Rhode Island Alliance for Retired Americans®

RI ARA

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Message from Alliance *for* Retired Americans Leaders

Nobel Laureate Economist Paul Krugman Details Decades of GOP Plans to Cut Social Security and Medicare

Robert Roach, President, ARA

Despite some Republicans' claims to the contrary, columnist and economist Paul Krugman **reminded** readers this week that many in the GOP do want to eviscerate Social Security and Medicare, writing that "to believe otherwise requires both willful naïveté and amnesia about 40 years of political history."

After President Biden's State of the Union address last week, Senate Republican Leader Mitch McConnell (KY), had tried to distance his party from Sen. Rick Scott's (FL) proposal to sunset all federal government programs, including Social Security and Medicare after five years; that would force Congress to reauthorize them. However, Krugman wasn't buying McConnell's argument when McConnell said, "that was the Scott plan, that's not a Republican plan."

On MSNBC's The Beat with Ari Melber Monday, Krugman **said**, "Republicans learned that being too explicit about what it is many of them want to do hurts them badly.....Mitch McConnell hates the fact that Rick Scott said [it]. That's not saying that Mitch McConnell is actually opposed to doing it, he just wants somebody else's fingerprints to be on it."

"Senate Republican Leader McConnell is trying to confuse us," agreed Robert Roach, Jr., President of the Alliance. "He has been at the forefront of an effort to cut Social Security and Medicare for years. He would like us to forget, but retirees will make sure the American people have the facts."

Earlier today Sen. Scott responded to widespread criticism of his "Rescue America" plan to sunset all federal legislation and **edited the document** to exempt "Social Security, Medicare, national security, veterans' benefits, and other essential services." However, this document was not the only time he has said that Social Security and Medicare must be altered.

Senators Sanders and Warren, Reps. Schakowsky and Hoyle Introduce Legislation to Expand Social Security

Rich Fiesta, Executive Director, ARA

As Republicans threaten cuts to Social Security and other essential federal programs, Sens. Bernie Sanders (VT) and Elizabeth Warren (MA), along with Reps. Jan Schakowsky (IL) and Val Hoyle (OR), **introduced** legislation Monday that would expand Social Security benefits by $200 a month across the board and ensure Social Security is fully funded for the next 75 years.

The bill would not raise taxes on the 93% of American households that make $250,000 or less per year.

S. 393, the Social Security Expansion Act, also increases Cost-Of-Living-Adjustments by adopting the Consumer Price Index for the Elderly (CPI-E) and updates the Special Minimum Benefit for Social Security recipients by making it easier to qualify, helping low-income workers to stay out of poverty.

The bill does not, however, repeal the Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO), which prevents 2.5 million retirees from receiving all of the Social Security benefits they have earned. The Alliance supports both Social Security expansion and repeal of the unfair WEP-GPO provisions.

"Social Security should be expanded, not cut or changed," said Richard Fiesta, Executive Director of the Alliance. "This bill shows that we can strengthen Social Security for current and future generations - and increase benefits - if we require the wealthiest American households to pay their fair share of Social Security taxes."

Congressional Republican Agenda Would Increase the Debt by Over $3 Trillion

Joseph Peters ARA Sec.-Trea.

The White House released a new fact sheet this week **showing** that the House Republicans' legislative agenda would increase the national debt by over $3 trillion over 10 years.

The first **bill** passed by the new Republican House majority would increase the debt by $114 billion by preventing the IRS from ensuring the wealthiest Americans and corporations pay their fair share in taxes.

Congressional Republicans have also proposed repealing — and are even running **ads** attacking — reforms President Biden signed to lower prescription drug prices for people on Medicare. Repealing these policies means Medicare would pay more to the drug corporations, increase prices for beneficiaries, and add $159 billion to the deficit.

House Republicans want to **repeal** several tax increases on large corporations that President Biden signed into law That would add another $296 billion to the debt.

The House GOP also wants to extend the expiring 2017 Trump tax cuts, giving Americans with incomes over $4 million per year a $175,000 tax increase. That would result in a **$2.7 trillion debt increase**.

"Republicans are saying we must increase the retirement age and cut Social Security and Medicare benefits to reduce the debt," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "In reality they want to cut the benefits we've earned to provide even more tax breaks to the wealthiest Americans and big corporations."

Download a copy of the White House Fact Sheet **here**.

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Millions of seniors on Social Security are at risk of losing benefits this summer if the GOP doesn't raise the debt ceiling, Janet Yellen says

The nation's top Treasury official just issued another warning on the consequences of failing to raise the debt ceiling. On Tuesday, Treasury Sec. Janet Yellen **told officials** during a Washington conference that their constituents are greatly at risk if Congress fails to raise the debt limit by the summer. In January, the Treasury Department **began to use "extraordinary measures"** to keep the US on top of paying its bills, and while Republicans raised the debt limit three times under former President Donald Trump, they are using it as leverage this time around to achieve their own priorities.

Yellen has warned numerous times of the consequences of using the debt limit as a bargaining chip, and she reiterated the economic catastrophe that would result should the US default.

"The solution is simple: Congress must vote to raise or suspend the debt limit. It should do so without conditions, and it should not wait until the last minute," Yellen **said** during her Tuesday remarks. "It is unlikely that the federal government would be able to issue payments to millions of Americans, including our military families and seniors who rely on Social Security," she added. "In the longer term, a default would raise the cost of borrowing into perpetuity. Future investments — including public investments — would become substantially more costly."

The US has never defaulted on its debt, and amid these negotiations, Speaker of the House Kevin McCarthy said earlier this month that "defaulting on our debt is not an option. But neither is a future of higher taxes, higher interest rates, and an economy that doesn't work for working Americans."

While McCarthy has not specified what exactly he is looking to cut in debt limit negotiations — the only thing he's made clear is that Social Security and Medicare are off the table — the White House has been adamant that raising the debt limit should be bipartisan, not a bargaining chip tied to demands for spending cuts.

"Congressional Democrats and Republicans in Congress voted three times in the Trump administration to lift the debt ceiling," White House Press Secretary Karine Jean-Pierre said during a press briefing.

"And let's not forget this has happened 78 times since 1960, 49 times under Republican presidents and 29 times under Democratic presidents," she added. "So, this has been done before. It's their constitutional obligation to do this."

As Insider previously **reported**, Biden could get around Congress through a process known as minting the coin, in which Biden could deposit a $1 trillion platinum coin in the Federal Reserve thanks to a loophole in the types of coins the Treasury can mint. But Yellen has dismissed that idea on numerous occasions and remains committed to Congress lifting the debt limit once again.

"It truly is not by any means to be taken as a given that the Fed would do it, and I think especially with something that's a gimmick," Yellen **previously said** about the coin. "The Fed is not required to accept it, there's no requirement on the part of the Fed. It's up to them what to do."

