Rhode Island Alliance for Retired Americans®

RI ARA

Affiliated with the Rhode Island AFL-CIO
"Fighting for the future of our members."
"NOW, more than ever!!!"

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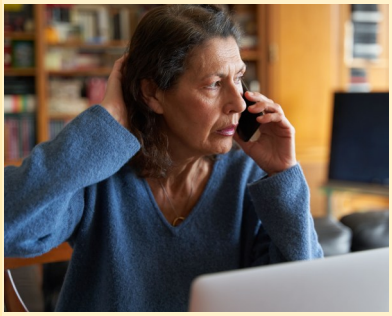
Friday Alert Message from the Alliance *for* Retired Americans Leaders

FRAUD ALERT: Phone Scammers Targeting Medicare Beneficiaries

Robert Roach, Jr
President, ARA

Law enforcement officials and the Federal Trade Commission are warning about a **new Medicare fraud scheme** targeting seniors.



Scammers are **exploiting** recent changes to Social Security and Medicare—introduced by Elon Musk's Department of Government Efficiency—to trick beneficiaries and defraud the Medicare system.

Posing as employees from the Centers for Medicare & Medicaid Services (CMS), scammers are **calling** seniors and claiming they need to "update" or "verify" personal information. But these calls are not legitimate. The scammers are **collecting** Medicare numbers and other sensitive information to submit fraudulent claims for medical equipment or medication, pocketing the reimbursements.

It's important to know: CMS will never call you unless you've contacted them first. They are not issuing new Medicare cards. If you receive a call claiming you need to verify your Medicare number or are being **issued** a new card, it's a scam.

"As long as older adults keep their Medicare information private and avoid phone calls asking for these details, they should not have to worry about being taken advantage of," said **Alliance President Robert Roach**, Jr. "Make sure to stay on high alert and protect your Medicare card and number as if it was a credit card."

If you believe your Medicare number has been compromised or want to report a suspicious call, contact Medicare directly at **1-800-MEDICARE (1-800-633-4227).**

UnitedHealth Confirms It Is Under Investigation for Medicare Billing Malpractices as House Committee Holds a Medicare Advantage Hearing

On Thursday, July 24, UnitedHealth **revealed** that they are facing an investigation from the U.S. Department of Justice. The company **disclosed** the investigation in a filing with the Securities and Exchange Commission, stating that it is cooperating with federal investigators.

This news follows a report earlier this year by The Wall Street Journal, which revealed that federal officials had launched a civil fraud investigation into how UnitedHealth records patient diagnoses that lead to higher payments for its Medicare Advantage plans.

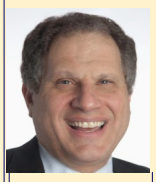
Medicare Advantage plans are privately run alternatives to traditional Medicare, primarily serving people aged 65 and older. More than 8 million people are currently enrolled in a UnitedHealth Medicare Advantage plan.

Separately, the House Ways and Means Committee held a hearing this week to examine ongoing issues with the Medicare Advantage program.

"Medicare Advantage was sold as a program to save taxpayer dollars and improve the quality of care," **said** Rep. Lloyd Doggett (TX) during the hearing, noting that the program has ended up costing taxpayers far more than traditional Medicare.

House Health Subcommittee Chair Vern Buchanan (FL) emphasized the importance of ensuring patients get the care they need. "We have heard many stories of access issues, prior authorization delays, and payment problems that negatively impact patients," he **said.**

"Medicare Advantage makes big promises to seniors and is allowed to offer services that traditional Medicare cannot," said **Richard Fiesta, Executive Director of the Alliance for Retired Americans**. "That's why it's especially important for Congress and the Administration to hold corporations accountable for delivering quality care and rooting out any waste and fraud in the program."



Rich Fiesta,
Executive
Director, ARA

You're Invited: Webinar on the Republican Tax and Budget Plan and Seniors

The Alliance is hosting a free webinar "The Ugly Truth About the One Big Beautiful Bill" on Thursday, July 31, at 4 PM ET. Join Legislative Representative David Simon and Field Mobilization Director Maureen Dunn to learn more about how the Republican budget bill will harm retirees, and ways Alliance members are fighting back. Please **click here to RSVP for the event**!

