

February 18, 2024 E-Newsletter



Message from Alliance for Retired Americans Leaders

Alliance Celebrates the Lunar New Year this Saturday



Robert Roach, Jr.
President, ARA

The Lunar New Year, an international holiday celebrated in many Asian countries, is this Saturday, February 10. It is sometimes

where economic and racial justice prevail and human rights and worker dignity are prioritized."

GOP Blueprint Shows Guaranteed Medicare Benefits are at Risk if Trump Returns to Office



Rich Fiesta,
Executive Director, ARA

On Monday **Rolling Stone**

magazine detailed GOP plans to move quickly to privatize Medicare if Donald Trump is elected in 2024. The Alliance issued a **press**

release to underscore the seriousness of this threat to earned benefits.

"After a lifetime of work, Americans have earned the right to guaranteed health care under Medicare," said **Richard Fiesta, Alliance Executive Director**, in the statement. "But those benefits are at risk if either Donald Trump or Nikki Haley is elected President this November."

He continued, "It's all in plain view. Rolling Stone magazine reported that the 887-page policy **blueprint** for a second Trump Administration written by well-connected Republican operatives calls for fully privatizing Medicare by making Medicare Advantage (MA) the 'default enrollment option for people who are newly eligible for Medicare.'"

Fiesta called the plan a scheme that would be a boon to the profits of private insurance corporations that are making billions in profits by reneging on their promises to provide seniors with more care for less money. He noted that MA plans are delaying and denying care and

that privatization would hurt the most vulnerable seniors: those with the least amount of money and the most need for health care. Fiesta then contrasted the GOP's Medicare plans with those of President Biden.

"Instead of privatizing Medicare, President Biden is strengthening it," Fiesta stated. "He is holding Medicare Advantage insurance companies accountable, requiring them to return improper payments and deliver the care patients need. He's also bringing down the cost of prescription drugs. Already, insulin under Medicare is capped at \$35 a month and even more lower prices are on the way through direct negotiation with the drug corporations." Fiesta concluded, "To truly look out for seniors' best interests, we must strengthen traditional Medicare — not end the promise of Medicare's guaranteed benefits in favor of giveaways to wealthy corporations."

The GOP blueprint can be read **here**.

GOP House Passes Bill that Threatens To Roll Back Medicare Drug Negotiation While Harming Public Health and Increasing Health Care Costs for Millions

In an effort to weaken the Inflation Reduction Act's (IRA) drug price negotiations and the Affordable Care Act, the U.S. House passed the Protecting Health Care for All Patients Act (**H.R.485**) by a margin of **211-208** Wednesday. Every Republican voted in support of the bill and every Democrat voted no.

The bill's supposed purpose is



Joseph Peters, Jr.
Secretary
Treasurer ARA

to ban any value measures like "Quality Adjusted Life Years" (QALYS) which are used by the government to determine the dollar

value of a particular treatment. In reality, this is unnecessary since the IRA already prohibits the use of QALYS in Medicare coverage determinations.

However, because the language in the bill is purposefully vague, analysts say that it would make it easier for prescription drug corporations to sue over the Medicare drug price negotiation law. In addition, the Congressional Budget Office said the measure would actually **add hundreds of millions of dollars** in costs for federal programs.

H.R.485 would also cut funds from the Prevention and Public Health Fund, established by the Affordable Care Act to provide retirees affordable access to preventive healthcare services, leading to even more artificially high drug and healthcare costs.

"This legislation is not about protecting health care for patients," said Rep. Frank Pallone, Jr., Energy and Commerce Committee Ranking Member (D-NJ). "Instead, it is a trojan horse intended to undermine the progress President Biden and Democrats have made in lowering prescription drug costs for American families."

"The Senate should not pass this harmful legislation," added **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "It is a gift to the drug corporations to protect their profits."



called the Chinese New Year, because it follows a calendar that was developed in China, but it is also celebrated in other parts of Asia, including Korea and Vietnam.

The Lunar New Year is celebrated on different dates from late January to mid-February depending on the year, and celebrations often last for a week. This new year, which begins on the 10th, is the Year of the Dragon. In the Lunar New Year tradition, the dragon is **symbolic** of many favorable traits, including strength, wisdom, success, and good fortune.

"During the Lunar New Year it is customary to travel and visit immediate family, other relatives and friends, especially older relatives," said **Robert Roach, Jr., President of the Alliance**. "It is also an opportunity to recognize the Asian Pacific American community and the work of the Asian Pacific American Labor Alliance (APALA), which shares the Alliance's vision of a society

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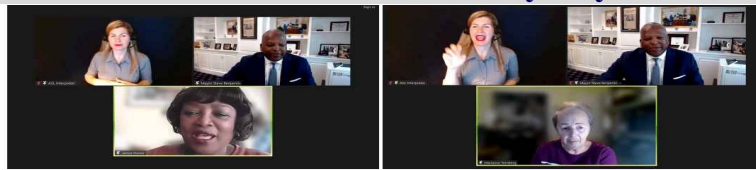
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Alliance Members Share How Much Less They Pay for Their Prescriptions

Alliance Members Share How Much Less They Pay for Their Prescriptions

On Tuesday officials from the **Biden-Harris** administration hosted a national webinar to highlight the difference the **Inflation Reduction Act (IRA)** has made in reducing health care costs, including lowering drug prices. Alliance members **Janice Poirier** and **Marianne Yernberg** shared their stories about how they have each benefited from the IRA.

"My 2022 out-of-pocket prescription drug costs were \$7,069, and my 2023 costs were \$7,629, so I will benefit greatly



Left photo (Clockwise from top left): American Sign Language Interpreter and Steve Benjamin with Janice Poirier on Zoom Tuesday; Right photo (Clockwise from top left): American Sign Language Interpreter and Steve Benjamin with Marianne Yernberg

from this year and next year's Inflation Reduction Act out-of-pocket caps," said Ms. Yernberg, a Minnesota Alliance member. "In 2024 Medicare Part D beneficiaries across the country will pay no more than \$3,200 out of pocket annually for drugs and in 2025, they will pay no more than \$2,000. It is such a change to look forward to things

improving rather than dreading that they will get worse."

"I had been paying \$120 to \$160 for 3 vials of insulin, and now pay only \$35," said Ms. Poirier, a Florida Alliance member and President of the Florida Education Association Retired. "Before the insulin cap took effect, I had gotten to the point where I was only taking

half of my recommended dosage in order to save money."

Administration speakers included Director of the White House Office of Public Engagement **Steve Benjamin**; Director of the White House Domestic Policy Council **Neera Tanden**; Secretary of Health & Human Services **Xavier Becerra**; Administrator for the Centers for Medicare & Medicaid Services **Chiquita Brooks-LaSure**; and Deputy Administrator and Center for Medicare Director **Dr. Meena Seshamani**.

Social Security Has an Income Inequality Problem, and It Can't Be Swept Under the Rug Any Longer

The rich are getting richer -- and that's not good news for a retirement program that's facing a greater than \$22 trillion long-term funding shortfall.

