums
- Any amount your plan pays toward drug costs
- Non-covered drug costs
- The cost of covered drugs from pharmacies outside your plan's network
- The 75% generic discount

Your plan should keep track of how much money you've spent out of pocket for covered drugs and your progression through coverage periods. You can find current information in your monthly statements!

I hope that helps!

-Marci

Dear Marci

Dear Marci is a biweekly e-newsletter that helps consumers—people with Medicare, their families and caregivers—understand their Medicare benefits and options. Each issue features Medicare coverage advice, basic health tips and links to vital health care resources.

Social Security: Imbalance Between Taxes Paid vs Benefits Received Set To Increase — How Much Do You Get on Average for What You Pay In?

The basic idea behind Social Security retirement benefits is that you'll spend your working years paying into the system through payroll or self-employment taxes, and the money you pay in will come back in the form of **retirement benefits**. It doesn't quite work that way, though. You'll **likely receive a lot more in benefits than you paid in** through taxes, according to a new analysis from the Tax Policy Center — and that discrepancy is contributing to Social Security's funding problems.

The analysis, released on Monday, Nov. 13, focuses on how much hypothetical workers receive in lifetime benefits compared to how much they pay in taxes that help fund **Social Security and Medicare.**

One of its findings was this: For a single male earning an average wage every year and who retired in 2020 at age 65, lifetime Social Security and Medicare benefits would equal about $640,000. However, total taxes paid in would be just less than $470,000 — a difference of $170,000.

For a couple with one average earner and one low-wage earner, average benefits would total about $1.24 million, while taxes paid would be about $680,000. In this case, the difference is $560,000. The amounts rise and fall for other hypothetical households as their incomes rise and fall relative to average wages.

Moreover, the imbalance between taxes paid and benefits received is expected to increase in coming years. In the case of Social Security, that increase is being driven by gains in real wages, while Medicare benefits "face upward pressure" from higher healthcare costs and new health services.

Both programs will also pay more in benefits because of **longer life expectancies**. Lifetime benefits would double for those turning 65 in 2060, according to the Tax Policy Center. A couple with one average earner and one low earner retiring in that year is projected to receive about $2.5 million in benefits.

"Lifetime benefit payments in excess of dedicated taxes have been supported for a long time by a number of factors — in particular, a ratio of workers to beneficiaries that has been declining especially rapidly as the **baby boomers** retire," Tax Policy Center co-authors C. Eugene Steuerle and Karen E. Smith wrote in the report. "Absent reform, lifetime benefits scheduled to be received by households increasingly exceed the taxes dedicated to these programs."

When boomers were in their prime working years, the Social Security Administration built up a funding surplus because the money coming in through payroll taxes exceeded the money going out in benefits. But that surplus is fast drying up as more boomers start collecting Social Security.

Social Security's Old Age and Survivors Insurance (OASI) Trust Fund is **expected to run out of money in about a decade**. When that happens, the program will have to rely solely on payroll taxes for funding — and those currently cover only about 77% of benefits.

Similarly, the **Medicare Trust Fund faces depletion within the next decade,** leading to debates on whether to cut funding for the seniors' healthcare program.

Given the near-term depletion of the Social Security and Medicare trust funds, the Tax Policy Center recommends reforms that would scale back the rate of benefit increases while still allowing lifetime benefits to "increase significantly" for each cohort of future retirees.

"Policymakers could also consider tax increases and longer work lives to address the challenge of having fewer workers supporting more and more retirees," Steuerle and Smith wrote. "But whatever mix of reforms Congress chooses, these findings reflect how the current math for these programs doesn't add up. Regardless, reform should target lifetime benefits and taxes across generations directly, not just accidentally as a byproduct of other choices."

House Republicans call for major cuts to Social Security and Medicare

Former President Trump does not want to admit that he supports major cuts to Social Security and Medicare, even though he has said so. He has backed off those comments. But, Republicans in the House of Republicans are underscoring their desire for major cuts to Social Security and Medicare, report Brett Arends for **MarketWatch** and Ellie Quinlan Houghtaling for **TNR**.

The proposed 2025 Republican budget from the **Republican Study Committee** in the House of Representatives calls for slashing $2.7 trillion from Social Security and Medicare over the next ten years. And, that's not all. The House Republicans want to raise the age of retirement, which could mean delaying Medicare and Social Security benefits or, at the very least, reductions to those benefits.

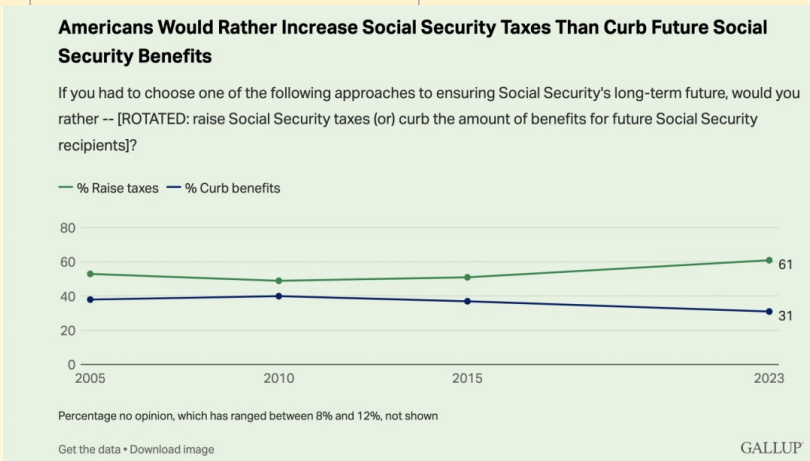
To be clear, nothing is clear about the Republican plan other than a desire to cut taxes and spend less on Medicare and Social Security. Republicans see no need to raise taxes on the wealthiest Americans.

