Rhode Island Alliance for Retired Americans®

RI ARA

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Message from Alliance *for* Retired Americans Leaders

Alliance Celebrates Black History Month with an Eye on Voting Rights

Robert Roach, President, ARA

As the nation marks Black History Month throughout the month of February, Alliance President Robert Roach, Jr. said this week that we must build on the achievements of the Reverend Martin Luther King, Jr. and his work with President Lyndon Johnson during the 1960's. Dr. King's activism led to passage of the **Civil Rights Act of 1964** and the **Voting Rights Act** in 1965.

"Black History Month is an opportunity to celebrate our heroes and our victories," said President Roach. "Dr. King put the rules in place that allowed Barack Obama to be elected our first Black President. While we have made tremendous progress in the fight for civil rights, the struggle for equality and justice continues – particularly in areas like voting rights, fair housing and education."

Voting rights activists are closely watching two cases on the Supreme Court docket this year. One case turns on the question of whether the state of Alabama violated the Voting Rights Act when it approved a congressional map that created one majority Black district, rather than two.

A second case involves a dispute over North Carolina's 14 congressional districts, and it could allow state lawmakers nationwide to upend election laws. The Supreme Court heard oral arguments in both cases last year and is expected to issue its rulings before the term ends in June.

"In addition to voting rights, Black Americans and other minorities also still need protection from discrimination in housing, whether they are renting or buying a home, getting a mortgage, or seeking housing assistance," said President Roach.

"Ted Kennedy's famous quote from 1980 continues to resonate today," President Roach added. "Senator Kennedy said, 'For all those whose cares have been our concern, the work goes on, the cause endures, the hope still lives, and the dream shall never die.'"

President Roach Joins Family Leave Anniversary Event at White House

President Roach attended a White House Celebration with President Biden, Vice President Kamala Harris and former President Bill Clinton in honor of the 30th anniversary of the Family and Medical Leave Act of 1993 Thursday.

"We have come so far on family leave over the last 30 years," said President Roach. "But as with many causes, more needs to be done. The adult children and grandchildren of our oldest and sickest family members must be able to fulfill their roles as caretakers when necessary. In addition to our moral obligations as a society, that ability is a vital component of working families' ability to achieve economic security."

President Biden, Speaker McCarthy Meet About Raising the Debt Ceiling

Rich Fiesta, Executive Director, ARA

The White House **hit back** after Speaker Kevin McCarthy (R-Calif.) said on Sunday that he wants to "strengthen" Medicare and Social Security, with administration officials stressing that the House GOP leader and his conference actually want to slash spending on the programs.

"For years, congressional Republicans have advocated for slashing earned benefits using Washington code words like 'strengthen,' when their policies would privatize Medicare and Social Security, raise the retirement age, or cut benefits," White House spokesman Andrew Bates said in an emailed statement.

McCarthy met with President Biden at the White House about the need to raise the debt ceiling on Wednesday. Afterwards, McCarthy said that he and Biden could negotiate a spending deal – but the real test may come in McCarthy's **negotiations with his own Republican conference**. Even with billions in cuts to other programs, reaching the stated GOP goal of FY 2022 budget levels without touching Social Security and Medicare seems nearly impossible, Democrats said.

Also, last Friday two dozen Senate Republicans, led by Utah Senator Mike Lee, sent a letter to President Biden vowing to vote against any bill to increase the debt ceiling that does not include "real structural spending reform that reduces deficit spending and brings fiscal sanity back to Washington."

"Congress must reject the threats to cut Social Security, Medicare and other critical social programs for seniors," Richard Fiesta, Executive Director of the Alliance, said. "We cannot, under any circumstances, allow extremist Republicans to dictate destructive policies that would be harmful not only to seniors but to all Americans." The Alliance's new position paper on increasing the debt ceiling is available **here**

Kaiser Health News: Government Lets Health Plans That Ripped Off Medicare Keep the Money

Joseph Peters ARA Sec.-Trea.

Medicare Advantage plans for seniors dodged a major financial bullet Monday as government officials gave them a reprieve for returning hundreds of millions of dollars or more in government overpayments — some dating back a decade or more. The health insurance industry had long feared the Centers for Medicare & Medicaid Services would demand repayment of billions of dollars in overcharges the popular health plans received as far back as 2011….More

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Advocates launch pledge campaign to protect Social Security and Medicare

Social Security Works, More Perfect Union, Indivisible, MoveOn, and **many other prominent organizations** have launched a campaign demanding that members of Congress pledge to protect Social Security and Medicare. This campaign is a response to Congressional Republican leadership **initiatives** signaling that Republicans will fail to support a lifting of the debt ceiling without Congress cutting Social Security and Medicare.

The advocates want all of our Congressional representatives to commit to never cutting Social Security and Medicare. As it is, Social Security pays for all of its costs through payroll contributions. It does not consume a penny from the treasury. It needs strengthening in a manner that is fair and continues to pay for itself. Congress should support Congressman Larson's **Social Security 2100 Act**, which would lift the cap on Social Security contributions so everyone paid in throughout the course of the year.

Medicare pays for part of its costs through payroll contributions and the rest through the general treasury. Medicare is critical for the health and well-being of older adults and people with disabilities. Congress cannot cut benefits or raise costs in Medicare without keeping more people with Medicare from getting needed care, driving some into disability and others to premature death.

That all said, those members of Congress who want to address waste and fraud need only look to the tens of billions of dollars in past excess payments and hundreds of billions of dollars in future excess payments to Medicare Advantage plans, as a result of the current payment system. Those overpayments are well documented and easy to recoup without repercussions on the health and well–being of people with Medicare. In fact, recouping those overpayments would bring down Medicare Part B premiums and strengthen the Medicare Trust Fund.

Every member of Congress should follow **President Biden's lead** in committing to no cuts to Social Security and Medicare and sign the **DontCutSocialSecurity.org** pledge. You can click on the website to see which members of Congress have signed and which are not signing.

"Democrats **were elected** on the promise that they would defend Social Security against Republican attacks. Now is the moment of the truth. Democrats must refuse to cut Social Security. And they must refuse to create a mechanism — such as a closed-door commission — to cut Social Security down the road." – Alex Lawson, Executive Director of Social Security Works

"We can't let dogmatic Republicans hold the most crucial government program protecting those who need it most hostage. It is critical for the Democrats to stay united and stand their ground against this latest effort to gut social security and medicare." – Faiz Shakir, Executive Editor at More Perfect Union

Americans, regardless of party affiliation, **overwhelmingly support protecting Social Security** and are opposed to program cuts. The same is true of Medicare. Social Security and Medicare are national treasures. Lifting the debt ceiling should not be conditioned on cuts to these invaluable earned benefits.

