Rhode Island Alliance for Retired Americans®

RI ARA

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Eliminating Social Security provisions that reduce benefits for some state and local workers is not the way to help retirees

All state and local workers should be covered by Social Security

President-elect Biden proposes to eliminate the Windfall Elimination Provision (WEP) and the Government Pension Offet (GPO). These provisions reduce Social Security benefits for workers with significant government pensions from jobs not covered by Social Security and for their spouses and survivors.

Eliminating these provisions would be a mistake. They are well-intentioned attempts to solve an equity issue that arises because about 25% to 30% of state and local workers are not covered by Social Security.

Exclusion from Social Security creates two types of problems.

First, employees lacking coverage are exposed to a variety of gaps in basic protection — most notably in the areas of survivor and disability insurance. Second, uncovered state and local workers can gain minimum coverage under Social Security and — until the introduction of the WEP in 1983 — could profit from the progressive benefit structure, which was designed to help low-wage workers.

To see how that happens, look at the Social Security benefit formula. It applies three factors to the individual's average indexed monthly earnings (AIME). Thus, in 2020, a person's benefit would be the sum of 90% of the first $960 of AIME, 32% of AIME between $960 and $5,785, and 15% of AIME over $5,785 (see Table 1).

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Since a worker's monthly earnings are averaged over a typical working lifetime (35 years), a high-wage earner with a short period of time in covered employment looks exactly like a low-wage earner. Both would have 90% of their earnings replaced by Social Security. Similarly, a spouse who had a full career in uncovered employment — and worked in covered employment for only a short time or not at all — would be eligible for the spousal and survivor benefits.

The WEP reduces the first factor in the benefit formula from 90% to 40%; the 32% and 15% factors remain unchanged. It is not a perfect solution. The benefit cut is proportionately larger for workers with low AIMEs, regardless of whether they were a high- or low-earner in their uncovered employment. Albeit, the WEP does guarantee that the reduction in benefits cannot exceed half of the worker's public pension, which protects those with low pensions from uncovered work.

Several years ago, Rep. Kevin Brady (R-Texas) introduced a bill with a new WEP formula. It involved two steps. First, the regular Social Security factors would be applied to all earnings — both covered and uncovered — to calculate a benefit. The resulting benefit then would be multiplied by the share of the AIME that came from covered earnings. Such a change would produce smaller reductions for the lower paid and larger reductions for the higher paid. That is a better approach.

Thus, the WEP would benefit from a little reform. But neither the WEP nor GPO should be eliminated. These provisions address a real inequity associated with having some state and local workers not covered by Social Security.

The bigger question, however, is whether it is worth the trouble of creating a whole new procedure when the real answer is to extend Social Security coverage to all state and local workers. Universal coverage would both offer better protection for workers and eliminate the equity problem.

Table 1. *Social Security Benefit Formula, 2020*

Factor	Average Indexed Monthly Earnings
90%	of the first $960 of AIME, plus
32%	of AIME over $960 through $5,785
15%	of AIME over $5,785

Source: U.S. Social Security Administration. 2020. "Benefit Formula Bend Points."

Ossoff, Warnock Senate Victories a Momentous Win for Retirees

The following statement was issued by Richard Fiesta, Executive Director of the Alliance for Retired Americans, regarding the results of the Senate runoff elections in Georgia:

"The 4.4 million members of the Alliance for Retired Americans, including our more than 69,000 members in Georgia, extend their congratulations to Senators-elect Raphael Warnock and Jon Ossoff for their hard won victories. Georgia voters turned out in record numbers and cast their ballots for two candidates who will put the interests of retirees and all Georgians ahead of the wealthiest Americans and corporations.

"These elections also mean the end to Senator Mitch McConnell's control of the Senate. We look forward to halting constant threats to our earned retirement benefits and making progress on the issues most important to retirees, including ending the pandemic, strengthening Social Security, and lowering prescription drug prices."

Rich Fiesta,

ADD YOUR NAME

Get The Message Out:
SIGN THE GPO/WEP PETITION!!!!

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Those Over Age 75, Essential Frontline Workers Should Be Next in Line for Covid 19 Vaccine

The Advisory Committee on Immunization Practices (ACIP), a federal panel advising the Centers for Disease Control and Prevention, has approved recommendations that people **over the age of 75 and essential frontline workers** be next in line for the Covid-19 vaccines. They would follow the health care workers, nursing home residents and staff vaccinated during the initial phase of the inoculations.

The panel's recommendations are non-binding and state officials will make the final decisions on the order of vaccinations; however, many states are looking to ACIP to help them settle challenging ethical questions over the distribution of the scarce supply of doses.

About 20 million people are 75 or older and there are about 30 million front-line workers, including police, firefighters, teachers and grocery workers. Seniors between the ages of 65-74, other essential workers and people between the ages of 16-64 with high-risk conditions would be inoculated after those groups.

"The recommendations reflect the fact that seniors are the most likely to face serious illness or death from the virus," said Alliance Executive Director **Richard Fiesta**. "Unfortunately it will take months to complete the process. We must continue to wear our masks and social distance as much as possible in the meantime. Please follow the CDC guidelines."

Rich Fiesta,

Nursing Home Occupancy is Down Sharply Across the Nation

The pandemic is changing the way Americans care for seniors, with a growing number of families opting for in-home care over nursing homes. Nursing home use has been decreasing gradually for years, with occupancy in 2019 at 80%, down from 84% a decade earlier. The pandemic has accelerated the trend due to deaths, fear of infection and family members' concerns over restricted visitation at the facilities.

This year alone **occupancy in nursing homes is down 15%**, or more than 195,000 residents. More than 115,000 deaths caused by Covid-19 have been linked to long-term care facilities.

Nursing-home operators say that rising numbers of baby boomers with a need for institutional care will drive occupancy rates back up.

Surveys have long shown many seniors prefer aging at home, and the pandemic has made nursing homes even less popular, according to a September survey of adults 40 and older by AARP. Just 7% said they would prefer a nursing home for family members needing long-term care, and 6% said they would choose one for themselves. Nearly three in 10 respondents said the pandemic had made them less likely to choose institutional care.

"Once the pandemic is over, long term care trends are unlikely to return quickly to the way they were," said **Robert Roach, Jr.**, President of the Alliance. "We are going to see the after-effects from the pandemic for a long time, with more seniors aging in place, before demographic changes bring the number of nursing home residents back up."

Robert Roach, Jr

When can I change my Medicare coverage in 2021?