A **recent Gallup poll** found that 61 percent of Americans support raising taxes to "ensure Social Security's long-term future" as compared to 31 percent who support curbing "the amount of benefits for future Social Security recipients." Arends notes that the percentage of Americans who favor raising taxes to strengthen Social Security has grown significantly over the last 15 years.

Republicans in Congress appear to care little that the majority of Americans, including Republican voters, want to strengthen Social Security through tax increases. They do not want to cut Social Security. However, the Republican Study Committee does attempt to stave off any hostility from people receiving Medicare and Social Security today; their proposal does not affect these Americans.

If they could, Republicans would turn Medicare into Medicare Advantage exclusively and likely cut back on payments to Medicare Advantage plans, driving up costs for older adults and people with disabilities, particularly those who need costly care.

While the Republican Study Committee might not be helping former president Trump by speaking out for Medicare and Social Security cuts, I give the Republicans credit for not hesitating to speak their mind. The Republicans know it's a long game to achieve these cuts and that's the hand they are playing.



Primary care in Medicare Advantage: A crapshoot

Don't join a Medicare Advantage plan because you believe it will offer good primary care. According to a new report by the **Commonwealth Fund**, primary care could be good and it could be bad in Medicare Advantage, depending upon the plan you are enrolled in and the primary care physician you use. What's for sure is that if you get sick and need costly care, you are taking a huge gamble with your health in Medicare Advantage.

For sure, some if not most insurers offering Medicare Advantage plans want you to see a primary care doctor. That's how they can most easily add diagnoses codes to your medical records in order collect more money from the government for your care. But, it's not clear whether seeing a primary care physician in Medicare Advantage will improve your health or not.

We know very little about whether a particular Medicare Advantage plan will ensure a **primary care doctor coordinates your care** in ways that keep you healthy. The government pays Medicare Advantage plans upfront regardless of whether they coordinate care. So, they could advise their primary care doctors to spend little time with you or pay these physicians more if they don't refer you for specialty care or refer you to specialists who cost less and provide lower quality care.

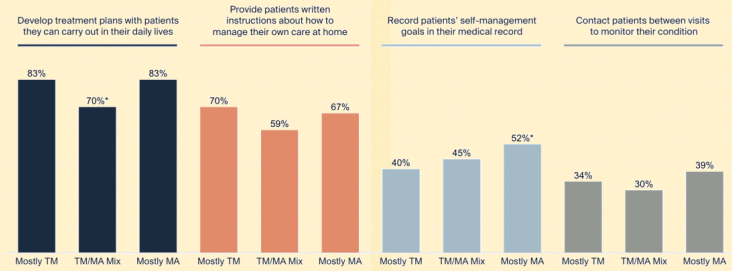
The Commonwealth Fund examined whether primary care physicians treat Medicare Advantage patients in different ways from physicians who treat Traditional Medicare patients. They found that, overall, there were not many meaningful differences between the care primary care physicians provide patients in Traditional Medicare as compared with the care they provide patients in Medicare Advantage.

Unfortunately, "overall," is not really helpful in this analysis. It's like saying that "overall" restaurants in NYC are fine. The question for people with Medicare is which are the good Medicare Advantage plans and which ones should be avoided. This Commonwealth Fund survey does not provide that information.

In short, it seems not to be the case that insurers are making it easier for their primary care physicians in Medicare Advantage to manage and coordinate care than Traditional Medicare

There were few significant differences between how PCPs who mostly saw MA patients and those who mostly saw traditional Medicare patients engaged with and cared for people with chronic conditions.

Percentage of primary care physicians who said their practice provides care for patients with chronic conditions in the following ways "usually" or "often," by patients' type of Medicare coverage



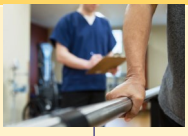
The Burden of Getting Medical Care Can Exhaust Older Patients

By Judith Graham, KFF Health News:

Susanne Gilliam, 67, was walking down her driveway to get the mail in January when she slipped and fell on a patch of black ice.

Pain shot through her left knee and ankle. After summoning her husband on her phone, with difficulty she made it back to the house.

And then began the run-around that so many people face when they interact with America's uncoordinated health care system.



Gilliam's orthopedic surgeon, who managed previous difficulties with her left knee, saw her that afternoon but told her "I don't do ankles."

He referred her to an ankle specialist who ordered a new set of X-rays and an MRI. For convenience's sake, Gilliam asked to get the scans at a hospital near her home in Sudbury, Massachusetts. But the hospital didn't have the doctor's order when she called for an appointment. It came through only after several more calls.

Coordinating the care she needs to recover, including physical therapy, became a part-time job for Gilliam. (Therapists work on only one body part per session, so she has needed separate visits for her knee and for her ankle several times a week.)

"The burden of arranging everything I need — it's huge," Gilliam told me. "It leaves you with such a sense of mental and physical exhaustion."

The toll the American health care system extracts is, in some respects, the price of extraordinary progress in medicine. But it's also evidence of the poor fit between older adults' capacities and the health care system's demands. **Read more here.**

Your Doctor or Your Insurer? Little-Known Rules May Ease the Choice in Medicare Advantage

Bart Klion, 95, and his wife, Barbara, faced a tough choice in January: The upstate New York couple learned that this year they could keep either their private, Medicare Advantage insurance plan — or their doctors at Saratoga Hospital.

The Albany Medical Center system, which includes their hospital, is leaving the Klions' Humana plan — or, depending on which side is talking, the other way around. The breakup threatened to cut the couple's lifeline to cope with serious chronic health conditions.

Klion refused to pick the lesser of two bad options without a fight.

He contacted Humana, the Saratoga hospital, and the health system. The couple's doctors "are an exceptional group of caregivers and have made it possible for us to live an active and productive life," he wrote to the hospital's CEO. He called his wife's former employer, which requires its retirees to enroll in a Humana Medicare Advantage plan to receive company health benefits. He also contacted the **New York StateWide Senior Action Council**, one of the nationwide State Health Insurance Assistance **Programs that offer free, unbiased advice on Medicare**.