Government overpayments to Medicare Advantage plans grow, while concerns remain about quality of care

Earlier this month, MedPAC, the agency that oversees Medicare payments, released a slide deck showing ever-increasing **government overpayments to Medicare Advantage plans**.The total overpayments stemming from "upcoding," additional diagnoses codes on patient records, are staggering, while concerns about quality of care remain. Will the administration and Congress stop the billions in overpayments and protect Medicare Advantage enrollees from health plans that are keeping people from getting needed care?

The overpayments that are the focus on MedPAC attention amount to more than $124 billion between 2007 and 2023. They stem from Medicare Advantage plans adding diagnosis codes to patient charts, as currently permitted. They are different from the overpayments from wrongful or fraudulent diagnosis codes.

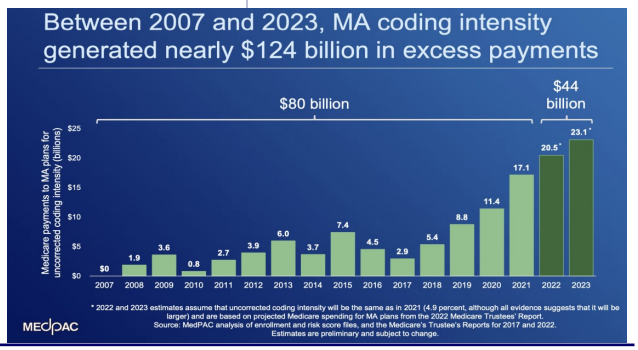
With each passing year, Medicare Advantage likely will grow, as will the permissible government overpayments to Medicare Advantage plans, unless things change. This year and last alone, according to MedPAC, overpayments totaled $44 billion, $17 billion in 2022 and $27 billion in 2023. Take a look at the chart accompanying this post.

These permissible overpayments are so high that people in Medicare Advantage plans theoretically have $2,350 in additional benefits each year. But, there is no evidence they do. They most likely end up in the coffers of Medicare Advantage plans. People in Medicare Advantage needing costly care continue to face **widespread and persistent delays and denials of care**, jeopardizing their health. MedPAC also expressed ongoing concerns about quality of care in Medicare Advantage.

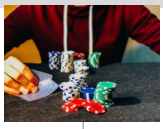
These Medicare Advantage overpayments are projected to total more than **$600 billion in the next eight years**. Over time, these additional payments will likely come back to haunt Medicare Advantage enrollees. They will probably face much higher out-of-pocket costs.

Congress and the administration eventually will change the Medicare Advantage payment system to eliminate these overpayments. If they don't, the cost of Medicare Advantage, which insurers argued back in 2003 would be 90 percent of Traditional Medicare, will become unsustainable. The government is currently spending 106 percent of Traditional Medicare on Medicare Advantage.

What will happen to people with Medicare when Congress changes the Medicare Advantage payment system? If they're in Medicare Advantage, most will be locked in, unable to switch to Traditional Medicare, and will have to pay significantly higher costs. Congress has opted not to have an out-of-pocket cap in Traditional Medicare nor has it given people a guaranteed right to supplemental coverage in Traditional Medicare so they can protect themselves from financial risk. What a big f#$% ing mess.



New government rule lets Medicare Advantage pocket tens of millions of taxpayer dollars they did not earn



For years, the federal government has been overpaying Medicare Advantage plans tens of millions of dollars for wrongful or fraudulent diagnosis codes without trying to recoup almost any of that money. A new government rule designed to "improve program integrity and payment accuracy" in Medicare Advantage allows these corporate health plans to keep all but a tiny fraction of that money. What's worse is that the rule continues a defective payment system that allows **hundreds of billions in overpayments** resulting from "upcoding"–a practice that allows Medicare Advantage plans to add diagnoses codes to patient records regardless of whether they provide services to treat the conditions associated with the codes–to grow.

As a result of the rule, CMS plans to recoup just $4.7 billion in overpayments from fraudulent or erroneous Medicare Advantage billing beginning in 2018. Publicly, the Medicare Advantage plans are balking, but I bet that they are laughing all the way to the bank.

CMS has opted not to collect these improper overpayments from the seven years prior to 2018, is still completing audits to calculate overpayments from 2014 and 2015, and will not try to collect any overpayments until after it completes its 2018 audit some time down the road. Almost certainly, CMS will need to fight the insurers in court to claw back the overpayments.

Moreover, CMS has done nothing to address the estimated $124 billion in additional Medicare Advantage overpayments from what is likely permissible upcoding. Fred Schulte reports for **Kaiser Health News** that the Medicare Advantage plans are not likely to feel the effect of this new government rule. That's an understatement. Here's a priceless **quote** from Dara Corrigan, director of the CMS's Center for Program Integrity. "The recoveries that we'll make are less than one-fifth of 1% of the amounts paid to Medicare Advantage plans,"

Officially, Medicare Advantage plans can keep virtually all overpayments based on wrongful diagnosis codes between 2011 and 2017. Unofficially, they can keep all overpayments of this nature for the foreseeable future. CMS has not even completed audits of Medicare Advantage plans from 2011.

Plain and simple, CMS does not have resources to conduct timely audits of Medicare Advantage plans or the tools to ensure that tens of millions of dollars in overpayments are returned to Medicare coffers expeditiously. If you ask me, that's reason enough to terminate Medicare Advantage. Even if CMS eventually attempts to collect the overpayments Medicare Advantage plans have received as of 2018, the insurers have said they will contest this clawback in court.

A CMS Deputy Administrator says the rule is a "commonsense approach to oversight," without claiming to know the amount of excess payments the Medicare Advantage plans will keep. If this is commonsense oversight, Congress should protect the integrity of the Medicare Trust Fund and end Medicare Advantage. Health and Human Services Secretary Becerra appears to recognize that this is not meaningful accountability, saying merely that it is a "move" in that direction.

It is beyond comprehension that an additional hundreds of billions in Medicare Advantage overpayments appear to be baked into the Medicare Advantage program, as MedPAC has reported. And, CMS does not appear to be doing anything about it.

It could not be clearer that the government's capitated payment system for Medicare Advantage leads to billions of dollars in overpayments and no ability to recoup the money. Congress must change the way Medicare Advantage plans are paid or end the program entirely. Medicare's sustainability is on the line.

Government agencies undeterred by fraud in their efforts to turn Medicare over to Wall Street

On January 17, the Center for Medicare and Medicaid Innovation (CMMI) announced **48 new model participants** in a controversial pilot program called Accountable Care Organization: Realizing Equity, Access, and Community Health, better known as ACO REACH. CMMI, created by the Affordable Care Act, is supposed to test alternative payment models for Traditional Medicare to lower costs and improve, or at least not worsen, the care of 30 million seniors and people with disabilities.

The program, launched in the waning days of the Trump Administration as Direct Contracting, was greenlighted by the Biden Administration in 2021 and renamed ACO REACH in 2022. The model, which started with 53 contracting entities under Trump **has grown** to 132 participants with 131,772 health care practitioners and organizations providing care to over 2 million beneficiaries on Traditional Medicare under President Biden. Startling **research** found many of the ACO REACH participants have a history of Medicare fraud. Nevertheless, Medicare continues to sign contracts with them.