Dear Marci,
I have been thinking about making changes to my Medicare coverage. I know there are specific times of the year during which I can make changes, though. When can I change my Medicare coverage in 2021?
- Alexandra (Roswell, NM)

Dear Alexandra,
Yes, there are certain periods of time when you can make changes to your Medicare coverage. These periods of time are called enrollment periods. If you have a Medicare Advantage Plan, you may be able to use the Medicare Advantage Open Enrollment Period (MA OEP).

- The MA OEP occurs each year from January 1 through March 31.
- During the MA OEP you can switch from your Medicare Advantage Plan to another Medicare Advantage Plan or to Original Medicare with or without a prescription drug plan.
- You may only make one change during this period, and it will be effective the first of the next month after you make the change.

Remember, you can only use this enrollment period if you have a Medicare Advantage Plan.

Depending on your circumstances, you may qualify for a Special Enrollment Period (SEP) to change your Medicare health and drug coverage.

There are many circumstances in which you may have a **Special Enrollment Period (SEP)**, such as if you moved outside of your plan's service area, your Medicare Advantage Plan terminated a significant amount of its network providers, or you are enrolled in a State Pharmaceutical Assistance Program (SNAP).

Those with Extra Help, the federal program that helps pay for drug costs, have an SEP to enroll in a Part D plan or switch between plans once per quarter in the first three quarters of the year.

If you need to make changes to your coverage but you are not sure whether you qualify for an SEP, call your State Health Insurance Assistance Program (SHIP) to learn more. If you do not know how to contact your SHIP, call 877-839-2675 or visit **www.shiptacenter.org**.

If you enrolled in a plan by mistake or because of misleading information, you may be able to disenroll and change plans.

- Typically, you have the right to change plans if you joined unintentionally, joined based on incorrect or misleading information, or, through no fault of your own, were kept in a plan you did not want.
- You can call 1-800-MEDICARE to explain to a customer service representative how you joined the plan by mistake and to request retroactive disenrollment or a Special Enrollment Period.

Finally, both individuals with Original Medicare and those with a Medicare Advantage Plan can make changes during Fall Open Enrollment.

- The Fall Open Enrollment Period occurs each year from October 15 through December 7.
- During this period you can join a new Medicare Advantage Plan or stand-alone prescription drug plan (Part D) plan. You can also switch between Original Medicare with or without a Part D plan and Medicare Advantage.
- You can make as many changes as you need during this period, and your last coverage choice will take effect January 1.

As you can see, there are various enrollment periods in which you can change your Medicare coverage. Which enrollment period you use depends on your specific circumstances and the kind of coverage you have.
- Marci

2020 Omnibus budget bill improves Medicare

The 2020 **Omnibus budget bill** that President Trump just signed into law includes key provisions that improve Medicare. The combined $1.4 trillion appropriations bill and $900 billion Covid relief bill will help millions of older and disabled Americans in a host of ways. On the healthcare front, it will make it easier to get Medicare coverage.

Among other things, the bill speeds up the time it takes to become eligible for Medicare. People who enroll late in Medicare will be able to gain coverage without a lengthy waiting period. For decades now, people who waited to enroll in Medicare were penalized for delaying their enrollment and often had to go without coverage for several months.

The Medicare provisions in the law were provisions in the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act (S. 1280/H.R. 2477). Senators Bob Casey and Todd Young and Representatives Ruiz, Bilirakis, Schneider, and Walorski sponsored that bi-partisan legislation. No longer will people be forced to go without coverage for several months because they delayed enrolling in Medicare. Beginning in 2023, if you sign up for Medicare in the fifth, sixth or seventh month of your initial enrollment period or during the general enrollment period, your Medicare coverage will begin the following month.

In addition, the **Medicare general enrollment period** will change to align with the Medicare annual open enrollment period. It will begin October 15 and run through December 31.

CMS will also now have greater authority to give people a Special Enrollment Period (SEP) for "exceptional circumstances."

All of these changes improve Medicare. They promote health and economic security for older and disabled Americans.

Two Courts Halt Rule Tying Certain Drug Prices to Other Countries

Near the end of this past November President Trump issued two rules aimed at lowering prescription drug prices that affect Medicare beneficiaries. The rules followed up on executive orders that Trump signed in July.

One rule, known as "most favored nation," would require Medicare to tie the prices it pays for drugs to those paid by other wealthy countries. The other rule would limit rebates paid to middle men (called "pharmacy benefit managers" or "PBMs") by drug makers in Medicare.

There are two points to remember about the first rule: Medicare has always been barred from negotiating prices directly with drug companies; and other countries regulate their health care spending more heavily, including for prescription drugs.

The first new rule affects Medicare Part B drug costs, which are typically infused or injected drugs used mainly in the treatment of cancer. The intent is to cap the cost of those drugs at the lowest price that drug manufacturers receive in other countries and to pay doctors a flat fee for each dose of a drug, instead of a percentage of each drug's cost.

The Centers for Medicare and Medicaid Services said the rule would be mandatory and will focus on 50 single source drugs and biologic drugs that comprise the largest majority of Medicare Part B drug spending.

However, one week ago a federal judge in California issued a ruling stopping the implementation of the rule because of the "government's failure to complete the notice and comment procedures required by the Administrative Procedure Act."

That was the second ruling in a week to delay the policy. A federal judge in Maryland had ordered on Dec. 23 that the rule, which was slated to take effect Jan. 1, be paused for two weeks.

The Health and Human Services Department finalized the policy through an interim final rule in November, meaning the agency skipped the comment period...**Read More**

Medicare coverage changes for 2021

Understandably, Americans fear the federal government these days at least as much as they value federal action. Federal action for the public good gets far less attention and credit than it deserves. Most recently, **HealthCareDive** reports that the Centers for Medicare and Medicaid Services (CMS) improved Medicare coverage, taking a lead yet again over the private health insurance industry in ensuring Americans get the health care they need.

Often more than local and state government, the federal government can be a force of good. When it comes to health insurance, for example, CMS tends to be a leader, supporting innovations in traditional Medicare–public health insurance–which private insurers end up following. Most recently, CMS expanded Medicare coverage of **telehealth services** and increased payments to primary care providers.

Telehealth services are growing dramatically for people with Medicare. Before the pandemic, in a given week, 15,000 people with traditional Medicare used telehealth services. In the seven months between mid-March and mid-October, 24.5 million people in traditional Medicare used telehealth services.

