

April 9, 2023 E-Newsletter



Message from Alliance for Retired Americans Leaders

Senators Draw Attention to the Sky-High Salaries of Medicare Advantage CEOs



Robert Roach,
President, ARA



Sens. Elizabeth Warren (MA) and Jeff Merkley (OR) are **calling attention** to the massive profits and "exorbitant" executive salaries of top Medicare Advantage insurers such as

UnitedHealthcare and Humana, which are leading a lobbying campaign against efforts to combat widespread fraud in the privately-run healthcare program.

"In 2022, the seven major Medicare Advantage health care insurers—UnitedHealthcare, CVS/Aetna, Cigna, Elevance Health, Humana, Centene, and Molina—brought in revenues of \$1.25 trillion and reported total profits of \$69.3 billion, a 287% increase in profits since 2012," the Democratic senators wrote in recent letters to the companies' CEOs, citing an analysis by Wendell Potter of the Center for Health and Democracy.

Humana chief executive Bruce Broussard took in more than \$17 million in 2021.

Profits on Medicare Advantage plans are at least **double** what insurers earn from other kinds of policies, according to a recent analysis by the Kaiser Family Foundation. The insurers receive a flat rate

for every person they sign up, and they get bonuses for those with serious health conditions, because their medical care usually costs more.

However, multiple studies from academic researchers, government watchdog agencies and federal fraud cases underscore how some insurers have gamed the system by attaching extra diagnosis codes to patients' records to collect the bonus payments.

"Containing costs for Medicare Advantage is one of the most important ways the president and Congress could improve Medicare's solvency," said **Robert Roach, Jr., President** of the Alliance.

"Reining in the absurd salaries of the CEOs of these insurance companies is warranted, too."

Trustees Report Shows Social Security Expansion is Affordable

On Friday the Trustees of the Social Security and Medicare



Trust Funds released their 2023 reports. Below is Alliance

Executive Director Richard Fiesta's statement: "Today's reports show once again that Social Security's Old-Age and Survivors Insurance (OASI) Trust Fund is strong and solvent, with enough money to cover full benefits and expenses until 2033, one year earlier than reported last year. If no changes are made, the Trust Fund can pay 77% of scheduled benefits.



Rich Fiesta,
Executive
Director, ARA

"Further, the Medicare Part A Trust Fund for hospital care has sufficient funds to cover its obligations until 2031, three years later than reported last year.

"The Trust Funds are strong because most Americans contribute to them with every paycheck. They could be even stronger if the wealthiest Americans paid their fair share. "We must strengthen Social Security by lifting the cap on earnings — currently \$160,200 — subject to the 6.2% payroll tax.

"President Biden's budget extends Medicare's solvency by decades by further lowering prescription drug prices and asking the wealthiest to pay a little more and should be passed by Congress.

"Eighty-eight percent of Americans oppose cuts to Social Security and Medicare. They do not want the government to lower benefits, change the retirement age, or let Wall Street gamble with their guaranteed benefits.

"Older Americans have earned these benefits after a lifetime of hard work and will not allow the rug to be needlessly pulled out from under them, their children, or their grandchildren."

Biden's Budget Would Raise Taxes On Top .1%, Cut Them For Many Others

According to a new **analysis by the Tax Policy Center**, President Biden's fiscal year



Joseph Peters
ARA
Sec.-Trea.

2024 budget would raise average after-tax incomes for low-income households — those who earn about \$31,000 or less — by nearly \$600, or 3.2%, next year. The budget would leave the incomes of middle-income households — those making between about \$60,000 and \$107,000 — effectively unchanged, and would lower after-tax incomes significantly for the highest-income taxpayers.

The top 1 percent, who take home at least roughly \$1 million in income, would pay an average of \$300,000 more than under current law, dropping their after-tax incomes by 14%. Those in the top 0.1 percent would pay almost \$2 million more on average, a 20% reduction in after-tax incomes. The biggest single source of tax hikes on high income households is Biden's proposal to raise the top rate on capital gains from 20% to 39.6%.

"President Biden has been very clear that he would not raise taxes on lower and middle-income households," said **Joseph Peters, Jr., Secretary-Treasurer** of the Alliance. "His changes to the tax code would go a long way in addressing income inequality by asking the top .1%, those who can most afford to contribute more, to pay their fair share."

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The quiet privatization of government health insurance programs

The biggest public health insurance programs have become increasingly privatized over the last decade, even while politicians sparred over whether government-run health care should be expanded to cover more Americans.

Why it matters: Although privately run Medicare and Medicaid plans are still highly regulated and funded by the government, the commercialization has complicated efforts to rein in medical spending and unleashed fierce partisan fights like the ongoing one over Medicare Advantage.

Driving the news: The insurers that administer Medicare benefits and **their allies** are running an **enormous lobbying blitz** against **proposed regulations** by the Biden administration that they say will cut their government funding and, in turn, harm enrollees.

- ◆ Supporters of the cuts say that the proposal corrects overpayment, which plans obtain by manipulating the billing system.
- ◆ The potency of the lobbying is a sign of just how ingrained Medicare Advantage has become among seniors over the years — and how important it is to some insurers' business mix.

The big picture: Medicare for All rose to prominence during Democrats' 2016 presidential primary, championed by Sen.

Bernie Sanders.

- ◆ Four years later, it returned as a key litmus test for Democratic presidential hopefuls. More moderate candidates, including President Biden, instead embraced a public option, which would extend eligibility for government-run insurance to more Americans.
- ◆ But as Democrats aired out **whether or not** to abolish private insurance, existing public programs became increasingly commercialized.
- ◆ Meanwhile, attempts to expand Medicare eligibility or benefits as part of Democrats' domestic policy agenda during Biden's first two years in office fizzled largely over the cost.

By the numbers: Medicare Advantage enrollment has grown from 22% of eligible Medicare beneficiaries in 2008 to 48% of beneficiaries in 2022, **per KFF**. This year's enrollment numbers, when they're released, will likely reveal that the majority of seniors are now enrolled in a Medicare Advantage plan.

- ◆ Private plans are even more ubiquitous in state Medicaid programs.
- ◆ In 2020, 72% of Medicaid beneficiaries were enrolled in a Medicaid managed care plan, also **per KFF**. In fiscal year 2021, more than half of



state and federal Medicaid spending went to managed care organizations.

- ◆ Although Medicaid managed care organizations can be private for-profit, private non-profit or government plans, as of 2020 half of the market was covered by plans owned by one of five companies: Centene, Molina, Elevance, UnitedHealth Group and CVS.
 - ◆ **Between the lines:** Administering entitlement benefits is an increasingly lucrative line of work for insurers.
 - ◆ **Another KFF analysis** found that in 2021, plans had gross margins of \$1,730 per enrollee — more than double those of other markets. The second highest were in Medicaid managed care, which had gross margins of \$768 per enrollee — higher than both the group and individual market.
 - ◆ The analysis cautions that gross margins aren't equivalent to profitability but are indicative of trends. A clear one presented in the analysis is that the employer-sponsored and individual markets were significantly less profitable in 2021 than they were in 2018, while managed care plans did better.
- The intrigue:** Humana recently nodded to these trends when it **announced last month** that it was exiting the employer market.