ACO REACH is a program designed to privatize what is left of public Medicare. Half of Medicare has been privatized through Medicare Advantage plans, which receive up-front "capitated" payments for Medicare beneficiaries from the Center for Medicare and Medicaid Services (CMS) and have the power to decide whether and how much of those Medicare dollars to spend on the beneficiaries who signed up for their plan. The Affordable Care Act allows Medicare Advantage plans to keep up to 15% of these Medicare dollars for administrative fees and profit (although they have **clever ways** to get around this restriction). To make these profits, Medicare Advantage plans create narrow networks for their beneficiaries, deny and delay care, and get overpaid by CMS, **cashing in on billions** of Medicare dollars.

What earthly reason would there be to exclude companies from ACO REACH but allow them to continue their plunder in Medicaid, Medicare Advantage, and subsidized on the ACA Exchanges?

ACO REACH uses similar tactics to those found in Medicare Advantage to profit from Medicare by overcharging Medicare, financially incentivizing providers to control healthcare costs for beneficiaries, and increasing the number of beneficiaries in their plans. But while some seniors "choose" to participate in Medicare Advantage, seniors and people with disabilities are auto-enrolled into an ACO REACH through their primary care physicians (PCPs). Thus, it is physicians and physician practices which are being lured into or forced to join the ACO REACH (Many physician practices are being swooped up by private equity or created whole-cloth). Physician practices, or their controllers, are enticed by the "shared savings" they will collect if they save money on their patients, shredding the trust between doctors and patients…..**Read More**

Economist Robert Reich: House Republicans won't say the real reason why the 'federal deficit has exploded'

With Republicans now in charge of the U.S. House of Representatives under Speaker Kevin McCarthy's leadership, they are once again arguing with Democrats over the United States' debt ceiling. Democrats, along with many economists, are warning that if the U.S. defaults on its debt obligations, that event could trigger a major financial crisis

Far-right Republicans in the House Freedom Caucus, meanwhile, are demanding big spending cuts. And many Democrats are emphasizing that cuts to Social Security and Medicare should not be on the table.

Liberal economist Robert Reich, in an **op-ed published by The Guardian** on February 1, agrees with Republicans and Libertarians that the United States' federal deficit is too large. But he disagrees vehemently with the right on the cause. Rather than blame social programs, Reich argues, Republicans need to be intellectually honest and acknowledge tax cuts for the ultra-rich as a key factor.

"When they're in power," **Reich explains**, "(Republicans) rack up giant deficits, mainly by cutting taxes on corporations and the wealthy — which amount to the same thing, since wealthy investors are the major beneficiaries of corporate tax cuts. Then, when Democrats take the reins, Republicans blame them for being spendthrifts. Not only is the Republican story false, but it leaves out the bigger and more important story behind today's federal debt: the switch by America's wealthy over the last half century from *paying taxes to the government to lending the government money."*

Reich goes on to describe the sizable tax cuts that the wealthiest Americans have enjoyed under Republican presidential administrations in recent decades, citing them as a key factor in the federal deficit that House Republicans are now complaining about.

"A half century ago," **the economist recalls**, "American's wealthy helped finance the federal government mainly through their tax payments. Tax rates on the wealthy were high. Under Republican President Dwight Eisenhower, they were over 90 percent. Even after all tax deductions, the wealthy typically paid half of their incomes in taxes. Since then — courtesy of tax cuts under Ronald Reagan, George W. Bush and Donald Trump — the effective tax rate on wealthy Americans has plummeted."

Reich adds, "Not only has their income tax rate dropped, but other taxes that hit them hardest, such as the corporate tax, have also declined. Even as the rich have accumulated unprecedented wealth, they are now paying a lower tax rate than middle-class Americans…. One of the biggest reasons the federal debt has exploded is that tax cuts on corporations and wealthier Americans have reduced government revenue."

Medicare coverage can be a bit of a mystery: Here are the big coverage gaps to watch out for

Navigating Medicare can be confusing, especially when you're trying to understand what the insurance actually covers.

BY
RICHARD EISENBERG

Turns out, there are a number of big health expenses that Original Medicare, the federal health insurance program for Americans over 65, doesn't cover. But—and it's a big but—for most of those there's often an exception to the rule.

It's also worth noting that Medicare Advantage plans—the private-insurance alternative to Original Medicare—sometimes offer coverage that Original Medicare doesn't. But, as you'll see below, that coverage may be skimpier than you think because Medicare Advantage benefits aren't standardized.

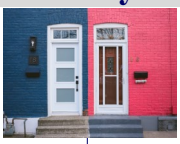
"Medicare Advantage plans are required to cover everything Original Medicare covers and nothing more. A supplemental benefit could be robust, or it could be not," says Casey Schwarz, senior counsel for education and federal policy at the Medicare Rights Center. "We hear from a lot of people who are surprised by what their Medicare Advantage plan doesn't cover."

The government's free annual handbook, ***Medicare & You***, and the **Medicare website**, provide specifics about what Original Medicare does and doesn't cover. The Medicare.gov site has a handy tool called **"Is my test, item, or service covered?"** where you type in a word or phrase to get the answer. State Health Insurance Assistance Programs, or SHIPs, also provide free information about Medicare rules—you can find the program in your state with a quick Google search.

Here are big coverage gaps to look out for, what to know about them, and how to appeal a Medicare claim denial if you believe your care is covered:

The big 3: Vision, dental, and hearing.....**Read More**

Multigenerational family housing can work



Paula Span reports for the **New York Times** on multigenerational family residences. Think of them as family compounds, with a main house and a separate unit for the extended family. These "accessory dwelling units" or ADUs can work well.

Portland, Oregon is one of a number of big cities with ADUs. They are far more affordable than your standard home and come in all shapes and sizes. They could be a one or two bedroom structure that is a converted garage. Or, they could be a converted basement. They could be attached to the primary home or a totally separate unit.

The value of these family compounds is that the different family units can have separate living spaces but easily share meals, activities, and tasks. The grandparents are there to babysit the kids or to take the dog for a walk.

Older adults can downsize into an ADU and still have money in the bank. Building an ADU costs about $150,000 for around 600 square feet. If the older adults' ADU is with a child or other loved one, they are likely to have built-in caregivers. ADUs are not only a great way to ensure that older adults are socially engaged, they are a cost-effective way to live, both for the occupants of the ADUs and the occupants of the primary residence.

Some states and cities had zoning barriers or parking restrictions that made it hard to build ADUs. But, many are now changing their laws to encourage development of more ADUs.

The ADU market is quite small, but it is growing rapidly. In just a five years, the number of ADUs built in California went from around 1,200 to around 20,000. In 2020, there were an estimated 1.4 million ADUs in the US. Most are located in Florida, Georgia, Texas and California.