Klion said they all told him the same thing: Keep your doctors or your insurance.

With **rare exceptions**, Advantage members are locked into their plans for the rest of the year — while health providers may leave at any time.

Disputes between insurers and providers can lead to entire hospital systems suddenly leaving the plans. Insurers must comply with extensive regulations from the Centers for Medicare & Medicaid Services, including little-known protections for beneficiaries when doctors or hospitals leave their networks. But the news of a breakup can come as a surprise.

In the nearly three decades since Congress created a private-sector alternative to original, government-run Medicare, the plans have enrolled a record 52% of Medicare's 66 million older or disabled adults, according to the CMS. But along with getting **extra benefits** that original Medicare doesn't offer, Advantage beneficiaries have discovered downsides. One common complaint is the requirement that they receive care only from networks of designated providers….**Read More**

Medicare insurance brokers 101: What you need to know

If you're thinking about working with a Medicare broker, it can be hard to know where to start. What does a Medicare broker (sometimes called an agent) do? How much do their services cost? Where do you find one? We're here to help you through it. Here's what you should know before beginning your search.

What is a Medicare broker?

Finding the right Medicare plan can seem like a daunting task – many people choose to work with a Medicare broker or agent for extra guidance. These licensed professionals help you evaluate, select and enroll in a plan. Experienced brokers have a detailed understanding of Medicare. They will be able to explain plan benefits and restrictions, as well as help you compare options, so you can find the best fit for you and your budget.

What's the difference between a Medicare broker and an agent?

Medicare brokers are often referred to as Medicare advisors or agents. In most cases, these titles are used interchangeably. In some organizations these may be separate roles, but in most cases, they are different ways to refer to the same kind of Medicare insurance professional.

Do I have to work with a Medicare broker?

No – working with a Medicare broker is entirely up to you. Many who do find the extra guidance helpful, but it depends on your needs. If you know what you're looking for, and don't have many questions, you can find and enroll in a plan directly.

What does a Medicare broker do?

Medicare brokers are the link between people in need of Medicare plans and the companies who offer them, and they work with both clients and insurance companies. Medicare brokers can also work with both clients and insurance companies to help them find individual, family and group plans that fit their needs.

From the client end, a Medicare broker guides and consults. They can answer your questions and help break down dense Medicare information in a way that makes sense. But what does a broker do for an insurance company? Simply put, they feature and sell their plans, helping private insurance companies get plan information to those who are most likely to enroll.

Are Medicare advisors legitimate?

Legitimate Medicare advisors, brokers and agents are all certified by the insurance companies they represent, according to guidelines set by the Centers for Medicare & Medicaid Services (CMS). All must be licensed in the state or region in which they do business and must adhere to strict regulations, especially regarding marketing and enrollment. Every year, brokers, advisors and agents are trained and tested on Medicare updates by the companies they represent.

Are Medicare brokers/agents unbiased?

As is the case with most services, when looking for a knowledgeable and trustworthy Medicare broker, it's all about the details. Most brokers should be unbiased and committed to helping you find the right plan that fits your budget and meets your needs. Still, it's important to **ask your broker the right questions** before getting started to ensure they're working in your best interests.

How do Medicare agents get paid?

Medicare agents working for a single insurance company are typically employed with and paid by that specific insurance provider. Medicare brokers who work with a wide range of organizations are contracted by these companies for featuring their plans and are paid by commission after enrolling a client. This means you're able to work with a broker at no cost to you.

Typically, broker and agent commission maximums are determined by CMS. This depends on many factors, including state or region, featured plans, whether an enrollee is a new member or renewal, and much more.

Social Security Adjustments Coming In 2024 - Here's What You Need To Know

As 2024 ushers in a wave of significant changes to Social Security, beneficiaries across the board are poised to experience shifts that could impact their financial futures. From the introduction of a reduced cost-of-living adjustment (COLA) to increased taxable maximum earnings, these updates promise to recalibrate the landscape of retirement and disability benefits.

This pivotal moment in Social Security's evolution not only reflects adjustments to economic realities but also signals a crucial time for Americans to reassess their financial planning strategies.

2024's COLA Adjustment

Social Security's cost-of-living adjustment (COLA) for 2024 is set at 3.2%, marking a significant reduction from the previous year's 8.7% increase. This adjustment reflects changes in inflation rates and is designed to help beneficiaries maintain their purchasing power. Every Social Security recipient, from retirees to those with disabilities, will see an increase in their monthly benefits, though the exact boost will depend on individual benefit types and when they were claimed.

Increased Taxable Earnings Ceiling

In 2024, the maximum earnings subject to Social Security payroll taxes will rise to $168,600 from $160,200. This change affects higher-income workers, who will contribute a larger portion of their earnings to the Social Security system. The adjustment is part of an annual update to keep pace with wage growth and affects only a small percentage of workers, ensuring the system's continued funding.

Boost in Maximum Benefits

The maximum Social Security benefit for individuals retiring at full retirement age will increase to $3,822, up from $3,627. This enhancement targets beneficiaries claiming their benefits at the age of 66 or 67, encouraging delayed retirement. It reflects the system's efforts to adjust for economic conditions, rewarding those who contribute for a longer period.

Updated Earnings Test Limits

The earnings test exemption limit for recipients working while collecting Social Security will increase to $22,320 from $21,240. This policy affects beneficiaries under full retirement age who continue to earn income, imposing a benefit reduction for earnings above the threshold. The adjustment allows retirees some flexibility to work without forfeiting their full benefits, encouraging continued workforce participation.

Adjusting for Cost of Living

Across all changes, a consistent theme for 2024 is the adjustment of Social Security policies to better align with the cost of living. Whether through the COLA increase, higher payment standards for SSI, or adjusted benefit amounts, the aim is to provide a stable income source that keeps pace with economic changes, safeguarding beneficiaries' financial well-being.