For most retired Americans, their monthly **Social Security check** is an indispensable source of income. Based on annually conducted surveys over the course of more than two decades, no fewer than 80% of then-current retirees rely on their monthly benefit to help cover their expenses.

Given how important America's top retirement program is to the financial health of our nation's retired workers, workers with disabilities, and survivor

beneficiaries, you'd think that ensuring the sustainability of the current payout schedule would be paramount.

However, Social Security's foundation has been showing signs of cracking for decades.

America's top retirement program has more than \$22 trillion in long-term unfunded obligations

For more than eight decades, the Social Security Board of Trustees has released an annual report that takes an under-the-hood look at the program's finances, as well as examines its short-term (10-year) and long-term (75-year) outlook. These



outlooks factor in ongoing demographic changes, as well as shifts in fiscal and monetary policy, to

determine how sustainable the existing payout schedule is for current and future beneficiaries.

Every year since 1985, the Trustees Report has cautioned that Social Security would be facing some degree of long-term unfunded obligation. In simpler terms, forecast revenue collection in the 75 years following the release of a Trustees Report was not expected to cover projected outlays. As of 2023, the trustees estimate Social Security is contending with a \$22.4 trillion

funding shortfall through 2097.

To provide clarity, this **doesn't mean Social Security is facing bankruptcy or insolvency**.

Rather, it means the current payout schedule, including annual cost-of-living adjustments (COLAs), can't be sustained, based on current projections. If the asset reserves of the Old-Age and Survivors Insurance (OASI) Trust Fund are exhausted by 2033, as the 2023 Trustees Report portends, retired workers and survivor beneficiaries could see their benefits reduced by up to 23%....**Read More**

Medicare Drug Negotiations Officially Underway

On February 1, the U.S. Department of Health and Human Services (HHS) sent **initial offers** to manufacturers of the first 10 Part D drugs **subject to price negotiation** under the **Inflation Reduction Act (IRA)**, a significant implementation milestone.

As **announced in August**, HHS selected these medications based on criteria outlined in the IRA, such as high Medicare spending and lack of competition. The **resulting list includes** drugs that millions of Medicare beneficiaries rely on to treat conditions such as cancer, diabetes, blood clots, heart failure, autoimmune conditions, and chronic kidney disease.

HHS estimates that in 2022,

Medicare paid \$46.4 billion for the 10 selected drugs, up from \$20 billion in 2018, and that Part D enrollees paid \$3.4 billion out of pocket. While the exact savings realized by the IRA's negotiation program will depend on the final prices, lower costs are expected system wide. The Congressional Budget Office (CBO) anticipates negotiation will save Medicare **\$98.5 billion** over the coming decade as **well** as reduce expenses for beneficiaries and taxpayers. By lowering drug prices and increasing affordability, CBO projects the changes will help people with Medicare adhere to their treatment plans, improving health outcomes and reducing the



need for more costly interventions.

The negotiations will continue over the next several months. HHS plans to publish the final prices this fall, and they will take effect in 2026. **Additional medications** will be selected for negotiation in future years, allowing the number of drugs with negotiated prices to accumulate over time.

Importantly, other IRA policies that are or will soon be in effect further bolster beneficiary health care access and affordability. Several key revisions took effect in 2023, such as the \$35 limit per monthly insulin prescription, the availability of no-cost **Part D vaccines**, and **reduced**

coinsurance on certain Part B drugs. This year, even more people with Medicare will see relief. In January, the IRA's Part D structural changes began to take shape—the law eliminated enrollee expenses in the Part D catastrophic coverage phase, essentially holding out-of-pocket costs to **roughly \$3,250 in 2024**. It also **expanded the full Part D Low Income Subsidy (LIS)**, also known as **Extra Help**, to people with incomes at or below 150% of poverty. And in 2025, the law will cap Part D drug costs at \$2,000 (indexed annually for inflation) and allow enrollees to pay those expenses in monthly installments, promoting financial security and peace of mind....**Read More**

Medicare Advantage May Face Big Plan Cuts, Price Hikes in 2025

The Medicare Advantage program could go through huge upheaval in 2025, with the changes showing up in annual enrollment period plan menus Oct. 15, as voters are heading to the polls for the fall general elections.

Executives from Humana, a major Medicare Advantage plan and Medicare drug plan provider, said Thursday during a conference call with securities analysts that it believes that some competitors' pricing has been unsustainably aggressive, new regulations are driving up costs, and that health care claim costs have been much higher than it had expected, even after adjusting for the new flu and COVID-19.

Humana will be "very

intentional" about which markets it will serve in 2025, Humana CEO Bruce Broussard said.

"Looking to 2025, we are evaluating MA pricing actions," Broussard said. "I look at next year as a year when I think the whole industry will possibly reprice."

What it means: Clients who have Medicare Advantage plan coverage may have to change plans in 2025 or face significantly higher premiums.

Many health coverage advisors and their clients strongly prefer combining original Medicare with Medicare supplement, or Medigap, insurance, and it's possible that problems in the Medicare Advantage market could lead to new insurer interest



in the Medigap policy market.

Humana's earnings: Humana talked about the

Medicare Advantage plan market when going over results for the fourth quarter of 2023.

The company is reporting a \$540 million net loss for the quarter on \$26 billion in revenue, compared with an \$18 million net loss on \$22 billion in revenue for the fourth quarter of 2022.

The company ended the year providing or administering medical coverage for 17 million people, or about 1.3% fewer people than it was covering a year earlier.

Some of the net loss was due to \$764 million in costs related to a decision to get out of the

employer health coverage market.

Susan Diamond, Humana's chief financial officer, said that Humana understood going into the fourth quarter that the new wave of COVID cases and other outbreaks of other respiratory diseases could drive up costs, and that the company had factored that into forecasts.

The effects of respiratory disease care turned out to be somewhat less than the company had feared.

Factors that Humana is analyzing include the effects of new Medicare Advantage plan benefits rules, a big influx of enrollees who have "aged into" Medicare, and the relatively high cost of covering age-ins.... [Read More](#)

Do We Simply Not Care About Old People?



The covid-19 pandemic would be a wake-up call for America, advocates for the elderly predicted: incontrovertible proof that the nation wasn't doing enough to care for vulnerable older adults.

The death toll was shocking, as were reports of chaos in nursing homes and seniors suffering from isolation, depression, untreated illness, and neglect. Around 900,000 older adults have died of covid-19 to date, accounting for 3 of every 4 Americans who have perished in the pandemic.

But decisive actions that advocates had hoped for haven't materialized. Today, most people — and government officials —

appear to accept covid as a part of ordinary life. Many seniors at high risk aren't getting antiviral therapies for covid, and most older adults in nursing homes aren't getting updated vaccines. Efforts to strengthen care quality in nursing homes and assisted living centers have stalled amid debate over costs and the availability of staff. And only a small percentage of people are masking or taking other precautions in public despite a new wave of covid, flu, and respiratory syncytial virus infections hospitalizing and killing seniors.

In the last week of 2023 and the first two weeks of 2024



alone, 4,810 people 65 and older lost their lives to covid — a group that would fill more than 10 large airliners — according to data provided by the CDC. But the alarm that would attend plane crashes is notably absent. (During the same period, the flu killed an additional 1,201 seniors, and RSV killed 126.)

