Rhode Island Alliance for Retired Americans®

RI ARA

Affiliated with the Rhode Island AFL-CIO
"Advocating for the future of our members."
"NOW, more than ever!!!"

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Friday Alert Message from the Alliance *for* Retired Americans Leaders

Administration Wants to Cut the Number of Visits to Social Security Field Offices in Half and Force Beneficiaries to Get Help Online

Robert Roach, Jr
President, ARA

There are more Social Security beneficiaries now than at any other time in history, straining an already under-resourced and understaffed Social Security Administration (SSA).

Documents revealed this week show that even more pressure is coming next year, as the Administration aims to slash field office visits next year by a whopping 50 percent**, according** to *Nextgov/FCW*. Given the total number of in-person visits to field offices this year – 31 million – the number of in-person visits would decrease to about 15 million if the plan goes forward. Officials also want to push more services online and reorganize claims processing work so that less of it happens in field offices.

During his confirmation hearing, SSA Commissioner **Frank Bisignano** reassured lawmakers that even though he wants to implement new technology at the agency, he would work to ensure beneficiaries can still access services in the form that works best for them, either in-person, on the phone, or online.

His assurance is out of sync with what's actually happened at SSA over the past year. The agency has been plagued by persistent understaffing resulting from cuts instigated by the Department of Government Efficiency (DOGE) and the decision to shift 1,000 SSA employees from field offices to answering the 1-800 number in July. Officials also **launched and then rescinded** identity proofing requirements that would have ended phone services for benefit claims and rolled out an AI chatbot on phone lines that beneficiaries have consistently described as difficult to use.

Older Americans shouldn't have to jump through hoops to access their hard earned benefits or get customer service support," said **Robert Roach, Jr., President of the Alliance**. "Making it more difficult to visit SSA field offices because of deliberate and unwarranted staff cuts is absolutely outrageous. We must fight back."

TAKE ACTION: **Send a message** to your member of Congress now telling them to co-sponsor and vote for the *Keeping Our Field Offices Open Act* (H.R. 1876). **All Americans should be able to visit a Social Security field office in person when they need to.**

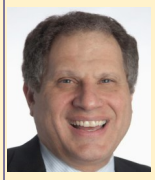
New Survey Finds Wealthier Americans Have Higher Satisfaction as they Age

New research **examines** ties between income and quality of life for older Americans. Those with higher incomes experience a higher quality of life compared to their middle and lower income peers. Criteria included physical, mental, and cognitive well-being.

More than half of high-income individuals, defined as a household income greater than $155,600, reported satisfaction as they aged, compared to fifty percent of middle income individuals and less than half of lower income individuals.

The study also found that younger adults who are still working are less confident about their future retirements than Baby Boomers who are about to or have already retired. Women, people of color, and adults under 50 were especially concerned about future financial stability, with a majority in each group stating they were only "somewhat confident" or "not too or not at all confident" about retirement.

In contrast, people over the age of 65 across all income brackets were likely to say they were confident about their current and future health. "This research shows that we still have a long way to go in making sure that every American can retire comfortably and with dignity after a lifetime of work,"



Rich Fiesta,
Executive
Director, ARA

said **Richard Fiesta, Executive Director of the Alliance.** "We can take steps to tackle this inequality by strengthening Social Security and increasing benefits and working to expand access to union jobs and traditional pensions for more American workers

KFF Health News: Health Savings Accounts, Backed by GOP, Cover Fancy Saunas but Not Insurance Premiums

By Amanda Seitz

With the tax-free money in a health savings account, a person can pay for eyeglasses or medical exams, as well as a $1,700 baby bassinet or a $300 online parenting workshop.

Those same dollars can't be used, though, to pay for most baby formulas, toothbrushes — or insurance premiums.

President Donald Trump and some Republicans are pitching the accounts as an alternative to expiring enhanced federal subsidies that have lowered insurance premium payments for most Americans with Affordable Care Act coverage. But legal limits on how HSAs can and can't be used are prompting doubts that expanding their use would benefit the predominantly low-income people who rely on ACA plans.

The Republican proposals come on the heels of a White House-led change to extend HSA eligibility to more ACA enrollees. One group that would almost certainly benefit: a slew of companies selling expensive wellness items that can be purchased with tax-free dollars from the accounts.

There is also deep skepticism, even among conservatives who support the proposals, that the federal government can pull off such a major policy shift in just a few weeks. The enhanced ACA subsidies expire at the end of the year, and Republicans are still debating among themselves whether to simply extend them.

"The plans have been designed. The premiums have been set. Many people have already enrolled and made their selections," Douglas Holtz-Eakin, the president of the American Action Forum, a conservative think tank, warned senators on Nov. 19. "There's very little that this Congress can do to change the outlook."

HHS Officially Rescinds Nursing Home Minimum Staffing Rule

Nursing home providers praised the move, while one patient group called it "very disappointing

The Trump administration on Tuesday rescinded a Biden-era rule that required a minimum number of healthcare staff in nursing homes.

The Department of Health and Human Services (HHS**) said Tuesday in a press release** it is taking the action "after determining the final rule imposed by the Biden administration disproportionately burdened facilities, especially those serving rural and tribal communities, and jeopardized [patients'] access to care."

Today's decision to repeal these provisions, in alignment with the One Big Beautiful Bill Act, underscores HHS's commitment to practical, sustainable approaches to improving nursing home care, and allows for further opportunity for engagement with community and tribal stakeholders," the release stated.

"Safe, high-quality care is essential, but rigid, one-size-fits-all mandates fail patients," HHS Secretary Robert F. Kennedy Jr. said in the release. "This administration will safeguard access to care by removing federal barriers -- not by imposing requirements that limit patient choice."

Mehmet Oz, MD, MBA, administrator of the Centers for Medicare & Medicaid Services (CMS) said in the release that "At CMS, our mission is not only to improve outcomes, but to ensure those outcomes are achievable for all communities. We cannot meet that goal by ignoring the daily realities facing rural and underserved populations. This repeal is a step toward smarter, more practical solutions that truly work for the American people."

The rule, **enacted in May 2024** by the Biden administration, required nursing homes that participate in federal programs such as Medicare and Medicaid to meet a total nurse staffing standard of 3.48 hours per resident day (HPRD), which must include at least 0.55 HPRD of direct registered nurse (RN) care and 2.45 HPRD of direct nurse aide care, according to a **CMS fact sheet.** Facilities could use any combination of nurse staff (RNs, licensed practical nurses [LPNs] and licensed vocational nurses, or nurse aides) to account for the additional 0.48 HPRD needed to comply with the total nurse staffing standard, the agency said. The rule also required nursing homes to have an RN on site 24 hours a day, 7 days a week, to provide skilled nursing care.