KFF Health News: Trump Voters Wanted Relief From Medical Bills. For Millions, the Bills Are About To Get Bigger. By Noam N. Levey

President Donald Trump rode to reelection last fall on voter concerns about prices. But as his administration pares back federal rules and programs designed to protect patients from the high cost of health care, Trump risks pushing more Americans into debt, further straining family budgets already stressed by medical bills.

Millions of people are expected to lose health insurance in the coming years as a result of the tax cut legislation Trump signed this month, leaving them with fewer protections from large bills if they get sick or suffer an accident.

At the same time, significant increases in health plan premiums on state insurance marketplaces next year will likely push more Americans to either drop coverage or switch to higher-deductible plans that will require them to pay more out-of-pocket before their insurance kicks in. **Click here to read more.**

Social Security's 2026 COLA Is Shaping Up to Be a No-Win Scenario for Retirees

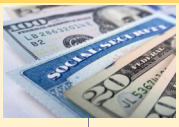
The Social Security cost-of-living adjustment (COLA) aims to help benefits maintain their buying power amid rising inflation, and many retirees look forward to receiving their annual "raise."

While the official COLA won't be released until October, after the Social Security Administration tabulates third-quarter inflation data, there are already a few insights we can glean from the year so far. Here's why there may be some not-so-good news on the horizon for retirees.

The COLA may increase in 2026

Again, we won't know the actual COLA for 2026 until October. However, nonpartisan advocacy group The Senior Citizens League (TSCL) releases monthly estimates based on inflation data throughout the year.

While the COLA may change between now and October, these estimates can still help spot trends in inflation. According to TSCL's most recent estimate, released on July 15, next year's COLA prediction is 2.6%. That's up from the 2.5% estimate last month and the 2.1% prediction in January.



A larger COLA may seem like good news on the surface, but it also means that inflation is increasing. The Consumer Price Index surged by 2.7% compared to last year, according to data from the Bureau of Labor Statistics, fueled at least in part by President Trump's tariff policies taking effect.

COLAs have a shaky history with inflation

Increasing inflation will put even more strain on retirees' budgets. Although the COLA aims to alleviate that, it hasn't been particularly effective in recent years.

According to a 2024 study from TSCL, Social Security benefits have lost around 20% of their buying power since 2010 -- even with annual COLAs. The average monthly benefit among retirees was around $1,860 per month at the time of the study, when it should have been around $2,230 had it maintained its buying power.

One of the reasons the COLA struggles to keep pace with inflation is the way it's calculated. The Social Security Administration bases the adjustment on the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), which measures price changes affecting workers. Because retirees and workers often have different spending habits, the CPI-W doesn't always accurately reflect inflation's impact on older adults.

In other words, not only does a higher COLA signal that inflation is on the rise yet again, but because of how the adjustment is calculated, even a larger raise may not provide much real relief for retirees.

New tax deductions could provide relief for retirees

Aside from the COLA, many retirees will receive some financial relief in the form of an extra tax deduction. Under President Trump's recently passed "Big, Beautiful Bill," individuals age 65 and older will receive an extra $6,000 annual tax deduction, with married couples receiving a $12,000 deduction.

While the bill doesn't eliminate federal taxes on Social Security, these deductions will reduce many seniors' taxable income enough that they will not owe federal taxes on their benefits. However, these deductions are only temporary and are set to expire in 2028.

In addition, because Social Security depends heavily on taxes as a source of income, reducing taxes will likely put more strain on the program's trust funds -- potentially leading to benefit cuts sooner than expected.

We won't know the official COLA for a few more months, but with inflation already heating up, we may see a larger raise in 2026. While there may not be much you can do when it comes to the COLA or inflation, by understanding the COLA's limits and what to expect, it will be a little easier to prepare your budget accordingly.