"It boggles my mind that there isn't more outrage," said Alice Bonner, 66, senior adviser for aging at the Institute for Healthcare Improvement. "I'm at the point where I want to say, 'What the heck? Why aren't people responding and doing more for older adults?'"

It's a good question. Do we simply not care?

I put this big-picture question, which rarely gets asked amid debates over budgets and policies, to health care professionals, researchers, and policymakers who are older themselves and have spent many years working in the aging field. Here are some of their responses.

The pandemic made things worse. Prejudice against older adults is nothing new, but "it feels more intense, more hostile" now than previously, said Karl Pillemer, 69, a professor of psychology and gerontology at Cornell University.... [Read More](#)

'Hell no': Trump allies' plan to privatize Medicare draws alarm and outrage

A right-wing coalition that's been laying the policy groundwork for another Trump presidency has developed a plan to further privatize Medicare by making **fraud-riddled Medicare Advantage** "the default enrollment option" for newly eligible beneficiaries. The plan, **highlighted** Monday by *Rolling Stone's* Andrew Perez, is outlined about halfway through Project 2025's **920-page** **playbook** for the first six months of a conservative presidency.

Republican administrations and

right-wing groups have long advocated funneling people who are newly eligible for Medicare into Medicare Advantage plans, which are funded by the federal government and run by for-profit insurers. During his first White House term, former President Donald Trump **took steps to actively encourage** seniors to choose Medicare Advantage plans over traditional Medicare and expanded the benefits that the privately run plans are allowed to



offer. Those efforts have had an impact. As Perez noted, "Last year, for the first time ever, a majority of Americans eligible for Medicare were on privatized Medicare Advantage plans."

"If Republicans win the presidential race this year," he wrote, "the push to fully privatize Medicare, the government health insurance program for seniors and people with disabilities, will only intensify."

Every year, new and existing Medicare recipients **have an**

opportunity to enroll in Medicare Advantage plans, which engage in aggressive and often **highly deceptive** advertising practices to lure seniors who are often seeking out benefits not currently offered by traditional Medicare, such as vision and dental care.

"Donald Trump and his MAGA Republican cronies plan to totally privatize Medicare if they win in November's election."... [Read More](#)

New to Medicare? 3 Things to Know About Medigap Plans.

Confused about Medigap? Read on for some important details.

If you're new to Medicare, learning the ins and outs of the program can be confusing -- and downright exhausting even. But there's another program you may want to familiarize yourself with if you're new to Medicare -- Medigap.

Medigap plans are plans sold by private insurers that serve as supplemental insurance for those enrolled in **Medicare**. During your initial Medigap enrollment window, which is six-months starting the first month you have Medicare Part B and you're 65 or older, you cannot be denied Medigap coverage due to pre-existing conditions.

Buying a Medigap plan could be a smart thing to do as a Medicare enrollee. Here are some things you should know about Medigap plans.

1. They won't cover services

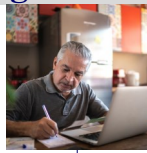
Medicare won't

When you receive care through Medicare, Parts A and B don't pick up the entire tab. This year, there's a \$1,632 deductible under Part A if you're admitted for a hospital visit. And with Part B, not only is there an annual deductible of \$240, but usually, Part B only pays 80% of your charges, leaving you to cover the remaining 20%.

The upside of having a Medigap plan is that your policy might pick up the tab for those deductible and coinsurance costs, thereby easing the financial burden on you. That said, Medigap plans won't pay for services Medicare itself doesn't cover.

Original Medicare does not pay for routine dental care or eye exams, for example. If you sign up for Medigap, don't expect that plan to pay for them, either.

2. Costs can vary for the same



plan

There are 10 different Medigap plan choices offered in most states, named by letters A, B, C, D, F, G, K, L, M, and N.

Coverage under each respective Medigap plan is standardized -- meaning, if you sign up for Plan A, you get the same benefits as someone else with Plan A.

That said, pricing for Medigap plans isn't standardized. This means that you might pay more for Plan A than another enrollee depending on factors that include where you live, your age, and your health.

3. Medigap only works with original Medicare

Some Medicare enrollees decide that they'd rather sign up for Medicare Advantage as an alternative to original Medicare (Parts A and B plus a Part D drug plan). Enrollees in Medicare Advantage can incur a number of out-of-pocket costs. However,

Medigap plans are not compatible with Medicare Advantage. You can only sign up for Medigap coverage if you're enrolled in original Medicare.

Now you may decide to sign up for Medicare Advantage as a new enrollee. If that doesn't work out, you'll generally have the option to switch to original Medicare at some point. But in that scenario, you might struggle to get supplemental insurance if you're beyond your initial Medigap enrollment window.

There's lots to know

All told, navigating the world of Medigap can be a time-consuming process, especially since there are so many different plans to choose from. Take the time to explore your options. And if you decide to buy a Medigap plan, shop around so you can hopefully snag the best possible rate.

Inflation Rate Starts Year Higher than COLA, But Big Drop Ahead

Millions of Social Security beneficiaries are facing an inflation rollercoaster this year. At the same time, they may be learning that they owe taxes on their Social Security benefits. December inflation for the CPI-W, the same price index used to calculate the COLA, indicates that inflation was 3.3%, slightly higher than the 3.2% Social Security cost-of-living adjustment (COLA). **"The far bigger story is the long-term inflation model, which suggests**

the COLA for next year could drop to 1.4% — the lowest level since 2020," says Mary

Johnson, Social Security and Medicare policy analyst for The Senior Citizens League (TSCL). "That's not necessarily good news if prices for housing, hospital care, auto insurance, and other costs remain at today's elevated levels," Johnson says.

Social Security recipients will need to run the numbers this tax season to determine if their Social



Security benefits are taxable — perhaps for the first time. The number of Social Security recipients reporting that they paid federal income tax on their Social Security benefits **for the first time** is climbing, according to the latest survey by The Senior Citizens League (TSCL). During the 2023 tax season, 23 percent of survey participants who received Social Security for three years or more said they paid tax for the first time. The question asked:

"If you received Social Security for more than three years, did you pay federal income tax on a portion of your Social Security benefits for the first time this tax season (April 2023)?"

◆ **Yes 23%**

◆ **No 49%**

◆ **Not applicable, have not received Social Security for more than three years 14%**

◆ **Uncertain 14%**

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Social Security: 2 Ways Washington Wants to Change Cost-of-Living Adjustments (COLAs)

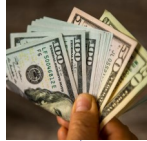
Many retired Americans have struggled with rising prices in recent years. A survey by the Employee Benefit Research Institute found that 58% of retired workers worry they will have to make substantial spending cuts due to inflation.

Naturally, rising prices have drawn attention to Social Security benefits, often the largest source of income in retirement. Specifically, while Social Security payments get an annual cost-of-living adjustment (COLA) to offset inflation, those adjustments are calculated using the Consumer Price Index for Urban Wage Earners and Clerical

Workers (CPI-W).