We still have a long way to go before we see a boom in the ADU market. The vast majority of the country–80 percent–includes neighborhoods that only allow for single-family homes. And, some communities that permit ADUs have parking rules and rules about occupancy that dissuade people from building ADUs.

Call to Action – Policy Makers Must Increase Medicare Advantage Oversight and Rein in Overpayments

For many years, the Center for Medicare Advocacy has advocated for legislative and administrative efforts to address the growing inequities between Medicare Advantage (MA) and traditional Medicare, that favor MA, and encourage the growing privatization of the Medicare program. These inequities include overpayments to MA plans that unnecessarily drive-up Medicare spending, and lax oversight of MA plans that fails to impose adequate consumer protections.

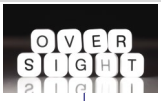
This week's *Special CMA Alert* focusing on the Medicare Advantage (MA) program includes five separate, but related articles outlining several critical issues.

- First, Marilyn Moon, Ph.D., Center for Medicare Advocacy Visiting Scholar and former Medicare Trustee, writes about the harm in letting MA take over the Medicare program in her opinion piece, **Medicare Advantage is Not the Solution to Medicare Equity or Solvency Problems**.
- Second, the Center for Medicare Advocacy's *CMA Alert*, entitled **Office of Inspector General (OIG) Issues Another Report Highlighting Inappropriate Medicare Advantage Denials,** offers an assessment of the latest evidence that MA plans deny too much care.
- Third, we discuss the **Insurance Industry v. Provider Response to the recent OIG Report re: MA Denials,** highlighting that despite how much the insurance industry tries to downplay the report's findings, many providers of care to MA enrollees are frustrated with MA plans' prior authorization and coverage denials.
- Fourth, while the OIG report's findings about MA denials are disturbing enough on their own, the Center describes how the **OIG Report Estimates of Inappropriate MA Plan Denials May be Understated**. Based on our own experience with OIG's audits of home health claims, coupled with the recent growth in MA plans' use of artificial intelligence (AI)-driven software that seems to result in terminations of skilled nursing facility and other care sooner and more frequently, we fear that problems with MA may be even worse than OIG found.
- Fifth, and finally, we continue our efforts to highlight that **(Most) Policy makers Fail to Act on Medicare Advantage Oversight and Overpayment**. Some lawmakers, however, are pushing back against the increasing privation of Medicare, the inertia to do anything about it, and the insurance industry's influence.

Government Watchdog Shows Limited Data on Medicare Advantage Supplemental Benefits

This week, the Governmental Accountability Office (GAO), a watchdog agency that works for Congress, **released a report** on Medicare Advantage (MA) supplemental benefits. The report found that most MA plans offer some supplemental benefits but that there are limited data on to what extent plan enrollees have been able to use new types of benefits and what effect those benefits have had on enrollees' health and function.

MA plans have been able to offer some forms of supplemental benefits for decades, but two new types of benefits came into the market in 2019 and 2020. The 2019 expansion allowed plans to offer supplemental benefits that were not directly considered medical treatment but were primarily health related. Most of these benefits are, at least theoretically, available to all plan enrollees. As of 2020, plans could offer supplemental benefits to individuals with chronic conditions that were not primarily health related but had a reasonable expectation of improving or maintaining health or function. These benefits are only for plan enrollees who qualify.



MA enrollment has expanded greatly since 2019, and the extra benefits have played a significant role. The Commonwealth Fund **estimates that 24% of people** who opted for MA were drawn by the extra benefits. But it is unclear how many people who are choosing MA for those extra benefits are actually using them.

The GAO found that utilization data are very limited. MA plans have not been reporting on supplemental benefits, despite regulations that require those reports. In addition, even where plans are willing, there are some technical problems in collecting that data, including a lack of procedure codes for some of the benefits, like fresh foods.

The GAO recommended that the regulations and guidance for plans be clarified to ensure plans understand they are required to submit data on supplemental benefits and for procedure codes or a similar workaround to be added to ensure plans can report on the full scope of benefits offered. The Centers for Medicare & Medicaid Services (CMS) agreed with both recommendations.

At Medicare Rights, we have long been concerned that MA plans are not transparent about supplemental benefits and that they are being used more as a marketing tool than as a true benefit that improves the lives of enrollees. We hope this report will shine more light on the issue and will result in more complete data on the use and value of supplemental benefits.

Kaiser Family Foundation Reports on Medicare-Medicaid Enrollment and Spending

This week, the Kaiser Family Foundation (KFF) released a **brief** examining national and state-level data on enrollment and spending for people enrolled in both Medicare and Medicaid, sometimes called dually enrolled individuals or duals. KFF used the 2019 and 2020 Medicare Beneficiary Summary Files and the 2019 Transformed Medicaid Statistical Information System to identify trends and patterns in enrollment across states and programs and spending in Medicaid and traditional Medicare, as spending data for individuals enrolled in Medicare Advantage is not publicly available.

KFF found that in 2020, 12.5 million people were enrolled in both Medicare and Medicaid, and 73% of those individuals were eligible for full Medicaid benefits, with the remaining 27% eligible for premium support and potentially cost-sharing assistance through the Medicare Savings Programs (MSPs). Further, they found that in 2019, dually enrolled individuals constituted 17% of the traditional Medicare population and 14% of the Medicaid population but accounted for a greater than proportionate share of spending in those programs. The per-beneficiary Medicare and Medicaid spending for dually enrolled beneficiaries was higher for those eligible for full Medicaid benefits than for those with MSP only, and both amounts were higher than the average spending for individuals who are enrolled in only Medicare or Medicaid.

The report also found that though dually enrolled individuals comprised 20% of the total Medicare population (both traditional Medicare and Medicare Advantage) and 14% of the Medicaid population, those percentages varied widely from state to state. KFF attributes this variation to multiple factors, mostly the underlying demographic makeup of the state, whether the state has expanded Medicaid eligibility for single adults and childless couples, and whether states have increased eligibility criteria for older adults and people with disabilities above the federal floor….**Read More**

The stupid and dishonest idea of raising the Social Security retirement age is back

The people who are in the forefront of pushing Social Security "reform" by cutting benefits have gotten pretty good at hiding their intentions behind plausible-sounding jargon and economists' gibberish.

The latest "reform" package offered by the Committee for a Responsible Federal Budget, for example, calls on lawmakers to "promote stronger economic growth and productive aging" by removing "work and savings disincentives in the current program."

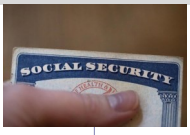
"Productive aging" — that's a good one. Sounds reasonable while being utterly vacuous. Monique Morrissey of the Economic Policy Institute provides a concise translation: "Raise the retirement age."

Committee for a Responsible Federal Budget

It may not be surprising that the CRFB, a Washington think tank that was heavily funded by the late hedge fund billionaire Pete Peterson, might want to hide its prescription behind a curtain.

