

February 11, 2024 E-Newsletter



Message from Alliance for Retired Americans Leaders

Alliance Joins AFL-CIO, White House in Celebrating Black History Month



Robert Roach, Jr.
President, ARA

The contributions of Black workers to the nation's labor movement date back generations. This February during Black History

Month, the AFL-CIO is spotlighting the critical role Black unionists played in the formation of unions, securing hard-fought workplace protections that we all enjoy today and advancing civil rights across the country.

Throughout the month, the AFL-CIO will be spotlighting Black leaders and activists from across the labor movement. The profiles will be posted on the [AFL-CIO blog](#) and on social media, and select profiles will be exhibited in the lobby of the AFL-CIO headquarters in Washington, D.C. The exhibition highlights Black workers who are shaping a new era for the labor movement and are leading the charge for a more equitable and just economy and society.

The Administration is also commemorating the occasion.

"In its **proclamation** celebrating Black History Month, the White House notes that more Black Americans have health insurance than at any previous time in American history," said **Robert Roach, Jr., President of the Alliance**. "We commend the Biden-Harris Administration on this accomplishment."

Medicare Drug Price Negotiation Reaches Important Milestone; HHS Launches Resource Hub for Medicare Beneficiaries



The U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) **sent initial price offers** to drug

manufacturers participating in the Medicare drug price negotiation program on Thursday, kicking off a months-long negotiation process. The ten drugs selected for the initial cycle of negotiation include vital treatments for diabetes, cardiovascular disease, and cancer taken by millions of Medicare enrollees. President Biden issued a **statement** on the **milestone**.

Also on Thursday, HHS launched **LowerDrugCosts.gov**, a resource hub for Medicare beneficiaries, community members, and advocates including educational information about the Administration's progress lowering drug prices, materials to share on social media, and fact sheets.

In addition, HHS officials released two reports this week: The **first** reveals that Americans pay 3x what people in comparable countries pay for the same drugs, underscoring the importance of the policies to lower costs in the Inflation Reduction Act. The **second report** analyzes the impact of Medicare's Extra Help program, which expanded last month to



Joseph Peters, Jr.
Secretary
Treasurer ARA

help low-income enrollees pay for their prescription drugs.

"The only reason Americans pay three times what consumers pay in other countries for the same drugs is corporate greed," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "The Alliance worked for more than 20 years to require Medicare to negotiate on behalf of the American people, and now we are seeing results."

"Drug corporations and their lobbyists have filed nine lawsuits against Medicare drug price negotiation as they desperately try to protect their profits," added **Richard Fieta, Executive Director of the Alliance**. "The overwhelming majority of Americans - Republicans, Democrats, and Independents, support this policy. We will not back down."



Rich Fieta,
Executive
Director, ARA

Click here to learn more about Black History Month

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Rhode Island Alliance for Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381

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Sen. Warren and Rep. Jayapal urge CMS to end Medicare Advantage overpayments, punish bad actors

Ahead of the Centers for Medicare and Medicaid Services' (CMS') release of proposed payment policy for Medicare Advantage plans, Senator Elizabeth Warren and Representative Pramila Jayapal sent a **letter to the Centers for Medicare and Medicaid Services** detailing ways the administration could wipe out a projected \$100 billion in overpayments to MA plans this year alone. Among other things, the letter proposes ending contracts with MA plans that violate their duty to cover Medicare benefits.

"It is imperative for [Medicare] to rein in these abuses and protect Medicare coverage for the seniors and people with disabilities who rely on it," say Warren and

Jayapal. Last month, Senator Warren **wrote CMS to start collecting critical data needed to oversee the Medicare Advantage plans.**

Thirty-one million older adults and people with disabilities are enrolled in Medicare Advantage plans. These health plans cost taxpayers \$500 billion last year. But, substantial evidence indicates that the government overpays insurers offering these plans tens of billions of dollars each year; and, some, if not many, of these MA plans inappropriately deny and delay care to their enrollees, especially care for people with complex and costly conditions.

The Biden administration has taken some steps to end some of the overpayment abuses. But,



many experts believe there's a lot more to be done. Mark Miller, former director of the Medicare Payment Advisory Commission, says "If [the Centers for Medicare and Medicaid Services] backs down ... then the beneficiary and taxpayer lose."

CMS gave the insurers immunity from overpayments detected over seven years of audits. CMS now plans to conduct more auditing of MA plans' billing processes. Warren and Jayapal are looking for payment policy changes as well as audits. For example, they want the government to adjust payments to MA plans because their enrollees are healthier than enrollees in Traditional Medicare. The five-star quality rating

system for MA plans also needs an overhaul. People cannot rely on the star-rating system as an indicator of whether an MA plan inappropriately denies care or has a narrow network that undermines their ability to get good care. Yet, the government pays insurers more for MA plans with a 4 or 5 star-rating.

Moreover, some data show that some MA plans provide their enrollees fewer benefits than they would get in Traditional Medicare, even though they are legally required to cover the same benefits. CMS has not penalized plans that inappropriately deny care. Warren and Jayapal want CMS to hold them accountable and end their contracts.....**Read More**

People Can Get Even More Extra Help in 2024

Beginning this year, the Inflation Reduction Act (IRA) **expands eligibility** for the **Part D Low Income Subsidy (LIS), also called "Extra Help."** This important program helps people afford their medication and coverage.

New in 2024, everyone with Extra Help will pay a \$0 premium, \$0 deductible, and a reduced amount for both generic and brand-name drugs.

For people who previously had any level of Extra Help and continue to meet the qualifications, these expanded

savings will apply automatically; they do not need to reapply.

To qualify for Extra Help, people must, in most cases, live in one of the 50 states or the District of Columbia, and have income and resources below a certain limit. **For 2024**, an enrollee's monthly income must be below \$1,903 for an individual (\$2,575 for a couple). Resources—which include stocks, bonds, and money in a checking, savings, or retirement account—must be below \$17,220 (\$34,360 for a



couple). Some people—those enrolled in Medicaid, Supplemental Security Income (SSI), or a Medicare Savings

Program (MSP)—**automatically qualify** for and are enrolled in Extra Help; they do not have to apply. Others **can apply** at any time, either online **ssa.gov/extrahelp** or by calling Social Security (1-800-772-1213).

For more information about Extra Help and other ways to lower drug costs, visit the

Department of Health and Human Services' newly launched resource hub

at **LowerDrugCosts.gov**.

Visit Medicare.gov/extrahelp or call 1-800-MEDICARE (1-800-633-4227) to learn about Medicare drug plans, Extra Help, and other ways to lower your prescription drug costs. TTY users can call 1-877-486-2048.