Some experts see that as a problem. The CPI-W measures price changes from the perspective of workers, but active workers tend to spend money differently than retired workers and other Social Security recipients.

As a result, experts argue that CPI-W COLAs underestimate rising prices for seniors, such that Social Security benefits are not increasing fast enough to keep pace with inflation. Some Washington lawmakers have proposed solutions to address that problem. Read on to see how two proposals could affect benefits.



1. Calculate Social Security COLAs using the CPI-E

The Consumer Price Index for the Elderly (CPI-E) measures price changes from the perspective of individuals 62 or older. The Social Security Administration (SSA) estimates that replacing the CPI-W with the CPI-E would increase **COLAs** by an average of 0.2 percentage points per year. Several bills proposing that change have been introduced in Congress, including the recent legislation listed below. **Social Security Expansion Act:** Introduced by Sen. Bernie Sanders (I-Vt.) in February 2023.

Protecting and Preserving Social Security Act:

Introduced by Sen. Mazie Hirono (D-Hawaii) and Rep. Ted Deutch (D-Fla.) in June 2022.

Experts argue the CPI-E is a better measure of inflation for the Social Security program because more than 85% of beneficiaries are 62 or older, and the CPI-E emphasizes spending categories most relevant to seniors. Specifically, it puts more emphasis on housing and medical care, and less emphasis on transportation, tuition, and food and beverages....**Read More**

How to make long-term care insurance more affordable

As you age, there's a high likelihood that you'll have increasing medical needs. That's why **insurance costs tend to rise with age**. And, that's also why it's important to **plan for increasing healthcare costs** as you prepare for retirement.

Nearly 70% of people ages 65 and older will need some form of long-term care service at some point in their lives, and that care can be costly. According to the **Genworth Cost of Care survey**, the average annual cost of long-term care ranges from \$22,161 to \$118,457 in 2024, depending on the **type of care** you need. Those costs are also expected to increase in the years ahead.

One way to plan for them is with a long-term care insurance policy but that type of coverage also comes at an additional cost. So is there any way to make long-

term care insurance more affordable?

How to make long-term care insurance more affordable

Depending on your age and overall health, **long-term care insurance can cost** anywhere from several hundred to a few thousand dollars per year. So can you **cut that cost**?

"There are several ways to reduce the costs for consumers looking for long-term coverage," says Larry Nisenson, chief growth officer at Assured Allies, a firm focused on helping consumers age successfully.

Here are a few options to make this type of coverage more affordable:

Don't purchase too much coverage

One of the biggest factors to play a role in your long-term care insurance premiums is the amount of coverage you purchase. That's



why, if your goal is to make long-term care insurance more affordable, "the first step is to determine how much coverage is needed based on geography, financial means and level of family support," Nisenson says. Here are a few factors that can play a role in **your coverage needs**:

◆ **Geography:** Long-term care support and services may be more or less expensive depending on where you live. For example, services in New York City are likely to be more expensive than services in certain areas of Florida. As you determine your coverage needs, consider the average cost of care in the area where you plan on spending your retirement.

◆ **Your financial means:** You may not need long-term care insurance to cover the full cost

of your long-term care. After all, there's a high likelihood that you have Social Security income and retirement savings at your disposal. In certain situations, it makes sense to consider long-term care insurance as a supplement to your retirement income rather than your sole source of payment for your care.

◆ **Family support:** Your family may be willing to provide some of the support you need. Though, even if your family provides most of your support, you may need to cover the cost of other services from time to time. Still, **familial support** can greatly reduce your need for formal care providers, reducing your coverage needs and the cost of your premiums in the process...**Read More**

Many Social Security Recipients Are Now Getting Hit by an Unwanted Side Effect From Last Year's Big Benefit Increase

Uncle Sam will want some money from many Social Security beneficiaries for the first time in 2024.

Every October, millions of Americans anxiously wait to find out how much their Social Security benefits will be in the next year. They usually (although not always) receive a raise that helps offset the higher costs they incur.

In 2023, Social Security recipients received an especially hefty **cost-of-living adjustment (COLA)** of 8.7%. This adjustment translated to hundreds of dollars in additional benefits paid last year. However, that wasn't the end of the story. Many

Social Security recipients are now getting hit by an unwanted side effect from last year's big benefit increase.

A COLA hangover

There aren't many negatives associated with making more money. But there's at least one downside: paying more taxes. This can especially be troubling for individuals who make estimated tax payments during the year and don't factor in the impact of their increased income.

Some Social Security recipients are finding themselves in this category in 2024. The 8.7% COLA received in 2023 will boost all beneficiaries' income.



And it will bump some individuals into a bracket where they will have to pay taxes on their Social Security benefits for the first time.

This isn't a new trend. A recent survey conducted by The Senior Citizens League (TSCL) found that 23% of respondents who had collected Social Security benefits for at least three years paid taxes on their benefits for the first time in 2023.

TSCL Social Security and Medicare policy analyst Mary Johnson noted, though, that it could be an even bigger issue this year. Johnson said, "We expect the higher Social Security income

will not only cause more Social Security recipients to pay taxes on their benefits this tax season, but taxes are taking a bigger portion of Social Security checks in 2024."

Will you be affected?

Around 40% of Social Security recipients have to pay federal income taxes on their benefits, according to the Social Security Administration (SSA). Will you be one of them for the 2023 tax year? The following table summarizes who has to pay federal income taxes on their Social Security benefits. ...**Read More**

KFF Health News: Halfway Through 'Unwinding,' Medicaid Enrollment Is Down About 10 Million

By Phil Galewitz

Halfway through what will be the biggest purge of Medicaid beneficiaries in a one-year span, enrollment in the government-run health insurance program is on track to return to roughly pre-pandemic levels..0

Medicaid, which covers low-income and disabled people, and the related Children's Health Insurance Program grew to a record 94 million enrollees as a result of a rule that prohibited states from terminating coverage

during the nation's public health emergency.0.

But since last April, states have removed **more than 16 million people** from the programs in a process known as the "unwinding," according to KFF estimates compiled from state-level data. While many beneficiaries no longer qualify because their incomes rose, millions of people have been dropped from the rolls for procedural reasons like failing to respond to notices or return



paperwork. But at the same time, millions have been reenrolled or signed up for the first time.

The net result: Enrollment has fallen by about 9.5 million people from the record high reached last April, according to KFF. That puts Medicaid and CHIP enrollment on track to look, by the end of the unwinding later this year, a lot like it did at the start of the coronavirus pandemic: about 71 million people.

"What we are seeing is not

dissimilar to what we saw before the pandemic — it is just happening on a bigger scale and more quickly," said Larry Levitt, executive vice president for health policy at KFF

Enrollment churn has long been a feature of Medicaid. Before the pandemic, about 1 million to 1.5 million people nationwide fell off the Medicaid rolls each month — including many who still qualified but failed to renew their coverage, Levitt said. Click **here** to read more.