The administration's next crack at lower drug prices

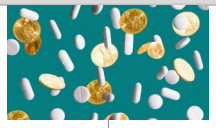
The Biden administration unveiled three drug payment programs Tuesday aimed at helping reduce patients' out-of-pocket costs, including one that would potentially lower Medicare payments for promising treatments approved by the FDA before clinical trials are complete.

Why it matters: The models wade into some of the most timely drug pricing issues of the day, and could boost President Biden's political arsenal for 2024.

Driving the news: In October, Biden **directed the CMS Innovation Center,** which runs experiments on new ways to deliver and pay for health care, to study how it can use its authority to lower drug costs.

The executive order — and the new programs announced Tuesday — build on **Medicare drug pricing reforms** enacted by Congress last year. But they don't require lawmakers' blessing.

The accelerated approval process has been in the spotlight as Medicare worked out how to cover a **controversial Alzheimer's drug approved** by the FDA on an expedited basis, before there was real-world evidence it worked.



The details: The three programs focus on different classes of treatments and coverage.

- One would encourage Medicare prescription drug plans to offer a standardized set of about 150 generic drugs to patients for a maximum copayment of $2 per month. The list would target drugs for chronic conditions like hypertension.
- Another would give state Medicaid agencies the option to coordinate with manufacturers and other states to test new ways to pay for gene and cell therapies based on health outcomes.
- The report specifically mentions gene therapies for sickle cell disease, two of which could hit the market this year with multi-million dollar price tags and would likely present significant affordability challenges for state Medicaid programs.
- **The third model** would try to incentivize manufacturers to complete timely clinical trials to confirm accelerated-approval drugs work by adjusting how much Medicare pays for the products.
- "Whether [payments] would go up or down — I think that's a design question that we would have to explore as we start developing the model," Innovation Center director Liz Fowler said during a press call.
- **The intrigue:** The Innovation Center has not ruled out requiring drug manufacturers to participate in the program testing new ways to pay for accelerated-approval drugs.
- Participation is usually voluntary, but Fowler has **said** she'd like to get more mandatory programs into the mix.
- The center is working with the FDA to figure out program details, Fowler said. Officials will start exploring the accelerated approval incentive program this year and move forward "if determined appropriate," a report on the programs said.

The big picture: The payment programs, if enacted, would become some of the Biden administration's most notable drug pricing policies made without Congress.

- But they risk drawing the ire of the health care industry, particularly pharmaceutical companies, who are already warning that Democrats' drug pricing legislation from last year will discourage new therapies from coming to market and finding new uses for already approved medicines.

What's next: The center wants to begin the program that lowers drug copayments as soon as operationally feasible, and the Medicaid cell and gene therapy program could launch by 2026.

- The center also wants to study ways to speed up the adoption of biosimilar drugs, support price transparency and improve cell and gene therapy access in Medicare.

Extra benefits in Medicare Advantage: Truth or Fiction?

A new **GAO report** reveals that the government has little data to know whether Medicare Advantage plans are offering additional benefits and whether their enrollees are using these benefits. Effectively, the government is **overpaying the Medicare Advantage plans billions of dollars** each year, with little clue of the extent to which the Medicare Advantage plans are using this money for the benefit of their enrollees or for the benefit of their shareholders. This madness must stop before it does irreparable damage to the Medicare program.

Today, about 30 million people with Medicare are enrolled in Medicare Advantage, private health plans that contract with the government to offer Medicare benefits. Medicare Advantage plans have repeatedly been found to **inappropriately delay and deny services that Traditional Medicare covers**. The "additional benefits" they offer sound good: vision or hearing services, in-home support services and, now, sometimes food and produce. But, it's unclear who benefits from them.

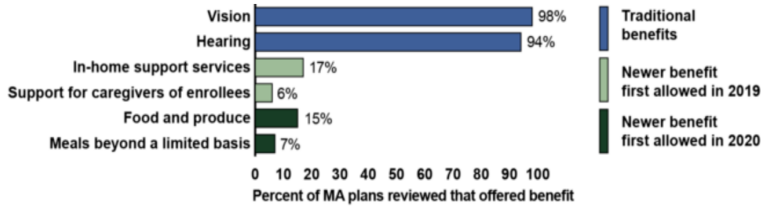
The Medicare Advantage plans are not providing the Centers for Medicare and Medicaid Services (CMS), the agency that oversees Medicare, with "detailed, service-level utilization data," the data it needs to assess the value of these additional benefits to Medicare Advantage plan enrollees. What's worse is that CMS is not demanding the Medicare Advantage plans turn over this data.

The GAO says that three Medicare Advantage plans told it that they are not required to turn over this data for supplemental benefits they offer. CMS says they are required to do so, just as they are required to release data for all Medicare benefits they provide an enrollee. But, CMS does not penalize the Medicare Advantage plans for not turning over complete and accurate data related to the Medicare benefits they cover, so the Medicare Advantage plans can flout their obligations with impunity.

With some supplemental benefits, such as food and produce, there are arguably challenges submitting data. There's no diagnosis code. But, the Medicare Advantage plans must have a way of recording coverage of this additional benefit, as some claim to pay for it. So, it defies reason that they cannot share their documentation with CMS.

CMS is drafting a workplan and timeline for collecting this information. The outstanding question is whether the extra benefits promote enrollees' health and function. If so, which enrollees benefit? If not, why is CMS allowing Medicare Advantage plans to spend money on them?

The GAO made just two recommendations to CMS. CMS should make clear to Medicare Advantage plans the supplemental benefit data they must submit for review. And, CMS must put in place a way to ensure that it gets comprehensive data on supplemental benefits that do not have procedure codes. Will CMS have the tools, resources and political will to do so?



Source: GAO review of Centers for Medicare & Medicaid Services data. | GAO-23-105527

Medicare expenses in retirement could top $383,000 for a couple with high drug costs, study finds

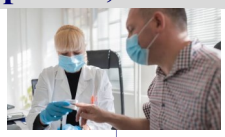
Health care in retirement can come with a hefty price tag.

A **new study** looks at how much money a 65-year-old — who's at the age of **Medicare** eligibility — would need to have set aside to secure a 50%, 75% or 90% chance of covering their health-care costs over the course of their retirement. Depending at least partly on a person's coverage choices through Medicare, the amount could reach into the hundreds of thousands of dollars, the research shows.

"Health care is likely going to be a big expense for you in retirement," said Paul Fronstin, director of health-benefits research at the Employee Benefit Research Institute and a co-author of the study.

"You don't want to be shocked when you get to retirement and find this out, or discover that Medicare doesn't cover everything," Fronstin said.

The study assumes that the pot of money set aside at age 65 is invested and even as you make withdrawals to cover health-care costs, the account is earning 7.32% in interest and investment returns yearly. In other words, you could end up spending far more than the amounts in the study.