CMS gave nursing homes 2 years to comply with some parts of the rule and 3 years for other parts; rural facilities were given extra time. However, Republicans and nursing home organizations **pushed back on the rule,** saying it would force some nursing homes to close. Two large nursing home provider organizations **sued over the regulations;** a federal court judge ruled in their favor and struck down several of the rule's key provisions. In addition, the One Big Beautiful Bill Act delayed implementation of the rule for 10 years. Tuesday's announcement was not a *surprise, because HHS in August had **sent the proposed rescission*** to the Office of Management and Budget for review.

Nursing home and hospital groups praised the rule's rescission. "The CMS staffing mandate repeal is a much-needed recognition of the very real barriers that our nursing home members navigate in recruiting and retaining staff," Katie Smith Sloan, president and CEO of LeadingAge, an association of nonprofit aging services providers, said in a statement. "We will continue to engage with federal policymakers and advocate for meaningful investments in the long-term care workforce and the advancement of smart policies to realize the necessary numbers of trained and qualified nurse aides, registered nurses, licensed practical nurses, and other [nursing home] caregivers."

"The AHA applauds CMS's repeal of the misguided minimum staffing requirements for long-term care facilities," Stacey Hughes, the AHA's executive vice president for government relations and public policy, said in a statement. "The AHA has repeatedly raised concerns that the requirements could exacerbate workforce shortages, lead to facility closures, and jeopardize access to care, especially in rural and underserved communities that often do not have the workforce levels to support these requirements.

But nursing home consumer groups felt otherwise. "We were very disappointed by CMS's announcement today," Sam Brooks, director of public policy for the National Consumer Voice for Quality Long-Term Care, a patient advocacy group, wrote in an email to *MedPage Today*. "Even though it claimed the rescission was in part due to congressional and judicial developments, it repeated the often-debunked lines from the nursing home industry that there are not enough staff and that rural facilities will be harmed. Both of these claims are not true."

"The rule had numerous opportunities for exceptions, meaning that nursing homes with legitimate hiring challenges would be exempted from compliance," he continued. "Further, there was no evidence rural facilities would have a harder time complying [than] non-rural facilities.... The real problem is that nursing homes treat workers poorly and cannot retain them."

Most disheartening was that CMS offered no plan to address the staffing crisis in nursing homes," Brooks added. "Instead, it is returning to the status quo, which results ... in residents suffering and dying because nursing homes are not staffed adequately."

3 Social Security Rules All Retirees Need to Know in 2026

Social Security serves as a key income source for millions of retirees. And chances are, it's an important income source for you -- or it will be one day. That's why it's so important to understand exactly how Social Security works.

Now as you might imagine, there are a lot of rules attached to **Social Security**. And familiarizing yourself with all of them may be a daunting task. But here are three Social Security rules in particular it pays to know as the new year approaches.

1. Filing for spousal benefits

Generally speaking, you earn the right to collect Social Security in retirement by working and paying taxes on your wages. If you accumulate 40 work credits in your lifetime, at a maximum of four per year, you can file for Social Security once you turn 62. You might assume that if you never worked, you won't be able to collect Social Security. But if you're married to someone who's eligible for **benefits**, you may be in luck. That's because Social Security pays **spousal benefits** to people whose current or former spouses are eligible for those monthly checks.

It's important to understand the rules around claiming spousal benefits if you're in line for them. Here's an overview:

- If you're married, you can't claim spousal benefits until your spouse signs up for Social Security.
- If you're divorced, you generally don't need to wait for your ex-spouse to claim benefits before getting them yourself.
- You can sign up for spousal benefits starting at age 62, but they'll be reduced if you don't wait until your **full retirement age.**
- If you're entitled to your own Social Security benefit based on an income history and a spousal benefit, you can only collect one at a time.

Knowing this should help you prepare to file for spousal benefits when the time comes -- whether that's in 2026 or a later year.

Read More

Here's the Maximum Possible Social Security Benefit for Retirees Ages 62 to 85 in 2026

The average Social Security retirement beneficiary is expected to receive a monthly payment of about $2,064 in 2026, based on the most recent data provided by the Social Security Administration. But some beneficiaries will receive much more.

Those with long, highly paid careers, can receive thousands of dollars more each month from the government retirement program. But there are several factors that will determine exactly how much more. Here's the theoretical maximum possible Social Security benefit for retirees at every age from 62 to 85 for 2026.

The biggest factors affecting your Social Security benefit

Before determining the maximum possible benefit for each age group, it's important to understand, at least at a base level, how the government calculates your benefit.

The first step the Social Security Administration takes when calculating your benefit is to determine your **average indexed monthly earnings**, or AIME. It takes your entire earnings history and adjusts each year's taxable wages and self-employment income for wage inflation tied to an index level from the year you turned 60. Any earnings after age 60 don't get an inflation adjustment. It then selects the 35 highest inflation-adjusted earnings years and determines their monthly average. That's your AIME.

Your AIME is then plugged into the **Social Security benefits formula** to determine your initial **primary insurance amount**, or PIA. The formula's bend points are also indexed to wage inflation and set the year you become eligible for Social Security (at age 62).

The year you were born plays a significant role in determining the fundamental factors underlying your Social Security benefit. As a result, the maximum possible benefit will vary depending on what year you were born.

The result of the Social Security benefits formula is your primary insurance amount, or PIA. But the SSA will adjust your PIA every year based on a couple of factors. If you had earnings in a given year, the SSA will recalculate your AIME, which could affect your PIA. In addition, your PIA gets an annual **cost-of-living adjustment.** The COLA applies whether you've claimed benefits already or not.

The final step in determining your Social Security benefit is assessing a penalty for early claimants or credits for those who delay their application. If you claim before your full retirement age, you'll receive less than your PIA. The penalty is also affected by when you were born, as Congress increased the full retirement age from 65 to 67, affecting those born after 1937. You'll receive a credit as a percentage of your PIA for each month you delay benefits up to age 70**….Read More**

The Beneficiary Experience: *The Costs of Medicare Advantage*

Medicare is becoming more costly and beneficiaries are increasingly struggling to afford care. In 2023, **41% of callers to the Medicare Rights national helpline** had questions about affording various Medicare costs, **nearly double** the percentage of callers who were primarily concerned about costs in 2012. With **54% of eligible beneficiaries enrolled in Medicare Advantage (MA) in 2025,** with projections indicating this number will continue to grow, reducing MA costs and overhauling its financial structure are key to making Medicare sustainable.

Medicare Advantage Marketing and Compensation

The **three new briefs in our Medicare Sustainability series** examine how MA plans can overpromise and underdeliver in order to drive up enrollment and compensation to MA organizations. During a time when Medicare costs are rising while coverage gaps remain, people are motivated to find the plan that offers the most benefits and savings. Using agents and brokers who receive commissions for enrolling beneficiaries, MA plans aggressively market supplemental benefits and attractive incentives. Increased enrollment results in increased compensation for plans and third parties, which increases funding for additional benefits and marketing. Combined with MA organizations' strategy to flood the market with similar plans and make it more difficult for people to switch or leave their plan—discussed **earlier in the Medicare Sustainability series**—the payment structure of MA creates an ever-increasing cycle of overspending.