Drug prices continue to be around three times higher in the US than other wealthy nations

The Assistant Secretary for Planning and Evaluation or ASPE, a government research agency, released a [report](#) showing that US drug prices—brand name and generic—are almost 2.78 times the price in 33 other wealthy countries. Even for people with Medicare Part D prescription drug benefits, drug costs can be high. That will only change when the US negotiates prices for all drugs as every other wealthy nation does for its residents.

ASPE hired RAND Health Care to conduct the analysis. When RAND compared brand-name drug prices in the US to

prices in OECD countries, it found that they were more than 3.20 higher even after adjusting for rebates. It also found that the preponderance of new drugs were first available in the US.

The US is also responsible for a disproportionate and ever larger share of total spending on new drugs as compared with other wealthy nations. The Inflation Reduction Act gave Medicare the ability to negotiate the price of several dozen drugs, beginning with 10 drugs in 2025.

Still, the price of drugs is rising faster in the US than in other wealthy countries. If you do not



factor in rebates, which insurers usually pocket, we pay more than four times the price of people in other wealthy countries for our drugs.

We pay about two-thirds less for generic drugs than people in other wealthy countries. And, these drugs represent 90 percent of US spending on prescription drugs. These drugs only represent about 41 percent of spending on prescription drugs in other countries.

Some drugs are particularly expensive in the US. For example, insulin prices are almost ten times higher in the US than in other wealthy countries.

We pay more than 10 times what people in France and the UK pay for insulin. We pay six times more than Canadians for insulin. Rebates for people with insurance and people who have met their deductible bring the price of insulin down to 2.33 times what people pay in other wealthy countries.

While most new drugs launch first in the US, a large number of them launch in other wealthy nations soon after. The researchers found that the drugs that are most beneficial are available in all wealthy countries within a short time.

Millions of People with Medicare Will Benefit from the New Out-of-Pocket Drug Spending Cap Over Time

[Juliette Cubanski](#), [Tricia Neuman](#), and Anthony Damico

In most states, tens of thousands, if not hundreds of thousands, of Medicare beneficiaries will feel relief from the new Part D out-of-pocket spending cap (Table 1). In California, Florida, and Texas, more than 100,000 Part D enrollees faced out-of-pocket costs of \$2,000 or more in 2021, and in another 6 states (New York, Pennsylvania, Ohio, Illinois, North Carolina, and New Jersey), between 50,000 and 82,000 did so. As at the national level, more Part D enrollees in each state will benefit over time.

For example, in Iowa, Louisiana, and Maryland, 73,000 Part D enrollees faced out-of-pocket costs of \$2,000 or more in at least one year between 2012 and 2021. In Michigan, New Jersey, and Georgia, 148,000, 158,000, and 159,000 Part D enrollees, respectively, spent \$2,000 or more in at least one year over this same 10-year period. In Texas, 364,000 Part D enrollees did so; in Florida and California, around 400,000 enrollees or more.

Capping out-of-pocket spending will help Part D enrollees with relatively high



drug costs, which may include only a relatively small number of Part D enrollees in any given year but, as this analysis shows, a larger number over time.

People who will be helped include those who have persistently high drug costs over multiple years and others who have high costs in one year but not over time. While a cap on out-of-pocket costs will help millions of Part D enrollees over time, higher plan costs to provide the Part D benefit could also mean higher plan premiums, a dynamic that the Inflation Reduction Act's [premium](#)

[stabilization](#) provision was designed to mitigate.

Although [KFF polling](#) shows that a relatively small share of older adults is aware of the Inflation Reduction Act's \$2,000 cap on out-of-pocket drug costs for Part D enrollees that takes effect in 2025, millions of them will benefit from this cap in the years to come.

This work was supported in part by Arnold Ventures. KFF maintains full editorial control over all of its policy analysis, polling, and journalism activities....[Click here to view charts](#)

In Fight Over Medicare Payments, the Hospital Lobby Shows Its Strength

In the battle to control health care costs, hospitals are deploying their political power to protect their bottom lines.

The point of contention: For decades, Medicare has paid hospitals — including hospital-owned physician practices that may not be physically located in a hospital building — about double the rates it pays other doctors and facilities for the same services, such as mammograms, colonoscopies, and blood tests.

The rationale has been that hospitals have higher fixed costs, such as 24/7 emergency rooms and uncompensated care for uninsured people.

Insurers, doctors, and [consumer advocates](#) have long complained it's an unequal

and unfair arrangement that results in higher costs for patients and taxpayers. It's also a profit incentive for hospitals to buy up physician practices, which health economists say can lead to hospital consolidation and higher prices.

In December, the [House passed a bill](#) that included a provision requiring Medicare to pay the same rates for [medical infusions](#), like chemotherapy and many treatments for autoimmune conditions, regardless of whether they're done in a doctor's office or clinic owned by a hospital or by a different entity. The policy, known as site-neutral payment, has sparked a ferocious lobbying battle in the Senate, not the first



of its kind, with hospitals determined to kill such legislation.

Don't bet against them. The House legislation would save Medicare an estimated [\\$3.7 billion](#) over a decade, according to the Congressional Budget Office. To put this in perspective, the program is projected to pay hospitals upward of \$2 trillion during that same period. But hospitals have long argued that any adoption of site-neutral payments would force them to cut jobs or services, or close facilities altogether — particularly in rural areas. And senators are listening. "The Senate is very much attuned to rural concerns," [Sen. Ron Wyden \(D-Ore.\)](#), who chairs the Finance Committee, told KFF

Health News. His panel has jurisdiction over Medicare, the health program for seniors and people with disabilities.

"I have heard lots of questions about how these proposals would affect rural communities and rural facilities," he said. "So we're taking a look at it."

Outpatient departments at rural hospitals can have outsize importance to their communities. Taking any funding away from stand-alone rural hospitals is seen as risky. [Scores have closed](#) in the past decade due to financial problems. With fewer patients, rural hospitals often struggle to attract doctors and update technology amid rising costs....[Read More](#)

Weight-loss drugs are a hot commodity and hard to get

Weight loss drugs are a hot commodity. They can be hard to come by. Getting them can try your patience and your pocketbook. Reed Abelson and Rebecca Robbins offer six reasons why it is so hard for people to get these drugs in the [New York Times](#).

1. A lot of people want these drugs. Already nearly four million people are taking these drugs. Between TikTok and advertisements, more and more people are looking for weight-loss drugs.

2. Production of these drugs is slow. Few factories can manufacture these weight-loss drugs. And, they come in five or more strengths. Eli Lilly also needs to make enough of its pens

used to inject Zepbound.

3. Insurance often won't cover these drugs, making them unaffordable. Medicare will only cover these drugs for people with diabetes. It does not cover weight-loss drugs for obesity. However, Medicare covers nutrition and weight-loss counseling.

Medicaid does not either. The insurers consider them "lifestyle" drugs, rather than medically necessary drugs. As a result about 40 percent of employers also do not offer this coverage to their workers.

These are injectable drugs that can cost as much as \$16,000 a year. With discounts or coupons from Eli Lilly, people can get



Zepbound, one weight-loss drug for \$550 a month if they have insurance. They can get a coupon from Novo Nordisk for Wegovy and pay \$1,000 a month instead of \$1,500 a month.