1.Basic Medicare plus Medigap and Part D

The first scenario involves pairing basic Medicare — Part A (hospital coverage) and Part B (outpatient care) — with a stand-alone Part D (prescription drug coverage) plan and a so-called **Medigap policy**, both of which are offered by private insurance companies.

Medigap covers some or most of the cost-sharing — i.e., deductibles, copays or coinsurance — that come with basic Medicare. Plans are standardized across most states — they are simply designated A, B, C, D, F, G, K, L, M and N and each lettered plan differs in what is covered. The standardization means the benefits are generally the same regardless of where you live or which insurance carrier is offering, say, Plan G or Plan N.

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While Medigap coverage means fewer out-of-pocket expenses — and therefore might be a more predictable budget item — the premiums can be pricey, depending on where you live and the specifics of the policy. And over time, those monthly payments add up.

This shows up in the study: A 65-year-old man enrolled in a Medigap Plan G with average monthly premiums — $204 is used for the calculation — would need to have saved $96,000 to have a 50% chance of having enough money to cover premiums and median prescription drug expenditures, the analysis finds.

A woman of the same age and with the same coverage choices would need to have $116,000 for the same 50% chance of having enough money. (The higher amount is due to women generally living longer than men.)

For a 75% chance, the same man and woman would need to have saved $137,000 and $159,000, respectively. And for a 90% chance, those amounts would be $166,000 and $197,000.

Representing an extreme case, a couple with high prescription drug expenses would need to have saved $383,000 to have a 90% chance of having enough to cover their health-care costs….**Read More**

Coronavirus: When public health emergency ends, so will some Covid coverage

The President has declared May 11 as the date for an end to the Covid-19 public health emergency. Rachel Cohrs reports for **Stat** that once the public health emergency ends, older adults and people with disabilities will be at greater risk of not getting needed care. The Centers for Medicare and Medicaid Services (CMS), which administers Medicare, says that people with Medicare will face higher costs for Covid-19 tests and treatments.

People with Medicare currently get free Covid-19 tests. They also get Paxlovid, a prescription drug which treats Covid-19 for free. Come May 11, Covid-19 tests will no longer be free. Paxlovid will remain free until supplies run out, most likely in the summer. But, people with Medicare could have out-of-pocket costs for other treatments.

Comprehensive coverage of Covid-19 tests and treatment is critical for people with Medicare; older adults are more likely to die of Covid than working people or any other age group. Paula Span reports for the **New York Times** that in January alone, 10,600 people with Medicare died of Covid, which represented 90 percent of all Covid deaths last month. Overall, people with Medicare over 75 represent 75 percent of Covid deaths–8,500 deaths in January.

People with Medicare are also five times more likely to be hospitalized because of Covid-19 than younger people. Hospitalizations and deaths are higher than they should be for people with Medicare because six in ten of them have not received the bivalent booster.

What Covid-related services will Medicare cover after the Covid public health emergency ends? After the public health emergency ends, vaccines, lab tests and antigen tests that a physician or other health care provider orders will remain free for people with Medicare. If there are monoclonal antibody treatments that are effective, they will also be covered through the end of 2023.

Insurers covering working people have yet to determine how much their enrollees will pay for Covid-19 tests and treatments once the public health emergency ends.

People with Medicaid will continue to get free vaccines once the public health emergency ends. But, they will not have protections against out-of-pocket costs for Covid testing and treatments beginning January 2025.

People who are uninsured are most at risk at the end of the public health emergency. States will no longer have funding through Medicaid to cover their Covid-19 tests, vaccines and treatments.

CMS Proposes Policy and Payment Changes for Medicare Advantage and Part D Plans

The Centers for Medicare & Medicaid Services (CMS) recommends policy changes to Medicare Advantage (MA) and Part D plans each year. This week, the Medicare Rights Center submitted **comments** on the **proposed rule** for 2024.

We appreciate and support many of the outlined updates. In particular, we applaud the proposals to improve access to substance use disorder and mental health care, changes that would remove barriers to care and further embed equity into Medicare. We also welcome the agency's efforts to curb prior authorization, inappropriate coverage denials, and predatory marketing. These harmful practices routinely interfere with access to care and beneficiary decision-making. We encourage CMS to further strengthen enrollee protections in future rulemaking and guidance.

Throughout our comments and in general, we urge CMS to provide more robust oversight of MA and Part D plans to ensure they are meeting their contractual and civic duties to beneficiaries, taxpayers, and Medicare. We recognize this may require additional CMS staff and resources, which we urge the agency to pursue as necessary.

We are disappointed, however, that the proposed rule does not address several important issues in needed depth: the overly-complex MA and Part D appeals processes; the cluttered MA plan choice landscape; the marketing of supplemental benefits; financial incentives for brokers and agents; and weakened network adequacy standards. In our comments, we discuss these matters and pose solutions.

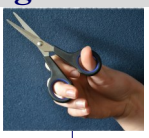
Another critical topic, plan payment, is the subject of separate annual rulemaking known as the **Advance Notice**. In our preliminary analysis of the proposed rates for 2024, we were pleased to see CMS taking initial steps to correct the decades-long problem of MA overpayments. We remain concerned that overpayments are negatively impacting Medicare's finances and long-term sustainability, as well as beneficiary premiums and taxpayer costs.

The amounts inappropriately paid to plans are significant and well **documented**. The Government Accountability Office estimates that in 2013 alone, MA plans received an extra **$14.1 billion,** and the Medicare Payment Advisory Committee has cataloged approximately **$140 billion** in MA overpayments over the past 12 years. In 2018, CMS identified an estimated **$650 million** in overpayments to 90 plans from 2011 through 2013; some analysts calculated overpayments of at least twice that much….**Read More**

Will Republicans and Democrats agree to cut waste in Medicare Advantage?

Republicans and Democrats in Congress claim that they **don't want Medicare cuts**. As we learn more, we find that "cuts" can mean different things to Republicans and Democrats. Cutting waste is one thing, cutting benefits is another.

President Joe Biden does not want to cut benefits or increase costs for people with Medicare. But, his administration, through the Centers of Medicare and Medicaid Services, "CMS," has proposed only a one percent rate increase to Medicare Advantage plans in 2024 as a means to reduce waste in Medicare Advantage. According to MedPAC, this year alone, excess payments to Medicare Advantage total $27 billion.



The one percent payment increase should have no effect on benefits or out-of-pocket costs in Medicare Advantage. As it is, Medicare Advantage plans receive between six percent and 15 percent more in payments from the government per enrollee than traditional Medicare. And, they receive rebates from the federal government of $196 a month per enrollee on average.

To level the playing field on per enrollee spending with Traditional Medicare, the federal government would need to reduce per enrollee payments to Medicare Advantage plans significantly. The Centers for Medicare and Medicaid Services has not proposed that.