Conclusion

As the dust settles on the changes to Social Security in 2024, it's clear that staying informed and adaptable is more crucial than ever for beneficiaries. These updates not only underscore the importance of strategic financial planning but also highlight the ongoing efforts to ensure the program's responsiveness to economic shifts and demographic trends.

Moving forward, individuals will need to navigate these changes proactively to secure their financial well-being in retirement and beyond.

New Report Explores Strengthening the Direct Care Workforce

Direct care workers are vital to ensuring older adults and people with disabilities can safely remain in their homes and communities. Such workers, as **formally classified** by the Department of Labor, include certified nursing assistants, home health aides, personal care aides, caregivers, and companions.

Medicaid funds many direct care workers, including those employed by home care agencies or as compensated family caregivers. Despite their essential role and the growing demand for home-based services as the population ages, they tend to have low wages and work in challenging conditions. This makes recruitment and retention difficult and contributes to a workforce shortage.

According to PHI, in 2022, 4.8 million direct care workers, predominantly women and people of color, provided help to 9.8 million people at home, 1.2 million in residential care facilities, and 1.2 million in nursing homes. That same year, the median hourly wage for direct care workers was $15.43, and in 2021 their median annual earnings were $23,688. As a result, 39% of direct care workers live in or near poverty, and 46% rely on public assistance programs to make ends meet. PHI also explains that between 2021 and 2031, the direct care workforce is projected to add more than 1 million new jobs, the largest growth of any job sector in the country. Nearly 9.3 million total direct care jobs will need to be filled, including new jobs and vacancies.

A new **issue brief from** The Commonwealth Fund examines how seven states are trying to strengthen their direct care workforces and outlines opportunities for federal and state policymakers to catalyze that progress. Key findings include:

Enhanced federal funds provided through Medicaid during the pandemic catalyzed state action.

The American Rescue Plan Act (ARPA), pandemic-era legislation, increased federal Medicaid payments to states for certain HCBS activities. Many states used this funding to stabilize their direct care workforces, with 48 states raising base payments and 41 offering incentive payments. Although wages for direct care workers grew as a result, they remain low overall. And as funding flexibilities end, maintaining even relatively modest gains will be difficult.

State recruitment and initiatives are underway but will take time to realize.

States are boosting direct care worker recruitment efforts, including through broader outreach and new marketing strategies. However, in addition to challenging workforce conditions, the lack of readily accessible information on job characteristics remains a barrier. To help correct this, some states are educating policymakers and the public on the necessity of direct care work, both to highlight the profession and improve the low wages, lack of benefits, and problematic environments many workers face. States said it will take time and resources to build the infrastructure needed for full transparency and meaningful change.

Investing in and professionalizing the direct care workforce is critical to addressing shortages.

Titles and training can vary widely across states, but there is movement towards standardization. States are adopting universal approaches, building on federal core competency requirements that aim to simplify employee onboarding and modernize training. But further investments are needed. States and advocates report that recruitment and training materials for people with disabilities or for whom English is a second language is an ongoing need, as is worker access to emotional support services and assistance for family members who function as direct care workers.

State and federal policymakers must work together to strengthen the direct care workforce.

The Commonwealth Fund notes that bolstering the direct care workforce will require sustained federal and state leadership, collaboration, and resources. And that "federal action can augment state efforts through additional resources, recognition of direct care jobs in federal workforce policy, standardized data collection, and a national evaluation of state workforce initiatives."

At Medicare Rights, we agree with these recommendations. A strong direct care workforce is necessary to ensure both workers and individuals receiving care get their needs met. As pandemic-era federal funds expire, dedicated federal investments will be necessary to sustain and build on recent progress. Federal agency support of state recruitment and retention practices must also continue, as must efforts to enhance national data collection and to recognize the value of both direct care jobs and workers.

Life expectancy in US remains lower than all other wealthy nations

Brett Wilkins reports for **Common Dreams** on new data from the federal government on life expectancy in the US. We continue to live shorter lives than people in every other developed nation. Advocates for a government-run national health care system argue that it's time that the our government moves away from for-profit health care and guarantees health care for all Americans under one single system.

Life expectancy in the US is up 1.1 years according to the Centers for Disease Control (CDC). It was 77.5 in 2022, the most recent year for which we have data. It's still significantly lower than dozens of other countries.

Cancer, heart disease, injuries and Covid-19 were most common causes of death in 2022. We lost 1.2 million lives to Covid-19. With guaranteed universal health care, we might have cut that number down by 338,000 to fewer than 900,000 lives, according to **one study.**

In 2020 and 2021, US life expectancy fell, in large part as a result of Covid-19. But, in 2019, life expectancy was 1.3 years higher than it was in 2022, 78.8 years. It should go without saying that the US spends significantly more per person on health care than other wealthy countries. Every other wealthy nation has guaranteed health care for all its citizens.

For-profit health care is not good for patient health. Eagan Kemp of Public Citizen advocates: "We must keep making the point that profit-driven healthcare is not only worse for patients—it's a national embarrassment. Our leaders must act to kick insurance companies to the curb and enact Medicare for All now."

Not only does guaranteed health care for all deliver longer life expectancies and better patient outcomes overall, it costs a lot less than our profit-driven health care system.

The **Congressional Budget Office** determined that guaranteed health care for all would cost as much as $650 billion less than we currently spend, back in 2020. It also found that without healthcare coverage, 68,000 people in the US die every year. Our health care system also drives millions of families into medical bankruptcy and financial distress.

In the words of the chair of the Congressional Progressive Caucus, Congresswoman Pramila Jayapal: "There is a solution to this health crisis—a popular one that guarantees healthcare to every person as a human right and finally puts people over profits and care over corporations. That solution is Medicare for All—everyone in, nobody out."