The payment structure of MA creates an ever-increasing cycle of overspending.

While federal cost-saving options like **Medicare Savings Programs** and the **Part D Low-Income Subsidy** remain underused due to notoriously difficult enrollment processes, MA organizations and third-party marketing organizations steer beneficiaries toward MA plans with benefits that claim to save them money. As a result, beneficiaries are pushed to enroll in plans that may not meet their care needs and don't deliver the cost assistance they promise, while brokers, agents, and third-party marketers reap commissions.

Beneficiary Experiences from the Helpline

This unsustainable incentive structure and overpayment cycle of MA have real impacts on beneficiaries' care. The new Medicare Sustainability briefs include real stories from callers to the Medicare Rights national helpline who were misled by MA marketing and steered by biased sources to act against their best interests.

These include people who were misled by marketers and enrolled in new MA plans without being given the chance to make a fully informed choice. These beneficiaries found themselves locked out of previous plans that had worked well for them.

Mr. CG was in an MA plan. A sales representative told Mr. CG that he could "fix his problems" while not switching his plan. Mr. CG was disenrolled from his plan and enrolled in a new plan. He tried to switch back to his old plan but is now in a different plan than his previous first-choice plan.

Some people enrolled in MA plans after being promised large discounts or cash-like benefits, only to find the benefits delayed or inaccessible and the new plan unfit for their health needs.

Ms. BC, who is dually eligible, enrolled in an MA plan in order to access a $250 credit that could be used for OTC or utilities. After enrolling, she learned that she would only be eligible for $193. She attempted to apply the credit to her electric bill. The plan claimed the transaction was complete, but the electric company never received payment. Ms. BC attempted to apply the credit to other bills and was told that those utility companies were not participating with the program.

Many callers enrolled in an MA plan for dental, vision, or hearing coverage, which aim to fill Original Medicare's significant coverage gaps in those areas. But when they try to receive care, they run into policy restrictions and insufficient coverage.

Ms. NG, who is dually eligible, got a letter from her MA plan approving coverage of two crowns to follow two root canals that had already been done. After receiving one of the crowns, Ms. NG got another letter from the plan denying coverage for both crowns.

Mr. CL, who is dually eligible, has an MA plan. He received an eye exam which his case manager said was covered. Then he started receiving denial letters that this case manager said were in error….Read More

House votes to extend acute hospital care at home

Senate needs to vote to extend program past Jan. 30, 2026, deadline.

The U.S. House of Representatives has unanimously voted on legislation to continue acute hospital care at home, a program supported by the American Hospital Association and numerous other provider organizations.

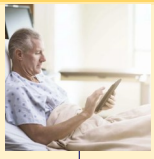
On Monday, the House passed the Hospital Inpatient Services Modernization Act (H.R. 4313), which extends the Acute Hospital Care at Home (AHCaH) through 2030.

It now moves to the Senate for a vote. The American Telemedicine Association has urged for passage and for President Donald Trump's signature before a January deadline when the program expires.

"This is an important step to avert another lapse of essential care for Medicare patients on January 30, 2026," said ATA Action, the advocacy arm of the American Telemedicine Association. "ATA Action strongly urges the U.S. Senate to quickly pass this legislation to ensure certainty for thousands of patients across the country."

The ATA has long been an advocate for not only extending the program, but making it permanent.

In a move supporting a continuation of the initiative, in September more than 140 healthcare organizations, including more than 50 health systems, sent **a letter** to Congress **urging inclusion** of a five-year extension of the Acute Hospital Care at Home waiver program in a government funding package.



In its own September statement to the Committee on Ways and Means, the American Hospital Association **said** that as of August 2025, 413 hospitals across 146 systems and 39 states had been approved to provide acute hospital services to patients at home.

Hospitals need stability to justify the needed investment for the program, the AHA indicated.

"Standing up a H@H program requires logistical and technical work, with an investment of time, staff and money," the AHA said in the September letter. "In addition to being approved for the federal waiver, some providers must navigate additional regulatory requirements at the state level. For some, this whole process could take a year or more to complete before the first patient can be seen at home."

WHY THIS MATTERS

Initiatives to move acute hospital care to the home are not new. John Hopkins began its Hospital at Home program around 1995. But acute hospital care at home gained traction during the COVID-19 pandemic when the Centers for Medicare and Medicaid Services allowed for the flexibilities needed for hospitals to provide, and get paid for, acute care services at home.

During the pandemic, many hospitals ramped up acute hospital care at home programs to free up beds needed for patients with COVID-19.

Hospitals also found an **economic benefit** by being able to backfill lower acuity patients with higher margin patients, said Mark Larson, principal of Sg2, a Vizient subsidiary, in a 2021 interview with *Healthcare Finance News.*

In a win-win situation, most patients prefer recovering at home. Those who receive hospital care at home generally have lower mortality rates than their brick-and-mortar inpatient counterparts, said a Centers for Medicare and Medicaid Services **report** on the acute hospital care at home initiative.

CMS also said it could not conclude that the acute hospital care at home program resulted in lower Medicare spending overall compared to brick-and-mortar inpatient care.

One of the flexibilities provided under the pandemic was for virtual care.

"The Acute Hospital Care at Home program, in place for over half a decade, has become a critical part of the nation's care delivery system. More than 330 hospitals across 37 states now rely on AHCaH to safely care for appropriate patients in their homes," said Alexis Apple, director of Federal Affairs at the American Telemedicine Association. "In a solid show of bipartisan support, the House passed legislation under suspension, to ensure that millions of Medicare beneficiaries will continue to have access to a proven care model that reduces complications, shortens recovery times and strengthens bed capacity for patients with life-threatening or complex illness requiring intensive medical care and monitoring."

THE LARGER TREND

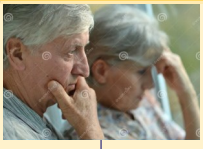
In November 2020, CMS approved waivers for six health systems to provide acute care at home. The hospitals included Brigham and Women's Hospital in Massachusetts; Huntsman Cancer Institute in Utah; Massachusetts General Hospital in Massachusetts; Mount Sinai Health System in New York City; Presbyterian Healthcare Services of New Mexico; and UnityPoint Health of Iowa.

The Hospital Inpatient Services Modernization Act extends the current Hospital at Home waiver program, first established by CMS in November 2020, through 2030.

Hospitals increasingly opt out of Medicare Advantage networks

In the last few years, dozens of hospitals and physicians across the country have opted out of Medicare Advantage networks, saying that insurers are endangering patient health, burdening them with needless administrative requirements, and underpaying them for their services. Michael Brady reports for **HealthcareDive** on the state of play.