4. People can't find these drugs at their pharmacies. While these drugs are often not in stock at pharmacies, they will order them when requested. The drugs cost too much money, literally tens of thousands of dollars for a pharmacy to stock.

5. Pharmacies sometimes claim that these drugs provide them no profit. In fact, some say that they lose money on weight-loss drugs because the insurers do

not reimburse them adequately for them. The insurers' pharmacy benefit managers or PBMs reimburse them below cost in some cases. This seems like a way for the insurers to avoid covering weight-loss drugs.

6. Most insurers create hurdles in order to cover weight-loss drugs. People need their doctors to verify they qualify for coverage. In some cases, before the insurer will cover these drugs, enrollees must take a six month nutrition and exercise program. Some insurers require people to try other less expensive drugs, before they will cover these drugs.

New Prosthetic Hand Can Sense Objects' Temperature

Fabrizio wasn't sure what to expect of his newly outfitted prosthetic hand, until he touched one of the researchers who'd given it to him.

"When one of the researchers placed the sensor on his own body, I could feel the warmth of another person with my phantom hand," said Fabrizio, a 57-year-old man from Pistoia, Italy. "It was a very strong emotion for me, it was like reactivating a connection with someone."

Fabrizio -- who lost his hand 37 years ago -- experienced that

sensation thanks to cutting-edge sensors installed in the prosthetic hand, according to a report published Feb. 9 in the journal *Med*.

Those sensors provide realistic and real-time thermal feedback to the wearer.

With the hand, Fabrizio was able to discriminate between and manually sort objects of different temperatures. Researchers did not provide Fabrizio's last name.

This is the first time that natural temperature sensation has



been incorporated into a functional artificial limb, the researchers said.

"Temperature is one of the last frontiers to restoring sensation to robotic hands. For the first time, we're really close to restoring the full palette of sensations to amputees," said co-senior study author Silvestro Micera, a professor of biorobotics research at the Sant'Anna School of Advanced Studies in Pisa, Italy.

The "MiniTouch" device uses off-the-shelf electronics and

doesn't require any surgery to restore temperature sensation to patients, the researchers noted.

"This is a very simple idea that can be easily integrated into commercial prostheses," Micera said in a university news release.

For the study, researchers linked the device to a point on Fabrizio's remaining forearm that caused him to experience thermal sensations from a phantom index finger....[Read More](#)

CPR's Lifesaving Powers Decline as Minutes Pass

CPR can save lives, but its ability to restore heart function goes from slim to none in a shockingly short time, a new study finds.

How short? A person's chance of surviving cardiac arrest while receiving CPR declines from 22% after one minute of chest compressions to less than 1% after 39 minutes of compressions, researchers report Feb. 7 in the *BMJ*.

Meanwhile, the chance of escaping major brain damage from cardiac arrest declines from 15% after one minute of CPR to less than 1% after 32 minutes with no re-established heartbeat.

These results could help guide

the grim decision of when to stop applying CPR to a patient whose heart is not responding.

"The findings provide resuscitation teams, patients and their surrogates with insights into the likelihood of favorable outcomes if patients pending the first return of spontaneous circulation continue to receive further cardiopulmonary resuscitation," concluded the study led by Dr. Masashi Okubo, a clinical assistant professor of emergency medicine at the University of Pittsburgh.

About 300,000 cardiac arrests happen in a hospital every year, researchers noted, and about 25%



of those patients survive to hospital discharge.

In the study, Okubo's team measured CPR duration for nearly 350,000 U.S. adults who had an in-hospital cardiac arrest between 2000 and 2021, using the largest dataset of such cases available in the world.

They found that two-thirds of patients (67%) responded to CPR within an average of seven minutes, while 33% failed to re-establish a heartbeat after an average 20 minutes of CPR.

Overall, about 23% of cardiac arrest patients survived to hospital discharge in this study.

"Most termination of resuscitation occurred before the

time point of traditional medical futility," or the point at which survival odds are less than 1%, the researchers noted in a journal news release.

"Further research is needed to evaluate whether patients' outcomes would improve with prolonged cardiopulmonary resuscitation before termination of resuscitation," the team continued.

They proposed a future clinical trial in which one group of patients receives CPR for as long as their doctors deem necessary, while a second group receives CPR for a predetermined -- and likely longer -- amount of time.

Adding Blood Thinners to Clot-Busting Meds Won't Improve Stroke Outcomes: Study

Adding blood thinners to clot-busting drugs does not improve outcomes for stroke patients, a new study claims.

Doctors had hoped that combining the two types of medications would improve treatment of stroke, as a similar combination has shown promise in treating heart attacks, the researchers said.

But they halted a clinical trial looking into the combo for stroke treatment after finding no apparent benefit for the first 500 participants out of the planned 1,200-patient study.

The findings were presented Wednesday at the American Stroke Association's annual meeting in Phoenix.

"When we began the trial, we believed the medications would improve outcomes, so we were surprised with the negative results," said lead researcher **Dr. Opeolu Adeoye**, chair of emergency medicine at Washington University's School of Medicine in St. Louis.

The clinical trial involved 57 different stroke centers throughout the United States.



All patients received a standard clot-busting drug within three hours of their stroke. They then were randomized to receive one of two blood thinners or a placebo drip of saline.

Clot-busting drugs activate an enzyme that breaks up a blood clot, while blood thinners inhibit the action of clotting factors in the blood.

"We designed the trial to allow us to efficiently answer the question for two blood-thinning medications in one trial," Adeoye said in a meeting news release.

Results did show that the combination was safe, and it did not increase the risk of brain bleeding.

Unfortunately, three months after treatment those patients that received the combo weren't doing any better than patients who only got a clot buster, researchers said.

Patients taking the blood thinner argatroban averaged 5.2 on a 10-point disability scale, and those who got the blood thinner eptifibatide averaged 6.3....[Read More](#)

Most Americans Don't Know Their Lifesaving 'Heart Numbers'

Ohio resident Erica Hutson was in her 20s when she found out she had high cholesterol through a health check required by insurance.

Because she was young and fit, Hutson shrugged off the test result.

But Hutson changed her mind about it a decade later, when her father died of coronary artery disease in his 60s and she discovered it ran in her family.

"His death really made me think about things and put my life into a whole different perspective," said Hutson, now 37.

More Americans need to follow Hutson's example and discover their heart risk factors earlier in life, according to a new national survey conducted by Ohio State University's Wexner

Medical Center.

Fewer than half of Americans know their blood pressure or ideal weight, and less than one in five know their cholesterol or blood sugar levels, the survey found.

"Recognizing heart disease risk factors early and adequately treating them can potentially prevent heart attacks, strokes and heart failure. As a society, we need to shift from sick care to preventative care so people can live their best and fullest lives possible," said **Dr. Laxmi Mehta**, director of preventative cardiology and women's cardiovascular health at Wexner.

The survey asked more than 1,000 adults nationwide if they knew their blood pressure level, ideal weight, cholesterol and



blood sugar levels.

The highest number knew their ideal weight (44%), while the fewest (15%) knew their blood sugar levels.