2024: Programs that lower your health care costs if you have Medicare

Medicare only covers about half of a typical person's health care costs, leaving people with average **annual out-of-pocket costs** of $7,000. So, **even with Medicare**, many people struggle to afford premiums, deductibles and other costs. Some people qualify for Medicaid, which fills most of the gaps in Medicare. But, if you do not qualify for **Medicaid,** there are other programs that lower your health care costs. Click **here** or contact your local **State Health Insurance Assistance Program (SHIP)** to find out if you are eligible for any of these programs and how to apply.

1. Medicare Savings Programs. Depending on your income, Medicare Savings Programs, administered by Medicaid, help pay for Medicare premiums and coinsurance, even if you don't qualify for Medicaid. There are three programs, Qualified Medicare Beneficiary (QMB), Specified-Low Income Medicare Beneficiary (SLMB) and Qualified Individual (QI). Income and asset limits, and how they are counted, are listed below for 2024, but vary somewhat by state. You might still qualify for these programs in your state even if your income or assets are higher than the federal amounts listed below. States sometimes exclude certain income and assets when determining your eligibility. You should apply through **your state Medicaid office**.

- **Qualified Medicare Beneficiary (QMB)**—100 percent of federal poverty level (FPL) + $20. If you have QMB, you should not have out-of-pocket costs for Medicare-approved services in traditional Medicare or for in-network services in a Medicare Advantage plan. It should cover premiums, deductibles, coinsurance and copays for Medicare-covered services.
  - **Income limit monthly** depends upon where you live but is around
    - $1,275 for individuals
    - $1,724 for couples
  - **Asset limit**
    - Individuals: $9,430
    - Couples: $14,130
- **Specified Low-income Medicare Beneficiary (SLMB)**—120 percent of FPL + $20. SLMB helps pay your Medicare Part B premium, if you have Part A and Part B.
  - **Income limit monthly** depends upon where you live but is around
    - $1,526 for individuals
    - $2.064 for couples
  - **Asset limit**
    - Individuals: $9,430
    - Couples: $14,130
- **Qualifying Individual (QI)**—135 percent of FPL +$20, helps pay your Medicare Part B premium if you have Medicare Part A and Part B.
  - **Income limit monthly** depends upon where you live but is around
    - $1,715 for individuals
    - $2,320 for couples
  - **Asset limit**
    - Individuals: $9,430
    - Couples: $14,600

Several valuable items are not counted as income and assets. No matter what state you live in, the first $20 of your income and the first $65 of your monthly wages are not counted as income. In addition, half of your monthly wages, after the first $65 is not counted, nor are food stamps. Some of your assets are also not counted, including your primary home, if you own it, your car, your wedding and engagement rings, a burial plot and $1,500 in burial funds, your life insurance with a cash value less than $1,500, and your furniture, household and personal items. Your bank accounts, stocks and bonds are counted.

Tip: If your income is low but too high to qualify you for Medicaid, it is worth looking into whether you qualify for any of these programs. According to **MACPAC**, an independent agency that advises Congress on Medicaid policy, less than a half the people over 65 who qualify for the Qualified Medicare Beneficiary program (48%) are enrolled. And, an even smaller share of people over 65 who qualify for the Specified Low-Income Medicare Beneficiary program (28%) are enrolled. About one in seven people over 65 (15%) who qualify for the QI program are enrolled.

2. Extra Help with Medicare Part D prescription drug coverage: You will automatically qualify for the **Extra Help** program, which is administered by Medicaid, if you qualify for Medicaid or any of the above low-income programs or receive Supplemental Security Income benefits. You can also **apply for Extra Help independently**. Extra Help pays for some or all of the cost of your Part D drug coverage and is estimated to be worth around $5,100 a year. The amount of help with cost-sharing depends on the level of your income and assets. In 2024, you may qualify if you have up to $22,590 in annual income ($30,660 for a married couple) and up to $17,220 in assets ($34,360 for a married couple). With Extra Help your drug costs are no more than $4.50 for each generic/$11.20 for each brand-name covered drug. If your total drugs costs–what you and your health plan pay) go above $8,000 this year, you'll pay nothing more. And, depending upon your income, you may pay only part of your Medicare drug plan premiums and deductibles. (Some states have **State Pharmaceutical Assistance Programs** that provide even more assistance.)

3. Federally Qualified Health Centers (FQHCs) and other programs run by the Human Resources and Services Administration: FQHCs are located across the country and provide a wide range of services to underserved populations and areas on a sliding-fee scale. They might waive the Medicare deductible and coinsurance, depending upon your income.

4. Hill-Burton programs offer **free or reduced care at Hill-Burton facilities** in 38 states. Hill-Burton does not cover services fully covered by Medicare or Medicaid. Eligibility depends on your family size and income.

5. Veterans' Administration: If you are a vet, the **Veterans' Administration** (VA) offers low-cost services and prescription drugs directly. And, you can have VA coverage as well as Medicare. Keep in mind that you may be eligible for Medicaid based on your income after paying for some health care costs. To contact your **state Medicaid office, click here.**

Medicare Spending on Ozempic and Other GLP-1s Is Skyrocketing

GLP-1 drugs such as Ozempic, Wegovy, and Mounjaro were initially developed to treat type 2 diabetes, but their effectiveness as anti-obesity medications has generated tremendous excitement and high demand among people who have struggled to lose weight by other means. These drugs are also being tested to treat other conditions, and the **FDA has just approved a new use** for Wegovy to reduce the risk of adverse cardiovascular events. But the annual cost of these drugs in the US – **upwards of $11,000** at recent list prices, though net prices may be lower with rebates negotiated by pharmacy benefit managers – has raised concerns about the fiscal impact of broad coverage of GLP-1 drugs on Medicare, other health insurers, and patients.