Medicare Advantage insurers often refuse to pay Traditional Medicare rates, if they don't want certain providers in their networks or don't care if they are out-of-network. The Centers for Medicare and Medicaid Services, for its part, allows the Medicare Advantage insurers to get away with having what appear to be inadequate networks in many cases. Mental health providers, rehabilitation providers and top cancer care providers are too often hard to come by for people in Medicare Advantage plans.



Many hospitals are fed up. 'Provider challenges in delivering patient care amidst onerous payer coverage barriers or insurer refusal to contract with providers — unless they accept below-cost reimbursement rates or business terms that interfere with efficient care delivery — may lead providers to make the difficult decision to not participate in a particular network,' according to an American Hospital Association spokesperson.

Of course, the insurers blame the hospitals for excessive charges that the insurers cannot understand. For sure, hospital bills are excessive and hard to understand. But, the insurers' denials and delays of care and administrative hassles do not add value.

What's unquestionably true is that hospitals lost a lot of money during the pandemic and the insurers seemingly made a bundle. The hospitals could not provide a lot of the care they typically provided. And, while the insurers were paid to cover care, far fewer people were getting or able to get care.

Some argue that insurers do not see profits in the Medicare Advantage market. But, they are doing extraordinarily well, bringing in more than $80 billion in government overpayments each year. And, Congress has yet to enact legislation to claw back this money.

Many health and hospital systems are no longer willing to work with Medicare Advantage insurers.

Here's a list of some of the hospitals ending Medicare Advantage contracts in 2026 and those that ended contracts in 2025. **Read states that are affected**

Social Security warning issued by senator as agency pushes 2026 change

Democratic U.S. Senator Elizabeth Warren of Massachusetts has issued a warning over **Social Security Administration (SSA) efforts** to reduce field office visits in 2026.

The SSA has said it aims to halve the number of people who go to field offices in the next year. On average, more than 31 million people visit the offices yearly and the agency's goal is to slash that figure to 15 million.

Why It Matters

Social Security Commissioner Frank Bisignano is looking to boost efficiency across the SSA with added technology but has said the agency is not "getting rid of field offices."

But Warren's concerns highlight growing criticism that the changes at the SSA could stir up problems for many beneficiaries who rely on the monthly payments to live

What To Know

The SSA's push to minimize field office visits is part of an effort to offer more online self-service options where recipients are able to view their claim status or access their Social Security number digitally.

Staffing across SSA offices is down by 2,000 people nationwide, according to the AARP, and the agency moved 1,000 field office employees to its national phone team in July.

"The Social Security Administration is prioritizing technology to serve the next generation of users — Gen X and younger baby boomers — who are generally more comfortable with online systems," Kevin Thompson, CEO of 9i Capital Group and host of the *9innings* podcast, told *Newsweek*. "While this digital shift could streamline services over time, it may unintentionally disadvantage older or rural Americans who still depend on in-person assistance. The brutal reality, this effort may help efficiency but risks alienating the very communities that it's supposed to serve."

Warren denounced the staff reductions and field office limitations on X, echoing many other Americans' concerns.

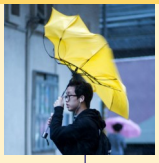
"This sure sounds like another way to make it even harder for Americans to get the benefits they've earned," Warren wrote. "I will not stop fighting to protect Social Security."

"It is disappointing yet unsurprising that the fake news media is eager to ignore the truth to scare seniors**.** The truth is simple: field offices are, and will always remain, our front-line, serving the approximately 75 million Americans who receive monthly payments and more than 330 million Americans with Social Security numbers," an SSA spokesperson told *Newsweek*.

"The Social Security Administration under President [Donald] Trump's leadership is serving more Americans than ever before at quicker speeds, and more customers are choosing to resolve their needs online or over the phone… Commissioner Bisignano has pledged to have the right level of staffing to operate at peak efficiency and deliver best-in-class customer service to the American people." …**Read More**

Trump administration's proposed Medicare Advantage reforms end several enrollee protections

All sorts of proposed changes for people in Medicare Advantage are afoot, reports Allison Bell for **ThinkAdvisor**. The Centers for Medicare and Medicaid Services has released **proposed rules effective 2027** that could offer one important protection to people in Medicare Advantage who lose their in-network doctors. But, the proposed rules largely benefit insurers, eliminating several protections against misleading marketing, health inequities, and prior authorization gaming.



The proposed rules, if finalized, would give Medicare Advantage enrollees who lose their in-network providers mid-year the right to switch to another Medicare plan without CMS approval. However, it does not appear that this new rule would give Medicare Advantage enrollees a guaranteed right to enroll in a Medigap plan if they opted to switch to Traditional Medicare.

Medicare Advantage enrollees currently only have that right if CMS deems that there has been a "significant change" in their provider network. But, they must wait for a CMS determination to switch out of their Medicare Advantage plan. The CMS determination can take a long time, preventing enrollees' continuity of care from the same physicians and hospitals

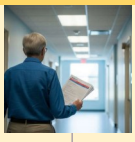
Of concern, if finalized, the proposed rules would also give **insurance agents more leeway to approach prospective customers and sign them up for a Medicare Advantage plan** after an "educational" meeting. Worse still, they would give third parties selling Medicare Advantage plans more leeway to use images of a Medicare card in their marketing materials; they would no longer need CMS approval.

Perhaps most unconscionable, CMS proposes to free agents and brokers from including in their sales material information about the independent unbiased free counseling people can get from State Health Insurance Assistance Programs (SHIPs). Right now, they must include this information….**Read More**

6 states seeing the biggest Medicare changes next month

WISeR pilot brings new prior authorization rules

Medicare beneficiaries across the country will experience significant changes starting January 1, 2026, but those in select states will see the biggest adjustments. These updates include a new federal pilot program requiring prior authorization in **Original Medicare**, rising Part B costs, and major disruptions in private Medicare Advantage and Part D plans. Understanding these changes can help you prepare, compare options, and avoid unexpected increases in costs or reductions in coverage.



WISeR pilot brings new prior authorization

Six states—Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington—will adopt expanded prior authorization for low-value services under the WISeR model.

AI-assisted reviews with clinician oversight

AI will help expedite reviews, but only licensed clinicians will issue final denials, raising concerns about delays and access.

More services now require approval

Skin and tissue substitutes, nerve stimulation implants, knee arthroscopy, cervical fusion, steroid injections, and impotence treatments will require prior approval.

Part B premiums rise sharply in 2026

The Part B premium increases to $202.90, while the deductible rises to $283, consuming a significant share of retirees' COLA.

Private plan shakeups nationwide

Over 2 million enrollees may lose Medicare Advantage plans, and Part D options drop from 464 to 360 nationwide.

Supplemental benefits face cuts

Dental, vision, and OTC allowances in many Medicare Advantage plans will be reduced or tightened for 2026.

Enrollment periods offer key opportunities

Reviewing your ANOC and using AEP (Oct. 15–Dec. 7) or OEP (Jan. 1–Mar. 31) helps you adjust to plan cancellations or rising costs.