Raising the retirement age is best described as a zombie reform plan. Despite being debunked repeatedly as a benefit cut that falls disproportionately on low-income and Black workers, it still walks among us.

Indeed, the idea has been getting a renewed airing, despite the evidence that it's a worse idea now than ever.



Joseph Chamie, a former demographer for the United Nations, proposed in **a November article for the Hill** raising the retirement age to 70 and eliminating the early retirement option, through which workers can start claiming Social Security benefits starting at age 62, with a reduction in lifetime benefits for each year before their normal retirement age. (For those born in 1960 or later, that's **age 67.)**

Revealing that, whatever he may know about demographics, he knows almost nothing about Social Security, Chamie asserted that his proposal "could save Social Security for us all." He managed to make that claim without mentioning any other proposals to shore up the program's finances, especially raising or eliminating the cap on payroll taxes, which effectively give the rich a free pass on supporting the program.

The retirement age panacea has been heard beyond these shores. French President Emmanuel Macron has proposed raising that country's minimum retirement age to 64 from 62. The proposal has sent unionized workers into the streets and prompted other forms of protest.

And that's in a country where the anti-poverty safety net is vastly better than in the United States: About 4.4% of French retirees older than 65 live in poverty, compared with **10.3% in the United States.**...**Read More**

2023 Social Security: 6 Numbers You Need to Know

If you are wondering about **Social Security earnings limits,** what is full retirement age, and average Social Security benefits**, here are six numbers** you should know.

Keep in mind that every Social Security rule carries exceptions and rules are subject to change. It's best to always reference the Social Security website, SSA.gov. You can also log in to your Social Security account online for specifics regarding your benefits.

For Many People, the Magic Number Is 67

What's so special about age 67? For many people, this represents Full Retirement Age, or the age you can begin receiving your full retirement benefit. You can retire early and collect a percentage of your benefits. Once you reach FRA, your benefits will increase to the full amount, according to SSA.gov. That amount is called your PIA, or Primary Insurance Amount.

If you were born between 1943 to 1954, your FRA is age 66. It increases gradually based on the year you were born, as indicated in the chart below. If you were born in 1960 or later, your full retirement age is 67.

For Survivor Benefits, FRA starts at age 66 for those born between 1945 and 1956 and increases in 2-month increments. Those born in 1962 or later reach full retirement age at 67.

How Does 124% of Your Benefits Sound?

You might wonder how much your benefits will be reduced by if you file before you reach full retirement age. The answer is: It depends. The percentages are different for individual retirement benefits, spousal benefits, and survivor benefits.

If your full retirement age is 67, the chart below shows the percentage of benefits you'll receive between ages 60 and 70.

However, there's good news, too. If you wait until you are 70 to file for Social Security, you'll receive 124% of your full benefit amount, which is a pretty large raise!

This Happens 36 Months Before Full Retirement Age

Each month before you reach full retirement age, your benefits will be reduced. In the 36 months before full retirement age, you'll lose 5/9 of 1% of your benefits each month. Any time prior to the 36 months before full retirement age, you'll lose 5/12 of 1%.

$21,420 Is a Number to Keep In Mind After Age 62, But Before Your Full Retirement Age

Until you reach full retirement age, the Social Security Administration may also reduce your benefits further if your earnings exceed a certain amount. The SSA counts wages and net earnings from self-employment toward your earnings limit but doesn't count pensions, dividends, annuities, IRA distributions, capital gains, or income earned from interest….**Read More**

Social Security's 2024 COLA Could Easily Be Zero. Here's How

Many people on Social Security rely on their benefits to provide the bulk of their income. One key advantage that Social Security offers its participants is that the monthly benefits it pays out are adjusted annually for inflation. Cost-of-living adjustments, or COLAs for short, help older Americans avoid a big loss in purchasing power.

COLAs were especially important for Social Security recipients in 2023 as soaring inflation led to an 8.7% boost to payments starting in January. Yet, even though it's far too early to make firm conclusions about what seniors should expect in 2024, it's entirely possible that COLAs for next year could fall sharply or even disappear entirely.

inishing 2022 with lower prices

Inflationary pressures have largely abated in the past several months. After soaring 9.8% in the 12 months from June 2021 to June 2022, the Consumer Price Index (CPI-W) has fallen in four of the past six months. As of December 2022, it was below its level from six months previously.

A host of factors led to diminishing inflation. Perhaps the most important area was energy prices, as costs for gasoline moved dramatically lower in the second half of 2022 after soaring over the previous year. Reversals in other areas that had seen huge gains, such as vehicle prices, also helped contribute to the turnaround.

How weaker inflation could make 2024's COLA go to zero

To figure out the COLA for each year, administrators within the federal government look at CPI-W readings and plug them into a formula. The numbers for July, August, and September get combined, and then the average for the three months is compared to the average for the same three months in the previous year. The percentage change becomes the COLA for the subsequent year….**Read More**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Estrogen Exposure Could Impact a Woman's Odds for Stroke

When it comes to reducing stroke risk among women, new research suggests that the more estrogen a woman is exposed to over the course of her life, the better.

The finding follows nearly a decade spent tracking stroke risk among roughly 123,000 Chinese postmenopausal women.

In the end, investigators concluded that those who had a relatively long reproductive period before menopause appeared to face a lower risk for both an ischemic stroke and a hemorrhagic stroke.

An ischemic stroke is the most common form of stroke, brought on by blood flow blockage to the brain. A hemorrhagic stroke is brought on by bleeding in the brain.

"These results were unexpected and provide new insights into the associations between reproductive factors and the risk of stroke," said study author **Peige Song**, a researcher with Zhejiang University's School of Public Health in Hangzhou, China.

To explore a possible protective link between estrogen and stroke risk, Song and her team focused on a pool of women between the ages of 40 and 79. None had a history of stroke when they had first enrolled in a prior Chinese study between 2004 and 2008.

The team first analyzed study enrollment information regarding the specific length of each woman's overall reproductive life span leading up to menopause.

Song and her colleagues also took into account how often participants had a child and/or whether or not (and for how long) they took birth control pills, as both typically drive up estrogen levels. Breastfeeding patterns -- which tend to drive down estrogen exposure -- were also noted.

Additional information was gathered on alcohol and smoking habits, overall medical background, and each woman's pregnancy, miscarriage and oral contraceptive history.

In turn, the team went on to track study participants for roughly nine years, during which time a little more than 15,000 strokes occurred. The vast majority (12,000) were ischemic.

Participants were then divided into four groups ranging from the shortest amount of time between first menstruation and menopause (31 years) and the longest amount of time (36 years).

After stacking each group up against stroke incidence, the team found that women in the longest estrogen exposure group had a 5% lower risk for ischemic stroke and a 13% lower risk for a hemorrhage stroke, compared with women in the shortest exposure group.

The findings took into account a wide range of other factors that can heighten stroke risk, including high blood pressure, older age, a sedentary lifestyle and smoking history.