Medicare is **prohibited under current law** from covering drugs used for weight loss, but Medicare Part D plans can cover GLP-1s for their other **medically-accepted indications,** including to treat diabetes, and now to cut cardiovascular risk based on a **recent memo** from the Centers for Medicare & Medicaid Services (CMS).....**Read More**

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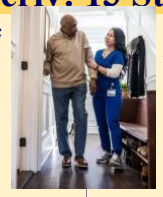
HealthLink Wellness "Taking Control"

Fall Prevention for the Elderly: 13 Strategies to Keep Them Safe

Is your elderly loved one at risk of falling? Learn about strategies and safety measures to help prevent falls.

Falls are the leading cause of injury in adults 65 and older – with reports showing about 14 million adults fall each year, according to the Centers for Disease Control and Prevention. Not only are falls common among older adults, but they can also lead to more serious injuries when they occur.

Falls can lead to severe health conditions like **traumatic brain injuries**, bone fractures and even death. According to the CDC, falls are also the leading cause of injury-related death in the 65-and-older population – and the fall death rate is growing.Here's what to know about what increases risk for falls in older adults, and get familiar with **fall prevention tips** and safety measures that can help reduce the risk.



What Causes Falls in Older Adults?

Anyone can slip and fall, but older adults are more prone to falling than younger people. "That's because aging affects our muscle strength and flexibility, making it more challenging to **maintain balance and stability**. Older adults are also more likely to have chronic conditions that can affect their mobility, coordination and overall stability," says Dr. Esiquio Casillas, senior vice president and chief medical officer for the AltaMed Health Services Program of All-Inclusive Care for the Elderly, or PACE, in the Los Angeles area. "Plus, age-related vision changes and **hearing loss** can make it harder to navigate and identify potential hazards."

Some areas of the body in which age-related changes can increase your fall risk include:

- **Eyes,** such as partial or total loss of vision.
- **Nerves,** including decline in or loss of nerve function, such as sensations in the feet.
- **Bones,** such as reductions in **bone strength**.
- **Muscles,** including muscle loss or impaired muscle function.
- **Brain,** including challenges with brain coordination.

Diagnoses like **Alzheimer's disease** and other **dementias**, which can develop in older adults but are not natural parts of aging, can also increase risk of falls in older adults due to the disease impact on memory and thinking….**Read More**

Too Often, Nearby Defibrillators Go Unused on People in Cardiac Arrest

There's been a big push over the past few years to get automated external defibrillators (AEDs) installed in public spaces, to help save lives threatened by cardiac arrest.

Unfortunately, the devices are very seldom used.

A new study finds that in nearly 1,800 cases where cardiac arrest occurred outside of a hospital, AEDs were only utilized 13 times.

In many cases, the devices were close at hand -- although bystanders may not have realized that.

"Public AED availability is critical for people to be able to use them in the appropriate time and fashion," said study lead author **Dr. Mirza Khan**. "However, people need to know it's there to be able to use it. It's not sufficient just to have them in the right places."

Khan is a physician and medical informatician at the University of Missouri-Kansas City. His team is slated to present the findings on April 6 at the annual meeting of the American College of Cardiology (ACC) in Atlanta.

According to U.S. Centers for Disease Control and Prevention, over 356,000 cardiac arrests occur in homes or public spaces each year, and only about 10% of affected people survive.

As the ACC explained in a news release, AEDs are small, sophisticated devices placed on the chest that quickly analyze a stricken patient's heart rhythms and then deliver a potentially lifesaving electric shock when necessary.

They "are designed to be easy for untrained bystanders to use, and many states have laws requiring these devices to be available in public places, such as airports, shopping malls, schools and gyms," the ACC said.

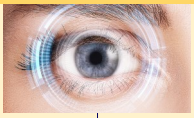
But are they being used?...**Read More**

Next frontier: Eye exams using artificial intelligence

Photos from a retinal camera allow an artificial intelligence (AI) algorithm to perform eye exams and quickly diagnose diabetic retinopathy, a condition that could lead to blindness, reports Hannah Norman for **California Health Line**. Diagnoses are immediate, and no doctor is involved.

Diabetic retinopathy is the principal cause of blindness for adults under 65 and a health condition that millions of Americans with diabetes are at risk of getting. Today, some 9.6 million Americans have diabetic retinopathy.

People with type 2 diabetes typically spend a lot of time and money getting tested for retinopathy. They must see an eye doctor, have their eyes dilated and then can easily wait seven days for a diagnosis. And, it is recommended that they do so each year or, at least, every other year.



To date, the FDA has approved lots of medical devices that work through AI.

What is diabetic retinopathy? It stems from injury to blood vessels in the retina from high blood sugar. People with diabetes can stave off diabetic retinopathy when they manage their condition. And, doctors can treat diabetic retinopathy. But, screenings allow for early treatment.

How easy is it to you an AI system to detect diabetic retinopathy? It takes only a few hours of training.

What happens during the AI diagnosis? Patients look into a special camera so that a technician can photograph their eyes. Generally, there is no need to dilate the patients' eyes.

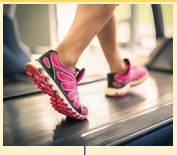
What are the risks of using AI to diagnose diabetic retinopathy? At the moment, using AI will only detect diabetic retinopathy. It will not detect other eye conditions that an eye doctor might detect. For example, it won't detect choroidal melanoma.

What are the benefits of using AI to diagnose diabetic retinopathy? Using AI to diagnose diabetic retinopathy is faster and less costly than going to the eye doctor. With AI, people are also far more likely to go for a follow-up visit after diagnosis than if they went to the eye doctor, according to one recent study. Researchers attribute the increased likelihood of follow-up to the fact that patients get a diagnosis right away.

Does Medicare cover this AI test? Medicare covers this AI eye test, albeit at a very low rate– $45.36. Corporate health insurers have an average negotiated rate of $127.81 for the test.

The technology is still in its infancy. But, based on what we know right now, it is more than likely to take off big time before long. And, of course, researchers are looking to expand the reach of AI to detect glaucoma and other eye diseases.