3 Reasons to Finally Ditch Medicare Advantage This Year

Medicare Advantage is an alternative to traditional Medicare. For many retirees, Medicare Advantage plans seem attractive because they allow you to get insurance from a private **health insurance** company that may provide more coverage than the government does.

If you've signed up for a **Medicare Advantage** plan, though, there may be some potential problems with your plan that you aren't even aware of until the time comes when you need to get healthcare services. You don't want to find out the hard way that your Advantage plan isn't all it's cracked up to be, so consider these three reasons why you may want to ditch your plan this year.

1. Out-of-network benefit issues when traveling

As part of the **retirement planning** process, many retirees dream of seeing the world, or at least hitting the road and seeing some of the United States that they didn't have the chance to visit while working.

Traveling can be a great way to spend your free time as a retiree, but if you have a Medicare Advantage plan, you could be faced with a big problem. Medicare Advantage plans usually have networks, and if you don't see an in-network doctor, your non-emergency care may not be covered, or you may have much higher out-of-pocket costs to pay.

The problem is, networks are usually local. So, if you've gone on a trip and left your network of doctors behind, you may not have many, or any, covered care providers. This becomes a problem not just for wanderers who are seeing the world, but for any senior who wants to go visit their grandkids or become a snowbird and escape cold weather for a while.

With original Medicare, this isn't an issue since Medicare Part B is accepted by doctors nationwide, so you'll only have to worry about health insurance coverage if you go abroad.

2. Possibility of denials

An increased risk of denials is another good reason to ditch Medicare Advantage plans this year. With traditional Medicare, you don't usually need pre-approval for covered services, and you aren't going to risk an insurer telling you that the care you want isn't going to be paid for .

You *do* face this risk with Advantage plans, though. If you don't want to have to fight with an insurance company to pay for services, ditching Medicare Advantage could be a better move.

3. Narrow networks

Finally, remember those networks mentioned above? They can sometimes be pretty narrow, even within your geographic region.

This means you may have a hard time finding a doctor to see you, especially if you need a specialist. Your network can also change from year to year, so if you have a doctor you love, there's no guarantee that you'll be able to keep seeing that doctor in subsequent years without changing your health insurance plan.

Again, this isn't an issue with original Medicare since the "network" includes every doctor that accepts Medicare coverage (which is pretty much every physician that provides care to seniors).

Should you ditch your Medicare Advantage plan?

All of these issues are good reasons to *stop* relying on Medicare Advantage. However, you'll need to go back to traditional **Medicare** if you drop your plan -- and that could leave you at risk of big coverage gaps and large coinsurance costs since Medicare Part B excludes many services like hearing aids and dental care, *and* requires you to pay 20% of most covered services.

Medigap policies can help to fill the gaps left by Medicare, but if you don't sign up for Medigap plans during your initial enrollment, it could be harder and more expensive to do so later.

Still, it's worth carefully considering the Medicare Advantage *disadvantages* and exploring your options to see if there is a better alternative that could help you avoid the risk of raiding your **retirement plans** to pay for healthcare costs if something goes wrong.

Senior advocacy group proposes 'one-time catchup payment' for Social Security beneficiaries

The Senior Citizen's League, a nonpartisan organization aiming to educate older Americans about laws, rights and financial issues facing their demographic, has proposed that the Social Security Administration consider a "one-time catchup payment" to help retirees make ends meet amid rising inflation.

The "catchup payment," also referred to as a "make-up payment" by The Senior Citizens League (TSCL), would ideally be paid to Social Security beneficiaries in addition to next year's cost-of-living adjustments (COLA), the group hopes.

"Many retirees have experienced a sharp erosion in their purchasing power, as Cost-of-Living Adjustments (COLAs) have failed to keep pace with the rapidly rising costs of essentials such as food, housing, and healthcare," reads a statement TSCL shared with Nexstar.

Which rising costs are seniors facing?

In a **press release** issued last month, TSCL projected next year's COLA to be 2.6% — 0.1% higher than **this year's increase**. But even though these increases are designed to keep pace with inflation and help Social Security recipients maintain their buying power, TSCL has long argued that the metrics used to calculate the annual increases (i.e., the Bureau of Labor's Consumer Price Index for Urban Wage Earners, which itself is a measure of the change in prices for common consumer goods and services) do not take into account the costs that elderly Americans are paying for things like medicine, housing and groceries.

A **recent survey** of nearly 2,000 Social Security beneficiaries, conducted by TSCL, indicated that a fifth of respondents were spending more than $1,000 on healthcare costs alone. And the vast majority (96%) thought the Social Security Administration should base their COLA calculations on another set of data, like the Consumer Price Index for the Elderly, which focuses on costs affecting Americans ages 62 and up.

"Many older Americans saw their Social Security buying power eroded during the recent inflation spike, and rising Medicare Part B premiums often wiped out their entire COLA increase," TSCL executive director Shannon Benton told Nexstar. "A catch-up payment would help restore that lost value and provide urgently needed relief for retirees living on fixed incomes."

Earlier this year, the Bureau of Labor Statistics also stopped collecting data for **its indexes in three cities** and reduced collection efforts in about 15% of 72 other metro areas, sparking concerns that the more limited data **might be less reflective of the prices seniors are paying**. (BLS, however, claimed in July that its new practices **did not result in any significant changes** when compared to previous methods.)

"If the government fails to act and the CPI's data quality begins to erode, it increases the likelihood of the government providing a COLA that doesn't match inflation," TSCL wrote at the time.

How would a 'catchup payment' help?

TSCL didn't go into much detail about the specifics of its proposed "catchup payment" in last month's press release. But in an email shared with Nexstar, TSCL suggested the money could be provided to eligible recipients in the same way that that 2009's $250 **Economic Recovery Payments** were doled out to Social Security and SSI recipients amid the Great Recession. (A third of recipients ultimately used the money to pay off debt, **the BLS later reported.**)...**Read More**

Dear Marci: What services are covered under the SNF benefit?

Dear Marci,

I recently had a hip surgery, and my doctor recommended a short stay at a skilled nursing facility (SNF) for rehabilitation. I have Part A but I'm unsure what services are included under the SNF benefit?

– Larry (Sioux Falls, SD)

Dear Larry,

Great question! **Skilled nursing facility (SNF) care** is post-hospital care provided at a SNF. SNFs can be part of nursing homes or hospitals.

During a Medicare-covered SNF stay, Part A covers:

- A semi-private room and meals
- Skilled nursing care provided by nursing staff
- Therapy, including physical therapy, speech therapy, and occupational therapy
- Medical social services and dietary counseling
- Medications
- Medical equipment and supplies

Ambulance transportation to the nearest provider of needed services, when other modes of transportation would endanger your health

Each benefit period, Part A covers the full cost of your first 20 days in a SNF. For days 21-100, Part A covers part of the cost and you pay a daily coinsurance. To be eligible for Medicare SNF coverage, your care must be medically necessary.