Speaker Kevin McCarthy says that he wants to cut waste in federal programs "wherever it is." The question is will he and his fellow Republicans agree to cut the tens of billions of dollars in annual waste in Medicare Advantage. Or, is that the kind of cut–one that saves taxpayer dollars and cuts into Medicare Advantage profits–that McCarthy and his fellow Republicans oppose?

For every year that Republicans and Democrats don't agree to cut waste in Medicare Advantage, Medicare Part B premiums rise and the Medicare Trust Fund is depleted, driving up costs in Medicare for older adults and taxpayers alike and weakening the Medicare program.

Dear Marci: How do I enroll in Medicare after being incarcerated?

Dear Marci,

My dad is 67 and was released from prison at the beginning of February. He didn't enroll in Medicare when he turned 65 while he was incarcerated, so now he is back home and without health insurance. How should he enroll in Medicare now? Will he owe a late enrollment penalty?

-Abigail (Fort Wayne, IN)

Dear Abigail,

It is usually best if someone enrolls in Medicare when they are first eligible. As you mentioned, many people who delay enrolling in Medicare must wait for the **General Enrollment Period** and then may owe a late enrollment penalty for life.

Beginning this year, though, if someone misses a first-time enrollment period, there are certain situations when they might qualify for an **exceptional circumstances Special Enrollment Period (SEP)**. One of these new SEPs is for people who were are released from the custody of a penal authority, including a prison, after January 1, 2023.

To be eligible for this SEP, your father would have to:

- Be eligible for Medicare
- Have failed to enroll in Medicare while he was incarcerated
- Be released on or after January 1, 2023

Note that **Medicare defines "incarcerated"** as individuals who are in the custody of certain authorities, including people under arrest, imprisoned, residing in halfway houses, living under home detention, or confined completely or partially in any way under a penal statue or rule. If he is eligible, the SEP lasts for twelve months.

- The SEP starts the day he was released.
- The SEP ends the last day of the twelfth month after his release.

He can choose to have his coverage begin on the first of the month after he signs up, or to have it begin up to six months retroactively (but not before January 1, 2023, or before his release). If he uses this SEP to enroll in Medicare, he will not owe a **late enrollment penalty**. To use this SEP, your father should contact SSA.

If your father then wants to enroll in a Medicare Advantage Plan or stand-alone Part D prescription drug plan, he should contact 1-800-MEDICARE (1-800-633-4227) to learn more about his enrollment period options. He may qualify for a Medicare Advantage or Part D SEP or have other enrollment periods available, depending on when he enrolls in Part B.

Best of luck to him as he enrolls in Medicare!

-Marci

Republicans plan to cut Social Security, President Biden should release a plan to expand it

President Joe Biden **called out** Congressional Republicans for their plans to cut Social Security and Medicare. Several Republicans erupted in outrage, and Rep. Marjorie Taylor Greene (R-GA) yelled "liar." In response, Biden said "I enjoy conversion…as we all apparently agree, Social Security and Medicare is off the books now, right?" and urged the entire room to "stand up for seniors." Many Republicans in the room, including Speaker Kevin McCarthy, stood up and applauded.

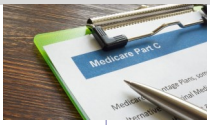
This was a masterful moment of stagecraft from President Biden. But no one should mistake it for any real commitment from Republicans to back off their deeply held desire to cut Social Security and Medicare. Fortunately, Biden himself doesn't appear to be making any such mistake.

After the speech, Biden **tweeted** "Look: I welcome all converts. But now, let's see your budget." Similarly, Senate Democratic Leader Chuck Schumer **said** yesterday afternoon that McCarthy "says he wants cuts, where? He hasn't named a single place where he wants them. Is it going to be Social Security or Medicare? Don't just say no, prove it. Show us your plan."

Biden and Schumer are right. Republicans have a long history of trying to cut Social Security and Medicare. Republican leaders keep saying — often to their donors behind closed doors — that they want to do it. Most recently, former Vice President Mike Pence **told** a closed door conference that he wants to "replace the New Deal with a better deal" by privatizing Social Security, handing our earned benefits over to Wall Street.

Pence was only the latest in a long line of Republicans with plans to cut Social Security and Medicare. Last year, the Republican Study Committee, which counts about 75 percent of House Republicans as members, released a budget **that would** raise the retirement age for Social Security and Medicare to 70, decimate middle class Social Security benefits, and voucherize Medicare. These are the very same House Republicans who erupted in outrage last night!...**Read More**

CMS, insurers clash over whether Medicare Advantage is going to be cut in proposed rule



Health insurers and the Biden administration are at loggerheads over whether Medicare Advantage (MA) plans will see a pay cut next year, the ramifications of which come amid increased regulatory scrutiny for the popular program.

Insurer groups and some politicians charge that **the latest 2024 payment rule** will wind up being a 2.27% cut to MA plans after considering risk adjustment changes and other factors. The Centers for Medicare & Medicaid Services (CMS) has pushed back, arguing that isn't true.

The debate comes amid increasing scrutiny of MA and after CMS has proposed an overhaul to plan audits to curb overpayments.

"We think it is important not to cherry-pick the numbers," said CMS Administrator Chiquita Brooks-LaSure during a call with reporters last week. "When we look at all the elements, we do see a net positive so an increase of little over 1%."

At issue is the proposed advance notice released earlier this month that details the payments to MA and Part D plans for the 2024 coverage year. The proposed rule lays out the payment policies and changes to MA capitation rates for the upcoming year as well as outlining key changes to risk adjustment.

When the rule was announced Feb. 1, CMS expected a 1.03% increase for plans. The agency came to this number after factoring in a decline in payments when taking in risk adjustment changes.

Since the rule was released, the insurance industry has pushed back that it will actually result in a 2.27% cut to plans if finalized.

The advocacy group Better Medicare Alliance (BMA) said that the rule "would raise costs and cut benefits for 30 million American seniors who rely on Medicare Advantage, a vital part of Medicare," said BMA President and CEO Mary Beth Donahue in a statement.

The insurance lobbying group AHIP told Fierce Healthcare that a series of policy changes would result in the 2.27% cut to average MA payments, not 1.03% as CMS predicted.

Rents soar for older adults in private-equity owned senior housing

Rebecca Burns reports for **The Lever** on the plight of older adults living in private-equity-owned senior housing. The bottom line: Watch out, private equity is buying up senior housing and hiking up rents; older adults are at risk of eviction.

Background: Older adults need affordable places to live, where they can age in communities with strong support systems. There are some **good options**, but many options are unaffordable. Seeing an opportunity for big profits, private equity has stepped in to the senior housing market.