- ◆ "It is in line with the company's strategy to focus our health plan offerings primarily on Government-funded programs (Medicare, Medicaid and Military) and Specialty businesses," Bruce Broussard, Humana's president and CEO, said in a statement.

What they're saying: "Humana is a telling anecdote here," said KFF executive vice president Larry Levitt. "With employer-based coverage largely stagnant, public programs are the main source of revenue and profit growth for insurance companies."

- ◆ "The debate over Medicare Advantage payments is good example of what this all means politically," he added. "The bottom line of health insurance companies now depends crucially on their lobbying clout and ability to boost payments in Medicare and Medicaid."

What we're watching: Medicaid programs will soon begin cutting loose millions of people who are no longer eligible for the program post-pandemic or who get caught up in administrative errors. It's unclear what financial effect this shrinking of program rolls will have on insurers.

And the Biden administration will issue its final rule on Medicare Advantage rates next week, revealing the impact of plans' lobbying.

15 Million Americans Could Lose Medicaid Coverage as Pandemic-Era Policy Ends

Some 15 million people could lose their Medicaid coverage over the next few months as pandemic-related emergency provisions come to an end—though residents in five states will feel its impact earlier than others.

During the pandemic, the yearly reapplication process for Medicaid was paused and states stopped checking if people were still eligible for its coverage. But starting April 1, people in Arizona, Arkansas, Idaho, New Hampshire and South Dakota could see their loss of healthcare coverage as

Medicaid begins to verify eligibility and will begin to disenroll patients.

Fourteen more states will cut off coverage for people who are no longer eligible in May, and another 20 (plus the District of Columbia) will do so in June, affecting the more than 90 million Americans who are **currently enrolled** in Medicaid.

Here's what to know about the change.

Why is this happening?

The Families First Coronavirus Response Act, which was enacted in March



2020, required Medicaid programs to keep people enrolled until the end of the public health emergency. The federal government promised to federally match state's Medicaid rates to help deal with the increase in enrollment.

But the federal spending package that passed in late December changed that law. Congress set March 31 as the final date for the continuous enrollment provision. Within the next 14 months, states must now verify if a recipient still qualifies.

This shift in policy puts some **6.7 million children** at risk, compared to the 4.4 million children that were uninsured in 2019.

"We know whenever these sorts of moments happen, it's people of color, it's kids, it's people that don't speak English that are always hit the hardest," Natalie Davis, a founder and the chief executive of nonpartisan advocacy organization United States of Care, **told the New York Times**.....**Read More**

75% of Medicare beneficiaries worry about affording costs beyond premiums. Here's how high out-of-pocket costs can go

For **retirees**, health-care costs can be among the most unpredictable expenses they face over the course of their golden years.

While many of them worry about affording their monthly Medicare premiums, their bigger concern is their out-of-pocket costs, according to a **recent report from eHealth.**

The report says 75% are either "very" or "somewhat" worried about affording those costs, which include deductibles, copays and coinsurance. That compares with 43% who worry about their ability to pay their premiums, according to the report, which is based on a February survey of more than 4,500 **Medicare** beneficiaries.

Exactly how much you spend on Medicare depends on both your coverage choices and your use of the **health-care system**. However, you may be able to pinpoint a worst-case scenario to help you budget.

Beneficiaries have coverage options

Basic, or original, Medicare consists of Part A (hospital coverage) and Part B (outpatient care) and covers 65 million people — 57.3 million are age 65 or older, and the remaining 7.7 million are younger with permanent disabilities. Many beneficiaries choose to get Parts A and B through an **Advantage Plan** (Part C), which also typically includes **Part D** (prescription

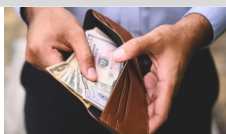
drug coverage) and often other extras such as dental and vision. These plans often have no monthly premium or a low one, and they limit how much you pay out of pocket each year for covered services. Deductibles, copays and coinsurance vary from plan to plan. Other beneficiaries instead decide to pair Parts A and B with a standalone Part D plan and, often, a **Medigap plan**, which covers part of the out-of-pocket costs that come with Parts A and B.

However, **premiums can be pricey**, depending on where you live and other factors. **Basic Medicare has no out-of-pocket limit**

If you have only basic Medicare, there is no cap on what you might spend in any given year.

"With no secondary coverage, there is no out-of-pocket maximum, which leaves a beneficiary financially exposed," said Elizabeth Gavino, founder of Lewin & Gavino and an independent broker and general agent for Medicare plans.

How hospital stays are covered
Part A, which comes with no premium **for most beneficiaries**, has a deductible of \$1,600 when you are admitted to the hospital. That covers the first 60 days of inpatient care in a benefit period.



Days 61 through 90 come with coinsurance of \$400 per day, and then it's \$800 daily beyond that (so-called lifetime reserve days). And for skilled nursing facilities, a daily coinsurance of \$200 kicks in for days 21 through 100.

If you have Medigap, all of those charges are either fully or partially **covered under most plans.**

Out-of-pocket maximums may range up to \$8,300

With Advantage Plans, because the cost-sharing differs from plan to plan, "they will all vary but at least their hospital spending would count toward the plan's out-of-pocket maximum, meaning it would be capped," said Danielle Roberts, co-founder of insurance firm Boomer Benefits.

In 2023, those maximums **can be as much as \$8,300** for in-network coverage, Roberts said.

"In most urban areas, you can find good plans with considerably lower limits," she said. "If you can find a plan that has a lower out-of-pocket limit, such as \$3,000 or \$4,000, that is a benefit to you."

'The sky is the limit' on Part B coinsurance with basic Medicare

Part B — which comes with a **standard monthly premium of \$164.90** in 2023 — has a deductible of \$226. But after that, you pay a 20% coinsurance for covered services with no cap on how high that goes.

"It means the sky is the limit on the 20% coinsurance," Roberts said. "Imagine trying to cover 20% of eight weeks of chemotherapy or for dialysis for the rest of your life or until you get a transplant."

"In my opinion, this is the most important thing that you want to get covered," she added. "Both Medigap and Medicare Advantage Plans do a good job of this, since most Medigap plans cover the 20% [coinsurance] and Advantage Plans have caps on Parts A and B spending."

Part D currently has no out-of-pocket maximum

Under current law, there is no out-of-pocket limit associated with Part D, regardless of whether you get your coverage as a standalone policy or through an Advantage Plan.

A deductible for Part D, which may come with a premium, can be up to \$505 in 2023, also regardless of how you get the coverage.