Medicare Part A covers SNF care if:

- You were formally admitted as an inpatient to a hospital for at least three consecutive days
- You enter a Medicare-certified SNF within 30 days of leaving the hospital, and receive care for the same condition that you were treated for during your hospital stay
- And, you need skilled nursing care seven days per week or skilled therapy services at least five days per week

Keep in mind that the day you become an inpatient count toward your three-day inpatient stay to qualify for Medicare-covered SNF care. However, the day you are discharged from the hospital does not count toward your qualifying days. Also remember that time spent receiving emergency room care or under observation status does not count toward the three-day hospital inpatient requirement for SNF coverage.

Speak to your doctor or hospital discharge planner if you need help finding a SNF that meets your needs. Ask them to find Medicare-certified SNFs in your area that will address your medical needs. If you are in a Medicare Advantage Plan, contact your plan to find out which SNFs are in their network.

Hope this is helpful!

-Marci

Achieving Better Finances: What Every Senior & Elderly American Should Think About

Financial matters affect the lives of all Americans. But, as a senior, finances may play an especially large role in your well-being. After all, at this stage of life, priorities often change. And new realities may influence your spending and saving habits. That's why it's a good idea to take a step back and make sure you're on a financial path that truly serves your interests. By managing your money well, you'll have an easier time achieving the lifestyle—and other goals—you want.

And isn't that the whole point? The more you know about your financial affairs and the options available to you, the brighter your senior years are likely to be. You get to make your money work for you. That's true whether you're currently retired, planning to retire, or working by choice or out of necessity.

But, of course, it's important to remember that sustaining healthy finances as a senior or elderly individual often requires taking some special factors into consideration. For example, your goals for the immediate and more distant future are probably very different from what they were a few decades ago. You also may have close relatives who want to help you, who need financial assistance of their own, or who may inherit your assets. Plus, you can't ignore your health care needs or the fact that protecting your money becomes increasingly important as you age.

It may seem like a lot to think about. But you can do this. Here are some things to consider:

- **Your various goals**
- **Short- and long-term planning**
- **Budgeting and managing your cash flow**
- **Getting help**
- **Avoiding scams and elder abuse**

Government's new negotiated Medicare prices for some drugs are twice as high as Canada's

The Centers for Medicare and Medicaid Services (CMS), which oversees Medicare drug price negotiation, just released details regarding the 15 drugs with negotiated prices that will take effect in 2027. The Medicare program should save billions, which could keep down premiums, but people with Medicare who use these drugs will save substantially less, Joyce Frieden reports for **MedPageToday**. Moreover, the new prices for some drugs are still twice as high as Canada's.

CMS **reports** that, in 2027, people taking these 15 drugs should see a total savings on Medicare Part D copays of $685 million or around 40 percent, down from $1.7 billion. CMS does not say whether the negotiated prices are as low as other wealthy countries negotiate for their citizenry. The discount for the government on these drugs is 36 percent.

The government reports that the new prices for the drugs are as much as 85 percent below their list prices. In terms of government savings, CMS reports that had the negotiated prices been in effect last year, Medicare would have saved $8.5 billion. So government savings for these negotiated drugs are significant.

CMS further reports that about 5.3 million people with Medicare use one or more of the drugs with negotiated prices through their Part D prescription drug benefit. Drugs with negotiated prices in 2027 include GLP-1's: Ozempic, Rybelsus, Wegovy. CMS reports that 2,282,000 people with Medicare take a GLP-1 drug.

CMS reports that 1,269,000 people with Medicare take Trelegy Elipta for Chronic Obstructive Pulmonary Disease and asthma. Around 66,000 more people with Medicare take a cancer drug with a negotiated price. You can see a list of all the drugs, as well as the conditions they treat, below.

The Inflation Reduction Act of 2022, which had no Republican support, called for CMS to negotiate Medicare drug prices on 10 drugs last year and 15 drugs this year. The Trump administration fulfilled its obligation under the law, though as of yet has done very nothing to lower prices on all drugs for all Americans to a level on a par with other wealthy nations, as President Trump said he intended to do. Moreover, Republicans in Congress added delays and exemptions to future Medicare drug price negotiations for some expensive drugs, blocking $9 billion in savings, according to Public Citizen….**Read More**

RI ARA HealthLink Wellness News

Please Note: All Articles In This Section Are For Information Only And Not Medical Advice

HealthLink Wellness "Taking Control"

Shingles Vaccine May Help Slow Dementia, New Study Finds

A routine **shingles** shot may do more than prevent a painful rash. It could also support long-term brain health, new research shows.

In a study published Dec. 2 in the journal ***Cell,*** Stanford University researchers found that adults who received the shingles vaccine were less likely to develop early memory and thinking problems.

And among those who already had **dementia,** getting the vaccine was linked to a lower risk of dying from the disease.

"We see an effect on your probability of dying from dementia among those who already have dementia," senior author **Dr. Pascal Geldsetzer**, an assistant professor of medicine at Stanford in California, told *CNN.*

"That means that the vaccine doesn't just have a preventive potential, but actually a therapeutic potential as a treatment, because we see some benefits already among those who have dementia," he added.

The findings come from health data of more than 282,500 older adults in Wales, where a shingles vaccine program began in 2013.

Because only people who were 79 years old on a specific date were eligible for the vaccine while adults who had just turned 80 were not, researchers were able to compare two very similar groups with very different vaccination rates.

Earlier analysis showed a 3.5-percentage point decrease in dementia diagnoses over seven years among these vaccinated folks.

The new analysis expanded on that:

- Adults who had no prior memory problems and got the shingles vaccine had a 3.1 -percentage point lower risk of developing mild cognitive impairment over nine years versus those who didn't get it.
- Among folks already living with dementia, vaccination was linked to a 29.5-percentage-point lower chance of dying from dementia over nine years.
- As was the same in the earlier study, the protective effects appeared stronger in women.

Scientists are still trying to figure out the "why."

But Geldsetzer said two ideas may explain the findings:

1. Lower inflammation in the nervous system: After a childhood chickenpox infection, the virus stays dormant in the nervous system. Even while "asleep," it can create ongoing immune activity. Since inflammation plays a major role in dementia, preventing these reactivations might have benefits for the dementia process.

2. A stronger immune system overall: Vaccines don't only create antibodies, they also play a broader role in making the immune system stronger. Because many infections are tied to dementia risk, an immune system that's ready to fight off infection may help protect the brain.

"These kinds of broader immune system activations may well have benefits for dementia disease development as well, and we know the immune system plays a key role in dementia. So that's the other mechanism," Geldsetzer explained.

Angelina Sutin, a behavioral sciences professor at Florida State University in Tallahassee, who was not involved in the research, explained that the findings are encouraging.