Of note, we have far less information about the services people in Medicare Advantage plans are using. Good data is not available. This is a serious limitation of private health insurance that should be of grave concern to people with Medicare, public health experts, researchers, lawmakers and the public at large.

The private Medicare Advantage plans are largely unaccountable for the hundreds of billions of dollars they receive every year to deliver Medicare-covered services, even though they have been found to be **overcharging the federal government tens of billions of dollars every year** and engaging in widespread inappropriate **delays and denials of care**. The private insurers covering working people are no better and likely far worse, as these insurers tend to be even less accountable than Medicare Advantage plans.

Under the new CMS rules, people in traditional Medicare can now receive group psychotherapy through telehealth as well as home visits and care planning services. People in Medicare Advantage plans should also be covered for these services, as Medicare Advantage plans are supposed to cover all Medicare- covered services.

The Medicare Payment Advisory Commission, MedPac weighed in on Medicare's new payment rules, saying that they could increase access to care for people with Medicare. Medicare, like private health insurers, has traditionally underpaid primary care providers. Traditional Medicare has now increased payment rates for evaluation and management services. Because it must be payment neutral, it has decreased rates for some specialty services.

Why Congress isn't stopping ambulances from issuing surprise bills?

The new federal law banning **surprise medical bills** does not do as good a job protecting people from unexpected bills as traditional Medicare–which does not allow them at all. It simply keeps out-of-network doctors, hospitals and air ambulances from charging patients directly for services they receive, over which they have little if any control. But, it doesn't stop out-of-network ground ambulances from charging people a small fortune for their services. Why doesn't it?

Of all the surprise bills people receive, ambulance bills are particularly common. By some accounts, more than seven in ten ambulance rides are out of network. And, the average cost to patients for the service is $450. But, even though these costs keep people from calling 911 in a health emergency, members of Congress could not bring themselves to ban out-of-network bills for ambulance services.

Part of the issue, according to the **New York Times**, is that federal lawmakers did not want to take on local lawmakers who are often responsible for allowing these ambulance bills. Many ground ambulances are run by municipalities that need the money they receive for out-of-network services, particularly given the economic devastation Covid has wrought.

High private ambulance charges are common. But, public agencies that provide ambulance services appear to be as bad as private ambulance companies at sending out surprise bills. In a given year, patients owe around $129 million for ambulance services.

Members of Congress also apparently felt that they did not know enough to regulate ambulance companies. For example, there is little information on what it costs to maintain an ambulance. They did not want to act rashly, perhaps thinking that they would drive ambulance companies out of business.

Many states that are regulating surprise bills do not yet regulate ambulance services. Shockingly, in Texas, 85 percent of ambulance services are out of network. City-run ambulances do not have contracts with health insurers. In Colorado, private ambulances cannot issue surprise bills; but, they can charge as much as 3.25 times Medicare's rate for ambulance services. Public ambulances can send out surprise bills, allegedly because the fire chiefs who often provide ambulance services lobbied against having the fire departments' bills regulated.

Instead of banning surprise ambulance bills, Congress established a commission to examine and report back information about ground ambulance services and bills. Traditional Medicare pays a regulated rate for ambulance services. It plans to collect more data on ambulance costs and share it.

Judge Rules Hospitals Must Disclose Prices

In yet a third judicial ruling, The U.S. District Court of Appeals for the District of Columbia upheld a rule by the Trump Administration that hospitals will have to publicly disclose the prices they negotiate with insurance companies.

While the other two rulings went against the Trump Administration, this one was a win on a key piece of Trump's health-care agenda at the end of his administration.

Under the hospital price transparency rule, some 6,000 U.S. hospitals will have to publicly provide their negotiated rates with insurers for 300 common medical services, along with the discounted cash price they're willing to accept for those procedures.

Industry groups and health systems led by the American Hospital Association challenged the rule, arguing that the rule would do more harm than good because it won't "tell consumers their actual out-of-pocket costs, will likely produce confusion and may be *less* effective than the price-transparency tools the hospital field has been developing."

Drug Discount Cards

In mid-December there were reports that the Administration expected to begin sending out President Trump's promised $200 drug discount cards to seniors by Jan. 1. However, we have not heard any report about whether or not that has begun. We will keep you posted when there is new information about the distribution of the cards.

Despite the coronavirus emergency, TSCL is continuing its fight for you to protect your Social Security, Medicare, and Medicaid benefits. We have had to make some adjustments in the way we carry on our work, but we have not, and will not stop our work on your behalf.

Florida senior citizens camp in line overnight for COVID-19 vaccine

Some senior citizens in Florida are so desperate to get coronavirus vaccinations, they spent a night camped in line for the first-come-first-served shots, according to reports Wednesday.

The sidewalk next to Lakes Regional Library in Fort Myers looked more like one outside a hot Broadway show — as dozens of elderly folks sat in folding chairs with blankets to get the life-saving jabs Tuesday, **according to WINK News.**

"This is worth it," said 80-year-old Aaron Stern, who said he'd never camped out for concert tickets or Black Friday deals. "The opportunity to feel safe again and to be able to go out is wonderful."

Other seniors in the state — where Gov. Ron DeSantis recently issued an order allowing people 65 and older to get vaccinated — said they were willing to brave long lines after seeing friends die from the virus.

"I'm scared, that's why, and I wanna [feel] free," senior Frank Mihalik told the outlet of why he'd come.

Other geriatric line-sitters — who brought snacks, coolers and sleeping bags — said they were desperate for the vaccination because they miss seeing family members and are sick of being stuck at home.

Senior Judy Morris said: "I haven't seen my children in about a year … [I'll do] whatever it takes."

Outside Estero Park and Rec Center in Cape Coral, the number of seniors waiting for shots exceeded capacity by noon Tuesday — two hours before the clinic was scheduled to begin giving out vaccinations, **according to USA Today.**

DeSantis issued an executive order Saturday that ignored **Centers for Disease Control and Prevention recommendations** for COVID-19 vaccine priority by letting seniors get the shots before essential workers.

The order sparked long lines at some sites in Lee County, prompting the sheriff's office to send out a traffic alert due to crowding, the paper reported.

Seniors Face Crushing Drug Costs as Congress Stalls on Capping Medicare Out-Of-Pockets

Sharon Clark is able to get her life-sustaining cancer drug, Pomalyst — priced at more than $18,000 for a 28-day supply — only because of the generosity of patient assistance foundations.