But, be it senior housing or nursing home care, private equity is watching out for its investors not older adults. In the nursing home arena, private equity firms have lost business as a result of a sharp rise in Covid-19 deaths. To maximize profits, they cut staff. Stories abound of residents not being cared for. The federal government has not addressed this crisis yet. President Joe Biden said in his State of the Union address last year that this type of predatory behavior "ends on my watch."

Wall Street firms have still done well in the nursing home arena, while older adults have struggled. In private-equity-owned nursing homes, at least one group of researchers has found that resident death rates were up by 10 percent. The private equity **firms reduce staffing to increase profits.** One study found a 50 percent increase in use of anti-psychotic medicines at private-equity owned nursing homes; it was the owners' way of compensating for fewer staff.

"Wellness" housing for seniors: Many Wall Street players have moved into owning and renting out "wellness" housing units to older adults. Wellness housing does not require nursing staff. It is different from an assisted living facility and does not provide long-term care services. Investors count on older adults to be able to pay the rent with the proceeds they received from selling their homes.….**Read More**

New Report Spotlights Underuse of Medicare Savings Programs

Far too many people with Medicare have trouble affording their health coverage and care. AARP recently **released a report** on one set of programs that can help people pay some of these costs—the **Medicare Savings Programs (MSPs)**. The report highlights the value of the MSPs, which AARP estimates will save enrollees at least $1,979 in Medicare premiums in 2023, as well as the struggle individuals may have learning about, qualifying for, and enrolling in the programs.

MSPs pay the monthly Medicare Part B premium on behalf of people with limited resources and may help with cost sharing as well.

The **eligibility criteria** are very strict in many states, with low **income and asset limits**. But even for those who qualify, the MSP enrollment process is **notoriously complex**. This likely contributes to **widespread under-enrollment; an estimated** 40% of those who are eligible—2.5 million people—are not enrolled.

AARP lays out issues with eligibility as well as barriers to enrollment. For example, each state has its own enrollment process and application, and many states use the least generous eligibility criteria, despite the flexibility to offer assistance to more people.

The report outlines **efforts from the federal government** to increase awareness of the MSPs, **make enrollment easier, and make retaining coverage easier once enrolled.** The report also goes into what states can do and are already doing to improve access and increase eligibility for the programs.

This issue is especially relevant at the moment, as Medicare Rights has **previously pointed out**. States will begin recertifying Medicaid eligibility soon. Those who no longer qualify will lose coverage, and enrollees who have difficulties navigating these burdensome administrative processes are also at risk. As part of this shift, **Medicaid enrollees who first became eligible for Medicare during the pandemic** but did not sign up will have to do so and apply for an MSP.

People with Medicare are less likely to get dental care

Only about half of older adults in the US have health insurance that covers dental care, according to **new research** out of Harvard. Millions cannot afford to pay out of pocket for dental care. Consequently, people with Medicare are less likely to get dental care and more likely to lose their teeth.

Although you are most at risk of needing dental care by the time you enroll in Medicare, you are least likely to have insurance coverage for dental care. Medicare helps promote health equity when it comes to medical and hospital care. But, because Medicare does not cover dental care, it promotes racial dental health inequities

Medicare Advantage plans often attract enrollees because they claim to offer dental coverage. But, Medicare Advantage plans have no data showing that the dental coverage they offer is easy to access or affordable. And, it appears that most people in Medicare Advantage plans offering dental coverage do not get this benefit. Out-of-pocket costs can be high and in-network providers can be scarce, preventing many Medicare Advantage plan enrollees from getting the dental services they need.

Researchers found that enrollees in Medicare Advantage with a dental benefit did not use dental services any more than people in traditional Medicare, even though traditional Medicare does not cover dental services. Moreover, Medicare Advantage enrollees had a significantly larger drop in dental spending from private insurance at age sixty-five than traditional Medicare enrollees.

The researchers looked at whether people in traditional Medicare and Medical Advantage were able to continue to get dental services after they turned 65. They did not see a decrease in annual visits. But, they saw that nearly nine percent fewer people were receiving fillings or crowns. The researchers also saw that millions more people–nearly one in 20–were losing all their teeth.

"Loss of teeth can have a number of negative downstream effects," said one expert. "It's associated with many geriatric conditions, including frailty and cognitive function."

Share Your Insulin SavingsStory With Us

Thanks to the Inflation Reduction Act, Medicare beneficiaries are paying no more than $35 a month for insulin.

Are you one of them? We need to identify 25 Medicare beneficiaries in your state who take insulin and are now paying less.

Alliance for Retired Americans

Hearing from Americans who are paying less for their insulin will help our work to lower the price of more drugs and cap insulin prices for all Americans who need it.

Please take a moment and click here if the $35 insulin cap is helping you. **Click here**

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RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

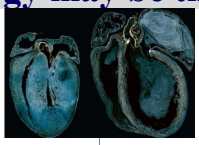
Changes in how the heart produces energy may be the earliest signal of cardiac deterioration

Heart failure is often identified only when the heart has already deteriorated. This is in large part because the cause is unknown for about 70% of people who experience heart failure. Researchers at The Hospital for Sick Children (SickKids) have discovered that one of the earliest signs of heart failure is a change in how the heart produces energy, with findings offering a potential way to preempt heart failure before the heart begins to deteriorate.

Led by Dr. Paul Delgado-Olguín, a scientist in the Translational Medicine program, the research may also help to explain the diversity of causes underlying heart failure.

"We were surprised to find that dysregulation of energy production was the earliest sign of heart failure," says Delgado-Olguín. "People associate deficiency in energy production with later stage heart failure, but our findings show this could actually be the cause of heart failure, not a result."

Changes in energy production signal heart deterioration



In a healthy heart, a protein called lysine demethylase 8 (Kdm8) helps to maintain a balanced energy use, also known as metabolism, by repressing TBX15, another protein that decreases energy production.

In a study published today in *Nature Cardiovascular Research*, the research team analyzed a large dataset on gene expression, the process by which DNA is converted to proteins, in human hearts at a later stage of heart failure and found that KDM8 was less active. This allowed TBX15 to be more highly expressed, leading to changes in metabolism. Researchers also found that TBX15 was expressed at the highest levels in hearts where energy production genes were most strongly suppressed.

"There are many genes that help regulate energy production in our bodies, but we were able to identify changes in specific proteins that occur well before cardiac deterioration," says Delgado-Olguín. After identifying change in energy production as an early sign of heart failure, the research team drilled down further to explore how metabolic pathways could be modified to prevent the failure. In doing so they found that the nicotinamide adenine dinucleotide (NAD^+) pathway, which regulates energy metabolism, was less active. The team was then able to intervene and prevent heart failure in a mouse model by providing NAD^+ injections and boosting energy production.