Part D does come with catastrophic coverage that kicks in once out-of-pocket expenses reach \$7,400 in a given year, Roberts said.

After hitting that threshold, "you pay only a small coinsurance or copayment for covered drugs for the rest of the year," she said.

In 2025, each beneficiary's annual out-of-pocket spending for Part D will be capped at \$2,000.

Also, be aware that Medigap plans do not cover any Part D costs.

Raincoats, Undies, School Uniforms: Are Your Clothes Dripping in 'Forever Chemicals'?

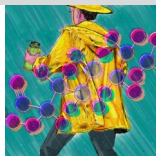
There could be more than just fashion risks involved when buying a pair of leggings or a raincoat.

Just how much risk is still not clear, but toxic chemicals have been found in hundreds of consumer products and clothing bought off the racks nationwide.

Thousands of perfluoroalkyl and polyfluoroalkyl substances, or PFAS, exist since the first ones were invented in the 1940s to prevent stains and sticking. PFAS chemicals are used in nonstick cookware, water-repellent clothing, and firefighting foam.

Their manufacture and persistence in products have contaminated drinking water nationwide. Also known as "forever chemicals," these substances do not break down in the environment and can accumulate in our bodies over time.

Drinking water is widely considered the greatest source of potential exposure and harm. And, in March, the Environmental Protection Agency **proposed the first national standard** for PFAS



levels in drinking water. But the chemicals can also pollute soil, fish, **livestock, and food products.** Researchers say they are present in the blood of **nearly all Americans.** Until now, federal regulations on PFAS in consumer products have largely focused on a handful of the older-generation forever chemicals, such as PFOA, or perfluorooctanoic acid. But new state-level laws are targeting all forever chemicals. Consumers concerned about clothing are also turning to the

courts. A torrent of **recent class-action lawsuits** claim brands falsely advertise their products as environmentally sustainable or healthy while containing toxic levels of PFAS chemicals. In January, **Thinx, which makes reusable period underwear,** agreed to pay up to \$5 million to settle a suit. Another lawsuit, **against REI,** largely targeting its raincoat line, is proceeding in court... **Read More**

Why Medicare Advantage plans are bad? And are they really?

At first glance, choosing a **Medicare Advantage plan** can appear like a “no-brainer”; after all, they combine **Part A** (in-patient hospital and nursing care), **Part B coverage** (physician medical services), and in some cases, also **Part D** (prescription medication) coverage. Still, it is important to read through the fine print and review **the pros and cons** so you can make an informed decision and not fall victim to the pitfalls in these plans.

Almost **half** of the 28 million **eligible Medicare population** are enrolled in a Medicare Advantage Plan, and enrollment has grown steadily since 2006. The **Open Enrollment period** allows beneficiaries to review changes to their current plan and elect to enroll in a different one. Still, according to the Kaiser Family Foundation (KFF), **71%** of beneficiaries did not **compare their current Medicare plan** to any other plans for the upcoming coverage period.

Changes to plans can occur

each year, which could result in unanticipated costs and interruptions in care for beneficiaries who don't annually review their coverage and compare annual options during the open enrollment period, so it is crucial for beneficiaries to properly review their current coverage, research what options are available and enroll in the option that best fits their needs.

Why are Medicare Advantage Plans bad?

Whether Medicare Advantage plans are a bad idea can entirely depend on the individual and their circumstances. Different people have different financial, health, lifestyle, and medical needs, so not every plan works for every person. There can be upsides and downsides to Medicare Advantage plans, so it is important to research and review your current coverage and all coverage options available each enrollment period.

Disadvantages of Medicare Advantage

The following is a list of disadvantages of Medicare



Advantage plans:

- ◆ Most Medicare Advantage plans **require members to seek care from a given network of providers**. Some plans will cover out-of-network providers but beneficiaries are charged higher fees than if they used in-network providers. **Original Medicare** covers any provider that accepts Medicare. So it is critical that before selecting a Medicare Advantage plan you check if your preferred providers are part of the plan's network.
- ◆ Some Medicare Advantage plans **may require pre-authorization for specialist visits**.
- ◆ **Additional costs for coverage**. Beneficiaries with Original Medicare (Parts A and B) are charged a premium, deductible, and co-insurance in addition to any Part D coverage expenses they may have enrolled in. Many Medicare Advantage plans often consolidate these expenses, but members may

also face co-pays for specialist visits and deductibles for some prescription medications.

- ◆ **Variations in Medicare Advantage coverage by state**. Original Medicare coverage is the same throughout the United States, but Medicare Advantage plans vary from state to state. If a member **moves to a new state**, they may need to find a new plan that covers them in their new location.
- ◆ Due to **restricted and limited provider networks**, Medicare Advantage plans are challenging for many people living in rural areas. **Research** has shown that beneficiaries enrolled in Medicare Advantage plans residing in rural areas were about two times as likely to switch to Original Medicare than Medicare Advantage beneficiaries living in urban areas.
- ◆ Medicare Advantage **does not cover clinical research study tests or care**.

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3 Social Security Rules You Should Know Ahead of Retirement

Millions of seniors today collect a monthly benefit from Social Security. And for many older Americans, those benefits are instrumental in helping them stay afloat financially.

Now ideally, you'll kick off retirement with a nice amount of savings so that **Social Security** doesn't have to constitute your only, or even your primary, source of senior income. But even so, it's important to make the most of the benefits you're entitled to. And do so, you'll first need to know these essential rules.

1. You're only entitled to your full monthly once full retirement age arrives

You may have heard that you're able to collect Social Security once you reach **age 62**. That's totally true. But if you want the full monthly benefit you're entitled to based on your personal earnings history, then you'll need to wait until full

retirement age, or FRA, to sign up.

Keep in mind that if you're married, you and your spouse might each have a different FRA, and that should inform your respective claiming decisions.

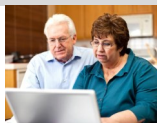
2. A delayed filing will give you a larger monthly benefit for life

There's no rule stating that you have to sign up for Social Security once your FRA arrives. Rather, you're allowed to delay your filing indefinitely.

However, it's a good idea to sign up for Social Security by the time you turn 70. For each year you delay your filing past FRA and up until the age of 70, your benefits will grow 8%. But beyond age 70, there's no financial incentive to delay your claim.

3. Surviving spouses get 100% of what their partners collect

You may be focused on your own financial needs and goals in



the context of claiming Social Security, and that's understandable. But if you're married, you should know that if your spouse outlives you, they'll be entitled to survivors benefits from Social Security that are equal to 100% of your monthly benefit. And that might influence your filing choice quite a bit.

You may, for example, be inclined to claim benefits early so you can enjoy that money sooner. But knowing that your spouse might rely on survivors benefits upon your passing might motivate you to wait until FRA or delay your filing so you can leave your life partner with a higher monthly income stream.