The team also concluded that higher overall estrogen exposure -- beyond simply the number of years between menstruation and menopause -- also contributed to a lower overall stroke risk.

Song touched on some ideas as to why greater estrogen exposure might offer women protection against stroke….**Read More**

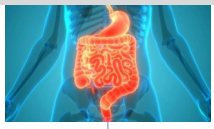
Gallbladder & Bile Duct Cancers: Rare, Silent and Deadly. Know the Signs

Bile duct and gallbladder cancers develop in organs deep inside the body, making them difficult to detect.

Knowing the signs of these rare cancers may help with earlier detection.

Gallbladder cancer and bile duct cancer are two separate diseases, according to **Dr. Miral Sadaria Grandhi**, director of hepatobiliary surgery at Rutgers Cancer Institute of New Jersey in New Brunswick.

Both tend to begin in glandular cells in tissue that lines the biliary tract, though which bile released by the liver travels to the small intestine.



When cancer develops in the gallbladder -- a small organ connected to the liver by the bile ducts -- it usually begins in its innermost layers, Sadaria Grandhi said in a Rutgers news release. The cancer then spreads to surrounding tissue. The gallbladder's job is to store bile, which is produced by the liver to aid in digesting dietary fat.

Bile duct cancer, also called cholangiocarcinoma, is caused by the abnormal growth of cells in the bile duct. It can occur in any portion of the biliary duct system.

Gallbladder cancer typically doesn't cause symptoms until later in the disease course, but some early signs are lumps in the belly, nausea and/or vomiting, pain and weight loss, Sadaria Grandhi said.

People with inflammatory bowel disease, those with chronic inflammation of the bile ducts and older people have an increased risk of bile duct cancer.

Symptoms can include jaundice, in which the skin and whites of the eyes turn yellow; itching, dark urine, abdominal pain, fever, nausea and vomiting.

Gallbladder polyps, choledochal cysts and biliary cystic tumors called biliary cystadenoma can be precursors to cancer. Surgical removal is recommended as a preventative measure, Sadaria Grandhi said.

An estimated 12,130 people are diagnosed with bile duct or gallbladder cancer each year, according to the American Cancer Society.

His Debilitating Back Pain Lasted Decades, Until a New Implant Changed Everything

After living with disabling low back pain for nearly 30 years, Dennis Bassett, 64, finally has a new lease on life.

The Hempstead, N.Y., native injured his back in the 1980s when helping a friend. He tried everything to relieve his back pain, from self-medication, acupuncture, and chiropractor work to steroid injections, physical therapy and exercise.

"My back only got worse," recalled the retired real estate professional. "Some days, I could barely make it into the house and up my stairs."

But that was then.

Everything changed a few months ago after his doctor suggested a new procedure that involves implanting a muscle-stimulating device called the ReActiv8 into his lower back to activate a dormant and withering core muscle. The U.S. Food and Drug Administration **gave its nod to the device** in June 2020.

The father of six underwent the procedure at Lenox Health Greenwich Village in New York City several months ago. Now, he is considering moving down South and starting a trucking business.

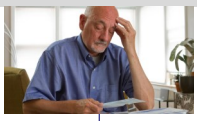
"I feel good enough that I can take a chance," he said. "I can walk upstairs, sit down and stand up with no problem. I thought, 'this is too good to be true.'"

But when this procedure is paired with the right patient, it's not too good to be true, said Bassett's surgeon, **Dr. Kiran Vishal Patel**, director of pain medicine at Lenox Hill Hospital in New York City.

"This is an unprecedented procedure because it is restorative, disease-modifying, can prevent further degeneration, and allows people to be so much more active than they were," she said.

It's not for everyone with low back pain, Patel said ….**Read More**

Fighting Liver Cancer Takes Big Financial Toll: Study



Out-of-pocket costs can leave Medicare patients with the most common type of liver cancer in financial distress.

While Medicare payments in the first year after diagnosis with hepatocellular carcinoma (HCC) exceeded $65,000, out-of-pocket costs were more than $10,000, **a new study** found.

"As has been shown for other cancer types, we found patients with liver cancer suffer from high cancer-related financial burden," said study co-author **Dr. Amit Singal**, a professor of internal medicine at University of Texas Southwestern in Dallas.

"Financial toxicity of cancer therapy can negatively impact patients, resulting in medical debt and even bankruptcy for some patients," Singal said in a university news release.

The researchers said the cost of liver cancer treatment has been little studied.

Patients have had the benefit of several new treatments in the past decade, including new surgeries, radiation-based therapies and immunotherapies. While they can be effective, they are also difficult to afford.

Researchers used data from a Medicare database to examine first-year treatment costs for 4,525 patients ages 68 and older who were diagnosed with liver cancer between 2011 and 2015.

They then compared costs for patients with HCC with those for a matched set of patients with liver cirrhosis. (Medication claims were not included because they were not available for all patients.)

The researchers found that patients with liver cancer had significantly higher inpatient, outpatient and doctor costs compared with the cirrhosis -only patients. In the first year of treatment, median out-of-pocket costs were more than $7,000 higher than the costs for the cirrhosis patients, meaning half were higher.

Patients with early-stage liver cancer had lower costs.

Those with coexisting conditions, such as non-alcoholic fatty liver disease and fluid in the abdomen, had higher costs.

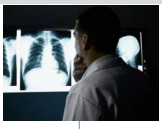
For most patients the cancer is diagnosed when it is beyond an early stage, researchers noted. Non-alcoholic fatty liver disease is an increasingly common underlying factor for liver cancer, they said.

"Our data highlight that HCC care not only causes considerable financial stress on the health care system but directly for patients and their family members, who suffer from high out-of-pocket costs," Singal said. "There is a clear need for policy interventions and financial support systems in this patient population."

By 2030, total cost of cancer treatment in the United States is expected to reach $250 billion.

Liver cancer deaths are also accelerating, partly due to detection in later stages. Liver cancer is expected to be the third-leading cause of cancer deaths by 2040, Singal said.

Targeted Drug Tagrisso Could Be Advance Against Lung Cancer



The best treatment for a genetically driven form of lung cancer continues to show lasting benefits, a new clinical trial update shows.

Tagrisso (osimertinib) nearly doubles disease-free survival in earlier-stage patients whose lung cancer is driven by a mutation in their EGFR (epidermal growth factor receptor) gene, researchers report.

After four years of follow-up, disease-free survival was 73% in the Tagrisso group versus 38% in patients who received a placebo, updated results showed.

Taken as a pill, the drug also cut patients' cancer recurrence in half compared to placebo, 27% versus 60%. In addition, patients were less likely to develop cancers in other parts of the body.

"One of the main benefits of this drug is that it has good brain penetration and it's a whole-body treatment," said **Dr. Nicholas Rohs**, an assistant professor of oncology with the Icahn School of Medicine at Mount Sinai, in New York City. "Often when this disease relapses, it can relapse in the brain, in the bones or other different organs, where it's much more difficult to treat."