"This research suggests it may be possible to alter certain metabolic pathways to prevent heart failure before damage to the heart begins," says Delgado-Olguín. "Our research sets the stage to identify children and adults that may be at a higher risk of heart failure, and to improve energy balance in their hearts to prevent it."

Precision health could help predict and prevent heart failure

For the study team, this research is helping contribute to the future of Precision Child Health at SickKids, a movement to deliver individualized care for every child.

"Heart failure is so diverse," says Delgado-Olguín. "But if we could determine that an individual's particular heart is not using energy efficiently early on and is at risk of heart failure, we may be able to predict how they respond to treatment targeted to specific metabolic pathways that could prevent cardiac deterioration."

While international research on NAD^+ treatment in late-stage heart failure is underway, the team hopes that this latest research from the Delgado-Olguín Lab will spark new research on early identification and preventative treatment.

Prior COVID Infection Brings Strong, Long-Lasting Immunity: Study

Natural immunity acquired from a COVID infection provides strong and lasting protection against severe illness if a person becomes reinfected, a new evidence review has concluded.

Ten months after a COVID infection, protection against hospitalization and death remains at 89% for Omicron and 90% for earlier variants, according to pooled data from 65 studies conducted in 19 countries.

However, protection against reinfection wanes quickly with Omicron, which is the dominant COVID strain at this time, researchers found.

After 10 months, a previous case of Omicron provides only 36% protection against a follow-up COVID infection, researchers reported Feb. 16 in *The Lancet*.

The analysis suggests that the level and duration of protection derived from COVID infection is at least on a par with that provided by two doses of the mRNA vaccines developed by Moderna and Pfizer-BioNTech, researchers said.

"These findings are not surprising as multiple studies have shown that prior infection confers protection against severe disease, though it may not confer protection against infection in the Omicron era," said **Dr. Amesh Adalja,** a senior scholar with the Johns Hopkins Center for Health Security in Baltimore. He was not involved in the research.

But because people first infected with the coronavirus run the risk of hospitalization, death and long COVID, researchers concluded that vaccination remains the overall best form of protection against COVID.

"The vaccines and boosters are still the safest way to acquire immunity, mainly for those who are in high-risk populations," said study co-author **Caroline Stein,** a postdoctoral researcher at the University of Washington's Institute for Health Metrics and Evaluation.

In fact, the best protection now appears to come from "hybrid immunity," the combination of an actual infection and vaccination, said **Dr. William Schaffner**, medical director of the Bethesda, Md.-based National Foundation for Infectious Diseases.

"The data are really coming through that that provides the most solid and the longest lasting protection, and that's going to be something that most of us have experienced," said Schaffner, who wasn't part of the study. "Most of us have been vaccinated, and many of us have had COVID infection and recovered. That puts us in reasonably good shape going forward."

The pooled data showed that prior to Omicron, a COVID infection provided strong and lasting protection against both reinfection and severe illness from a follow-up infection.

The protection from reinfection conferred by pre-Omicron strains started at 85% in the first month and declined slightly to about 79% at 10 months.

Unfortunately, the higher contagiousness of the Omicron variants upended that protection.

"The risk of reinfection starts quite reasonable, like 76% at the first month, but up to 10 months it drops to 36%" following an Omicron infection, said co-author **Dr. Hasan Nassereldine**, a postdoctoral researcher also at the Institute for Health Metrics and Evaluation.

The good news: Protection against hospitalization and death remained around 90% for both the earlier strains as well as Omicron

The researchers concluded that natural immunity should be taken into account when testing, approving and scheduling future COVID vaccines and boosters….**Read More**

A New Study Hints That 38% of Cognitive Decline Is Impacted By These Lifestyle Factors

If you can still sing along to every boy band song of the early 2000s and can recite your childhood best friend's phone number, you might be thinking you'll never have to worry about memory challenges.

While it's true that a minority of Americans are officially diagnosed with dementia or Alzheimer's disease, it's probably far more common than you might expect. According to an October 2022 study published in ***JAMA Neurology***, 1 in 10 American seniors is **currently living with dementia**, and another 22% of those 65 and older experience mild cognitive impairment; one of the early signals that more serious cognitive challenges may be on the horizon. That's about one-third of all individuals 65 and older.

Cognitive decline naturally occurs as we get older; it's natural that our ability to remember details, understand, learn and think degrade slightly over time. But when it starts to impact the quality of daily life and the ability to lead a happy, healthy, secure life, that's when a brain-related diagnosis might occur.

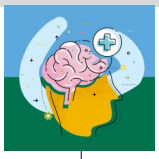
Family history certainly plays a role in the risk for dementia and other cognition-related conditions, and scientists have discovered a variety of habits can also move the needle. Things that have been previously shown to reduce the risk for cognitive complications later in life include:

- Eating **more fruits and vegetables**
- Keeping a **stable blood sugar**
- Limiting intake of **ultra-processed foods**
- Maintaining a **healthy blood pressure**
- Not smoking
- Scoring enough sleep
- Staying socially engaged

Incorporating regular physical activity

But there still appears to be a gap in the understanding of all of the possible risk factors for cognitive decline, so researchers at Ohio State University and the University of Michigan decided to focus their recent efforts to help clear up the cognitive confusion…and potentially prevent cases of cognitive decline in the future.

According to a study published February 8 in the journal ***PLoS ONE***, a handful of less-commonly-cited factors account for about 38% of the cognitive function variation at age 54: personal education level, parental education, household income and wealth, race, occupation and depression status.



What This Brain Health Study Found

For this study, lead author **Hui Zheng, Ph.D.**, professor in the Department of Sociology at Ohio State University and his team crunched the numbers from more than 7,000 American adults born between 1931 and 1941 who had enrolled in the **Health and Retirement Study**. This cognition-related study includes participants' health biometrics from 1996 to 2016, and also has details about lifestyle, such as exercise, smoking status, medical diagnoses and socioeconomic factors.

Dr. Zheng and his team used a statistical approach to try to estimate the role (if any) and the percentage each of their studied factors might impact **neuropathology** (aka diseases of the brian, such as cognitive decline). They found that early life conditions and adult diseases and behaviors played a fairly small role—about 5.6%. But teaming up to contribute a whopping 38% in risk level was a combo platter of socioeconomic status (including education level of both the person and their parents, income/wealth and occupation), race and mental health.

Prior to this study, doctors and scientists had mainly suggested that an individual's choices and actions matter most in maintaining cognitive functioning. This study suggests that it's time to turn some attention to social determinants of health, too.

The Bottom Line

This new brain health study found that education level, income, race and depression status, in tandem with healthy lifestyle habits, play a surprisingly large role in the potential development of dementia or Alzheimer's disease.

You can't isolate one habit or factor and deem it *the* cause of cognitive decline. Brain health is impacted substantially by personal well-being throughout the lifespan. This includes how secure one feels at home, whether or not they're experiencing a mental health challenge like depression, thier level of financial freedom and how much they've been able to study to build up their "brain bank."