In fact, it's really important to consider your spouse's financial needs if you're a lot older than they are, and if you don't have a particularly large nest egg to fall back on for retirement

income. A higher monthly Social Security benefit could help compensate for less savings and help ensure that your spouse doesn't end up struggling financially in your absence.

Social Security is loaded with rules, and it can be tricky to keep track of each and every one. But these essential rules are ones you definitely shouldn't gloss over in the course of filing for benefits.

FRA hinges on your year of birth, and you can consult this table to see what your FRA looks like: see below.

Year of Birth	Year of Retirement
1943-1954	66
1955	66 & 2 months
1956	66 & 4 months
1957	66 & 6 months
1958	66 & 8 months
1959	66 & 10 months
1960- or later	67

Dear Marci: Does Medicare consider me homebound?

Dear Marci,

I learned that Medicare may cover home health care for people who are homebound. How do I know if I am considered homebound?
-Alejandro (Madison, WI)

Dear Alejandro,

That's a great question. As you said, Medicare covers home health care **if you qualify**. One of the requirements to qualify is that you be homebound. But what exactly does this mean?

Medicare considers you homebound if both of the

following apply to you:

- ◆ You need the help of another person or medical equipment to leave your home. For example, you need crutches, a walker, or a wheelchair to leave your home. Or, your doctor believes that your health or illness could get worse if you leave your home
- ◆ And, it is difficult for you to leave your home and you typically cannot do so
Your doctor should decide if



Dear Marci

you are homebound based on their evaluation of your condition. If you qualify for Medicare's home health benefit, your **plan of care** will also certify that you are homebound. After you start receiving home health care, your doctor is required to evaluate and recertify your plan of care every 60 days.

Even if you are homebound, you can still leave your home for medical treatment, religious services, or to attend a licensed or accredited adult day care center, without putting your

homebound status at risk. Leaving home for short periods of time or for special non-medical events, such as a family reunion, funeral, or graduation, should also not affect your homebound status. You may also take occasional trips to the barber or beauty parlor.

I hope this helps as you and your doctor consider your needs for home health!

-Marci

Medicare Rights Applauds CMS Efforts to Reduce Medicare Advantage Overpayments

The 2024 Advance Notice **released** today by the Centers for Medicare & Medicaid Services (CMS) makes small but important adjustments to Medicare Advantage (MA) payment methodology. The Medicare Rights Center welcomes the provisions that would begin to rein in soaring, unnecessary MA costs and urges additional, comprehensive reforms.

CMS projects its updates will increase MA payments by 3.32% in 2024. Though greater than

initially **proposed**, this is a lower growth rate than in recent years—an essential step towards correcting the decades-long problem of MA overpayments. The amounts inappropriately paid to MA plans are significant. The Medicare Payment Advisory Committee cataloged **\$140 billion** in overpayments during the past 12 years, and CMS estimates that in 2021 alone, plans improperly received **\$23 billion**. Independent research



consistently finds these excess payments are **negatively impacting** Medicare's finances and long-term sustainability, as well as driving up beneficiary premiums and taxpayer costs. Addressing this wasteful spending becomes more urgent by the day.

Expert **analysis** indicates overpayments will only grow as MA plan and enrollment numbers do, and both are **surging**. CMS' actions are largely responsive to these

realities, and to concerns many current and future beneficiaries have about **rising Medicare costs, the program's future, and the need for solutions**.

We applaud CMS for finalizing a 2024 Advance Notice that recognizes beneficiary priorities and flaws in MA financing. We strongly urge the Biden administration to build upon these policies to swiftly and more fully improve payment accuracy, insurer accountability, and access to care.

Social Security Recipients Just Got Some Really Bad News

Millions of seniors today rely on Social Security to cover their bills in retirement. And for many older Americans, those benefits are their primary or only source of income.

The problem, though, is that **Social Security** is facing a funding shortfall. The program's main revenue source is payroll taxes. But in the coming years, that source is expected to shrink. We can thank a mass exodus of baby boomers from the workforce for that.

Now, Social Security has trust funds it can tap to keep up with scheduled benefits, even once its payroll tax revenue is cut. But once those funds are depleted, Social Security may have to reduce benefits, despite the financial upheaval recipients are apt to experience as a result.

Meanwhile, the Social Security Trustees just released their latest report. And it

contains one piece of pretty unfavorable news.

Benefit cuts could happen sooner than anticipated

The Social Security Trustees are now projecting that the program's trust funds will be out of money by 2034. At that point, Social Security will only have the financial means to pay 80% of scheduled benefits.

What makes this news particularly disturbing is that 2034 was not the projected trust fund depletion date the Trustees pointed to last year. Rather, it was 2035. So basically, this latest report puts benefit cuts one year ahead of last year's anticipated timeline.

Of course, benefit cuts are bad news for current workers who hope to collect their share of Social Security once they retire. But they're even worse news for the millions of seniors who are



already retired and can't afford a hit to their income. Are benefit cuts a definite thing?

It's possible that lawmakers will come up with a viable solution to **fix Social Security** so that benefits don't have to be cut, or at least not to the tune of 20%. But as of now, there's no official solution in the works. And that's problematic, seeing as how the program's trust funds could be out of money in a little more than a decade.

One proposal that's been floated to pump more money into Social Security is to raise full retirement age, which is when seniors are entitled to their full monthly benefits based on their respective earnings histories. Right now, full retirement age is 67 for anyone born in 1960 or later. Moving

that age to 68 or 69 buys Social Security some financial leeway, but it also might force millions of hardworking Americans to delay their retirement when they'd rather not.

Another potential means of avoiding benefit cuts is to raise the Social Security tax rate. But that could put a strain on workers who are already losing a large chunk of their income to taxes.

All told, preventing Social Security cuts won't be easy. But apparently, lawmakers now have even less time to put a solution in place. If they don't act quickly, millions of retired Americans might find themselves teetering on the edge of poverty when their primary source of income is slashed substantially.

Can I have Medicare and Medicaid at the same time?

Medicare and Medicaid aim to provide affordable healthcare coverage for Americans who may be vulnerable or who would otherwise struggle to get insurance. There are different healthcare plans that fall under the umbrella of each programme, but **Medicare and Medicaid are completely separate** and are controlled by different entities.

In some instances, **it is possible to be enrolled in both Medicare and Medicaid at the same time**. Individuals covered by both Medicare and Medicaid are known as **‘dual eligibles’** and typically are not required to pay any out-of-pocket costs for the healthcare.

Dual eligibles are thought to account for 20% of Medicare beneficiaries, roughly 12.3 million people.

What are the differences between Medicare and Medicaid?

While the two programmes both offer health coverage they differ in a number of key ways. Firstly the administration of **Medicare is done at a federal level** with the federal government establishing uniform rules for the programme across the nation. In contrast, **individual states manage their own Medicaid provision**.