"When people find out that I study dementia, they often ask what I recommend to keep the brain healthy with age. I always respond with three things: exercise, be social, and do things you enjoy that make you feel purposeful," she told *CNN* in an email.

"Now, I will add talk to your doctor about getting the shingles vaccine. There is no guarantee that doing these things means you will not get dementia, but all are relatively easy and accessible and help maintain healthy cognition for longer," Sutin added.

Other experts stressed that more studies are needed, however.

"I would view these results as promising, providing unique evidence that shingles vaccination may have meaningful cognitive benefits, but not yet as definitive proof that we should vaccinate solely for dementia risk reduction**,"** **Dr. Joel Salinas**, a neurologist at NYU Langone in New York City, said to *CNN.*

"This study is a very important advance in understanding because it provides the closest to causal evidence for the shingles vaccine that is possible. Unfortunately, it does not directly answer the why," Sutin said. "This research sets a strong foundation for future research to find out why it is so protective."

Cognitive Decline Can Show Up Early in Driving Patterns

By Ernie Mundell HealthDay ReporterMONDAY, Dec. 1, 2025 (HealthDay News) — Researchers say changes in folks' driving patterns could be an early signal of cognitive decline.

"We found that using a GPS data tracking device, we could more accurately determine who had developed cognitive issues than looking at just factors such as age, cognitive test scores and whether they had a genetic risk factor related to **Alzheimer's disease,"** explained study lead author **Ganesh Babulal** of Washington University School of Medicine in St. Louis, Missouri. His team reported their findings Nov. 26 in the journal ***Neurology.***

As Babulal explained in a journal news release, the "early identification of older drivers who are at risk for accidents is a public health priority, but identifying people who are unsafe is challenging and time-consuming."

What if simply tracking everyday behaviors, such as driving, could help?

In the new study, the St. Louis team first enrolled 56 people already diagnosed with mild cognitive impairment (MCI), which can sometimes be a precursor to Alzheimer's disease.

They also enrolled another 242 people of similar age but without such diagnoses. Together, the group averaged 75 years of age, and everyone said they drove at least once a week.

All participants also took standard tests for thinking skills, and all agreed to having special GPS tracking installed in their vehicles to monitor their driving.

At first, driving patterns between cognitively impaired and non-impaired people seemed similar, the researchers said.

However, that began to change over time: People with MCI began to drive less frequently, drove less at night, and there was less variance in where they drove, compared to folks whose cognition was not impaired.

Adding that information to other data on a person's age, other demographics, cognitive test scores and whether or not they had a gene associated with Alzheimer's, accuracy in spotting cognitive decline rose to 87%, the researchers said.

"Looking at people's daily driving behavior is a relatively low-burden, unobtrusive way to monitor people's cognitive skills and ability to function," Babulal said. "This could help identify drivers who are at risk earlier for early intervention, before they have a crash or near miss, which is often what happens now. Of course, we also need to respect people's autonomy, privacy and informed decision-making and ensure ethical standards are met."

WHO Issues First Guidance on Using GLP-1 Drugs to Treat Obesity

The World Health Organization (WHO) released its first-ever **guideline** on using GLP-1 medications to treat obesity.

The disease now affects more than 1 billion people worldwide and is tied to 3.7 million deaths in 2024.

The new recommendations reflect a major change in how obesity is viewed and treated.

The WHO classifies obesity as a chronic, relapsing condition that often needs long-term care, including medication, nutrition support, physical activity and continued follow-up from health professionals.

"Obesity is a major global health challenge that the WHO is committed to addressing by supporting countries and people worldwide to control it, effectively and equitably. Our new guidance recognizes that obesity is a chronic disease that can be treated with comprehensive and lifelong care," WHO director-general **Dr. Tedros Adhanom Ghebreyesus**, said.

"While medication alone won't solve this global health crisis, GLP -1 therapies can help millions overcome obesity and reduce its associated harms."

The WHO issued two conditional recommendations based on current evidence:

- GLP-1 medicines may be used for long-term treatment in adults with obesity, except for pregnant women. The WHO noted that these drugs have shown clear benefits for weight loss and metabolic health, but there is limited data on how safe and effective these drugs are over the long term, in addition to cost and access challenges for many people who need them.
- People prescribed GLP-1 drugs may also benefit from intensive behavior programs, including structured guidance on healthy eating and physical activity. Early evidence suggests that adding this to drug therapy could improve results.

GLP-1 medications, the same class of drugs used for type 2 diabetes, were added to the WHO's Essential Medicines List in 2025 for folks with high-risk **diabetes**.

Obesity increases the risk of several serious illnesses, including heart disease, type 2 diabetes and some cancers. It can also worsen outcomes in those battling infectious diseases.

But the WHO stressed that medication alone will not reverse the obesity problem. The guideline calls for a broader plan built around three pillars:

- Healthier environments including policies that support health.
- Targeted screening for people at higher risk.
- Lifelong care that focuses on each person's needs.

The WHO also noted the enormous economic burden. Obesity is expected to cost the world $3 trillion each year by 2030.

GLP-1 drugs are expensive and the WHO warns that without clear policies, these treatments may worsen existing health inequalities.

Even with increased production, the agency expects the medications will reach fewer than 10% of people who could benefit by 2030.

To improve access, the WHO is urging communities to explore tools like tiered pricing, pooled purchasing and voluntary licensing.

The guidelines were developed through extensive evidence review and consultation with researchers and folks living with obesity.

The WHO says the guidance will be updated regularly as new research becomes available.

Next year, the organization plans to work with international partners to help ensure treatment reaches people with the greatest need first.

Obesity Could Speed Alzheimer's Progression, Study Suggests

Obesity might contribute to faster progression of **Alzheimer's disease,** a new study says.

Some blood markers associated with Alzheimer's increased nearly twice as fast among people with obesity compared to people who didn't have obesity, according to results presented today at the Radiological Society of North America's annual meeting in Chicago.

"This is the first time we've shown the relationship between obesity and Alzheimer's disease as measured by blood biomarker tests," senior researcher **Dr. Cyrus Raji**, a principal investigator in the Neuroimaging Labs Research Center of the Mallinckrodt Institute of Radiology (MIR) at Washington University School of Medicine in St. Louis.

For the study, researchers tracked five-year data on more than 400 participants in an ongoing brain imaging study of Alzheimer's patients.

Results showed that people with obesity had blood biomarkers for Alzheimer's that rose more rapidly, including:

- Tau proteins, which form toxic clumps in the brains of Alzheimer's patients.
- Protein fragments of neurofilament light chain (NfL), which are released from damaged or dying brain cells.
- Glial fibrillary acidic protein, a protein produced by cells that heal and protect neurons in the brain and spinal cord.

Overall, tau levels increased up to 95% faster in people with obesity, results show. There also was a 24% faster rate of increase in NfL levels in participants with obesity versus those with Alzheimer's without obesity.