All of this points to the importance of viewing brain health through the individual and the systemic lens. A community must be designed in a way to support economic and educational access, mental health resources, has safe places for physical activity, access to a wide variety of foods and the opportunity for social connection. Admittedly, this is a lofty and substantial prospect, and is much easier said than done. But with nearly one-third of all Americans over 65 affected by cognitive impairment, it certainly can't hurt to start exploring ways to improve our current landscape.

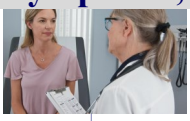
Scabies: What It Is, Symptoms, Treatment & More

Talk about the stuff of nightmares. You have extremely itchy skin at bedtime, not to mention a pimple-like rash. What is it?

Those are fairly clear signs of scabies, a microscopic parasitic infestation where mites burrow under your skin and lay eggs there.

Scabies infection comes from prolonged contact, not just a quick brush against someone else's skin. It can also be passed through bedding or clothing.

"Anyone who is diagnosed with scabies, as well as his or her sexual partners and other contacts who have had prolonged skin-to-skin contact with the infested person, should be treated," the U.S. Centers for Disease Control and Prevention advises.



What is scabies?

This "human itch mite" lives and lays eggs in the upper layer of the skin, according to the CDC.

About 200 million people worldwide have scabies at any one time, including up to 10% of children in poor areas, according to the **World Health Organization**.

Once the eggs hatch, the larvae can travel to the skin's surface, spreading to other areas or other people, according to the **Mayo Clinic**.

What does scabies look like? It may resemble hives, tiny bites, knots under the skin or even eczema-like scaly patches, according to the **American Academy of Dermatology** (AAD). Sores may develop from scratching.

Under magnification, the mite is creamy-white, has eight legs and a round body. It is roughly the size of a needle tip, according to the **Cleveland Clinic.**

How to identify scabies

A doctor can best do this, but signs can include the rash and intense itching that worsens at night.

Mites are most commonly found between the fingers, around the fingernails, on elbows, wrists, at the belt line, in the genital area and around the nipples, according to the AAD.

Sometimes children will have an all-over rash, including their scalp. Infants typically have it on the palms and soles, according to the AAD.

Although scabies is contagious, children can typically return to school the day after treatment, according to an article recently published by *HealthDay*.

A severe form called crusted scabies, or Norwegian scabies, leads to widespread crusts on skin with hundreds or thousands of mites, instead of 15 or 20. It can impact someone with a weakened immune system, according to the AAD….**Read More**

What Is Congestive Heart Failure?

Congestive heart failure is a scary diagnosis nobody wants to hear, but what is the condition and how do you manage it?

Plenty of people are affected: Roughly 5.7 million Americans are living with congestive heart failure, with 670,000 new cases diagnosed each year, according to the **American Heart Association** (AHA).

But, in reality, having heart failure doesn't mean that your heart will never work properly again. Just like there's more than one reason for heart failure, there are several medical treatments available to help you live well with the condition, according to the **National Heart, Lung, and Blood Institute** (NHLBI).

To better understand how to prevent and manage heart failure, it is important to learn what it is, its stages, symptoms, causes and treatments, and the measures you can take to help lower your risk of developing the condition.

What is congestive heart failure?

Congestive heart failure occurs when your heart muscle is too stiff, weak or damaged to pump enough blood to meet your body's needs, according to the NHLBI.

The condition can manifest itself in one of two ways. Acute heart failure comes on suddenly, while chronic heart failure develops over time. Both can lead to additional medical conditions, especially if left untreated. These include liver or kidney damage, **irregular heartbeat**, cardiac arrest and heart valve disease.

What are the 4 stages of congestive heart failure?

According to the **National Center for Biotechnology Information**, the four stages of congestive heart failure are:

- Stage A: A high risk for developing heart failure is present, but there are no symptoms or structural damage to the heart.
- Stage B: Structural damage to the heart is present with no symptoms.
- Stage C: Both structural damage and symptoms are present.
- Stage D: This is end-stage heart failure, which requires advanced treatment interventions such as a heart transplant….**Read More**

Folks With Type 1 Diabetes Are No More or Less Likely to Be Overweight: Study

Type 1 diabetes has long been considered a thin person's disease, but a new study challenges that notion.

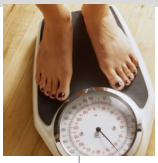
About 62% of adults with type 1 diabetes were overweight or obese, the researchers found. That compared to 64% of those without diabetes and 86% of those with type 2 diabetes.

For the study, the researchers used data on more than 128,000 people from the U.S. National Health Interview Survey.

The investigators found that 34% of adults with type 1 diabetes were overweight. About 28% had obesity.

Despite these high numbers, only slightly more than half of adults with type 1 diabetes who were overweight or had obesity received lifestyle recommendations from health care providers, such as to increase physical activity or cut calories, the findings showed.

The study authors said this is likely because the insulin required to treat type 1 diabetes carries the risk of dangerously low blood sugar levels (hypoglycemia) if combined with intense exercise or severely reduced calorie intake.



"The lack of evidence for safe, effective methods of diet- and exercise-based weight control in people with type 1 diabetes may be keeping doctors from recommending such methods," said study first author Michael Fang, an assistant professor in Johns Hopkins' Bloomberg School of Public Health, in Baltimore. "Large clinical trials have been done in type 2 diabetes patients to establish guidelines for diet- and exercise-based weight management, and we now need something similar for type 1 diabetes patients."

While people with type 1 diabetes were strongly affected by the overweight and obesity epidemic in the United States, they aren't being advised to control their weight to the same extent as people with type 2 diabetes.

"Our study busts the myth that people with type 1 diabetes are not being affected by the global obesity epidemic," senior study author **Elizabeth Selvin**, a professor in the Bloomberg School's department of epidemiology, said in a Hopkins news release. "These findings should be a wake-up call that we need to be aggressive in addressing the obesity epidemic in persons with type 1 diabetes."

Type 1 diabetes is an autoimmune condition that often develops in childhood, though it can also occur in adults. Type 2 diabetes is common in older adults and those who are overweight.

In type 1, a person's immune system mistakenly attacks and destroys pancreatic cells that produce insulin. This is the essential hormone that directs cells to take up glucose from the blood.

About 1.6 million American adults aged 20 and up have type 1 diabetes, according to the U.S. Centers for Disease Control and Prevention. They must rely on an insulin pump or insulin injections.

While being overweight can bring increased risk for a range of serious health conditions, patients with type 1 diabetes may have additional risks. For example, obesity tends to make the body less sensitive to insulin. This could mean needing higher insulin doses or having less predictable blood glucose responses.