Obesity Genes Mean Some Folks Must Exercise More for Same Results



Some folks struggling with obesity appear to be hampered by their own genes when it comes to working off those extra pounds, a new study finds.

People with a higher genetic risk of obesity have to **exercise** more to avoid becoming unhealthily heavy, researchers discovered.

"Genetic background contributes to the amount of physical activity needed to mitigate obesity. The higher the genetic risk, the more steps needed per day," said senior researcher **Douglas Ruderfer**, director of the Center for Digital Genomic Medicine at Vanderbilt University Medical Center in Nashville, Tenn.

Because of that, physical activity guidelines might not be so helpful when it comes to maintaining a healthy weight, since individual genetic differences drive how much exercise each person requires, Ruderfer noted.

People instead need to be "active enough to account for their genetic background, or their genetic risk for obesity, regardless of how high that risk might be," Ruderfer said in a Vanderbilt news release.

For the study, researchers tracked more than 3,100 middle-aged people who weren't obese and who walked an average 8,300 steps a day for more than five years. Obesity increased 43% among people with the highest genetic risk scores for obesity, but only by 13% among those with the lowest risk, researchers found.

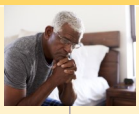
Results showed those with the highest genetic risk for obesity had to walk an average of 2,280 more steps per day than those with average risk to avoid packing on pounds.

Further, people with high genetic risk and BMIs between 22 and 28 needed to walk an additional 3,460 to 6,350 steps per day to have a risk comparable to folks with the least genetic predisposition to obesity.

Healthy weight BMI runs from 18.5 to 24.9, while overweight runs from 25 to 29.9.

"I think it is intuitive that individuals who have a higher genetic risk of obesity might need to have more physical activity to reduce that risk, but what is new and important from this study is that we were able to put a number on the amount of activity needed to reduce the risk," said lead researcher **Dr. Evan Brittain**, an associate professor of cardiovascular medicine at Vanderbilt….**Read More**

Black Men Less Likely to Receive Heart Transplants Than White Men or Women



The odds in the United States that a well-functioning donor heart will go to a Black man are lower than for white transplant candidates of either gender, new research shows.

The news is troubling, since "Black patients have a two to three times greater risk of developing **heart failure** than white patients, and they have the highest risk of dying from heart failure compared with all other racial and ethnic groups," said study author **Dr. Khadijah Breathett**. She is an associate professor of medicine at the Indiana University School of Medicine in Indianapolis.

The new study, published March 25 in the ***Journal of the American Medical Association***, tracked what is known as the "acceptance" of donor hearts by health care teams who care for candidate recipients for transplant.

Breathett's team looked at data from United Network for Organ Sharing (UNOS) from late 2018 to March of 2023.

Of the nearly 15,000 Americans waiting on a list for a donor heart, 69% were white and 31% were Black. About 74% were men.

Black candidates (of either gender) for heart transplant were 24% less likely to be accepted for a healthy donor heart compared to white candidates of ether gender, the study found. That was true for multiple "offers" of a donor heart.

Women tended to be more readily accepted for donor hearts than men, the study found.

Ranked by likelihood of receiving a healthy donor heart, white women ranked highest, followed by Black women, then white men and finally Black men, the research showed.

"Black patients are less likely to be referred for a heart transplant, approved for transplant and receive a transplant after listing," Breathett said in a university news release. "The intersection of race and gender often worsens access for Black women."

Breathett is also a cardiologist at Indiana University Health. She explained that organ transplants currently rely on a computer algorithm that matches candidates and donors based on various factors, such as blood type, severity of illness, urgency for transplant and location.

Next, members of the transplant team review the data and make a decision as to whether to accept the heart for a particular patient in need.

"We wanted to understand how the process of receiving a transplant after listing varied by race and gender, and the combination of the two, so that steps can be taken to make that process more equitable," Breathett explained.

She stressed that decisions as to who gets a donor heart aren't easy.

Transplant teams need to look at whether the heart suits the patient in terms of body size, the health of the donor, how the donor died and the travel distance between the donor's hospital and that of the prospective recipient...**Read More**

Could Deep Frying Foods Harm the Brain? Rat Study Suggests It Might

Fried foods not only wreck the waistline, but they could also be harming the brain, a new study of lab rats suggests.

Fed chow that was fried in sesame or sunflower oil, the rodents developed liver and colon problems that wound up affecting their brain health, researchers found.

These brain health effects not only were found in the lab rats that munched down the fried food, but also in their offspring, noted lead researcher **Kathiresan Shanmugam**, an associate professor with the Central University of Tamil Nadu in India.

These results suggest that reused frying oil could affect connections between the liver, gut and **brain**, Shanmugam said.

"Deep-frying at high temperatures has been linked with several metabolic disorders, but there have been no long-term investigations on the influence of deep-fried oil consumption and its detrimental effects on health," Shanmugam said. "To our knowledge we are first to report long-term deep-fried oil supplementation increases neurodegeneration in the first-generation offspring." Scientists stress that this is early research, however, and animal studies don't always pan out in humans.

The study was presented Sunday at the American Society for Biochemistry and Molecular Biology annual meeting in San Antonio, Texas.

Deep frying adds loads of fat calories to food, researchers noted. In addition, frying oil that's reused often loses many of its natural antioxidants and health benefits, while gaining harmful compounds.

To explore the long-term effects of eating fried foods, female lab rats were divided into groups that ate either standard chow, chow soaked in room-temperature oils, or chow fried in reheated oil.

Rats that ate fried chow developed inflammation of the liver, and their colon microbes began to release more bacterial toxins, results show….**Read More**

Another Study Warns of Surgery Risks for Folks Taking Ozempic, Wegovy

People taking weight-loss drugs like **Ozempic** and Wegovy need to drop them in the days or weeks prior to surgery, a new study warns.

Folks on one of these drugs -- known as GLP-1 receptor agonists -- have a 33% higher risk of developing pneumonia by breathing in their own vomit during surgery, researchers found.