Learn more about Extra Help and how to apply from Medicare Interactive

Many Adults Confused and Anxious about Long-Term Services and Supports

KFF explored how people thought about long-term care, including the current care landscape, what programs cover long-term care, how individuals will pay for care if they need it, and whether those individuals have taken steps to prepare for any need.

The survey shows that few adults have had important conversations about future care needs with family members. This includes asking who would be willing to help with activities of daily living such as eating, bathing, dressing, toileting, and moving from one place to another, as well as discussions about how the family will pay for

necessary care.

A little over 40% of respondents lacked confidence in their ability to pay for care as they age, and most adults 50 and older reported anxiety about affording care and unexpected medical expenses. Around a third of adults under 65 reported that they have been able to set aside money for future help; this number climbs to around 50% for those 65 and older.

Many of the respondents are also confused about which governmental programs provide significant help for long-term care costs. While 52% of all respondents correctly identified Medicaid as the main source of



coverage for nursing home care for people with lower incomes, 41% thought it was Medicare.

Unsurprisingly, people 65 and older were less likely to be confused about this question, with 66% of this population identifying Medicaid. In 2021, Medicaid **paid \$207 billion** for long-term services and supports, compared to Medicare at \$92 billion.

These results suggest that more outreach is needed for all ages to explain long-term care costs and resources and to better support people in having important conversations with family members as they age. In addition, they reinforce the

need for better coverage of care needs. Direct care workers and **family members** need additional support and resources to ensure they are willing and able to provide care. And statutory change would be helpful as well. We need legislation to eliminate wait lists for home- and community-based services (HCBS) that allow people to age in place and avoid institutionalization; make HCBS a mandatory benefit on par with nursing home care; and **fund HCBS work across all states**, especially increased pay for direct care workers.

Understanding the Medicare Advantage and Medigap Dilemma

The growing enrollment in **Medicare Advantage (MA)** plans has raised concerns about the challenges beneficiaries who wish to switch between MA and **Original Medicare** face. Despite the increase in marketing tactics to sell people on MA plans, many MA enrollees feel buyers' remorse and **decide that they prefer coverage under Original Medicare**. But those who wish to switch back to Original Medicare sometimes find that the out-of-pocket costs can be higher because they cannot get Medigap insurance.

Medigaps are health insurance policies that offer standardized benefits to work with Original Medicare (not with MA). They

are sold by private insurance companies and pay part or all of certain remaining costs after Original Medicare pays first. Medigaps may cover outstanding deductibles, coinsurance, and copayments and may also cover health care costs that Medicare does not cover at all, like care received when traveling abroad.

But unlike beneficiaries who choose a Medigap when they initially enroll in Original Medicare, those transitioning from MA plans may face barriers to this form of coverage. There are **federally protected times to purchase a Medigap**. In most states, **people looking to**



buy a Medigap policy outside this protected enrollment period run into trouble. For instance, insurance

companies can refuse to offer this coverage or impose certain medical requirements. If an insurance company does agree to sell a policy, they may charge a higher monthly premium and require a six-month waiting period before the Medigap will cover pre-existing conditions.

In response to these challenges, there are changes that can improve beneficiary protections and access to Medigap coverage. These include:

- ◆ Ensuring that beneficiaries who switch from MA to

traditional Medicare are guaranteed access to Medigap policies without being subject to waiting periods or increased prices.

- ◆ Implementing measures to enhance transparency and consumer education regarding the differences between MA and Original Medicare, as well as the implications for Medigap eligibility.
- ◆ Addressing concerns about aggressive sales tactics and misleading coverage claims by MA insurers to better protect beneficiaries making informed enrollment decisions....**Read More**

Free preventive care: New avenue for health care price gouging

Watch out. Don't assume that the **free preventive care services** to which you are entitled under the Affordable Care Act (ACA) will not cost you a bundle. Samantha Liss reports for **KFFHealthNews** on how a free colonoscopy service turned into a huge bill.

One couple with coverage through the Illinois state health insurance exchange were charged \$600 for their "free" preventive care colonoscopies. Of course, the health care facility did not bill them for their colonoscopies, since that would be illegal.

Rather the health care facility, seemingly in cahoots with the couple's insurer, billed the couple for "supply trays." The story exposes how providers and insurers game the system at the expense of patients in our current out-of-control health care system.

Here's what happened: At 45, the couple went to a facility for what they believed to be free colonoscopies. The bill for the two procedures was \$4,068. The insurer discount brought the bill down to just under \$800—the insurers' cost.



Afterwards, the couple were each billed \$600 by the facility for "supply trays." Their insurer brought their charges down to \$250 each. But, their bill still totaled \$500 for the two "free" colonoscopies and the couple appealed.

What happened? The story suggests that the gastroenterology practice, owned by a private equity company, did an end-run around the ACA. It does not make clear whether charging for supply trays is legal, although it's hard to believe it is. It also appears that the couple's

insurer was in on the game since the gastroenterology practice had arranged this charge with the couple's insurer. The more revenue the gastroenterology practice can get from patients, the less it needs to get from their insurers.

The couple filed complaints. Federal law does not protect people in these cases, even though the ACA is federal law. States are in charge. The couple were at the mercy of their insurer.

How some people escape the steep Medicare surcharge on premiums known as IRMAA

Most people on Medicare will pay about \$2,100 in **Part B** premiums this year. But high-income beneficiaries will get socked owing as much as \$6,708 instead, due to the surcharge they'll pay known as **IRMAA** (income-related monthly adjustment amount)—except, that is, for a select group who are IRMAA exempt.

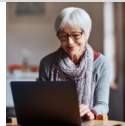
Who are those people, and how can they avoid paying the IRMAA surcharge assessed for Medicare beneficiaries whose 2022 modified adjusted gross incomes exceeded \$103,000 (\$206,000 for couples)?

They're former workers for the federal government and

sometimes ex-state-government employees.

When the IRMAA surcharge doesn't kick in

But their exemption isn't really about a way for them to skate pass the IRMAA surcharge, which was enacted by Congress in 2003. They don't owe it because they've chosen not to enroll in Medicare Part B because of continued coverage from the generous **Federal Employees Health Benefits Program**, the nation's largest employer-sponsored group health insurance program. (Part B is for doctor bills, outpatient care, home health care, medical equipment, and



preventive services.) "Our federal health benefit program started in 1960 and Medicare didn't start until 1965, so we always had lifetime coverage as federal retirees," explained Tammy Flanagan, principal of the Retire Federal consulting firm in Bradenton, Fla. "The majority of federal retirees still don't have to take Medicare."

Former federal employees can keep their federal health insurance after 65 for as long as they like if they had that coverage for at least the last five years of their career and were eligible for an immediate federal pension.