About 10% to 15% of lung cancers in the United States are driven by an EGFR mutation, according to the American Lung Association. These patients tend to have minimal to no smoking history.

EGFR is a protein on cells that helps them grow. This mutation causes cancer by promoting runaway growth.

Tagrisso works by interrupting the mutated EGFR's effect on cancer cells.

"There's a signal in these cells saying grow, grow, grow, grow, grow because of this mutation in the EGFR domain," said Rohs, who was not part of the study. "We basically block that signal and say, 'Hey, stop telling this cell to grow out of control.'"

The U.S. Food and Drug Administration **first approved Tagrisso** in 2018 for treatment of patients with metastatic solid-tumor lung cancers driven by EGFR mutations.

A second clinical trial then commenced to see whether Tagrisso could be used to help prevent lung cancer recurrence in patients with earlier-stage disease, following surgery to remove their tumors.

"We've been using this with great success in the metastatic setting for quite a while," Rohs said. "And when we find something works well in a more advanced setting, we often try and see if there's any way we could trickle down into the earlier -stage setting."

In the study, nearly 700 patients with stage IB to IIIA EGFR-driven lung cancer were randomly assigned to take 80 milligrams of Tagrisso or a placebo once a day for three years….**Read More**

U.S. Tourists in Northern Mexico Are Buying Counterfeit Pills Containing Fentanyl

Researchers have uncovered groundbreaking evidence that pharmacies in tourist areas of Northern Mexico are selling counterfeit pills containing fentanyl, heroin and methamphetamines.

The pills, mainly sold to U.S. tourists without a prescription, were passed off as controlled substances, including oxycodone, percocet and Adderall, **the study** found.

This could add to the already high number of overdose deaths from these drugs in the United States and Mexico, U.S.-based researchers said.

"These counterfeit pills represent a serious overdose risk to buyers who think they are getting a known quantity of a weaker drug," said senior study author **Chelsea Shover**. She is an assistant professor at the David Geffen School of Medicine at the University of California, Los Angeles (UCLA).

About 68% of 40 pharmacies studied in four cities in Northern Mexico had at least one controlled substance for sale without a prescription, the researchers found. These were sold in either bottles or as individual pills.

The investigators found counterfeit pills containing fentanyl, heroin and/or methamphetamine from 11 pharmacies. Nine pill samples sold as Adderall contained methamphetamine. Eight sold as oxycodone contained fentanyl. Three sold as oxycodone had heroin in them.

"It is not possible to distinguish counterfeit medications based on appearance, because identically appearing authentic and counterfeit versions are often sold in close geographic proximity," the researchers reported. "Nevertheless, U.S. tourist drug consumers may be more trusting of controlled substances purchased directly from pharmacies." ...**Read More**

Sleeping Pills Linked to Higher Risk for Dementia

Seniors who frequently take sleeping medications may be raising their risk for developing Alzheimer's disease, a new study warns.

Sleep medications are one of the most commonly used medications in older adults, the authors say, but their frequent use may not be without harm.

Researchers found that older white adults who said they "often" or "almost always" took sleep aids had a 79% higher chance of developing dementia compared to those who "never" or "rarely" used them.

The connection was only seen among white adults, not Black participants.

In addition, "further studies are needed to confirm whether sleep medications themselves are harmful for cognition in older adults or [if] frequent use of sleep medications is an indicator of something else that links to an increased dementia risk," said study lead author **Yue Leng**.

In other words, the investigation "cannot prove causation," stressed Leng, an assistant professor in the Department of Psychiatry and Behavioral Sciences at the University of California, San Francisco.

Percy Griffin, director of scientific engagement with the Alzheimer's Association, seconded the thought.

"We do want to be careful," said Griffin, who wasn't part of the study. He noted that observational studies of this kind can only identify an association between a "modifiable risk factor" -- like medication habits -- and dementia risk. "They don't prove cause and effect," he said.

For the study, Leng and her team enlisted roughly 3,000 seniors to share their sleep medication routines starting in 1997.

Participants were between 70 and 79 years old, and none had dementia. All lived in Memphis or Pittsburgh. Nearly 6 in 10 were white and 4 in 10 were Black.

Three times over five years all were asked how often they took sleeping aids: never, rarely (once a month or less), sometimes (2 to 4 times a month), often (5 to 15 times a month), or almost always (16 to 30 times a month).

Participants also discussed the quality of their sleep, indicating how frequently they struggled with falling asleep and/or getting up too early in the morning. Routine sleep duration was also noted….**Read More**

CDC Warns of Dangerous Infection Risk With EzriCare Eyedrops

U.S. health officials are investigating whether a specific brand of over-the-counter eyedrops are behind one death and dozens of bacterial infections in several states.

The infections have not been traced to preservative-free **EzriCare Artificial Tears**, but a majority of people who became ill reported using the drops, the U.S. Centers for Disease Control and Prevention said in a **statement**.

The agency found the bacteria in bottles of the eyedrops, and it's now testing to see if the strain found in the eyedrop bottles matches that found in patients.

CDC officials recommended that "patients immediately discontinue the use of EzriCare Artificial Tears until the epidemiological investigation and laboratory analyses are complete."

At least 50 people in 11 states have been infected with the bacterium *Pseudomonas aeruginosa*, which is resistant to most antibiotics. One of those infected died after the bacterium entered the patient's bloodstream.

"That's what's so concerning," **Dr. Jill Weatherhead**, an assistant professor of tropical medicine and infectious diseases at the Baylor College of Medicine in Houston, told *NBC News*. "Our standard treatments are no longer available" to treat this infection.

In 11 cases, people developed eye infections. Three were blinded in one eye. Some of those infected had respiratory or urinary tract infections.

P. aeruginosa infections typically happen in hospital settings in people with weakened immune systems, though the bacteria can be found in water and soil. People can also carry it on their hands.

The eyedrops may have been contaminated during manufacturing or as a person with bacteria on their hands opened them. The drops being investigated do not contain preservatives to inhibit the growth of germs, *NBC News* reported.

Health officials have not said whether those infected had an underlying eye condition that would have made them more vulnerable to infections.

Cases were reported in California, Colorado, Connecticut, Florida, New Jersey, New Mexico, New York, Nevada, Texas, Utah and Washington.

EzriCare Artificial Tears have not been recalled at this time. They were sold on Amazon and at stores such as Walmart, *NBC News* reported.

Eye infection symptoms include pain and swelling. A person may experience redness, discharge, blurry vision, light sensitivity and the feeling of having a foreign object in the eye.

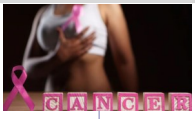
MRI Might Boost Cancer Detection for Women With Dense Breasts

Nearly half of women have dense breast tissue, which can be a double whammy on their odds for breast cancer.