Clark, 57, a former insurance agent who lives in Bixby, Oklahoma, had to stop working in 2015 and go on Social Security disability and Medicare after being diagnosed with multiple myeloma, a blood cancer. Without the foundation grants, mostly financed by the drugmakers, she couldn't afford the nearly $1,000 a month it would cost her for the drug, since her Medicare Part D drug plan requires her to pay 5% of the list price.

Every year, however, Clark has to find new grants to cover her expensive cancer drug.

"It's shameful that people should have to scramble to find funding for medical care," she said. "I count my blessings, because other patients have stories that are a lot worse than mine."

Many Americans with cancer or other serious medical conditions face similar prescription drug ordeals. It's often worse, however, for Medicare patients. Unlike private health insurance, Part D drug plans have no cap on patients' 5% coinsurance costs once they hit $6,550 in drug spending this year (rising from $6,350 in 2020), except for very low-income beneficiaries. President-elect Joe Biden favors a cap, and Democrats and Republicans in Congress have proposed annual limits ranging from $2,000 to $3,100. But there's disagreement about how to pay for that cost cap. Drug companies and insurers, which support the concept, want someone else to bear the financial burden.

That forces patients to rely on the financial assistance programs. These arrangements, however, do nothing to reduce prices. In fact, they help drive up America's uniquely high drug spending by encouraging doctors and patients to use the priciest medications when cheaper alternatives may be available.

Growing Expense of Specialty, Cancer Medicines

Nearly 70% of seniors want Congress to pass an annual limit on out-of-pocket drug spending for Medicare beneficiaries, according to a KFF survey in 2019. (KHN is an editorially independent program of KFF.)

The affordability problem is worsened by soaring list prices for many specialty drugs used to treat cancer and other serious diseases. The out-of-pocket cost for Medicare and private insurance patients is often set as a percentage of the list price, as opposed to the lower rate negotiated by insurers….**Read More**

Treasury Warns Banks of Covid-19 Vaccine Fraud

The Treasury Department alerted financial institutions to fraud related to Covid-19 vaccines, warning of ransomware attacks that target vaccine delivery operations and supply chains.

The Treasury's Financial Crimes Enforcement Network cautioned on Monday of an array of vaccine-related crimes, including the sale of unapproved, counterfeit or illegally marketed vaccines. In addition, fraudsters have offered to provide individuals with a vaccine sooner than provided under authorized distribution plans, FinCEN said.

Cybercriminals, meanwhile, have targeted vaccine researchers with ransomware, the Treasury unit said. It warned financial institutions as well as their customers to be on the lookout for phishing schemes seeking to snare victims with misinformation about vaccines.

Financial institutions are required to report all transactions that might be dubious. Such suspicious activity reports, or SARs, are intended to help federal authorities disrupt the flow of money to terrorists, drug traffickers, arms proliferators and other bad actors.

FinCEN asked that banks pay close attention to Treasury-issued guidance on reporting suspicious activity, particularly pertaining to the Covid-19 pandemic. The Treasury unit called on banks to offer detail on how a possible scammer contacted the purported victim and how payments were made or attempted….**Read More**

Report Calls for Congress to Add Oral Health and Other Key Coverage to Medicare and Medicaid

A recent Center on Budget and Policy Priorities (CBPP) report ***Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits*** highlights the need for dental, vision, and hearing benefits in the two programs, and calls on Congress to fill these gaps in coverage.

As the Center for Medicare Advocacy has detailed in previous *CMA Alerts* and advocacy, Medicare does not currently provide comprehensive coverage for oral health, or for vision or hearing. The CBPP report cites this gap in Medicare coverage, while also highlighting the limited benefit in Medicaid. "States are not required to offer dental, vision, or hearing services to adult Medicaid enrollees. . . . the scope of the benefits varies widely between states, and states often cut these benefits when facing budget shortfalls."

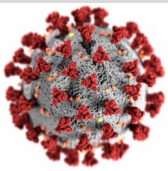
Serious health consequences can arise from untreated dental, vision and hearing needs in both populations. Lack of coverage can lead to delays in necessary treatment, often resulting in more expensive treatment at a later time, decreased quality of life, additional emergency department visits, complications for other chronic conditions and harm to overall health.

In calling for Congressional action, the Report also cited disparities in care, with statistics demonstrating that low-income adults and people of color were more likely to have poor access to care and increased unmet needs, such as untreated cavities. "Among adults aged 65 and older, 37 percent of those in poverty had complete tooth loss, compared to just 16 percent of those with incomes at or above 200 percent of the poverty line."

The Report emphasized that only expanding coverage in Medicare would be insufficient to meet the vast need for such services among vulnerable adults. "Fixing gaps in coverage only in Medicare without making the corresponding changes in Medicaid would exclude many people with significant unmet needs. Providing access to a full range of preventive services and treatment for non-elderly adults with Medicaid coverage could prevent more serious conditions later in life as well as the need for more invasive, costly procedures."

RI ARA HealthLink Wellness News

Precautions Even More Important With New Coronavirus Variant: Experts



A new and more infectious variant of the COVID-19 virus has shown up in separate cases in Colorado and California, weeks after it first emerged in the United Kingdom.

Doctors on the pandemic's front line say people shouldn't panic, but should definitely adhere even more closely to proven infection control measures, like mask wearing and social distancing.

"While the new strain is more transmissible -- up to 70% by a recent analysis -- the mutation itself has not previously been thought to be more virulent [able to cause harm] than the current strains that have been circulating in the U.S. and abroad," said Dr. Robert Glatter. He's an emergency medicine physician at Lenox Hill Hospital in New York City.

There is no evidence that the new variant makes people any sicker or increases the overall risk of death from COVID-19, according to the U.S. Centers for Disease Control and Prevention. It also appears that COVID-19 vaccines should protect against it.

U.K. researchers first detected the new variant in September, and it now is highly prevalent in London and southeast England, the CDC says.

About 15% of people exposed to someone carrying the variant wind up infected, compared with a 10% infection rate associated with the standard COVID-19 coronavirus, according to a report by British public health officials.

But data from the United Kingdom has shown that the new variant doesn't appear to have any resistance against the COVID-19 vaccines being distributed across America, Glatter said.

"The new strain has not yet been shown to be more resistant to the Pfizer and Moderna mRNA-based COVID-19 vaccines that have recently been rolled out, along with other vaccine candidates in Phase 3 trials and yet to be granted emergency use authorization," Glatter said.

These mRNA vaccines are engineered to induce the immune system to produce antibodies to multiple areas of the spike protein, he said. The spike protein, found on the outer surface of the virus, is the primary way the virus attaches to cells in the body, he explained.