That pension plus Social

Security can sometimes be enough to lead to an IRMAA surcharge for former federal workers in Medicare.

Roughly 20% to 25% of former federal workers eligible for Medicare don't enroll in Medicare Part B and aren't subject to a potential IRMAA surcharge, says Flanagan.

How IRMAA works

IRMAA's surcharge is a sliding scale that, in 2024, starts at \$244.60 a month for people with 2022 income between \$103,000 and \$129,000 and goes up to \$559 a month for incomes of \$500,000 or more....**Read More**

There's a big gap in a new plan to speed up health insurance authorizations

There's a notable gap in new federal rules requiring insurers to streamline decisions on whether they'll **cover treatments** ordered by doctors: They don't apply to drugs.

Why it matters: Drugs account for a significant share of **prior authorization** requests, and patients and doctors argue that the new rules, as is, won't increase access to needed treatments.

◆ The Biden administration says it wants to improve the coverage request process for physician-administered drugs, but it's still figuring out how to navigate the systems that insurers have in place to cover medications.

Driving the news: Patient advocates and the health industry **applauded**

rules released earlier this month that require federally funded insurers to act faster on prior authorization requests, give a reason for coverage denials, and update electronic systems that facilitate prior authorizations.

◆ But the rules only apply to medical items and services.

◆ Lawmakers have started to probe insurers' use of prior authorization to deny necessary care, and Congress may **revive legislation** to codify the administration's prior authorization changes and further expedite insurer approvals.

What happened: Providers have been pushing the administration to address prior



authorization of drugs for **nearly a year**. But the Centers for Medicare and Medicaid Services **decided not to** because standards and technical systems can differ depending on whether drugs are administered in a physician's office or a hospital or picked up at a pharmacy.

Where it stands: Past laws and **regulations** have already put some guardrails around prior authorizations for drugs, especially for those covered through prescription drug benefits.

◆ Medicare prescription drug plans have to offer electronic prior authorization and respond to urgent requests within 24 hours and regular inquiries within 72 hours.

◆ Medicare Advantage plans have to follow the same response timeframes for drugs administered in a doctor's office or hospital. State Medicaid programs have similar rules for outpatient drugs.

But the decision to exclude drugs from the latest prior authorization revamp means other new protections, like standards around electronic information-sharing and reporting, won't apply to cancer drugs and other kinds of specialty care that patients receive in a doctor's office or hospital.

◆ According to KFF, **99% of Medicare Advantage enrollees** are in plans that require prior authorization for medical benefit drugs....**Read More**

Medicare Advantage Enrollment Just Surpassed Original Medicare. But Is an Advantage Plan Right for You?

Clearly, Medicare Advantage is a popular option. But there are pitfalls you might encounter if you go this route.

Once you reach 65 years of age, you're eligible to enroll in Medicare. But from there, you have choices. You could stick to original Medicare -- Parts A, B, and a Part D drug plan. Or, you could sign up for a Medicare Advantage plan.

A lot of people are going the latter route these days. The Kaiser Family Foundation reports that enrollment in Medicare Advantage plans has surpassed original **Medicare** for the first time. But while there are certain, well, advantages of signing up for a Medicare Advantage plan, there

are also some major drawbacks you should know about.

The problem with Medicare Advantage

Seniors are often drawn to Medicare Advantage because these plans commonly offer a wider range of benefits than original Medicare. Original Medicare won't pay for services that include dental care, eye exams, and hearing aids. But it's common for Medicare Advantage plans to include coverage for these necessities.

Another benefit of Medicare Advantage is that under one of these plans, you'll have a cap on your annual spending. With original Medicare, there's no



maximum out-of-pocket for the year. However, you may have the option to buy Medigap coverage, or supplemental

insurance, to help address that issue.

Despite these perks, Medicare Advantage plans have their share of pitfalls. And a big one that might impact you is that with Medicare Advantage, you're limited to a specific network of providers. This means you may have difficulty securing the care you need, especially if you have a condition that requires you to see specialists often.

Also, just because Medicare Advantage covers certain extra services doesn't mean you'll be

approved for them. In fact, Medicare Advantage plans often make it difficult for enrollees to get the authorization they need for different tests and procedures. That delay in essential care could be costly from not just a financial standpoint, but a health-related one, too.

Finally, while Medicare Advantage *can* be a cost-effective alternative to original Medicare, that's not guaranteed. And if you have a lot of health issues, you may find that Medicare Advantage leaves you on the hook for higher bills.

Think carefully before signing up for Medicare Advantage....Read More

5 caregiving terms to help you access essential services and reduce expenses for an aging parent

People living longer and in poor health has become a costly trend. An estimated **7 out of 10 people will require long-term care** in their lifetime.

The median cost for a private room in a nursing home is more than \$100,000 a year — and it's \$60,000 or more a year for a home health aide, **according to a Genworth survey**. The median cost for an assisted living facility is \$54,000.

"In some cases, residents and their families don't know their total costs until they receive their

monthly bill," Sen. Bob Casey, D-Pa., who chairs the Senate Special Committee on Aging, said in a hearing Thursday on costs and transparency in assisted living facilities.

"These substantial costs and hidden fees make it nearly impossible for older adults and their families to accurately budget for long-term care," he added.

The alternative — **caring for aging family members on your own** — can also come with hefty expenses.



About 38 million family caregivers in the U.S. provide unpaid care valued at about \$600 billion a year, according to a 2021 AARP report. That figure doesn't include out-of-pocket costs related to looking after a loved one.

"The average family caregiver spends about 26% of their income [on caregiving activities], which nationally averages out to about \$7,000," said AARP's family and caregiving expert Amy Goyer, referring to the 2021 AARP

analysis. "Some spend much more and some spend much less," depending on their location and the care they provide, she added.

Knowing a few key terms can help you understand the services an aging parent or relative may need — and plan ahead for how to afford them.

Here are five essential terms you should know: Activities of daily living, Continuous care retirement communities, Medicare and Medicaid, Long-term care insurance, and Respite care....Read More

Working and Claiming Social Security? There's Good News for 2024

This rule change could help you keep more of your benefits this year.

Many seniors don't realize it, but the Social Security Administration can withhold money from your checks if you're still working while you claim benefits. Not all seniors run into this issue as there are rules that determine which seniors could face this benefit withholding, and they just got a little more flexible as of January 1st.

Below we'll look at what you need to know so you're not caught off guard if you encounter benefit withholding this year.

What is the Social Security earnings test?

The Social Security earnings test is what the government uses to determine whether to withhold money from a senior's benefit checks. It only applies to those working and claiming while still under their **full retirement age**.