They target different types of recipient too, with very different



eligibility requirements. Medicare is designed to do exactly that; provide ‘care’ for those **aged 65 or older or who have**

disabilities, regardless of their income level.

Medicare has **standardised premium costs**, but certain claimants can receive deductibles and coinsurance benefits to reduce their price of their coverage. Given the programme’s focus, **Medicare attempts to offer basic healthcare coverage** with medical services, hospital care and certain medical equipment included in the coverage.

Some prescriptions drugs are covered under **Part D**.

In contrast, **Medicaid is more like a form of financial ‘aid’ for low-income Americans** who may otherwise struggle to afford healthcare coverage. The **eligibility requirements** are based on income requirements, regardless of age, and they are generally free. All recipients of Social Security supplemental benefits will qualify for Medicaid.....**Read More**

Social Security: Whether You’re 62, 65, 67 or 70, Here’s Why Your Age Matters

Retirement is a numbers game in the United States, and those numbers can make a big difference in terms of the **Social Security benefits** you ultimately receive. For Social Security purposes, the most important numbers to remember are 62, 66, 67 and 70 — all of which are ages that can have an impact on your retirement benefits. Another age that used to be important, 65, has little significance anymore.

Let’s begin with 62. That’s the age when you can first start claiming Social Security retirement benefits, though at a reduced monthly payment. The next two ages — 66 and 67 — are when you reach full retirement age (FRA), depending on your birth year. The FRA is when you become eligible for unreduced Social Security retirement benefits. Age 70 is when you can get the maximum benefit.

Age 65 was the retirement age for decades before Congress overhauled Social Security in 1983, leading to a gradual rise in the FRA.

In 2023, many **people born in 1956 and 1957 will reach full retirement age**. The FRA for those born in 1956 is 66 and four months, according to the SSA. For those born in 1957, the FRA is 66 and six months. Full retirement ages increase in two-month increments if you were born in 1958 and 1959. For all Americans born in 1960 or later,

the FRA is 67 years old.

One reason these ages matter is that they impact how much money you’ll get from Social Security once you begin collecting benefits. Collecting at age 62 means you will get the lowest possible benefit, and waiting to collect at age 70 guarantees the highest possible benefit.

As previously reported by GOBankingRates, a recent study from Fidelity found that if you claim Social Security at age 62 rather than waiting until your full retirement age, you can **expect a 30% average reduction in monthly benefits**. For every year you delay claiming benefits past your FRA up to age 70, you get an 8% increase in your benefit. There is no advantage to waiting until past age 70 to collect.

Another important number regarding Social Security is 2032. That could be the year the program’s Old-Age and Survivors Insurance (OASI) Trust Fund runs out of money. Other estimates put the year at 2034 or 2035. Regardless of the actual year, when the OASI runs dry Social Security will have to be funded solely by payroll taxes, which will only cover about 75% to 80% of current benefits.

The trust fund’s impending insolvency has become a hot-button political issue in 2023, as lawmakers offer different theories on how best to deal with it. Some,



including a coalition of legislators led by U.S. Sens. Angus King (I-Maine) and Bill Cassidy (R-La.), have proposed **raising the full retirement age to 70**.

Others who have recently suggested that the FRA be raised are 2024 Republican presidential candidate Nikki Haley and U.S. Rep. Nancy Mace (R-S.C.), CNN reported. However, neither has said what the new FRA should be.

The idea behind raising the full retirement age is that it will push more Americans to wait an extra couple of years to start claiming Social Security benefits, which could save money over the short term. Opponents of such a move say it will lead to reduced benefits for seniors who still have to claim Social Security early for financial reasons.

Another proposal to bolster Social Security is to **raise the payroll tax on the program**. The current tax is 6.2% of wages, paid by both employees and employers. Others want to raise the maximum earnings subject to Social Security payroll taxes. Currently, any wages above \$160,200 are not taxed. Proposed **legislation co-sponsored by U.S. Rep. Peter DeFazio (D-Ore.) and U.S. Sen. Bernie Sanders (I-Vt.) would hike that to \$250,000**.

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While all these numbers are being juggled around, one thing almost everyone agrees on is that something needs to be done to prop up Social Security before the trust fund is depleted. Alicia Munnell, director of the Center for Retirement Research at Boston College, says the two main choices are to cut benefits or raise revenues through higher taxes.

“People say the following: We can do it either through benefit cuts, tax increases or raising the full retirement age,” Munnell told CNN. “There’s no third option — there are only benefit cuts or tax increases. Raising the full retirement age is a mechanism for cutting benefits.”

When Will Medicare Cover Medical Marijuana?

From regulatory to more practical issues, here are the hurdles on the road to Medicare coverage of cannabis.

Many older adults are using medical marijuana to treat a variety of conditions, but experts say that conflicting laws, unclear safety standards and complicated rulemaking processes mean it could be years before Medicare may cover the drug.

One in five Medicare recipients currently uses medical marijuana, according to an April 2022 poll by the Medicare Plans Patient Resource Center, an organization that provides Medicare guidance and information. And nearly a quarter have used it in the past. Two-thirds of Medicare recipients think Medicare should cover it, the poll found.

But **Medicare** doesn't cover medical marijuana because it's not federally legal and not approved by the Food and Drug Administration. Here's where the situation stands.

Why cover medical marijuana for older adults?

In one analysis of data from a large cannabis dispensary in New York, 60% of patients were 50 or older, according to an April 2022 paper in the journal, Cannabis and Cannabinoid Research. The patients used cannabis for severe or chronic pain, cancer, Parkinson's disease and neuropathy, among other things.

And marijuana isn't cheap: Patients might pay as much as \$5 per dose for edible products or \$5

to \$20 per gram for plant buds, according to New York Cancer & Blood Specialists, which provides care to patients with cancer and blood disorders. (That's about \$142 to \$567 per ounce.) Even in states where medical marijuana can be legally prescribed, patients might not be able to afford the prescription.

"This medicine is so expensive," says Debbie Churgai, executive director of Americans for Safe Access, a nonprofit dedicated to ensuring safe and legal access to cannabis for therapeutic use and research. "There are some states now where insurance will cover the cost of the doctor visit or the cost of the marijuana card, but no insurance will cover the cost of the actual products."

What are the federal roadblocks?

Two significant issues stand between medical marijuana and Medicare coverage. The first is that the government classifies marijuana as a **Schedule I drug**, a category of drugs with "no currently accepted medical use and a high potential for abuse" in the United States, according to the Drug Enforcement Administration.

"There is no way the federal government is going to reimburse people through a federal program for a substance they deem as illegal," says Paul Armentano, deputy director of NORML, the National Association for the



Reform of Marijuana Laws.