Not only are dense breasts a risk factor for cancer, but this glandular and fibrous connective tissue make it harder to detect cancers on a mammogram, the usual method for breast cancer screening.

New research looked at other kinds of imaging to see which might be more effective for the 47% of women who have dense breasts with low levels of fatty tissue.

One emerged as an effective alternative: Breast MRI was superior to other methods, using that detection criteria.



Researchers also looked at hand-held breast ultrasound, automated breast ultrasound and digital breast tomosynthesis.

All showed about the same level of effectiveness, said study co-author **Dr. Vivianne Freitas,** an assistant professor at the University of Toronto and a staff radiologist at the Joint Department of Medical Imaging, also in Toronto.

"I would say supplementary image modalities in those with dense breasts and negative mammogram are recommended and should be performed," Freitas said. "This is my first message to [patients who have dense breasts]."

Even though the studies found MRI superior in terms of cancer detection, Freitas urged patients to discuss the pros and cons of each method with their health care providers.

Among the concerns about breast MRI is its availability and its price.

"The costs are actually the biggest barrier for our widespread implementation of MRI," Freitas said.

Screening mammograms are highly effective for women with fatty breasts, detecting about 98% of cancers. For those with dense breasts, they can give false reassurance, however.

Both dense tissue and breast cancer show up as white on the image, making it harder to detect cancer in dense breasts, Freitas said.

On average, women have a lifetime risk of 12% to 13% for developing breast cancer. A history of treated breast cancer or previous breast biopsies with high-risk lesions boosts that to an intermediate risk. ….**Read More**

Black Stroke Survivors Less Likely to Get Treated for Complications

Having a stroke is a life-altering experience, and complications can crop up afterwards, but a new study finds the color of your skin may determine whether you are treated for them.

In the year following a stroke, Black and Hispanic patients were not treated for common complications as often as white patients were, researchers found.

"Black patients were less likely to receive medical treatment for nearly every post-stroke complication, the largest differences were for the treatment of fatigue, depression and spasticity [muscle stiffness]," said lead researcher **Dr. Kent Simmonds**, from the University of Texas Southwestern Medical Center in Dallas.

"The large magnitude of treatment gaps ensures the pressing need for health care systems and providers to do a better job of actively recognizing post-stroke complications within minority populations and provide patients with explanations towards how and why medical treatment may help," Simmonds said.

These disparities exist because of a complex set of "bio-psycho-social-environmental factors," he added.

This type of study is best at identifying the what rather than the why, but the results are consistent with earlier studies that found quality stroke care is not a given, Simmonds said.

"Quality care requires cultural competence and trust between providers and their patients," he explained. "Many of the complications, such as fatigue and depression, require health care providers to dig a little deeper to identify these issues prior to offering and discussing appropriate medical treatments."

For the study, Simmonds and his colleagues analyzed the health records from 65 large U.S. health care centers of patients hospitalized for stroke between August 2002 and July 2022.

They found that Black patients were less likely to be treated for any complications except seizure, when compared with white patients. The biggest difference was in the treatment of central nervous system arousal, fatigue, muscle spasms and mood within two weeks of a stroke. ….**Read More**

What Is Coronary Heart Disease?

That seemingly sudden heart attack? It may have been triggered by underlying coronary heart disease.

Heart attack is a big event, but for some it might be the first sign of a problem that has been building for quite some time.

Coronary heart disease -- also known as coronary artery disease -- is the most common type of heart disease in the United States, according to the U.S. Centers for Disease Control and Prevention.

Doctors often use the terms coronary heart disease (CHD) and coronary artery disease (CAD) interchangeably, although CHD is really a result of CAD, according to the American Heart Association (AHA).

"Coronary artery disease is preventable," **Dr. Johnny Lee**, president of New York Heart Associates, said in a recent **story about the condition**. "Typical warning signs are chest pain, shortness of breath, palpitations and even fatigue."

What is coronary heart disease?

The condition happens when blood flow to the heart muscle is limited because of plaque growth caused by waxy cholesterol in the coronary artery walls, according to the AHA.

It affects the large arteries on the surface of the heart, according to the U.S. National Heart, Lung, and Blood Institute (NHLBI). That plaque may narrow the arteries over time.

Or a sudden rupture of plaque may lead to blood clot, according to the AHA. That narrowing process, called atherosclerosis, can block some or all blood flow.

It's so common that 18.2 million Americans have CHD, the leading cause of death in this country, the NHLBI noted.

The latest AHA statistics show that the prevalence of cardiovascular disease was 48.6% in adults 20 and older. CVD numbers include those with coronary heart disease, heart failure, stroke and hypertension

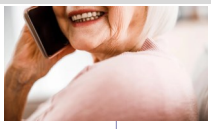
What causes coronary heart disease?

Although people may think of heart disease as an issue for seniors, it's never too early to start protecting against it.

The disease can begin in childhood, noted **Dr. Edward Fisher,** a professor of cardiovascular medicine at NYU School of Medicine in New York City.

"Preventive measures instituted early are thought to have greater lifetime benefits. Healthy lifestyles will delay the progression of CAD, and there is hope that CAD can be regressed before it causes CHD," Fisher said recently….**Read More**

How Phone Calls Could Boost Survival for Heart Failure Patients



A phone call from a nurse may be the lifeline needed to help improve survival for heart failure patients.

New research from the Smidt Heart Institute at Cedars-Sinai in Los Angeles finds that check-in calls may help save lives.

"There's a lot of new technology and new ideas about how to manage people who have heart failure remotely, but we demonstrated that low-tech and old-fashioned talking on the phone, essentially monitoring the response to, 'How are you feeling?' can improve outcomes," said corresponding study author **Dr. Ilan Kedan**, a professor of cardiology at the institute.

About one-third of people die within a year of being hospitalized for heart failure, a condition in which the heart does not pump enough blood to support the organs. About 15% to 20% of heart failure patients who were hospitalized return to the hospital within 30 days, according to past research.

To study the impact of phone calls on outcomes, the researchers included just over 1,300 patients aged 50 or older who were hospitalized for acute heart failure between October 2011 and September 2013 at six academic medical centers in California.

Half of the patients were randomized to receive a new post-hospitalization care plan.

In this new plan, patients were given a blood pressure monitor and a scale. The patients received pre-discharge heart failure education, along with an average of five calls over a 180-day period during which nurses asked about weight, blood pressure, heart rate and any unusual symptoms.

Patients who reported abnormal results or symptoms received more follow-up calls.

The other half of the study participants received usual care, including a nurse educating them about heart failure before being discharged and, for most patients, one call from the hospital after returning home.

The investigators also grouped patients based on the number of other health conditions they had ("comorbidities"), ranging from zero to nine or more.

Patients categorized in the grouping with the highest number of other conditions who were also in the intervention group were 25% less likely to die at 30 days and 180 days than patients in the control group. Those in this group also stayed out of the hospital a mean of 152 days versus a mean of 133 days for the patients who did not receive the intervention….**Read More**