By comparison, 68% could recall their childhood address and 58% knew their best friend's birthday.

While they don't know their health numbers off the top of their heads, Americans are having them regularly checked.

A majority of poll participants said they'd had their blood pressure and heart rate checked within the last year, and their blood sugar and cholesterol within the last five years.

"Most people can get screened at their physician's office or, if they don't have one, there are free health screening fairs as well

as blood pressure machines at pharmacies," Mehta said in a university news release. "It's important to not only know your numbers but be proactive with medication and lifestyle changes like diet and exercise."

The healthy heart numbers include:

- ◆ Blood pressure under 120/80 mm Hg.
- ◆ Fasting blood sugar less than 100 mg/dL or a hemoglobin A1C of less than 5.7.
- ◆ Cholesterol levels, including "good" HDL cholesterol, "bad" LDL cholesterol and triglycerides.
- ◆ A body-mass index between 18.5 and 24.9.
- ◆ Sleeping an average of seven to nine hours each day....[Read More](#)

New Stool Test May Spot More Colon Cancers Sooner

Dutch researchers have developed a new stool test that appears to detect colon polyps better than the current test does.

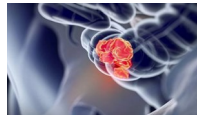
"The current test performs well, but leaves room for improvement," said **Dr. Gerrit Meijer**, principle investigator at the Netherlands Cancer Institute in Amsterdam.

"We want to be able to detect the tumors before they have become invasive, that is at the stage of larger premalignant polyps," he added in an institute news release. "Treating physicians then can remove these polyps during a colonoscopy, rather than by surgery."

That could save thousands of lives worldwide. Each year, an estimated 1.9 million people around the world are diagnosed with colon cancer, and the disease claims 935,000 lives. It is curable if detected early.

In many countries with population-wide colon cancer screening programs, the fecal immunochemical test (FIT) is used. It measures the presence of the blood protein hemoglobin.

Meijer and his team have been working on a new test for years. Their multitargetFIT-test (mtFIT) measures hemoglobin as well as two other proteins.



In the Feb. 9 issue of the ***Lancet Oncology***, they reported on a comparison of the two tests in more than 13,000 participants in the Dutch national screening program.

"The new test can detect cancer precursors more effectively," Meijer said. "Our results predict that the test can reduce the number of new cases of colorectal cancer and [death rates] resulting from it."

The new test is as easy to use as the current one.

It found abnormalities in 299 people, compared to 159 who used the current FIT test. The

difference mainly involved a high-risk precursor of cancer.

"The new test detects more larger polyps without a significant increase in 'false-positive' results and thus unnecessary colonoscopies," Meijer said.

How many cases of colon cancer could be prevented with the new test is unclear. Researchers said that depends on how different countries use the current FIT test....[Read More](#)

What's your cholesterol level?

More than 25 percent (86 million) of Americans have high cholesterol. Another 33 percent (120 million) do not know their cholesterol level. But, if you want to reduce your risk of plaque in your arteries and heart disease as well as protect your health overall, you want your cholesterol levels under control, writes Knvul Sheikh for the **New York Times**.

What is cholesterol? Cholesterol is a waxy "lipid," or fat that your liver produces for good health. Among other things, it creates cell membranes and hormones. But, if the amount of cholesterol is not right, it can cause health problems.

Can you have good cholesterol or is it all bad? You have **two types of cholesterol**,

"good" cholesterol and "bad" cholesterol. If your LDL or "bad" cholesterol is high, it can cause health problems. If your HDL is high, it can reduce your risk of health problems.

What causes high LDL cholesterol levels? If you eat too much meat and dairy products, you can create too much cholesterol. Your genes can also contribute to high LDL cholesterol levels.

What's the danger of high cholesterol levels? Too much cholesterol can cause heart attacks and stroke. And, you might not know you are at risk because you are not likely to have symptoms.

When should you check your cholesterol levels? By the time you have Medicare, you should



have regular cholesterol checks. But, as early as your 20's, it's good to check your cholesterol levels every several years.

And, if you have a family history of heart attacks and stroke, you might want to get more frequent checks. Talk to your doctor.

Your cholesterol levels will likely rise as you get older. For women, they rise after menopause.

What should you be tracking? Track your LDL, which is the "bad" cholesterol. It should not go above 100 mg/dL and should be as low as possible. If you have diabetes, you should keep it below 70. Your HDL, the "good" cholesterol, brings the cholesterol you don't need back to your liver

from your arteries, so you can discharge it. You want your HDL to be greater than 40 mg/dL and ideally above 60.

How can you lower your LDL cholesterol level? Exercise more, eat healthy and avoid alcohol. Eat more whole grains, vegetables, fruits, seeds and legumes—"soluble fibers." You can also eat avocados, nuts and fatty fish. Don't eat butter, cheese and red meat or ultraprocessed foods.

Should you take drugs to lower your cholesterol? Sometimes. Especially if you've had a heart attack or a stroke or your LDL is high or your arteries are severely blocked.

Viagra, Cialis May Help Reduce Alzheimer's Risk

Could drugs that give a boost to men's sexual performance help them stave off Alzheimer's disease?

That's the main finding from a study suggesting that erectile dysfunction meds like Cialis, Levitra and Viagra might lower the odds for the memory-robbing illness.

The study wasn't designed to prove cause-and-effect, cautioned British researchers at University College London.

"More research is needed to confirm these findings, learn more about the potential benefits and mechanisms of these drugs and look into the optimal dosage," explained study co-

author **Ruth Brauer**, a lecturer in pharmacoepidemiology and medication safety at the university.

She also believes that, "a randomized, controlled trial with both male and female participants is warranted to determine whether these findings would apply to women as well."

The findings were published Feb. 7 in the journal **Neurology**.

Erectile dysfunction medications work by dilating blood vessels and increasing blood flow.

The new study involved almost 270,000 men, averaging 59 years of age, who had all been newly



diagnosed with erectile dysfunction (ED). A little more than half of them were prescribed an ED drug. None of the

men had any cognitive or memory issues when they entered the study.

Over five years of follow-up, 1,119 of the men were diagnosed with Alzheimer's disease.

Bauer's team reported that men who were taking an ED drug had an 18% lower odds of developing Alzheimer's compared to those who weren't. That finding held even after the researchers had adjusted for other risk factors, such as age, smoking status and alcohol consumption.

The jury is still out on whether the ED meds directly caused the drop in Alzheimer's risk, and more study is needed. But Bauer believes the research points in interesting directions.

"Although we're making progress with the new treatments for Alzheimer's disease that work to clear amyloid plaques in the brain for people with early stages of the disease, we desperately need treatments that can prevent or delay the development of Alzheimer's disease," she said in a journal news release. "These results are encouraging and warrant further research."

Do wall squats, improve your heart health and build strength

If you'd like to improve your health health as well as your strength, do wall squats, reports Knvul Sheikh for the **New York Times**. This isometric exercise can reduce your blood pressure better than aerobic exercise or other types of workouts. And, no, it does not involve using a barbell or any other weight!