The second issue is that Medicare requires that the FDA approve a covered drug as safe and effective. Although the FDA has approved one cannabis-derived drug product and three synthetic cannabis-related drug products for prescription use, the agency hasn't approved the marketing of cannabis for medical treatment.

What about in states where it's legal?

Sure, marijuana is illegal at the federal level, but medical marijuana is now legal in 37 states and Washington, D.C. Could private insurers — companies that offer Medicare Advantage, for instance — decide to cover it?

Not likely, says Kyle Jaeger, a cannabis policy reporter and senior editor at Marijuana Moment, a cannabis news site. Like banking institutions that have hesitated to offer services to marijuana businesses, major health insurers will likely decline to cover cannabis as long as it remains a Schedule I drug under federal law.

Also, private insurers rely on the FDA to guide them on which drugs to cover. Consider that the FDA **released a statement** in January saying that current regulatory pathways are insufficient to allow the agency to classify CBD as a dietary supplement.

"It's incredibly frustrating for

consumers, because all they want is a safe, consistent product," Jaeger says.

How high is the bar for cannabis coverage?

Among other things, the marketplace needs more data on the medicinal use of cannabis. "(Insurers) need data to show that the outcomes from cannabis care are equivalent to, if not better than, existing options that they do cover," says Dr. Benjamin Caplan, founder and chief medical officer of CED Clinic, which provides services to people seeking cannabis treatment.

This is partly complicated by the free-market dispensary system in which patients are free to buy any product. "The system has to be tweaked," Caplan says. "Patients can't just have carte blanche to buy whatever they want and the insurance companies are on the hook to cover that."

Considering the breadth of legal and regulatory obstacles facing the process, plus an overhaul of the dispensary system, the road to cannabis coverage is lengthy, says Jaeger. "I'd say we are many years from having that conversation and rulemaking for something like Medicare."

This article was written by NerdWallet and was originally published by The Associated Press.

AHA News: Irregular Sleep Schedule Linked to High Blood Pressure

People with irregular sleep patterns may face substantially higher odds of high blood pressure than those who stick to a schedule, even when they get the recommended amount of sleep each night, new research suggests.

The study, published Tuesday in the journal Hypertension, found people who slept in on the weekends or varied the times they went to sleep and woke up throughout the week were substantially more likely to have high blood pressure, also known as hypertension, than those with

more consistent sleep routines.

"This indicates that people may need to consider not only how long they sleep, but also recognize the importance of keeping a regular sleep schedule for optimal cardiovascular health," said senior study author Danny Eckert, director of the Adelaide Institute for Sleep Health and a professor in the College of Medicine and Public Health at Flinders University in Adelaide, Australia.

The American Heart



Association recommends adults get seven to nine hours of nightly sleep to promote optimal heart and brain health. The recommendation is based on prior research that found people who get less than six hours of sleep per night on average face a much higher risk for high blood pressure, obesity, cardiovascular disease and premature death. Likewise, those who get too much sleep — more than an average nine hours per night — face higher risks for high blood pressure, stroke, Type 2 diabetes

and death.

The authors of the new study note prior research examining the links between sleep duration, nightly variation in sleep schedules and high blood pressure has relied on data reported over just a few weeks.

In the new study, researchers looked at sleep patterns over a nine-month period for 12,287 adults with and without high blood pressure from 20 countries. Participants were predominantly middle-aged men who were overweight.**Read More**

Hidden Heart Disease Can Raise Your Odds for Heart Attack 8-Fold

Millions of middle-aged folks may be walking around with no symptoms of heart disease, and yet they still face a higher risk for a heart attack, new research shows.

What gives? Subclinical or silent heart disease may be responsible. This is the early thickening or hardening of the heart arteries that can worsen over time and cause crushing chest pain, known as angina, or even a heart attack. Middle-aged folks with such subclinical heart disease face a much higher risk of a surprise heart attack, researchers discovered.

But they were quick to caution that the absolute risk of having a heart attack without any signs or symptoms remains low.

"Subclinical heart disease refers to changes of the

circulatory system that are mainly seen with advanced age, and in some individuals may cause heart attack and premature death," explained study author **Dr. Klaus Fuglsang Kofoed**, a cardiologist at Copenhagen University Hospital in Denmark. "Importantly, many individuals may have these changes, yet will never have any clinical heart disease."

For the study, more than 9,500 people aged 40 or older without known heart disease had scans to get a closer look at what was happening in their heart arteries. Of these, 54% of people showed no signs of subclinical heart disease; 36% had nonobstructive disease, and 10% had obstructive, or artery-clogging, disease. Folks with obstructive disease were



more than eight times as likely to have a heart attack.

The study appears in the March 27 issue of the *Annals of Internal Medicine*.

These findings should serve as a wake-up call, said **Dr. Evan Appelbaum**, a cardiologist at Men's Health Boston. People may be walking around with the earliest stages of heart disease and don't have a clue.

"For example, cholesterol builds up in the arteries before a blockage or narrowing of significance develops," Appelbaum said. "It can affect anyone and is the reason that screening for cardiovascular disease is so important and can detect problems early enough to start on a preventive regimen that can save lives."

Dr. Matthew Tomey, a cardiologist with the Mount Sinai Health System in New York City, agreed. Clinical disease -- such as heart attack, chest pains from blocked arteries and strokes -- represent only the tip of the iceberg.

Atherosclerosis, or the buildup of cholesterol plaque in the walls of arteries, progresses beneath the surface for years, Tomey said.

"Symptoms of atherosclerosis might not appear until an individual has a sudden obstruction of blood flow by a clot or the progressive narrowing of an artery by plaque, typically by 70% or more," he said. "A person can be walking around with 69% blockages of all three major heart arteries with no clinical disease."...[Read More](#)

Weight Loss Helps Your Heart Even If Some Weight Comes Back

It can be downright discouraging to work hard to lose 10 pounds, only to regain a few later.

But don't be downhearted -- a new evidence review says the important heart health benefits of weight loss are sustained even if some of the weight comes back.

People who drop some pounds still have lower blood pressure and better cholesterol and blood sugar numbers even if they regain a little, British researchers reported March 28 in the journal *Circulation: Cardiovascular Quality and Outcomes*.

"It should serve as encouragement for people to try

to lose weight, and do so in the most effective way by joining a behavioral weight loss program,"

said senior researcher **Paul Aveyard**, a professor of behavioral medicine at the University of Oxford. "Even if weight is regained, which most people do, the health benefits persist."

For this review, Aveyard's team analyzed the combined results of 124 weight loss clinical trials involving more than 50,000 people and with an average follow-up of more than two years.

The participants' average age was 51, and their average body



mass index (BMI) was 33, which is considered obese. BMI is an estimate of body fat based on height and weight.

On average, people assigned to a weight loss program shed 5 to 10 pounds as a result of the initial experiment, which typically lasted around seven months.

Behavioral weight loss programs help people lose weight by encouraging lifestyle changes such as eating healthy foods or stepping up physical activity.