"Aspiration during or after endoscopy can be devastating," said researcher **Dr. Ali Rezaie**, medical director of the GI Motility Program at Cedars-Sinai Medical Center in Los Angeles.

"If significant, it can lead to respiratory failure, ICU admission and even death," Rezaie said. "Even mild cases may require close monitoring, respiratory support and medications including antibiotics. It is important we take all possible precautions to prevent aspiration from occurring."

People are typically asked to fast prior to surgery because general anesthesia can cause nausea, and they might inhale and choke on their own vomit.

Unfortunately, part of the way that GLP-1 receptor agonists help prompt weight loss is by slowing the digestion process, researchers said. That means it takes longer for food to pass through the stomach.

These results jibe with guidance issued last year by the American Society of Anesthesiologists that calls for screening for weight-loss drug use before surgery, and informing patients of the risks involved.

Further, another study published earlier this month in the journal ***JAMA Surgery*** found that about 56% of people taking these drugs still have significant amounts of food in their stomach at the time of surgery.

For this latest study, researchers analyzed the data from nearly 1 million U.S. patients who underwent an endoscopy between January 2018 and December 2020. Endoscopies involve long flexible tubes inserted into the mouth or anus, through which doctors can examine the GI tract for signs of illness.

They found that people on the weight-loss drugs had a 33% greater risk of aspiration pneumonia.

The new study was published March 27 in the journal ***Gastroenterology.***

"When we apply this risk to the more than 20 million endoscopies that are performed in the U.S. each year, there may actually be a large number of cases where aspiration could be avoided if the patient safely stops their GLP-1RA medication in advance," Rezaie said in a Cedars Sinai news release.

"The results of this study could change clinical practice," said lead researcher **Dr. Yee Hui Yeo**, a clinical fellow in the Karsh Division of Gastroenterology and Hepatology at Cedars-Sinai. "Patients taking these medications who are scheduled to undergo a procedure should communicate with their healthcare team well in advance to avoid unnecessary and unwanted complications."

High-Strength Lidocaine Skin Creams Can Cause Seizures, Heart Trouble, FDA Warns

Some pain-relieving skin products contain potentially harmful doses of the numbing agent lidocaine and should be avoided, the U.S. Food and Drug Administration warns.

These creams, gels, sprays and soaps are marketed for topical use to relieve the pain of cosmetic procedures like microdermabrasion, laser hair removal, tattooing and piercing, the FDA said.

The agency has issued warning letters to six companies that are marketing products containing concentrations of lidocaine heavy enough to harm people, particularly after cosmetic procedures that could cause the cream to be absorbed more readily through the skin.

Products containing lidocaine over 4% can contribute to health problems like an irregular heartbeat, seizures and breathing difficulties, the FDA explained. They also can interact with other medications or supplements a person is taking.

"These products pose unacceptable risks to consumers and should not be on the market," Jill Furman, director of the Office of Compliance in the FDA's Center for Drug Evaluation and Research, said in an agency news release. "We are committed to using all available tools to stop the sale of these illegal high-risk products."

The companies and products covered by the warning letters include:

- TKTX Company: TKTX Numb Maximum Strength Pain Reliever, Mithra+ 10% Lidocaine, TKTX During Procedure Numbing Gel 40% and J-CAIN cream [LIDOCAINE] 29.9%
- SeeNext Venture, Ltd.: NumbSkin 5% Lidocaine Numbing Cream (15 grams), NumbSkin 5% Lidocaine Numbing Cream (30 grams) and NumbSkin 10.56% Lidocaine Numbing Cream
- Tattoo Numbing Cream Co.: Signature Tattoo Numbing Cream and Miracle Numb Spray
- Sky Bank Media, LLC, doing business as Painless Tattoo Co.: Painless Tattoo Numbing Cream and Painless Tattoo Numbing Spray
- Dermal Source, Inc.: New & Improved Blue Gel, Superior Super Juice, Premium Pro Plus, Five-Star Vasocaine and Maximum Zone 1
- Indelicare, doing business as INKEEZE: Ink Eeze Original B Numb Numbing Gel, Ink Eeze B Numb Numbing Spray Black Label and Ink Eeze B Numb Numbing Foam Soap
- The FDA is particularly concerned if these products are applied over large areas of skin for prolonged periods of time, especially if the skin is irritated or broken.

Consumers also should not wrap skin treated with any over-the-counter pain relief products with plastic wrap or other dressings, which can increase the risk of side effects, the FDA said.

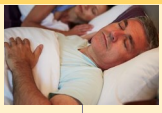
Good Sleep Can Make You Feel Young

A good night's sleep can make you feel years younger, while crummy sleep leaves you doddering around like an oldster, a new study shows.

Sleeping well enough to feel extremely sharp when you wake is associated with feeling four years younger than one's actual age, researchers found.

On the other hand, extreme **sleepiness** makes a person feel six years older than they really are, results show.

"This means that going from feeling alert to sleepy added a striking 10 years to how old one felt," said researcher Leonie Balter, with Stockholm University's Department of Psychology.



For this study, researchers first surveyed 429 people ages 18 to 70 about how old they felt, how much sleep they get and how sleepy they felt.

The survey results showed that for each night a person had insufficient sleep, they felt about three months older than they actually were, on average.

Based on this, the researchers designed an experiment to test whether good sleep could make someone feel young and vibrant.

Previous research has shown that feeling younger than one's actual age is associated with living a longer and healthier life, and there's even evidence that people who feel young have younger brains, researchers said.

"Given that sleep is essential for brain function and overall well-being, we decided to test whether sleep holds any secrets to preserving a youthful sense of age," Balter said.

The experiment involved 186 people ages 18 to 46. Participants were asked to restrict their sleep to just four hours in bed for two nights, and at another time asked to sleep nine hours in bed for two nights….**Read More**