Dr. Ashish Jha, dean of the Brown University School of Public Health in Providence, R.I., agreed with Glatter.

"There's no evidence so far -- and we're still studying it -- that it's any deadlier," Jha told *ABC News*. "And I'm not at all worried it's going to escape the vaccine."

However, the fact that a new variant has reared its head shows that researchers will need to maintain a constant watch, to make sure the coronavirus doesn't eventually mutate away from the protection afforded by these vaccines, Glatter added.

"We can't be complacent and must focus our attention on critical mutations by engaging in active genomic surveillance as the pandemic continues to rage throughout the U.S. and globally," Glatter said. "This may ultimately require us to adjust the makeup of current vaccines over the next several years."

The presence of this new variant provides additional impetus to protect yourself and those around you against the spread of the coronavirus, Glatter said.

"With the reality of a variant strain now circulating globally, the importance of adherence to tried-and-true measures of mitigation -- physical distancing, wearing a mask and hand hygiene -- are now more important than ever to reduce transmission," he said.

'Warp Speed' Officials Say U.S. COVID Vaccine Distribution Too Slow

Even though 11.4 million doses of the approved Pfizer and Moderna COVID-19 vaccines had been distributed across the United States by Monday morning, just 2.1 million had made it into the arms of high-risk Americans.

That's far too slow a pace, said one official charged with spearheading the vaccination of Americans.

"We agree that that number is lower than what we hoped for," Moncef Slaoui, scientific adviser of Operation Warp Speed, the federal effort to accelerate vaccine development and distribution, said at a Wednesday news briefing, *The New York Times* reported. "We know that it should be better," he said, "and we're working hard to make it better."

Already by Wednesday, the number of distributed doses had risen to 14 million, and the 2.1 million vaccination tally -- compiled by the U.S. Centers for Disease Control and Prevention -- could be somewhat low. At a separate news briefing held Wednesday, the CDC announced the number of Americans who'd gotten the first dose of vaccine stood at 2.6 million, the *Times* said.

Still, even that number is a far cry from an earlier prediction federal officials had made that 20 million people would have gotten a dose of vaccine by the end of December.

Just why delays are happening is unclear.

Speaking at the "Warp Speed" news briefing, logistics coordinator Gen. Gustave Perna cited possible reasons as the holiday season, winter weather and lags in reporting as possible factors slowing delivery. According to the *Times*, he said that health care facilities are still learning how to store the vaccines at super-low temperatures, and many states are setting aside doses for use at long-term care facilities, an effort that's expected to take several months.

Right now, most shots are being given at hospitals, clinics and nursing homes, but Perna and Slaoui agreed that the pace of vaccination should pick up considerably once doses are given out by the major pharmacy chains.

"What we should be looking at is the rate of acceleration over the coming weeks," Slaoui said, "and I hope it will be in the right direction."

President-Elect Joe Biden has been critical of the slow pace of vaccine deployment. Speaking Tuesday in Wilmington, Del., he said that at current rates, "it's going to take years, not months," to vaccinate the entire U.S. population.

Biden is vowing that upon taking office on Jan. 20, he will he activate a law known as the Defense Production Act to "order private industry to accelerate the making of the materials needed for the vaccines as well as protective gear."

But the Trump administration has already taken that step to speed up vaccine manufacturing, the *Times* noted, so it's unclear how Biden's plan will differ. Biden has pledged to administer 100 million vaccine doses -- enough to provide 50 million people with the two doses needed for protection -- within the first 100 days of his presidency.

"This is going to be the greatest operational challenge we've ever faced as a nation," Biden said, "but we're going to get it done."

***New coronavirus variant now spotted in California, Colorado*...Read More**

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Many Health Plans Now Must Cover Full Cost of Expensive HIV Prevention Drugs

Ted Howard started taking Truvada a few years ago because he wanted to protect himself against HIV, the virus that causes AIDS. But the daily pill was so pricey he was seriously thinking about giving it up.

Under his insurance plan, the former flight attendant and customer service instructor owed $500 in copayments every month for the drug and an additional $250 every three months for lab work and clinic visits.

Luckily for Howard, his doctor at Las Vegas' Huntridge Family Clinic, which specializes in LGBTQ care, enrolled him in a clinical trial that covered his medication and other costs in full.

"If I hadn't been able to get into the trial, I wouldn't have kept taking PrEP," said Howard, 68, using the shorthand term for "**preexposure prophylaxis**." Taken daily, these drugs — like Truvada — are more than 90% effective at preventing infection with HIV.

Starting this month, most people with private insurance will no longer have to decide whether they can afford to protect themselves against HIV. Most health plans must begin to cover the drugs then without charging consumers anything out-of-pocket (some plans already began doing so last year).

Drugs in this category — Truvada, Descovy and, newly available, a generic version of Truvada — **received an "A" recommendation** by the U.S. Preventive Services Task Force. Under the Affordable Care Act, preventive services that receive an "A" or "B" rating by the task force, a group of medical experts in prevention and primary care, must be covered by most private health plans without making members share the cost, usually through copayments or deductibles. Only plans that are grandfathered under the health law are exempt.

The task force recommended PrEP for people at high risk of HIV infection, including men who have sex with men and injection drug users.

In the United States, more than 1 million people live with HIV, and nearly 40,000 new HIV cases are diagnosed every year. Yet fewer than 10% of people who could benefit from PrEP are taking it. One key reason is that out-of-pocket costs **can exceed $1,000 annually**, according to a study published in the American Journal of Public Health last year. Required periodic blood tests and doctor visits can add hundreds of dollars to the cost of the drug, and it's not clear if insurers are required to pick up all those costs….**Read More**

Tips for Making 2021 a Healthier Year

A New Year's resolution to take better care of yourself is one you should keep, especially in the era of COVID-19.

Wearing a mask, maintaining a safe distance from others and washing your hands frequently are going remain important in 2021. But don't forget to prioritize a healthy lifestyle that improves your overall health and quality of life, and helps prevent cancer, according to experts at the Rutgers Cancer Institute of New Jersey.

The institute offers the following tips:

Eat a healthy diet and watch your weight.

- For cancer prevention, the American Institute for Cancer Research and the American Cancer Society recommend maintaining a healthy weight, staying active and eating a healthy diet. That's one rich in whole grains, vegetables, fruit and beans, with a minimum of red and processed meats, fast food and processed foods high in fat, starches or sugars. Avoid sugary drinks.
- Cutting out alcohol lowers the risk of many cancers, including breast cancer.