"[The programs] help people clarify their goals and set goals and they monitor how well people are doing," Aveyard said. "They give them support to think

through their lives and how they can follow the dietary restrictions and boost their physical activity. They boost motivation, and also help people to feel understood and better about themselves and their weight."

During follow-up, participants regained an average 0.26 to 0.7 pounds a year, a slow drip of weight gain that experts say isn't unusual.

"It's very hard to maintain lost weight," Aveyard said. "The reasons a person gained weight have not gone away after weight loss, so most people do regain weight."...[Read More](#)

Drinking Alcohol Brings No Health Benefits, Study Finds

Dozens of studies have purportedly shown that a daily glass of wine or mug of beer could reduce your risk of heart disease and death.

But these studies are flawed, a new evidence review asserts, and the potential health benefits of moderate alcohol use vanish when those flaws and biases are taken into account.

At best, a drink or two each day has no effect good or ill on a person's health, while three or more drinks daily significantly increase the risk of an early death, researchers report.

"Low-level or moderate drinking is roughly defined between one drink per week and two drinks per day. That's the amount of alcohol that many studies, if you look at them uncritically, suggest reduces your risk of dying prematurely," said co-researcher Tim Stockwell. He is former director of the Canadian Institute for Substance Use Research at the University of Victoria in British Columbia.

But after adjusting for study flaws and biases, "the appearance of the benefit from moderate



drinking greatly diminishes and, in some cases, vanishes altogether," Stockwell said.

A standard drink in the United States contains roughly 14 grams of pure alcohol, according to the U.S. National Institutes of Health. That equates to about 12 ounces of beer, 5 ounces of wine or 1.5 ounces of distilled spirits.

For this analysis, Stockwell and his colleagues evaluated 107 studies that assessed the relationship between alcohol use and death. These studies included

nearly 5 million participants from multiple countries.

"This is an overview of a lot of really bad studies," Stockwell said. "There's a lot of confounding and bias in these studies, and our analysis illustrates that."

Former drinkers aren't lifetime abstainers

For example, many studies tend to place former drinkers in the same group as lifetime abstainers, referring to them all as "non-drinkers," Stockwell said....[Read More](#)

Fatal Drug ODs Among U.S. Seniors Have Quadrupled in 20 Years

Drug overdose deaths -- both accidental and intentional -- have quadrupled over the past 20 years among older adults in the United States, a new study finds.

This increase in people ages 65 and older suggests the need for greater mental health and substance use policies, the authors said.

"The dramatic rise in overdose fatalities among adults over 65 years of age in the past two decades underscores how important it is for clinicians and policymakers to think of overdose as a problem across the life span," said co-author **Chelsea Shover**, an assistant professor of medicine at the University of California, Los Angeles David Geffen School of Medicine.

"Updating Medicare to cover evidence-based treatment for substance use disorders is crucial,

as is providing harm reduction supplies such as naloxone to older adults," Shover said in a school news release.

About three-fourths of those who died accidentally were using illicit drugs, including synthetic opioids such as fentanyl, heroin, cocaine and methamphetamine. In 67% of intentional overdoses, seniors used prescription medication, including opioids, antidepressants, benzodiazepines, antiepileptics and sedatives.

The researchers calculated overdose deaths among seniors from 2002 to 2021, using a database from the U.S. Centers for Disease Control and Prevention. The investigators compared demographics, specific drugs, and whether the deaths were intentional, unintentional or undetermined.



They found that fatal overdoses quadrupled from 1,060 in 2002, which was 3 per 100,000, to 6,702 in 2021, or 12 per 100,000. Black seniors had the highest rates, at 30.9 per 100,000.

By 2021, 1 in 370 senior deaths was from an overdose, the report noted. About 57% of those involved opioids, 39% involved stimulants and 18% included a combination of the two types of drugs.

About 13% of overdoses in 2021 were intentional and 83% were unintentional. Another 4% were undetermined, and 0.7% -- five people -- were murdered.

Women comprised 57% of the intentional overdoses and 29% of the accidental overdoses, according to the study.

The researchers also determined that 37%, of

overdoses among Asian-Americans were intentional compared to 17% among white people and 1% among Black people.

Deaths from alcohol poisoning rose from less than 0.03 per 100,000 to 0.5 per 100,000 during the study period.

"Even though drug overdose remains an uncommon cause of death among older adults in the U.S., the quadrupling of fatal overdoses among older adults should be considered in evolving policies focused on the overdose epidemic," the researchers wrote. "Current proposals to improved mental health and substance use disorder coverage within Medicare, for example, applying mental health parity rules within Medicare, acquire greater urgency in light of this study's results."

FDA Approves First Over-the-Counter Nasal Spray for Opioid Overdoses

The U.S. Food and Drug Administration on Wednesday approved the over-the-counter use of a nasal spray that can reverse an opioid overdose.

Research has shown that wider availability of naloxone (Narcan) could save lives as the opioid epidemic rages on in this country. "The FDA remains committed to addressing the evolving complexities of the overdose crisis. As part of this work, the agency has used its regulatory authority to facilitate greater access to naloxone by encouraging the development of and approving an over-the-counter naloxone product to address the dire public health

need," FDA Commissioner **Dr. Robert Califf** said in an agency **news release**.

"Today's approval of OTC naloxone nasal spray will help improve access to naloxone, increase the number of locations where it's available and help reduce opioid overdose deaths throughout the country," Califf said. "We encourage the manufacturer to make accessibility to the product a priority by making it available as soon as possible and at an affordable price."

Emergent BioSolutions, the Maryland company that makes the Narcan spray, made no



mention of price in a statement it released after the FDA approval was announced, but the company's president applauded the move.

The approval "marks a historic milestone as we have delivered on our commitment to make this important emergency treatment widely accessible, given the alarming rates of opioid overdoses occurring across the country," **Robert Kramer**, president and CEO of Emergent BioSolutions, said in a company **news release**. "We are dedicated to improving public health and assisting those working hard to end the opioid

crisis -- so now with leaders across government, retail and advocacy groups, we must work together to continue increasing access and availability..."

Addiction experts also applauded the approval.

"The FDA's long-awaited decision to make intranasal naloxone available over the counter is a critical step in tackling the opioid overdose public health crisis that is devastating communities across the country," said **Alex Bennett**, director of the Opioid Overdose Prevention Program at the NYU School of Global Public Health....**Read More**

Suspicious Mammogram? Out-of-Pocket Costs Keep Some Women From Follow-Up

Breast cancer screening may be free for women with health insurance, but high costs may still keep some from getting needed follow-up tests, a new study finds.

The study, of more than 230,000 U.S. women who underwent screening mammography, found that those in insurance plans with higher out-of-pocket costs were less likely to get follow-up testing after an abnormal screening result.

That testing is necessary to either diagnose breast cancer or

rule it out.