(FRA). This is somewhere between 66 and 67 for today's workers. Those who have already attained their FRA may earn as much as they'd like without fear of benefit withholding.

Early claimers -- those who sign up for Social Security before their FRA -- could lose money from their Social Security checks if their annual income exceeds a certain amount. In 2023 those who were under their FRAs the entire year lost \$1 for every \$2 they earned over \$21,240. Those who reached their FRA during 2023 only lost \$1 for every \$3 they earned over \$56,520 (if they earned this much before their birthday).

Fortunately, the Social Security Administration increased the above limits for 2024. Those under their FRA all year can now earn up to \$22,320 before losing



any money from their checks, and those who will reach their FRA this year only have to worry about benefit withholding if they earn more than \$59,520

before their birthday. For some, this could be the bit of wiggle room they need to avoid losing any of their Social Security checks this year

Can you avoid the Social Security earnings test?

It might be possible for some workers to reduce their income enough to avoid the earnings test, especially if they're only working part time. However, for others this might not be feasible. There are two ways you could handle this.

If you haven't begun claiming yet and are worried about losing money to the earnings test, you may want to hold off on applying for **Social Security** until you're ready to retire. But this might not

be an option if you need your checks now to help cover your bills.

Your other option is to just plan for smaller benefit checks in the near term. When you reach your FRA, the government will recalculate your benefit to include the money it previously withheld, and your checks from that point on will be slightly larger. If you don't need all of your benefits today, this could work to your advantage in the long run.

Keep in mind that earnings test limits typically rise every year, so even if you encounter this benefit withholding in 2024, that's not a guarantee it'll be an issue in subsequent years. And if you have any questions about how the earnings test could affect your specific benefit, reach out to the Social Security Administration for clarification.

Why doesn't the federal government regulate assisted living facilities?

The Senate Special Committee on Aging is looking into quality and cost issues in Assisted Living Facilities, reports Jordan Rau for [KFF Health News](#). But, the federal government does not regulate these facilities, even though it pays for them in some cases for people with Medicaid. It's not likely that Congress will enact legislation to regulate them.

More than 800,000 Americans live in an Assisted Living Facility (ALF) today. ALF

residents include people who can't bathe themselves or feed themselves. People with dementia. People unable to walk unassisted.

The cost of living in an ALF is prohibitive for most Americans, typically around \$4,500 a month, way more than the typical Social Security check. In cases where residents need substantial amounts of care, the cost can be \$10,000 a month. Some facilities



impose additional charges for basic services. One ALF charges \$93 a month simply to order medications for its residents.

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Medicare does not cover ALFs. And, only 20 percent of ALFs accept Medicaid patients. But, one argument for federal oversight of ALFs is that the federal government spends more than \$10 billion dollars on these ALF residents.

What services do people get

for their money in an ALF? They should get assistance with activities of daily living. However, staffing levels in ALFs are too often low and workers can be poorly trained.

Today, it's up to each state to regulate ALFs. Given that few states have the will, the skill, the power and the resources to oversee these facilities, many patients in these facilities are not getting quality care....**Read More**

The FTC Is Attacking Drugmakers' 'Patent Thickets'

The Federal Trade Commission has challenged the validity of over 100 drug product patents, focusing on devices used to deliver medicines, like inhalers and autoinjectors, in an effort to increase competition and potentially lower some prices.

The FTC says drugmakers illegitimately use the patents to prevent competitors from offering cheaper generic alternatives.

It's the first time the FTC has tried the tactic, said Hannah Garden-Monheit, director of the FTC's Office of Policy Planning.

“We are using all the tools we have to bring down drug prices and reduce barriers to generic

competition,” she said in an interview.

President Joe Biden has instructed his Federal Trade Commission to be more aggressive in reining in the pharmaceutical industry. Under its chairperson, Lina Khan, the agency is aggressively testing the limits of its powers in pursuit of that goal.

The targeted patents cover devices that propel medicines for asthma and emphysema into the lungs or inject epinephrine to treat a severe allergic attack. Drugmakers list them in the FDA's "Orange Book," which



can afford the products greater protection from generic competition.

Many of the medicines delivered by the devices are decades old, years off patent. But manufacturers have long tweaked the delivery methods, patenting the changes, in ways that sometimes make the drugs more convenient to administer.

They might, for example, change the propellant in an inhaler or add a counter that tells a patient how many doses are left. Autoinjectors mean patients don't see a needle or syringe but merely press a device with a hidden

needle against the skin to deliver the medicine. Some autoinjectors even talk patients through the process.

Though there has long been a procedure for disputing the validity of Orange Book-listed patents, it is rarely used.

In challenging Orange Book listings, the FTC is trying to cut away at what are known as patent thickets. While a single patent once would cover a single active medicine, many drugs today are protected by half a dozen patents or more, creating additional obstacles for cheaper generics seeking to enter the market...[Read More](#)

Choose your hospice provider carefully

Hospice care has grown in popularity for people with terminal conditions who seek comfort care rather than curative treatment. But, now, more than ever, you need to choose your hospice provider carefully. Ava Kofman continues to write for **Pro Publica** on how profiteers have taken over hospice in the US, at huge financial cost to the Medicare program and huge risk to patients at the end of life.

As a result in significant part of Kofman's earlier reporting, described in this **Just Care post**, the Centers for Medicare and Medicaid Services (CMS) conducted more hospice inspections. But, CMS continues to certify new hospices, even in California, where the state has banned new hospice licenses because of mounting hospice

fraud.

It appears that CMS does not have the ability or desire to close down hospices engaging in fraud. After visits to 7,000 hospices, CMS stopped just 46 of them from billing the government for their services. The travesty: The 46 hospices were nonoperational.

CMS claims that it's up to the states to stop the proliferation of hospices. CMS appears to be unwilling or unable to prevent even fraudulent or unneeded hospices from receiving certifications to deliver the hospice benefit to people with Medicare.

Arizona, California, Nevada and Texas have seen a huge spike in the number of its hospice providers. CMS showed marginal concern at best about fraudulent



bills from these hospices and the lack of need for additional hospices in these states. CMS said it would look at their bills more closely.

California attempted to put a moratorium on new hospices in its state, with little success. Its auditors detected "a large-scale, targeted effort to defraud Medicare." Hospice providers charged Medicare for patients who were not terminally ill and sometimes for patients who were fictitious.

Notwithstanding California's good oversight, CMS is allowing these hospice providers to bill Medicare for their "services." CMS claims to need "evidence of sanctions" against a hospice in order to block a hospice from the Medicare program.