Reconciliation Bill Timeline Stretches Far Into Future, Giving Some Opportunities for Correction

On July 4, President Trump **signed the damaging Republican budget reconciliation bill** into law. But that does not mean each provision takes effect immediately. Instead, implementation stretches across many years, with many of the most controversial aspects timed to fall after future elections. Below, we explore some of these timelines, focusing only on health-related aspects of the bill that are likely to impact people with Medicare. It is not an exhaustive list. The **National Health Law Program** and the **National Academy for State Health Policy** have more detailed analyses and extensive timelines for the law's numerous provisions.

Provisions that Take Effect Immediately or in the Near Term

Denying Medicare Coverage

Upon enactment, the bill **immediately limits new Medicare coverage,** denying enrollment for people with lawful immigration status who have paid into the system unless they are citizens, green card holders, or are from Cuba, Haiti, or one of the Compact of Free Association (COFA) states—the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau.

The law will terminate existing coverage within 18 months for people who do not fit one of these categories and are already enrolled in Medicare. This population will also not be able to enroll in Medicaid or receive any Affordable Care Act (ACA) cost assistance.

This population will also not be able to enroll in Medicaid or receive any Affordable Care Act cost assistance.

For more information about the many immigration provisions in the law, see the **National Immigration Law Center's explainer**.

Prohibiting Important Rule Enforcement

Immediately on signing, the law blocks enforcement of three rules. Two of the rules made it easier for people to get and keep **Medicaid and Medicare Savings Program (MSP)** coverage by streamlining those systems.

The **Congressional Budget Office (CBO) projected** that without these modernizations in place, nearly **1.4 million low-income people with Medicare** would lose out on MSP coverage despite still being eligible. People with Medicare who struggle to enroll in or retain Medicaid or MSPs face lower Social Security checks, higher costs for coverage and prescription drugs, and less access to care.

The law also immediately blocks enforcement of the **nursing home staffing rule** that required nursing homes to have adequate staff on site to protect the health and safety of residents.

Automatic Medicare Cuts

By ballooning the national deficit, the **law is set** to trigger **$500 billion** in mandatory Medicare cuts over the next decade—including a $45 billion reduction next year alone—unless Congress steps in to prevent them.

After the 2026 Mid-Term Elections

Medicaid Work Reporting Requirements

One of the most controversial aspects of the law, the provision that requires states to establish and enforce **work reporting requirements** for people covered through expansion Medicaid, goes into effect on January 1, 2027, right after the 2026 midterms. **Most people** covered by expansion Medicaid work or fall into one of the statutory exemptions, but this provision is likely going to kick many eligible people out of coverage because they will struggle to provide the right paperwork and meet arbitrary, repeated, and overly strict deadlines….**Read More**

Trump tax bill drives up Medicare drug costs

Medicare drug-price negotiation is one of the signature achievements of the Biden administration. The Inflation Reduction Act finally allowed Medicare to negotiate drug prices for ten to fifteen drugs each year. But, the tax bill that President Trump recently signed into law prohibits negotiation for some drugs currently subject to price negotiation, driving up Medicare drug costs, reports Rebecca Robbins for **The New York Times**.

President Trump's tax bill, which is projected to leave **17 million Americans uninsured** as a way to pay for tax cuts for the ultra-wealthy, also puts nearly $5 billion back in the pockets of pharmaceutical companies, according to the **Congressional Budget Office**. The Trump bill prevents more prescription drugs from being subject to Medicare price negotiation, allowing manufacturers to increase their prices on these drugs further.

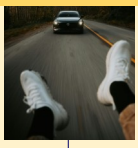
Essentially, in response to a lame Pharma argument about misaligned incentives, the Trump administration signed off on a provision that exempts certain drugs from price negotiation, even if they treat more than one rare disease. They are only subject to drug price negotiation if they help a large group of people.

The irony is that Trump is driving up drug prices at the same time as he is saying he wants to lower them. Unfortunately, he has yet to put forth a policy that would lower drug prices in the US.