Experts said the findings underscore a known and longstanding problem: "Cost-sharing" has been largely eliminated when it comes to breast cancer screening, but that still leaves many women unable to afford the next step.

"We know this is an issue, and we need to push for solutions," said **Molly Guthrie**, vice president of policy and advocacy for the breast cancer nonprofit Susan G. Komen.



Guthrie, who was not involved in the study, said Komen is advocating for policies to remove the financial barrier.

Some states, she noted, have passed laws to require insurers to cover follow-up tests at no cost. But that only covers women living in those states and in health plans that the states can regulate, Guthrie pointed out.

Federal lawmakers have introduced similar bills to address the issue at the national level. But

so far, they have stalled out.

The Affordable Care Act, better known as "Obamacare," eliminated out-of-pocket costs for most U.S. women who are insured and undergo mammography screening. (It did the same for Americans having recommended screenings for colon, cervical and lung cancers.)

That was hailed as a step in the right direction, Guthrie said, but it did not address the costs that patients face after screening detects an abnormality....**Read More**

Remodeling Your Home for Wheelchair Access

Millions of Americans get around with the help of wheelchairs, from those born with disabilities to those who have been struck with disabilities later in life.

Home is a sanctuary for many - a place where comfort, safety and ease are especially important -- so remodeling a house for wheelchair access makes sense.

Like with any renovation project, when remodeling for wheelchair access there are a lot of details to consider.

About 1 in 4 Americans has some type of disability, according to the [U.S. Centers for Disease Control and Prevention](#). About 1 in 10 has a mobility disability.

Although about 88% of

Americans between the ages of 50 and 80 want to age in their own homes, 47% have given little thought to how they'll manage that, according to the University of Michigan's [National Poll on Healthy Aging](#).

Where to start?

"When it comes to adapting a home for wheelchair accessibility, it's critical to consider both the inside and outside of your home," according to the [UDS Foundation](#), a Pennsylvania-based nonprofit that helps seniors, veterans and others with disabilities lead more independent lives.

Outside modifications

What's outside is important



because it's key to getting safely into your home. In its checklist for wheelchair-friendly home renovation, the UDS Foundation recommends that an entry ramp rise no more than 1 inch per foot. The ramp should be at least 36 inches wide and have secure handrails.

A handicapped parking space will need 48 inches of clearance for loading and unloading a wheelchair. The walkways should also be 48 inches wide, the UDS Foundation recommends.

You should be able to purchase a metal wheelchair ramp online. Local contractors may also be able to build one in wood or concrete, depending on your

circumstances.

Installing an aluminum ramp may not require the same builder permits as other ramps, depending on local codes, and it can be acquired and put in quickly, one expert noted. "They are great for emergencies," [Kurt Clason](#), a certified aging-in-place specialist with the National Association of Home Builders Remodelers, [said in a recent AARP story](#). "They go up fast and are super stable."

Widen the doorways

Having a zero-threshold doorway in your home can be helpful, according to the [Christopher and Dana Reeve Foundation](#)...[Read More](#)

Nerve 'Pulse' Therapy May Help Ease Sciatica

People suffering from sciatica gain lasting relief from a procedure that uses a fine needle to heat nerve roots near the spine, a new clinical trial shows.

The minimally invasive procedure, called pulsed radiofrequency (RF), provided superior pain reduction and disability improvement out to one year for patients with sciatica, according to findings published March 28 in the journal [Radiology](#).

The procedure could help people with sciatica avoid or delay back surgery, said lead researcher [Dr. Alessandro](#)

[Napoli](#), an associate professor of radiology with the Policlinico Umberto I – Sapienza University of Rome in Italy.

"Pulsed radiofrequency with this method can relieve pain in 10 minutes, with no surgery, no hospitalization, and faster recovery and return to daily activities. It is an important card to play," Napoli said.

People with sciatica have a sharp pain that shoots through their hips and buttocks and down one leg. The condition is typically caused by a herniated or slipped spinal disc that's putting



pressure on the sciatic nerve, the largest nerve on the body.

The standard of care is a steroid injection aimed at calming the nerve down, said [Dr. Jack Jennings](#), a professor of radiology and orthopedic surgery at the Washington University School of Medicine in St. Louis.

"The steroids are basically to fool the nerve, to say nothing's wrong," said Jennings, who wrote an [editorial](#) accompanying the new study.

The clinical trial added pulsed RF to the standard steroid injection to see if it would

provide better, longer-lasting pain relief.

In pulsed RF, doctors use CT scans to slide a fine needle precisely into the nerves that are causing sciatic pain.

The needle is then heated using pulses of radio waves. The heat disrupts the nerve, preventing it from sending pain signals to the brain.

"It is similar to a reset of an operating system," Napoli said.

The procedure takes about 10 minutes and is performed on an outpatient basis without general anesthesia, researchers said in background notes....[Read More](#)

How Does Stress Affect the Body?

Figuring out how stress affects your body can be a challenge, because the answer can depend on how stressed out you are, and for how long.

For instance, recent research has shown that [low-to-moderate stress levels](#) may actually be good for your ability to learn and apply knowledge. High stress levels, on the other hand, can negatively impact your [working memory](#).

Likewise, short-term stress can impact your body differently than long-term stress.

So, how does stress affect the body when it's momentary versus chronic? Here, experts break down the most common physical, mental and emotional outcomes for both, and offer some tips on

how to manage stress to help prevent long-term health issues.

Short-term stress effects on the body

Cleveland Clinic psychologist [Dr. Susan Albers-Bowling](#) noted that daily stressors such as forgetting to pay a bill or missing the bus to work tend to cause short-term, low-to-moderate stress on the body.

"What happens in the body is that our muscles begin to tense, our heart begins to beat faster and more oxygen goes to our lungs, this is to help prepare for the stressor," she said in a Cleveland Clinic [article](#). "The good news is that often, stressors are minor. After the stressor passes, our body goes back to its normal



resting state."

[Dr. Suchita Shah](#), a University of Oxford undergraduate primary care tutor and examiner, explained in

an [article](#) that short-term stress may also be "acute" if the stressor involves an unexpected crisis, such as a car accident. For these situations, your stress response usually lasts about two to three days.

In addition to experiencing the same physical symptoms that you would with short-term, low-to-moderate stress, the health impacts of short-term intense stress may include:

- ◆ Abdominal pain
- ◆ Nausea

- ◆ Headaches
- ◆ Anxiety
- ◆ Irritability and moodiness
- ◆ Chest pain
- ◆ Wanting to isolate
- ◆ Sleep issues
- ◆ Difficulty breathing
- ◆ Fatigue
- ◆ Feelings of detachment
- ◆ Trouble concentrating

Long-term stress effects on the body

"Chronic stressors are things like financial issues and conflicts with family members," said Albers-Bowling....[Read More](#)