In California, people enrolled in

hospice fraudulently—people who are not terminally ill or who do not want hospice—are reportedly at risk of not getting needed care. Medicare covers hospice services only for patients who agree not to receive curative care for their conditions. That said, they should be able to get care for any condition unrelated to a terminal condition. Moreover, they are also always able to opt out of hospice to get curative care.

In one case, a nursing home resident with dementia was fraudulently enrolled in hospice by a doctor she did not know. Medicare paid the hospice \$7,500. But, the patient lost her ability to have her pacemaker checked and to receive physical therapy. CMS is now investigating.

Republicans support "backroom scheme" to cut Social Security and Medicare

Jake Johnson reports for **Common Dreams** on the Republican push in Congress for a "Fiscal Commission" and the Democratic pushback against it. Senate Finance Committee Chair Ron Wyden correctly calls the proposed Commission a "backroom scheme" to cut Medicare and Social Security.

The House Budget Committee's Fiscal Commission Act, which Republicans intend to link to a must-pass government funding bill, would allow Congress to cut "Americans' earned benefits" behind closed doors, said Senator Wyden.

Senator Wyden and the overwhelming majority of

Democrats oppose the Commission. Wyden argues that Congress should be raising taxes to strengthen Medicare and Social Security: "Instead of trying to cut Social Security, Medicare, and Medicaid, Republicans should work with Democrats to ensure the wealthy pay their fair share, which would go a long way towards securing Social Security and Medicare long into the future." Go, Wyden! (If only Senator Wyden would speak as fervently against the tens of billions in overpayments to Medicare Advantage plans, which is endangering Medicare as well.)

The question now is whether



the Democrat-led Senate will allow the Fiscal Commission Act to become law. If so, the Commission, a 16-person panel, made up of members of Congress from the House and Senate and private sector influentials, would develop and vote on Medicare and Social Security policies that Congress would consider passing into law, with no amendments permitted.

It's no secret that Republicans want to privatize both Social Security and Medicare and cut spending, leaving older adults and people with disabilities at even greater financial and health risk than they already are. Republicans

have no intention of enacting legislation that would raise revenue to strengthen these programs and never have. Indeed, Republican members voted against a change to the Fiscal Commission legislation that included this language concerning the work of the Fiscal Commission: It "shall propose recommendations to strengthen and secure Social Security" by "protecting Social Security benefits" and requiring the **wealthy to contribute more** to the program....**Read More**

CMS Releases Proposed Payment Updates for 2025 Medicare Advantage and Part D Programs

Today, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2025 Advance Notice for the Medicare Advantage (MA) and Medicare Part D Prescription Drug Programs that would update payment policies for these programs. The Advance Notice complements a **proposed rule**, also for CY 2025, that CMS released in November 2023 that would, if finalized, strengthen protections for the millions of people who rely on MA and Medicare Part D prescription drug coverage. MA payments from the government to MA plans are expected to increase on average

by 3.70 percent, or over \$16 billion, from 2024 to 2025, as proposed.

CMS is also detailing improvements to the structure of the Medicare Part D drug benefit for CY 2025 that will result in lower drug costs for millions of people with Medicare through the concurrent release of the Draft CY 2025 Part D Redesign Program Instructions. Thanks to the Inflation Reduction Act, in 2025, annual out-of-pocket costs will be capped at \$2,000 for people with Medicare Part D.

"Prescription drugs should be affordable. Today, we are



continuing to take steps to lower prescription drug costs so that no one must choose between feeding their family and taking their medicine," said HHS Secretary Xavier Becerra. "The Biden-Harris Administration is committed to making sure the millions of people who have managed care plans called Medicare Advantage get the best care possible, and that taxpayer dollars are used efficiently."

"CMS continues to ensure that Medicare Advantage and Part D prescription drug plans remain strong, stable, and affordable

offerings," said CMS Administrator Chiquita Brooks-LaSure. "The Advance Notice upholds robust and stable options for people with Medicare while strengthening payment accuracy so that taxpayer dollars are appropriately spent. The Advance Notice also continues our effective implementation of the Inflation Reduction Act on schedule, including capping out-of-pocket costs at \$2,000 for people with Medicare Part D prescription drug plans in 2025. This out-of-pocket cap will be truly life-changing for millions of people."...**Read More**

Nurse Warns Against Applying For Medicare Advantage Plans Because They Deny Care Medicare Would Have Covered

‘It will bankrupt them’: Nurse says you should never enroll in Medicare Advantage plans. Here’s why

In a recent [TikTok](#) video, a nurse has issued a PSA to her viewers, advising against enrolling in Medicare Advantage plans.

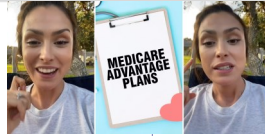
The video, posted by Christy (@christypn) on Nov. 21, has amassed over 128,900 views, sparking a lively debate among commenters about the pros and cons of these private health insurance alternatives.

In the video, Christy recounts encountering a billboard on her way home: “I saw a big billboard that said, ‘Enroll in a Medicare Advantage plan, and you’ll get a free gym membership!’ and it reminded me to give you guys your yearly reminder to not enroll in a Medicare Advantage

health insurance plan.”

She explains, “When those Medicare health insurance plans are managed by the government, that is just called Medicare or some of us call it traditional Medicare. However, a while back, the government started allowing private insurance companies to distribute these plans as well. These are called Medicare Advantage plans.”

Christy goes on to express her reservations about these private insurance plans, citing concerns that they may deny crucial healthcare services that traditional Medicare would cover, “A lot of health care workers really don’t like these Medicare Advantage plans because they tend to deny a lot of



really important care that traditional Medicare would have covered,” she claims.

However, while emphasizing the need for careful consideration, the TikToker gives out a disclaimer: “There may be some instances where a Medicare Advantage Plan offers some additional benefit that might be more beneficial to a patient than traditional Medicare.”

Since it was posted, the video has sparked a lively debate in the comments section, with healthcare workers and viewers sharing their experiences and opinions.

Some echoed Christy’s concerns, with one commenter saying, “I work in outpatient care and the Medicare advantage plans are the worst. We can’t get

anything covered.”

“thank you say it louder. Advantage plan are thieves,” a second added.

“RN here. Amen sister. It will bankrupt them,” a third wrote.

However, others disagreed, recounting their positive experiences with their plans.

“My father was on different medicare advantage plans here in NC. They worked out great for him. No extra monthly cost and more docs to choose from,” one such commenter wrote.

“Medicare Advantage has worked great [for] me. My Dr’s med group totally has their act together,” a second claimed.

“No doctors in my area accept regular Medicare. I can only use it at urgent care clinics,” a third commenter remarked. [View Christy’s video](#)

Will My Retirement Plan Withdrawals Impact My Social Security Benefits?