Exercise regularly. It has many benefits for physical and mental well-being.

- Current guidelines recommend at least 150 to 300 minutes a week of moderate-intensity, or 75 to 150 minutes a week of vigorous-intensity aerobic physical activity.
- Muscle-strengthening activities should also be included.
- Sitting for a long time watching TV or using the computer is discouraged.
- Find fun ways to stay active, such as online exercise classes, or walking or jogging in your neighborhood.

Quit smoking.

- Lung cancer is the leading cause of cancer death. Quitting smoking will lower the risk for many cancers, including those of the lungs, mouth, throat, blood, bladder, esophagus, stomach, pancreas and kidneys.

Getting preventive care is an important step to manage your health.

- This includes cancer screenings, which can detect cancer before it spreads.

Top FDA Officials Say Two Full Doses of COVID Vaccines a Must

Two top officials at the U.S. Food and Drug Administration said Monday that any American who gets the Moderna or Pfizer coronavirus vaccines must get two full doses, despite international debate on possible ways to stretch vaccine supply.

"We have been following the discussions and news reports about reducing the number of doses, extending the length of time between doses, changing the dose [half-dose], or mixing and matching vaccines in order to immunize more people against COVID-19," FDA Commissioner Dr. Stephen Hahn and Dr. Peter Marks, who heads FDA's vaccine division, said in an agency statement.

"These are all reasonable questions to consider and evaluate in clinical trials. However, at this time, suggesting changes to the FDA-authorized dosing or schedules of these vaccines is premature and not rooted solidly in the available evidence," they added.

On Sunday, Operation Warp Speed's top adviser, Moncef Slaoui, told *CNN* that the FDA would consider giving half-doses of Moderna's vaccine to people aged 18 to 55 -- which could deliver the vaccine to twice as many people in that age group.

Slaoui said earlier data showed that the vaccine appeared to rouse similar antibody responses among volunteers under age 55 who received either the full 100-microgram dose or a half dose.

But Marks and Hahn said these preliminary findings covered only a few people who were not followed long enough to see if their immune responses held up over time.

"What we have seen is that the data in the firms' submissions regarding the first dose is commonly being misinterpreted. In the phase 3 trials, 98% of participants in the Pfizer-BioNTech trial and 92% of participants in the Moderna trial received two doses of the vaccine at either a three- or four-week interval, respectively," they said in their statement. "Those participants who did not receive two vaccine doses at either a three-or four-week interval were generally only followed for a short period of time."

Changing the dosage could also hamper the U.S. vaccine effort just as the public is starting to trust the program, Dr. Anthony Fauci told *The New York Times*.

"One of the dangers of making a change in midstream is that it could confuse the public," he explained…

He also suggested that changing the vaccine dosage was "the right answer to the wrong question.....**Read More**

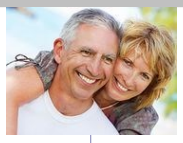
Vasectomy Reversal Just as Successful in Men Over 50

Vasectomy reversal is as viable in men over 50 as in those who are younger, a new study says.

About 20% of American men who have a vasectomy want to father children in the future, and about 6% will seek a vasectomy reversal, previous research shows.

However, it's been unclear how a man's age may affect his chance for a successful reversal.

To find out, researchers analyzed the outcomes of vasectomy reversal in about 3,000 men older than 50 (average age: 54) and 350 younger men (average age: 39). All of their procedures were performed by one surgeon.



After vasectomy reversal, the partners of 33.4% of the younger men and 26.1% of the older men got pregnant.

The study found that the chances of pregnancy were better when the woman was under 35 and/or the man had had his vasectomy fewer than 10 years before. The odds were lower if the man smoked.

"When we did a statistical analysis, and examined all these other factors involved, the data showed that age had no bearing on success," said study lead investigator Dr. Mary Samplaski, a specialist who treats male infertility at Keck Medicine of the University of Southern California.

Researchers noted that one reason older men in the study were statistically less successful than younger men in getting their partners pregnant was because older men tended to have older partners.

"These results are exciting for men looking to start families later in life who have had a vasectomy," Samplaski said in a USC news release. "This research is especially timely because anecdotally, fertility doctors are seeing an increase in the number of men interested in vasectomy reversals as couples focus on family planning during the COVID-19 pandemic," she added.

Couples wanting to get pregnant after a vasectomy have two main choices: vasectomy reversal and sperm extraction with in vitro fertilization (IVF).

IVF has risks, such as psychological distress and multiple births, and typically costs more than a reversal, making reversal a better choice for many couples, Samplaski said.

Factors ID'd for Mortality in Nursing Home Residents With COVID-19

Increased age, male sex, impaired cognitive and physical function associated with increased odds of 30-day mortality

For nursing home residents with COVID-19, the odds of 30-day mortality are increased with older age, male sex, and impaired cognitive and physical function, according to a study published online Jan. 4 in *JAMA Internal Medicine*.

Orestis A. Panagiotou, M.D., Ph.D., from the Brown University School of Public Health in Providence, Rhode Island, and colleagues identified risk factors for 30-day all-cause mortality among 5,256 nursing home residents with COVID-19-related symptoms and confirmed severe acute respiratory syndrome coronavirus 2 infection at 351 U.S. nursing homes.

The researchers found that the odds of death were 1.46, 1.59, and 2.14 times higher for residents aged 80 to 84, 85 to 89, and 90 years or older compared with those aged 75 to 79 years. Compared with men, women had a lower risk for 30-day mortality (odds ratio, 0.69). Diabetes and chronic kidney disease were associated with mortality (odds ratios, 1.21 and 1.33, respectively). An increased risk for 30-day mortality was also seen in association with fever, shortness of breath, tachycardia, and hypoxia (odds ratios, 1.66, 2.52, 1.31, and 2.05, respectively). The odds of death were increased for residents with moderate cognitive impairment and severe cognitive impairment compared with cognitively intact residents (odds ratios, 2.09 and 2.79, respectively) and for those with moderate and severe versus no or limited impairment in physical function (odds ratios, 1.49 and 1.64, respectively).

"These findings can be used to aid in prognostication and risk stratification in this population to inform treatment decisions and conversations around goals of care," the authors write.

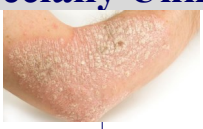
Heart Risk Factors May Be Especially Unhealthy in People With Psoriasis

People with metabolic syndrome and the skin condition psoriasis are at especially high risk for heart attack and stroke, a new study warns.