Two Vaccines May Soon Shield Seniors Against RSV

Older people have vaccines available to prevent severe influenza and COVID-19, but there's been nothing to protect against the third respiratory virus that contributed to this season's wretched "triple-demic."

Until now.

Two major pharmaceutical companies published clinical trial results this week that pave the way for an RSV (respiratory syncytial virus) vaccine to be available for adults by the time next cold and flu season rolls around.

"RSV continues to be the last of the major winter respiratory viruses for which we don't have a vaccine, but as these two articles in the *New England Journal of Medicine* indicate, we're getting close," said **Dr. William Schaffner**. He is medical director of the National Foundation for Infectious Diseases, in Bethesda, Md.

The companies — **GlaxoSmithKline** (GSK) and **Janssen** — both have RSV vaccine candidates that can prevent severe illness in seniors, results show.

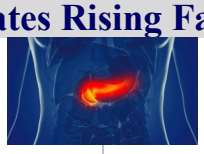
The GSK vaccine provides 94% protection against severe lower respiratory tract RSV, and about 83% protection against lower respiratory tract infections overall, said **Dr. Leonard Friedland**, vice president and director of scientific affairs and public health for GSK U.S. Vaccines.

"We're very, very pleased and excited because this is the first time that an RSV vaccine has made it through phase 3 and has published data in a peer-reviewed journal," Friedland said.

The Janssen vaccine also provided good protection in a phase 2b proof-of-concept trial, preventing severe lower respiratory tract infection in up to 80% of patients, the results showed.

Both vaccines target the virus' F protein, which allows it to attach to human cells in a way similar to COVID's spike protein….**Read More**

Pancreatic Cancer Rates Rising Faster Among Women



While rates of pancreatic cancer are increasing for both men and women, they're climbing the fastest among young women, particularly those who are Black.

"We can tell that the rate of pancreatic cancer among women is rising rapidly, which calls attention to the need for further research in this area," said senior study author **Dr. Srinivas Gaddam**, associate director of Pancreatic Biliary Research at Cedars-Sinai in Los Angeles. "There's a need to understand these trends, and to make changes today so this doesn't affect women disproportionately in the future."

The increase is small, however, and shouldn't be alarming, but future studies will need to examine these trends, Gaddam said.

"The data shows us a small increase in risk of pancreatic cancer," he said in a Cedars-Sinai news release. "And that awareness might refocus people on the need to stop smoking, reduce alcohol use, eat a healthy diet, exercise regularly and manage their weight. These lifestyle changes all help decrease the risk of pancreatic cancer."

In the study, researchers used data from the National Program of Cancer Registries database, which represents approximately 65% of the U.S. population, on patients diagnosed with pancreatic cancer between 2001 and 2018.

The investigators found that rates of pancreatic cancer increased among both women and men.

But rates among women under the age of 55 rose 2.4% higher than rates among men of the same age. Similar increased rates were observed among older men and women.

And rates among young Black women rose just over 2% higher than among young Black men.

"And while we're reporting improving survival in pancreatic cancer each year, that improvement is largely among men," Gaddam added. "The mortality rate among women is not improving."

Reasons may include the type and location of tumors.

Rates of pancreatic head adenocarcinoma, which is an especially aggressive and deadly type of tumor situated at the head of the pancreas, appear to be increasing, according to the study.

The job of the pancreas is to secrete enzymes and hormones that help the body digest food and process sugars. It is located just behind the stomach.

Pancreatic cancer has the highest death rate of all major cancers. It is more common among men than women.

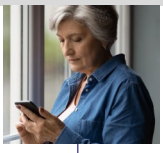
Apple co-founder Steve Jobs, Jeopardy's Alex Trebek, Supreme Court Justice Ruth Bader Ginsburg and actor Patrick Swayze all died from pancreatic cancer.

Unexplained weight loss and jaundice can be signs of pancreatic cancer. People experiencing those symptoms should seek medical attention. Chronic abdominal pain is usually a sign of another condition.

Gaddam plans to research the causes of these trends, including examining potential differences between pancreatic tumors in women and in men.

"This continuing work will help us to evaluate the effectiveness of new health care interventions, with the goal of identifying and addressing disparities in patient outcomes and access to effective treatment," said **Dr. Dan Theodorescu**, director of Cedars-Sinai Cancer. "This is an ongoing focus throughout Cedars-Sinai Cancer as we serve our diverse population and can also inform public health policies to benefit patients everywhere."

Scrolling, Staring at Screens Could Give You 'Tech Neck'



If you spend hours a day scrolling on your smartphone or tablet, you might get "tech neck."

"Humans are upright creatures, and our bodies aren't designed to look down for long periods of time, which puts extra pressure on the cervical spine," said **Dr. Kavita Trivedi**, associate medical director of the Spine Center at UT Southwestern Medical Center in Dallas.

Americans spend about five hours a day on their cellphones and more on laptops and computers, Trivedi noted in a university news release.

As a result, people can experience muscle stiffness, joint inflammation, pinched nerves, arthritis, and even bone spurs or herniated discs.

A typical adult head weighs 10 to 12 pounds. Bending it at a 45-degree angle increases the force on the neck to nearly 50 pounds.

"With repetition, that force can strain or injure the facet joints that connect our vertebrae," Trivedi said. "When that happens, the surrounding muscles naturally tighten up to protect nearby nerves, which leads to inflammation, pain and knots in your neck — what is often referred to as tech neck."...**Read More**

HealthLink Wellness *"Taking Control"* Science for the Individual

Some of the Highlights:

- Revolution in Personal Control of Health Based on Science

There is a revolution taking place in personal health and wellness. This book is the results of 20 years of a community-based wellness program "HealthLink Wellness". As you open the book you will see that it is the culmination of the cooperation and funding of many groups, both labor and non-labor. A true community partnership.

Scientifically Derived Health Outcome Measures:

- HealthLink Risk Profile Index

Ten-year probability estimates of coronary heart disease, originally developed by the Framingham Heart Study. It has the endorsement of both the American College of Cardiology and American Heart Association. A Risk Profile calculator was developed so that individuals can monitor their own personal progress.

- Wellness-Comorbidity Matrix.

It is designed to outline for the individual the dynamics of wellness and comorbidity interaction. Its use, in conjunction with the Risk Profile Index, is to make it easier for individuals to set reasonable incremental goals.

Some of Our Results with Retiree Health:

- Reduce the number of individuals with hypertension from 61% to 37%
- Increase the number of individuals with normal blood glucose from 51% to 71%
- Increase the number of individuals with normal Total Cholesterol from 48% to 70%
- In addition to the science of wellness, this book also covers how HealthLink Wellness successfully determined the feasibility of coordinating our community efforts with those of primary care physicians, creating an environment where the patient, community, and medical office work as a team. ***Now Available On Amazon.com*** **& Kindle e books. Click on image below.**