Many people work really hard to amass savings for retirement. So if you have a nice pile of cash in your IRA or 401(k), you may be hesitant to start tapping it right away. After all, you want that money to last.

Still, the whole purpose of saving in an [IRA](#) or 401(k) is to be able to cover your living expenses in retirement without worry -- and perhaps, ideally, have money left over to pay for leisure, travel, and other fun things. So at some point, you’re apt to want to start taking withdrawals from your retirement account.

In fact, if you have your money in a traditional IRA or 401(k), as opposed to a Roth

savings plan, you’ll actually *have* to start tapping your account once required minimum distributions begin to apply.

But what if you’re receiving monthly benefits from Social Security? Will the money you take out of your IRA or 401(k) affect those benefits?

Your withdrawals won’t shrink your benefits

If you earn money from a job and collect Social Security at the same time before reaching full retirement age, you may have some of your Social Security income withheld if your wages exceed the [earnings-test limit](#). But withdrawals from an IRA or 401(k) aren’t the same as



wages from a job. So distributions taken from a retirement plan won’t cause your Social Security benefits to shrink or be withheld.

However, that doesn’t mean your retirement plan withdrawals won’t affect your Social Security benefits at all. Social Security income has the potential to be taxable at the federal level. And your total income will determine whether federal taxes on your benefits apply.

If you start taking money out of your IRA or 401(k), that will count as taxable income if you have a traditional retirement plan. With a Roth, it won’t. So if your retirement plan withdrawals cause enough of an increase to

your income, it could result in you having to pay taxes on some of your Social Security benefits.

To be clear, taxes on Social Security benefits could apply even if you’re not yet tapping your IRA or 401(k). It may be that you have another income source at your disposal, whether it’s a job or a home you rent out. But either way, the more income you have, the greater your chances of being taxed on some of your Social Security. So if you start taking withdrawals from a traditional retirement plan, that could be just the thing that puts you over the threshold where those taxes start to apply....[Read More](#)

Social Security: ‘Win-Win’ Bill To Cut Federal Taxes Would Extend Funds to 2054

Aproposed Congressional bill aims to relieve the tax burden on [Social Security beneficiaries](#) while also bolstering a key trust fund’s finances so it [remains fully funded for a longer period of time](#). One lawmaker referred to the bill as a “win-win,” though it likely faces an uphill battle making it into law.

The bill, dubbed the “You Earned, You Keep It Act,” was reintroduced last week by U.S.

Reps. Angie Craig (D-Minn.) and Yadira Caraveo (D-Colo.). It proposes to repeal federal [taxes on Social Security benefits](#) and delay the looming insolvency of the program’s Old Age and Survivors Insurance (OASI) Trust Fund by two decades to 2054, Think Advisor reported.

OASI Fund Could Be Depleted in a Decade

The OASI is expected to run



out of money by 2033 or 2034. When it does, the program will be solely funded by payroll taxes, which currently cover only 77% of benefits.

As Think Advisor noted, the proposed legislation would keep the trust fund solvent by expanding Social Security payroll taxes to wages above \$250,000. In 2024, taxes are imposed only on income up to \$168,600. Under the Craig-

Caraveo bill, the cap would continue to rise until it hits \$250,000 and beyond.

Social Security’s Office of the Chief Actuary found that the bill’s two key provisions would “extend the ability” of the OASI fund to pay scheduled benefits for an additional 20 years, according to a blog from the National Association of Plan Advisors (NAPA). [Read More](#)

Americans Have Mixed Feelings on Tech, AI in Health Care: Poll

Americans are cautiously optimistic that AI will be able to improve the health care they receive, a new Cleveland Clinic survey finds.

About three out of five Americans believe that AI will lead to better heart care, and 65% say they would be comfortable receiving heart advice from AI technology, the **poll** showed.

But people are still reluctant to place their health solely in the hands of a computer chatbot.

For example, nine out of 10 (89%) said they would seek a second opinion from a doctor before acting on AI

recommendations, even though 72% believe that the advice they get from AI is accurate.

"The increasing number of advancements in AI and in digital health has the potential to transform healthcare delivery, especially in cardiovascular care," said **Dr. Samir Kapadia**, chair of cardiovascular medicine at Cleveland Clinic.

"As clinicians, we are getting a lot of questions from our patients about this topic," Kapadia said. "As these [technologies] continue to advance, we'd like to educate our patients about the role of AI and technology in assisting



healthcare professionals, rather than replacing them."

Overall, half of

Americans say they use at least one type of technology to monitor their health, the survey found.

Daily step count is the most frequently tracked health metric, with three in five Americans (60%) using tech to track the amount they walk.

That's followed by heart rate (53%), calorie burn (40%) and blood pressure (32%).

Personal health technology is helping improve well-being, as far as Americans are concerned.

Four out of five users (79%) said they noticed positive changes to their physical or mental health after using health-monitoring tech.

More than half (53%) said they began exercising more regularly once they started using wearable health trackers, and half are now getting in more steps per day.

One-quarter of Americans (23%) say they use health monitors to find motivation or accountability for meeting daily activity goals.

The survey involved 1,000 Americans ages 18 or older who were polled between Nov. 10 and Nov. 21 in 2023.

Women Are More Prone to Autoimmune

Women are much more prone than men to develop autoimmune diseases like rheumatoid arthritis, multiple sclerosis and lupus.

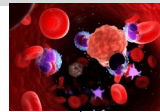
Now, researchers have come up with a potential explanation for that -- one that's rooted in genes that drive a person's gender.

The female body has a complex means by which it handles the additional X chromosome, and it appears this process also renders some women more susceptible to autoimmune diseases, according to a report published Feb. 1 in the journal **Cell**.

This finding helps explain why women account for about 80% of all cases of autoimmune disease, in which the immune system turns on the body and attacks its tissues and organs.

More importantly, it could lead to better ways to detect and treat dozens of these disorders, researchers say.

"It's a question that's been irking immunologists and rheumatologists for the past 60 or 70 years," **Dr. Robert Lahita**, a rheumatologist at the Hackensack



Meridian School of Medicine in Nutley, N.J., told the journal **Nature**.

Lahita was not involved in the study.

Biological sex is determined in mammals by the presence of two X chromosomes in every female cell. Males have just one X chromosome, paired with a shorter Y chromosome.

The X chromosome carries hundreds of active genes that support life, while the Y chromosome contains only a handful, researchers explained.

Unfortunately, having two X chromosomes ups risks that the female body will produce a lethal double dose of these proteins, so nature has devised a way to deactivate one of them.

A special type of RNA called Xist -- pronounced "exist" -- is produced by the extra copy in a XX pair.