Under the Inflation Reduction Act, the first round of drugs with negotiated prices will take effect in 2026. The second round will take effect in 2027, including Ozempic and Wegovy. But, in 2028, additional costly drugs will be deemed exempt from negotiation.

To be clear, drug companies have generated billions in profits because of drugs developed for rare diseases. And, the Trump tax law will continue to allow pharmaceutical companies to reap huge profits from drugs they develop to treat rare diseases, especially some cancers. One study found that 20 percent of the best-selling drugs in the US treat rare diseases.

Don't be fooled: Medicare Advantage can be deadly



Today, more than half of older adults and people with disabilities with Medicare are enrolled in a Medicare HMO or other type of Medicare Advantage plan. These plans are run by big corporate health insurers with the goal of maximizing profits for their shareholders. Don't be fooled: Medicare Advantage can be deadly. Steer clear if you can.

You may be enrolled in a Medicare Advantage plan rather than traditional Medicare, which the government administers directly. If you are a typical older adult, there's a good chance AARP helped steer you to a Medicare Advantage plan administered by UnitedHealthcare. **AARP reaps more than $1 billion in revenues from its partnership with UnitedHealth**, and it does not appear to be ensuring that UnitedHealth provides its Medicare Advantage enrollees with the Medicare benefits to which they are entitled.

Indeed, what's clear is that these Medicare HMOs and PPOs in Medicare Advantage **operate with little transparency or accountability**. The federal government doesn't have the will, the skill or the resources to keep them in line. As a result, the insurers operating these health plans can delay and deny care with near impunity. And, according to many reports, including reports by the HHS Office of the Inspector General, they too often do.

Medicare Advantage plans are particularly concerning because most people have no choice but to enroll in one. It's possible to enroll and pay no upfront costs. So, low-income people, Blacks and Hispanics enroll in Medicare Advantage at particularly high rates.

Only wealthy people with Medicare tend to enroll in traditional Medicare, which covers care from most physicians and hospitals across the US without prior authorization. They can afford the upfront costs of supplemental coverage, which picks up coinsurance, and the Part D premium.

Without a level playing field between traditional Medicare and Medicare Advantage, including an out-of-pocket limit in traditional Medicare, there's no meaningful competition between them. People tend to be locked into Medicare Advantage. If you are relatively healthy, there's little to be concerned about. Unfortunately, once you get sick, you are likely to find that you can't get the care you need. At that point, most people are locked out of Traditional Medicare. Not only is supplemental coverage expensive, insurers usually are not required to sell it to you, except when you first enroll in Medicare at 65.

Traditional Medicare should be a meaningful option for everyone with Medicare. For that to be the case, it needs an out-of-pocket limit. At the same time, Medicare Advantage plans need transparency and accountability. Insurers should not be able to play games with people's health. Ask your Congressperson to step in to protect our nation's vulnerable older adults. And, if you belong to AARP, ask AARP to demand transparency and accountability in Medicare Advantage.

The Medicare Grocery Allowance: What It Is and How to Get It

A Medicare grocery allowance can help older adults maintain a healthy diet and save money. Learn who's eligible and how this benefit works. If you feel like you've been **paying more money for less food lately**, you're not alone. Recent inflation and supply chain pressures have pushed up the prices of many items at supermarkets nationwide. These increases can be difficult for anyone to manage, but the rising cost of food can be especially challenging for seniors on fixed incomes. However, the **Medicare** grocery allowance – a benefit that may help offset some of the costs of **healthy foods for seniors** – can help.

Here, we'll walk through everything you need to know about the Medicare grocery allowance offered by some **Medicare Advantage plans**.

Is the Medicare Grocery Allowance Real?

For seniors struggling to make ends meet, the concept of a grocery allowance connected to their Medicare benefits is appealing. However, it's not available with every plan. "**Original Medicare** (parts A and B) does not offer any grocery allowances, but some of the Medicare Advantage plans do," notes Stephanie Pogue, a St. Louis-based certified Medicare insurance planner and the CEO of St. Louis Insurance Group in Chesterfield, Missouri.

Specifically, she is referring to **Special Needs Plans** (SNPs), a type of Medicare Advantage plan available to individuals who meet specific financial and health eligibility guidelines.