A study in the **British Journal of Sports Medicine** found that if you could squat with your back against a wall—as if you were seated on a chair, sort of—four times for two minutes each time, with two minute breaks between

each squat, you could improve your health. All it takes is 14 minutes and endurance!

All it takes is eight minutes of isometric exercise three times a week to reduce blood pressure in a meaningful way. Of course, if you can do brisk walking for 30 minutes five times a week, that's a great too. But, if you do the wall squats, you can address high blood pressure without the aerobic exercise.

Of course, all exercise is good. And, many exercises could reduce



blood pressure. If walking 150 minutes a week isn't getting your blood pressure down, it could be worth adding on the wall squats to your repertoire. You might avoid having to take a prescription.

The researchers did not review studies on the value of doing planks. But, they did look at 270 trials of nearly 16,000 people to see the effects of different isometric exercises on blood pressure..

Isometric exercises work to lower blood pressure because the

positions reduce blood flow to muscles that are contracted. When the exercise ends, your muscle tissue receives greater blood flow. Then your blood vessels relax and allow for easier blood flow.

Here's how to do a wall squat. Stand with your feet hip width apart a couple of feet in front of a wall. With your back facing the wall, lean against it. Then lower your upper body down. If not the first time, over time your goal should be to get your back down as if you were seated.

Your Brain Finds Ways to Compensate Against Age-Related Decline

No one's brain is as sharp at 60 as it was at 20.

However, new research supports the notion that folk's brains can make subtle adjustments with age to compensate for that decline.

A team of British researchers has found more evidence that as the mind ages, it sometimes recruits help from certain brain regions to make up for deficits elsewhere.

This does not happen for everyone equally, stressed study lead author **Dr. Ethan Knights**.

Still, "now that we've seen this compensation happening, we can start to ask questions about why it happens for some older people, but not others, and in some tasks, but not others," said Knights, who works in the Medical Research Council Cognition and Brain Sciences Unit at Cambridge University.

"Is there something special about these people -- their education or lifestyle, for example

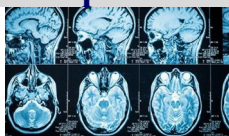
-- and if so, is there a way we can intervene to help others see similar benefits?," Knights said in a university news release.

His team published its findings Feb. 6 in the journal *eLife*.

Working with researchers at the University of Sussex, Knights' group sought to elucidate the brain's means of coping with age.

"Our ability to solve abstract problems is a sign of so-called 'fluid intelligence,' but as we get older, this ability begins to show significant decline," noted senior study author **Dr. Kamen Tsvetanov**.

"Some people manage to maintain this ability better than others. We wanted to ask why that was the case -- are they able to recruit other areas of the brain to overcome changes in the brain that would otherwise be detrimental?," said Tsvetanov. He's an Alzheimer's Society Dementia Research Leader



Fellow in the department of clinical neurosciences at Cambridge.

Prior brain scan studies had already shown that fluid intelligence relies on what's been dubbed the brain's 'multiple demand network' (MDN). That's a neurological system that connects regions at the front and the back of the brain.

However, MDN activity seems to falter with age. To see if the brain compensated for that drop-off, the U.K. team conducted brain imaging on 223 adults between 19 and 87 years of age.

While placed within a functional MRI scanner (which tracks real-time brain blood flow) participants were asked to work a number of puzzles of varying complexity.

To no one's surprise, the puzzles became tougher to solve the older the participant was.

But while scans showed the brain's MDN remaining active,

older participants also showed an increased activity in two key brain areas.

One was the cuneus, located at the back of the brain, and the other was an area of the frontal cortex.

However, only the jump in activity in the cuneus appeared linked to better performance by older folks at completing the puzzles, the researchers noted.

It's not clear why the brain seeks out extra help from the cuneus, although the researchers note that it's a neurological center for visual focus. They theorized that some older folks may employ it to better keep track of their puzzle pieces if faced with age-related lags in visual memory.

Overall, the study "hints that compensation in later life does not rely on the multiple demand network as previously assumed, but recruits areas whose function is preserved in ageing," said University of Sussex co-researcher **Dr. Alexa Morcom**.

Dementia Care Costs Can Quickly Burn Through People's Savings: Study

Dementia care can eat through the savings of cash-strapped seniors, a new study warns.

The average senior with dementia in non-nursing residential care facilities spent 97% of their monthly income on long-term care, researchers found. Meanwhile, those living in nursing homes spend nearly 83% of their monthly income on their care, results show.

"Because dementia is such an expensive illness, it really is in a category of its own when we start to think about funding for long-term care," said senior study author **Jalayne Arias**, an

associate professor in the Georgia State University School of Public Health.

"Our study shows that if you compare people with dementia to their age-matched counterparts, they experience costs that are untenable to manage," Arias added in a university news release.

For the study, researchers analyzed data from a national sample of more than 4,500 adults aged 70 and older, focusing specifically on out-of-pocket expenses for dementia care.

"It's really striking to see that



the [average] individual with dementia is basically putting nearly all of their income toward long-term care,"

said lead researcher **Jing Li**, an assistant professor of health economics at the University of Washington School of Pharmacy. "We hear about this anecdotally, but to get confirmation of that from the data is really concerning."

On average, seniors with dementia paid \$3,090 a month out-of-pocket for non-nursing residential care at places like an assisted living facility, and \$3,849

a month at full-fledged nursing homes, results show.

By comparison, older adults without dementia spent \$2,801 a month average for non-nursing residential care and \$2,176 a month at nursing homes.

No matter where they were, more than three-quarters of seniors with dementia paid for helpers to assist them with daily tasks like dressing, bathing, doing laundry, shopping for groceries and running other errands, researchers found... **[Read More](#)**

Many Cancer Patients With Heart Issues Also Have Sleep Apnea

Sleep apnea appears to be linked to an increased risk of heart failure among cancer patients, a new study says.

Obstructive sleep apnea occurs when relaxed muscles cause a blockage of the windpipe, interrupting breathing and causing a person to temporarily wake.

The new study involved 296 general heart patients and 218 cancer patients with heart problems, researchers said.

Sleep apnea was actually more common among heart patients in

general than in those undergoing cancer treatment, 54% versus 39%, results show.

However, sleep apnea among cancer patients with heart problems was equal to or greater than other traditional factors now used to assess their heart health risk, researchers found.

For example, left ventricular ejection fraction (LVEF) -- a measure of how well the heart is pumping blood through the body -- is used to predict heart problems



related to cancer therapy. But cancer patients who had a normal LVEF showed more evidence of heart strain if they also had untreated sleep apnea, the study found.

Cancer treatments like chemotherapy, radiation therapy and immunotherapy are known to be toxic to the heart.

"Sleep apnea should be incorporated into current risk algorithms and a larger study is needed to evaluate the impact of

sleep apnea in this high-risk population. We feel that sleep apnea assessment must be a part of routine risk assessment for patients undergoing cancer therapeutics," lead researcher **Dr. Mini Das**, medical director of the cardio-oncology program at Baptist Health in Louisville, Ky., said in a meeting news release.

More information

Yale School of Medicine has more about the **[heart effects of cancer treatment](#)**.