Psoriasis has been known to increase the risk of heart disease, but researchers have now pegged metabolic syndrome as a key reason.

Metabolic syndrome is a condition that includes obesity, diabetes, high cholesterol and high blood pressure -- all big risk factors for heart disease. It is common among psoriasis patients, according to a team from the U.S. National Heart, Lung, and Blood Institute (NHLBI).

The researchers said the new findings might lead to new ways to help prevent heart disease in people with psoriasis.



"Metabolic syndrome, so common among our psoriasis patients, drives up coronary artery disease in this population by increasing the plaque buildup that clogs the heart's arteries," said study author Dr. Nehal Mehta, head of the NHLBI's Lab of Inflammation and Cardiometabolic Diseases.

He said the study shows two components of metabolic syndrome -- high blood pressure and obesity -- contribute most to artery-clogging plaques and, therefore, can be good targets for intervention.

Psoriasis worsens vascular and systemic inflammation and not only increases but speeds up atherosclerosis.

Mehta and his team collected data on 260 psoriasis patients, including 80 with metabolic syndrome.

The researchers found that inflammation, insulin resistance and blood cholesterol were significantly higher in those who had both psoriasis and metabolic syndrome. Those with metabolic syndrome had higher buildup of plaque in their arteries, putting them at high risk for heart attack.

"Even after adjusting for individual [metabolic syndrome] factors, blood pressure and obesity assessed by waist circumference were the most significant links to coronary plaque buildup," Mehta said in a NHLBI news release.

Belly fat was linked to waist size, blood pressure, triglycerides and high cholesterol, researchers found.

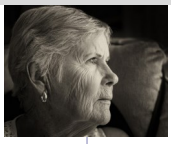
The study, Mehta said, demonstrates a critical link between excessive belly fat and metabolic syndrome in psoriasis patients.

Because this was an observational study, it does not prove cause and effect, Mehta noted. But it is strong evidence that psoriasis patients with metabolic syndrome have high levels of plaque.

Bipolar Disorder in Seniors

This disorder affects all age groups — and the number of seniors with bipolar disorder is expected to increase as the population ages. Here's what you need to know.

Bipolar disorder can affect people of all ages, including older adults. According to one study, 10 percent of new cases occur after the age of 50. In the past, it was believed that **bipolar symptoms** "burn out" and slowly disappear with age. However, newer research has shown that this is not so, and other research suggests that untreated **bipolar** disorder actually worsens over time. Individuals who are first diagnosed with bipolar disorder late in life may well have had undiagnosed bipolar disorder for decades, with symptoms that simply became more noticeable and problematic with age. And as the American population grows older, the number of bipolar cases in seniors is expected to increase. Caring for seniors with the illness often falls on the shoulders of family members, such as spouses and adult children. Here's what family members need to know about bipolar disorder in older adults.



Bipolar Disorder in Seniors: Symptoms

Just as depression is not a normal or natural part of aging, neither are the manic episodes associated with bipolar disorder. However, seniors may not exhibit the classic signs of mania, such as elation and feeling on top of the world. "Another version often seen in older folks is agitation and irritability," says Michael First, M.D., a professor of clinical psychiatry at Columbia University and editor of the American Psychiatric Association's latest diagnostic guidelines. Other common symptoms in 60-plus adults include distractibility, confusion, hyperactivity, and psychosis. "When bipolar shows up for the first time after age 60, it can be quite severe," says Carrie Bearden, Ph.D., associate professor of psychology and behavioral sciences at UCLA and an expert in the disorder. Often, it's the rapid-cycling form of the disorder, characterized by frequent episodes of depression and mania or having symptoms of both at the same time. As a result, bipolar seniors may appear to be in a state of irritable depression. Additionally, seniors with bipolar disorder show significant changes in cognitive functioning, including difficulties with memory, perception, judgment, perception, and problem-solving.

Bipolar Disorder in Seniors: Diagnosis

The first step in getting help for an older family member is to schedule a complete medical examination to rule out other medical problems. Alzheimer's disease, dementia, and even a brain tumor can mimic some aspects of bipolar disorder. Some medications can produce bipolar symptoms too. Antidepressants and cortico steroids, for instance, can cause mania. "Anyone over age 60 with suspected bipolar disorder needs a full medical workup, including a discussion of past health complaints, family history, and an evaluation of all over-the-counter and prescription medications," advises Dr. First. If warranted, a referral to a mental health professional is the next step. For help in locating a psychiatrist with special training in bipolar disorder in older adults, log onto the Web site of the American Association of Geriatric Psychiatry….**Read More**

Smoking Plus Vaping Just as Deadly as Smoking on Its Own: Study

Smokers who swap some traditional cigarettes for the electronic kind may not be doing anything to protect their arteries, a new study hints.

People who smoke sometimes use "e-cigarettes" in a bid to get a nicotine fix without inhaling tobacco. But little is known about the effects of e-cigarettes on the risk of heart disease -- the top killer of smokers.

That's because heart disease develops over many years, and vaping is a relatively new phenomenon, explained study author Andrew Stokes, an assistant professor at Boston University School of Public Health.

So, his team decided to look at a more immediate question: Do certain biological markers of heart disease risk differ between smokers and those who use both cigarettes and e-cigarettes?

Specifically, the researchers looked at blood levels of substances that indicate ongoing inflammation or oxidative stress -- a sign of cell damage.

Those processes are key contributors to heart disease in smokers, explained Stokes. Overall, his team found, levels of those biomarkers were comparable in smokers and dual users alike.

According to Stokes, the finding casts doubt on the idea that smokers can benefit from replacing some daily cigarettes with the electronic version.

"Dual use doesn't seem to be an effective way to reduce risk," he said.

It's not clear why. But, Stokes noted, some smokers use e-cigarettes just for "convenience" -- vaping only in situations where traditional smoking is not acceptable.

Other smokers do use e-cigarettes as a way to cut down on tobacco smoking. But that moderate reduction, Stokes said, might not be enough to mitigate the damage of traditional smoking.

Then there's the question of whether e-cigarettes, by themselves, contribute to inflammation and oxidative stress. Lab research has indicated that they can.

But in this study, adults who said they used only e-cigarettes, and not traditional ones, showed no signs of heightened inflammation and oxidative stress: Their biomarker levels were similar to those of adults who did not smoke or vape.

It was a surprising finding, Stokes said. But it does not prove that e-cigarettes are safe for the heart, he stressed.