Xist attaches to long sections of the extra X chromosome, cutting its genetic output to zero or close to it, while leaving the other X chromosome alone to do its job...**Read More**

Stroke Recovery Could Depend on Where You Live

For stroke survivors, the relative affluence of their neighborhood could be a factor in how well and how soon they recover, **new research** shows.

Compared to Americans living in better-off locales, those living in areas plagued by high unemployment, lower levels of education, poor housing and low income had higher risks for a poor post-stroke recovery a year after the attack, the study found.

"The magnitude of this impact is what was most surprising," said study lead author and Yale School of Medicine postgraduate researcher **Leah Kleinberg**.

"We did not expect a large disparity in outcomes, yet we found patients in the most economically disadvantaged areas

were twice as likely to have unfavorable outcomes," she said in a news release from the American Heart Association.

Her team is slated to present its findings next week at the American Stroke Association's annual meeting in Phoenix.

The study is based on data collected between 2018 and 2021 as part of the Yale Longitudinal Study. It tracked outcomes for stroke survivors admitted to the Yale Health System, collecting data at three months, six months and then each year after hospital discharge.

For nearly 2,200 of these patients, zip code data was available. Patients averaged 69 years of age, with about 15% of



the population being either Black or Hispanic.

Patients' levels of stroke-related disability were ranked on a standard scale.

Kleinberg's team found that, one year after surviving their stroke, nearly half (46%) of patients living in what the researchers classed as a "high-deprivation" area still had a poor recovery from the disabling attack.

That's compared to the 40% seen among folks living in intermediate deprivation neighborhoods and 35% for those residing in the most affluent areas, the researchers said.

A "poor outcome" in stroke recovery was defined as the patient still requiring assistance

for some of the tasks of daily living. Good outcomes meant the person might still face some residual effects of their stroke, but they were able to live independently, the researchers said.

"This research was inspired by the people I work with daily," Kleinberg said. "Although stroke patients from differing socioeconomic backgrounds often have similar functional status at discharge, outcomes can vary dramatically a year later. As a clinical research associate, I get to interact with them far beyond the completion of their urgent treatment, which sparked my interest in exploring the long-term outcomes for these patients..."**Read More**

Latest COVID Vaccine Shields Against Current Dominant Strain

In some good news for those folks who rolled up their sleeves for the latest COVID vaccine last fall, new government research shows the updated shots halve the chances of getting a symptomatic infection.

"Everything from this study is reassuring that the vaccines are providing the protection that we expected," study author **Ruth Link-Gelles**, head of the vaccine effectiveness program for COVID and RSV at the U.S. Centers for Disease Control and Prevention, told *CNN*. "While we don't have an estimate of vaccine effectiveness specific to immunocompromised people, the fact that the vaccine is working in the general population provides, I think, reassurance for the whole population."

Last summer, vaccine makers updated their shots to target the Omicron variant XBB.1.5, which dominated during much of 2023. Luckily, the new CDC data

shows these vaccines work just as well against JN.1, the variant that has been fueling most COVID infections in the United States since late December.

For the CDC analysis, researchers analyzed trends among more than 9,000 adults who were tested for COVID at Walgreens and CVS pharmacies between mid-September and mid-January. For some people with positive results, the researchers were able to test for a "quirk" in the virus that lets them differentiate between variants.

Overall, the updated vaccines provided 54% protection against symptomatic infection among healthy adults who were recently vaccinated compared with those who did not get the latest shot, according to the report published Thursday in the CDC publication **Morbidity and Mortality Weekly Report**.

U.S. vaccination programs



primarily aim to prevent severe disease, but measuring how well a shot guards against symptomatic infection gives an early sign

of how well vaccines are working.

"That's a really nice feature of this analysis, that it checks that box: Yes, the vaccine is working, it's providing protection, it's providing protection for JN.1, which is the current most common variant," Link-Gelles said.

The latest COVID shots have only been available since September, so this analysis could only track effectiveness through about four months post-vaccination.

It's expected that protection from the latest vaccine will wane over time. A very slight "hint" of that was seen in the new study, Link-Gelles acknowledged.

While the United States no longer tracks COVID cases,

wastewater data suggests the virus continues to circulate at high levels and there are still plenty of COVID hospitalizations and deaths reported each week.

During the week ending Jan. 20, there were 26,607 COVID hospitalizations and 936 deaths, CDC **data** shows. Still, only about 22% of adults and 11% of children have gotten the latest COVID shot, the CDC **estimates**.

Conversely, nearly half of adults and children have gotten the **flu vaccine** this season. And a flu season where the vaccine matches the circulating strain with 50% effectiveness would be considered a good match, Link-Gelles noted.

"There's never a bad time to get a COVID vaccine," she said. "Even with relatively low levels of hospitalization right now... that extra protection is going to go a long way."

Weight-Loss Med Zepbound Lowers High Blood Pressure in Obese People

The weight-loss drug Zepbound provides more health benefits than dropping pounds and controlling diabetes, a new study shows.

It also appears to help people with obesity manage their high blood pressure, results show.

Patients taking Zepbound (tirzepatide) experienced a significant reduction in their systolic blood pressure, the top number in a blood pressure reading, according to a study published Feb. 5 in the journal *Hypertension*.

Systolic blood pressure is a

stronger predictor for heart-related death than the diastolic bottom number, researchers said in background notes.

"Although tirzepatide has been studied as a weight-loss medication, the blood pressure reduction in our patients in this study was impressive," said lead researcher **Dr. James de Lemos**, chair of cardiology at UT Southwestern Medical Center in Dallas.

Tirzepatide works by mimicking two hormones in the body that stimulate insulin



secretion and sensitivity after a person eats. The drug helps slow down digestion, reduce appetite and regulate blood sugar levels.

For the study, 600 adults with obesity were assigned to take either a placebo or varying doses of tirzepatide, which is administered through injection.

◆ After 36 weeks, results showed that:

◆ Participants taking 5 mg of tirzepatide had an average systolic blood pressure reduction of 7.4 mm Hg

◆ People taking 10 mg had an average systolic blood pressure reduction of 10.6 mm Hg

◆ Participants taking 15 mg had an average systolic blood pressure reduction of 8 mm Hg "While it is not known if the impact on blood pressure was due to the medication or the participants' weight loss, the lower blood pressure measures seen with tirzepatide rivaled what is seen for many hypertension medications," de Lemos said in a journal news release....**Read More**

Study finds significant disparities in diagnosis and treatment of dementia

A new study from UC Davis Health and Oregon Health & Science University reveals significant disparities in dementia care. The researchers found that people living with dementia from minoritized racial and ethnic populations are less likely to receive an accurate and timely dementia diagnosis compared to non-Hispanic whites. They were also less likely to be prescribed anti-dementia medication or use hospice care. **Minoritized populations are those marginalized due to systemic**

oppression.