Which Medicare Plans Offer a Grocery Allowance?

Certain Medicare Advantage SNPs may offer a grocery allowance. These plans include: **Chronic Condition SNPs (C-SNPs)**, designed for people with chronic illnesses, such as **diabetes** or **congestive heart failure**

Dual Special Needs Plans (D-SNPs), specifically for beneficiaries who qualify for both **Medicare and Medicaid**...**Read More**

Is there a good alternative to prior authorization?

Talk to just about anyone who has had an encounter with our health care system and, most likely, they will tell you about the headaches they faced getting prior authorization. Insurers are increasingly using prior authorization to delay and deny all sorts of care inappropriately in order to maximize profits. There's a better way, writes Michele Kowalski-McGraw, MD, et al. in an opinion piece for **MedPageToday**.

Too often insurers say they will not cover life-saving care or life-improving care. They claim that prior authorization keeps health care costs down because they make sure they are not paying for unnecessary care. They try to keep you from believing that they are endangering their enrollees' health and well-being.

Prior authorization also costs our health care system–patients, as well as physicians and hospitals– **billions of dollars each year**.

Patients have to pay for care that should be covered. Physicians and hospitals spend time and money working to get approvals for needed care. Almost one in four doctors say that prior authorization creates **"serious adverse" outcomes** for their patients.

And, prior authorization creates physician burnout. A team of physicians, the End Burnout Group (EBG) proposes a way to reduce unnecessary care in ways that help patients and physicians, while reducing administrative costs. They want to use national clinical guidelines for certifying whether a procedure is appropriate. Put differently, they want to implement a standardized system that verifies whether a procedure meets clinical guidelines.

Evidence-based Care Optimization (ECO) is an alternative to prior authorization. Rather than assume that the care is not needed, ECO assumes that the treating physician is delivering needed care unless the clinical evidence shows that clinical guidelines do not support the care being proposed. If there are no guidelines, ECO assumes the care is needed.

If there are clinical guidelines, the data in a patient's electronic health record (EHR) determine whether the care is appropriate based on those guidelines. If more data is needed, the physician can update and revise information quickly.

With ECO, the insurers are not deciding what is clinically appropriate, as they do with prior authorization. The insurers are responsible only for letting clinicians know whether their services are covered, the amount of coverage and payment. There is no insurer conflict of interest.

ECO, as imagined, would be an open-source project. It would require no additional tools to determine whether EHR documentation is in keeping with clinical guidelines. The Agency for Healthcare Research and Quality has said that real-time decision support is feasible, drawing from a centralized source that houses the clinical guidelines.

Of course, a governing body would need to oversee ECO guidelines as they develop. The End Burnout Group believes that this oversight body should be independent of medical societies but include representatives from all societies.

Part D Benefit Restructuring Reduces Out-Of-Pocket Exposure, Changes Risk to Prescription Coverage Access and Choice

Prescription drug coverage in Medicare, provided via private health insurance plans under Part D, covers more than 53 million Americans. The Part D benefit—first available in 2006—has undergone significant policy changes in its nearly 20-year history. As initially designed, Part D left beneficiaries with substantial out-of-pocket cost obligations; they were responsible for the full cost of their drugs during a deductible period, faced cost sharing in the form of co-pays or coinsurance during the initial coverage period, were responsible for the full cost of their drugs during the coverage gap or "donut hole," and had reduced, but uncapped, coinsurance if they reached the catastrophic phase of coverage.

As initially designed, Part D left beneficiaries with substantial out-of-pocket cost obligations.

Changes over time have reduced the risk of extremely high drug costs for Part D enrollees. This includes the Affordable Care Act's (ACA) reduction of the beneficiary's share of cost during the donut hole and the implementation of a $2,000 out of pocket cap under the Inflation Reduction Act (IRA). Other challenges, however, remain.