Dr. Joseph Wu, a volunteer with the American Heart Association, agreed. He was not part of the study.

Only a small number of study participants were vaping exclusively, said Wu, who also directs the Stanford Cardiovascular Institute in California. That, he explained, may have made it harder to detect an effect on the five biomarkers the researchers assessed.

Still, "this is an important exploratory study that will likely lead to many other studies in the future," Wu said.

The findings, published Jan. 4 in the journal *Circulation,* were based on 7,130 U.S. adults taking part in a long-term health study.

In all, about 59% said they had not smoked or vaped in the past month. Another 30% had smoked, while 10% had smoked and vaped. Just under 2% said they'd only used e-cigarettes.

On average, smokers and dual users showed similar blood levels of the five biomarkers. And both groups looked worse relative to non-users. People who exclusively vaped, on the other hand, looked similar to non-users.

Stokes said it all raises the possibility that smokers could benefit if they switched entirely to e-cigarettes.

But that comes with important caveats. E-cigarettes deliver a hefty dose of nicotine, and there is no evidence, Stokes noted, that they serve as a "bridge to quitting" for smokers.

"What's the end game?" Stokes said. "Will people just trade one addiction for another?"...**Read More**

5 Tips to Help Quit Smoking in 2021

Many smokers make a New Year's resolution to quit, so the American Lung Association offers advice to improve their chances of success.

Smoking is a risk factor for severe COVID-19, so quitting is more important than ever, the association noted.

But keep in mind: Switching to electronic cigarettes is not quitting, the lung association stressed. E-cigarettes are tobacco products that contain nicotine, and the U.S. Food and Drug Administration hasn't approved any e-cigarette as a smoking cessation aid.

Learn from past experience. Most smokers have tried to quit before and can get discouraged when they look back at previous failed attempts. Instead, analyze what helped you during previous attempts and what you'll do differently this time, the association advised in a news release.

And remember: You don't have to tackle quitting alone. Enrolling in a tobacco counseling program -- such as the American Lung Association's Freedom From Smoking -- can improve your chance of success by up to 60% when used in combination with medication, according to the lung association.

Talk to a doctor about FDA-approved medications to help you quit. Be sure to follow the directions and use them for the full duration they're prescribed.

Every smoker can quit. Find the right combination of techniques for you and don't give up, the association urged. Slip-ups -- having a puff or smoking a few cigarettes -- are common, but don't signify failure. The important thing is to keep trying.

"The COVID-19 pandemic presents an opportunity for people, when they're ready, to find the proven quit smoking support they need," said Harold Wimmer, the association's president and CEO.

"Quitting smoking will immediately improve your health and might also decrease your odds of severe illness from COVID-19," he added. "It's the perfect way to set yourself up for a healthy new year and healthy years to come."

More information

HelpGuide.org has more on **quitting smoking**.

How to Sleep Better in 2021

If you're like most American adults, you're not getting enough sleep.

This could be the year to change that, according to the American Academy of Sleep Medicine (AASM), which recommends adults get at least seven hours of sleep each night. A survey conducted in July showed that 85% of adults in the United States get less.

"Our survey findings show a worrying trend of national sleep deprivation," said Dr. Kannan Ramar, president of the academy.

"Insufficient sleep contributes to the risk for several of today's public health epidemics, including cardiovascular disease, diabetes and obesity," he said in an academy news release. "As such, it is critical that we incorporate healthy sleep habits and routines into our daily lives to be our best in 2021."

The survey found that 34% of American sleep seven or more hours only two or fewer nights each week.

Sleep makes you healthier, happier and smarter, the AASM said, and affects mood, relationships, learning, memory recall, creativity and thinking.

Regularly sleeping less than seven hours a night may increase the risk for chronic conditions such as obesity, diabetes, high blood pressure, heart disease, stroke and frequent mental distress.

The AASM survey found that 68% of participants lost sleep due to drinking alcohol past bedtime. About 88% reported staying up late to binge-watch a TV show or stream a video series. About 66% stayed up to read; 58% watched sports, and 50% played video games.

About 22% said they are sleeping worse because of the pandemic and 19% are getting less nightly sleep.

To sleep better in 2021, the AASM recommends setting a bedtime that allows enough time to sleep so you'll wake up feeling refreshed. Develop a calming nightly routine, which could include reading, journaling or meditating. Limit noise and distractions in your bedroom, which should be quiet, dark and a little bit cool.

If you're having trouble getting to sleep on time, avoid alcohol after bedtime, caffeine after lunchtime and sugary snacks at night. Keep any nighttime snacks small, the AASM suggested.

Consider turning off electronic devices 30 minutes to an hour before bedtime.

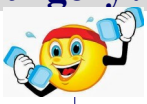
"Despite the fact that many Americans are no longer commuting to and from work, it is paramount to establish and maintain morning and bedtime rituals, such as getting up and going to bed at regular times to achieve adequate sleep," Ramar said.

Older and Getting Surgery? Get Fit Beforehand

Getting fit *before* surgery can limit the amount of muscle older adults will lose during their recovery, researchers say.

Strength training before a scheduled operation ("prehabilitation") helps counteract muscle wasting during bed rest after a procedure. But it needs to be a long-term, targeted exercise program to be effective, according to the new report.

For the study, British researchers had a group of older adults lift weights four times over one week. But participants exercised one leg, and not the other.



Participants then rested in bed for five days, which is the duration of a typical hospital stay for an older patient after surgery.

The researchers expected that the exercised leg would have less muscle loss, but it was about the same in both legs.

Further analysis showed that five days of bed rest resulted in roughly the same amount of muscle wasting (3% to 4%) that older adults would typically lose over three to five years.

The findings suggest that longer-term strength training before surgery could reduce muscle loss while older patients are in the hospital.

"Although short-term prehabilitation offers a cost-effective and easy-to-implement strategy, it does not prevent muscle wasting among older adults undergoing bed rest," said study author Leigh Breen. "This muscle loss may be extremely hard to recover from and can lead to long-term health and disease complications."

Breen is a senior lecturer in the School of Sport, Exercise and Rehabilitation Sciences at the University of Birmingham in the United Kingdom.

Prehabilitation programs should include aerobic exercise as well as strength training to protect heart/lung health, along with a protein rich diet to boost muscle mass, the study authors recommended in a university news release.

In addition, the researchers said that hospitalized patients should try to get back on their feet as soon as possible after surgery -- if it's appropriate and safe -- and be provided with post-surgery exercise and dietary programs.