Overall, blood tests proved better than PET medical imaging scans in capturing the impact of obesity on Alzheimer's, researchers concluded.

"The fact that we can track the predictive influence of obesity on rising blood biomarkers more sensitively than PET is what astonished me in this study," Raji said.

These results imply that obesity might be a risk factor for Alzheimer's, said lead researcher **Dr. Soheil Mohammadi**, a postdoctoral research associate at MIR.

"According to the 2024 report of the Lancet Commission, 14 modifiable risk factors total approximately 45%, or close to half, of the risk for Alzheimer's disease," Mohammadi said in a news release. "If we can reduce any of those risk factors, we can significantly reduce Alzheimer's cases or lengthen the amount of time until the onset of the disease."

Raji believes that in the future doctors will use both blood tests and brain imaging scans to track Alzheimer's patients, particularly those being treated with newly approved drugs meant to slow the disease's progression.

"This is such profound science to follow right now because we have drugs that can treat obesity quite powerfully, which means we could track the effect of weight loss drugs on Alzheimer's biomarkers in future studies," Raji said.

"It's marvelous that we have these blood biomarkers to track the molecular pathology of Alzheimer's disease, and MRI scans to track additional evidence of brain degeneration and response to various treatments," Raji continued. "This work is foundational for future studies and treatment trials."

Results presented at medical meetings should be considered preliminary until they're published in a peer-reviewed journal.

Researchers Have Discovered 2 New Dementia Risk Factors. Here's What They Are.

Strides have been made in the world of dementia research compared with even just a few years ago. There's now a blood test that can diagnose **Alzheimer's accurately 90% of the time**, and more is understood about the factors (many of which are lifestyle habits) that can put you at higher risk for the condition. In a new **dementia** report published in **The Lancet journal** by researchers who are part of The Lancet Commission, two new modifiable risk factors have been identified: high cholesterol after 40 and untreated vision loss.

In 2020, these same researchers determined 12 modifiable risk factors that are known to put folks at higher risk of developing dementia. These are:

1. Physical inactivity
2. Smoking
3. Excessive alcohol consumption
4. Air pollution
5. Head injury
6. Infrequent social contact
7. Less education
8. Obesity
9. Hypertension
10. Diabetes
11. Depression

According to the report, these 12 factors, along with the two new ones, account for 49% of dementia cases across the world. Researchers determined these two new risk factors by looking at recent meta-analyses and studies on the topics; they looked at 14 papers on vision loss and 27 on high cholesterol.

"It makes a lot of mechanistic sense," said **Dr. Arman Fesharaki-Zadeh,** a behavioral neurologist and neuropsychiatrist at Yale Medicine in Connecticut. "A lot of these factors are very much interrelated." (Fesharaki-Zadeh is not affiliated with the report.)

"There are many sources of vision loss, of course, but it tends to be a lot more common in folks who have metabolic risk factors such as high blood pressure, such as poorly controlled diabetes, such as high cholesterol, which is the other risk factor [identified in the report]," he said.

Moreover, vision is our primary sensory organ — it's how we process the world around us — and when you can't see clearly, you're less likely to spend time doing brain-boosting activities like puzzles, reading or even spending time with other people, said Fesharaki-Zadeh. And these activities are known to help prevent dementia. .

When it comes to high LDL cholesterol (the so-called bad cholesterol), it can lead to the hardening of the blood vessels in the heart and brain, Fesharaki-Zadeh said, adding that high blood pressure and uncontrolled diabetes also affect the blood vessels.

This can **make it more difficult for oxygen** to get to the brain, which over time can lead to neuron damage — "and dementia is essentially an end product of the neurons dying out, so it's a neurodegenerative process," Fesharaki-Zadeh explained...**Read More**

Men's Beer Bellies Could Pose Special Risk to Heart

That beer belly a guy's toting around could mean trouble for his heart, a new study says.

Said belly fat is linked to changes in heart structure that can contribute to heart failure, researchers reported Monday at the Radiological Society of North America's annual meeting in Chicago.

"Abdominal obesity, a high waist-to-hip ratio, is associated with more concerning cardiac remodeling patterns than high body mass index alone," lead researcher **Dr. Jennifer Erley**, a radiology resident at University Medical Center Hamburg-Eppendorf in Germany, said in a news release.

A beer belly appears to contribute to changes "where the heart muscle thickens but the overall size of the heart doesn't increase, leading to smaller cardiac volumes," Erley said.

"In fact, the inner chambers become smaller, so the heart holds and pumps less blood. This pattern impairs the heart's ability to relax properly, which eventually can lead to heart failure."

For the new study, researchers analyzed MRI images for more than 2,200 adults 46 to 78 without known heart disease. They compared these images to the participants' BMI and waist-to-hip ratio.

Results showed that high levels of belly fat were associated with thickening of the heart muscle and smaller heart chambers.

These changes were more pronounced among men, particularly in their right ventricle — the chamber that pumps blood out of the heart to the lungs.

This could be due to the fact men are more likely to develop beer bellies earlier than women, or because women receive some heart health protection from the female hormone estrogen, Erley said.

"The sex-specific differences suggest that male patients may be more vulnerable to the structural effects of obesity on the heart, a finding not widely reported in earlier studies," Erley said.

"Rather than focusing on reducing overall weight, middle-aged adults should focus on preventing abdominal fat accumulation through regular exercise, a balanced diet and timely medical intervention, if necessary," Erley added.

Findings presented at medical meetings should be considered preliminary until published in a peer-reviewed journal.

Millions of Abbott Glucose Sensors Recalled After Faulty Readings Linked to Deaths

Millions of people rely on continuous glucose monitors to help manage **diabetes.** But a new **alert** from the U.S. Food and Drug Administration (FDA) warns that some sensors from Abbott may give incorrect blood sugar readings, which could lead to unsafe treatment decisions.

The issue affects about 3 million FreeStyle Libre 3 and FreeStyle Libre 3 Plus sensors, the FDA said. No other Libre products are included in the alert.

So far, the FDA has linked these incorrect readings to at least seven deaths and more than 700 serious injuries worldwide. About 60 of those injuries happened in the United States, according to **Abbott.** None of the U.S. cases were fatal.

"Patients should verify if their sensors are impacted and immediately discontinue use and dispose of the affected sensor(s)," the FDA stated.

Incorrect readings can be dangerous. If the device shows blood sugar levels that are falsely low, someone may eat more carbohydrates than needed or skip or reduce insulin, believing their blood sugar is under control.

Overtime, "these decisions may pose serious health risks, including potential injury or death, or other less serious complications," the FDA alert stated.

The FDA said this issue is considered a "potentially high-risk" problem and updates will continue as more information becomes available.

Abbott said a manufacturing issue caused the problem, but the issue has now been fixed. The company expects no major supply delays for replacement devices or new orders.

Diabetes affects about 38 million people in the U.S., according to the **U.S. Centers for Disease Control and Prevention**.