In addition, the study found the same populations have a higher risk of hospitalization and receive more aggressive life-sustaining treatment in end-of-life care. The **study** was published in *Alzheimer's & Dementia*.

"Reducing disparities in Alzheimer's disease and related dementias and receiving timely, high-quality health care services is essential to advance health equity," said Ladson Hinton, first



author of the study and a professor in the UC Davis Department of Psychiatry and Behavioral Sciences.

Hinton is also associate director for research in the Family Caregiving Institute at the Betty Irene Moore School of Nursing at UC Davis.

The researchers conducted a scoping review, identifying and analyzing the results of 71 research studies conducted between 2000 and 2022. The studies examined health care access and quality for people

with **dementia** and their caregivers. The studies reported findings related to race and ethnicity.

"Our review provides timely and compelling evidence of disparities in health care quality and access for people living with dementia from minoritized populations," Hinton said. "It also highlights significant gaps in data, particularly for Asian Americans and Pacific Islanders and American Indians and Alaska Natives populations."...**Read More**

Dental Group Says Lead Aprons No Longer Needed for X-Rays

The heavy lead apron dentists drape over you during dental X-rays may soon be a thing of the past.

On Thursday, the American Dental Association (ADA) announced that its member dentists can dispense with the aprons, technically called "thyroid collars" because they were used to shield that organ from radiation.

"After reviewing nearly 100 articles, guidance documents and regulations related to radiography, the expert panel determined thyroid and abdominal shielding during dental imaging is no longer recommended, and the use of these forms of protective shielding should be discontinued as routine practice," the ADA said.

The organization points out that

X-ray and other diagnostic technologies have gotten more precise in recent decades, cutting down on the amount of radiation exposure.

Therefore, dentists should dispense with lead aprons and instead think about which and how many scans are really needed.

In some cases, the use of lead aprons could block imaging and hinder a diagnosis, the organization added.

"When this happens, more radiographs need to be taken and unnecessary X-rays are what we want to avoid," said **Dr. Purnima Kumar**, chair of the ADA's Council on Scientific Affairs.

"The central point of these recommendations is that clinicians should order radiographs in moderation, to



minimize both patients' and dental professionals' exposure to ionizing radiation," Kumar added in an ADA news release.

The new recommendation to abandon aprons applies to all patients, including women who are pregnant, the ADA noted.

To better safeguard patients, the group advises that:

- ◆ Dentists consult patients X-rays obtained in prior exams, and if new ones are needed, only order those needed to "optimize diagnostic information"
- ◆ Use digital rather than conventional radiographic film
- ◆ Restrict the X-ray "beam size" to only that area of the anatomy that needs to be assessed
- ◆ Position patients properly for an X-ray

◆ Use a higher-radiation technology, called cone-beam computed tomography (CBCT), only in instances where other technologies with lower radiation levels won't work

◆ Sticking with "all applicable federal, state and local regulations on radiation safety"

"We encourage dentists and their teams to review these best-practice recommendations, comply with radiation protection regulations and talk with their patients about any questions or concerns before ordering dental imaging," said Kumar, a professor of dentistry and chair of the department of periodontology and oral medicine at the University of Michigan School of Dentistry.

Nighttime Driving: Know the Risks

Driving at night can be risky business, as a dangerous combination of darkness and the glare of bright lights can make it hard to see the road, but one expert offers some safety tips.

"If you have to drive in the evening time and you're not comfortable, try to stick with roads that you know and make sure you know where you're going so you don't have to be looking at street signs, which are harder to see at night," said **Dr. Sumitra Khandelwal**, a professor of ophthalmology at Baylor College of Medicine in Houston.

If you do have to venture out in your car after dark, check your vehicle first, she stressed.

"One of the first things to do for

nighttime driving has nothing to do with the eyes; it's to optimize all aspects of driving with your car that allow for better nighttime vision," Khandelwal explained.

A dirty windshield can make starbursts, halos, glares, smearing and streaking more apparent in the dark, so cleaning it is critical for clear vision. Headlights get dirty just as easily, particularly if it rains and mud or water gets splattered on them, so Khandelwal recommends wiping off any dirt or splash marks before you get behind the wheel.

Even after cleaning your windshield and headlights, there are plenty of vision issues that can



make it difficult for drivers to see clearly.

Your pupils get larger at night, which can cause more glares and halos and

lowers the effectiveness of prescription glasses and contact lenses, making people more nearsighted, Khandelwal noted.

"Your prescription is generally set up in the eye doctor's office, but sometimes it can be weak at night, so it's important to get your eyes checked if you haven't recently to get a better prescription for glasses or contact lenses. You want to make sure those are maximized," she said.

Cataracts, which can weaken nighttime vision, also hamper your vision as you age. And dry

eye makes streaking, halos and glares worse. Khandelwal suggests using artificial tears or prescription eye drops to help keep the corneas clear and lubricated.

If you decide to use lubricating eye drops, take them about 30 minutes before getting behind the wheel, because the drops can make vision temporarily blurry.

Those who struggle with nighttime driving should not drive in the dark for long distances, Khandelwal added. Local driving where speed limits are lower might not bother people at night, but the high speeds of a freeway are another story....**[Read More](#)**

Need Mental Health Services Via Telehealth? Many Clinics Still Don't Offer It

Accessing mental health care via telehealth boomed during the pandemic, and it continues to be a valuable resource for patients.

However, it could still be tough to find, depending on the clinics available in your area, new research finds.

"We found considerable variation in the types of services telehealth offered by mental health clinics across the U.S.," said study author **Jonathan Cantor**, a policy researcher at RAND Corp., a nonprofit research

organization.

His team published its findings, based on a "secret shopper" study, in the Feb. 2 issue of **JAMA Health Forum**.

Between late 2022 and March 2023, Cantor and his colleagues tried phoning more than 1,900 outpatient mental health treatment facilities treating adults across the United States.

For more than 500 clinics called, the researchers failed to reach anyone.



"The fact that we could not reach anyone at one in five facilities suggests that many people may have trouble reaching a clinic

to inquire about mental health care," Cantor noted in a RAND news release.

Of the remaining 1,404 clinics that did have someone respond to the "secret shopper" queries, 87% said they were accepting new patients and 80% said they offered telehealth services.

Those services varied in terms of how they were offered. For example, about half of clinics offering telehealth said it was available via video appointments only, 5% said it was only offered via audio appointments, and 47% said they were open for both video and phone appointments.

Private clinics were twice as likely to offer telehealth services compared to public facilities, the study found....**[Read More](#)**