Plans Shift Costs Pre-Cap

A recent paper published by the Leonard D. Shaeffer Institute for Public Policy and Government Service examines trends in **Part D plan design among stand alone Part D plans (PDPs) as well as Part D plans that are combined with a Medicare Advantage Plan (MA-PDs).** Coverage rules, including the ACA and IRA policy changes described above, apply to both types of plans, but there are some financing and operational differences. Namely, MA-PDs can use savings (**or overpayments**) realized in the administration of Part A and Part B services to offset Part D expenses, while PDPs cannot.

The paper examines how both types of plans are responding to the shifting landscape under the IRA. The authors note the cost cap "provides important insurance protection for beneficiaries, but other Inflation Reduction Act changes incentivized plans to increase beneficiary exposure to cost sharing prior to reaching the cap."

They found that both PDPs and MA-PDs are shifting costs to enrollees in the form of higher deductibles and increased use of coinsurance, rather than copays.

They found that both types of plans are doing so by shifting costs to enrollees in the form of higher deductibles and increased use of coinsurance, rather than copays. Coinsurance is tied to the list price of the drug; a copay is a set amount for a month's supply of all drugs on a particular tier. These shifts have been seen since 2020, but increasingly in more recent years.

These findings suggest that beneficiaries with moderate prescription drug expenses—**those who do not reach the annual out-of-pocket limit of $2,000—may see out-of-pocket costs increase** due to plan decisions to raise cost sharing. The researchers note, however, that they did not examine changes in premium amounts or take into account the reductions in cost-sharing obligations for people who are enrolled in the Low-Income Subsidy (LIS), also called Extra Help, factors which may lower beneficiary obligations.

They also note that the implementation, starting in 2026, of CMS negotiated prices for certain medications will "likely decrease" beneficiary cost sharing. This is because "the prices set by CMS are notably lower than the drugs' list prices," which will decrease beneficiary costs even if a plan uses coinsurance.

Although the paper draws attention to important trends, the risk of increased out-of-pocket costs is not unavoidable. Indeed, in light of changing benefit design, it is even more important for beneficiaries to carefully consider their current enrollment and plan options for 2026 during the Fall Open Enrollment period.

The Future of Part D Plan Premiums

Choosing one's PDP or MA-PD enrollment carefully can help avoid significant costs and barriers to care. This **which makes the concerns raised by a recent report from KFF about the future availability and costs of PDPs** especially important. That article asks two big questions about Part D: "Will the Trump administration continue Medicare's **Part D premium stabilization demonstration** for a second year, and what will the PDP market look like in 2026 and in subsequent years?"...**Read More**

Immediate effects of Trump's tax bill

A new Senate Finance Committee Democratic memo documents the immediate damaging effects of Trump's reconciliation bill and provides information on taxpayer-funded slush funds, established to pay back Republicans for supporting the legislation.

The legislation all but destroys the Affordable Care Act and its health insurance exchanges. It drives up health care costs, makes it harder to enroll and ends coverage for millions of Americans. It lets premium subsidies for people who cannot afford coverage to expire effective January 2026.

About 20 million people who get help paying their premiums today will face an average of $700 more in premiums. In some cases, they will see their premiums double. And about seven million Americans will lose coverage as a result of these higher costs and enrollment challenges.

Rural America is becoming a health care desert. Rural hospitals are struggling to stay afloat. Medicare Advantage plans don't pay them adequately and Trump's tax bill cuts deeply into their revenues. It cuts $1 trillion in Medicaid dollars, a significant portion of which goes to them.

Some hospitals are shutting down entirely. Others are closing units. Or, they are not investing in cybersecurity. As many as 330 of them could close any day as a result of the Trump bill. The health care of rural Americans is at serious risk.

For that matter, health care for everyone is at serious risk. There's a domino effect when hospitals close. Inner city hospitals are in the same position as rural hospitals and many of them are likely to close. Hospitals that are somewhat healthier financially will be forced to deliver uncompensated care. The consequences are likely to be pretty ugly.

A shorter open enrollment period in ACA health plans and new enrollment red tape will make it harder for people to get coverage in state health insurance exchanges. More people will need to pay $5 premiums. And, insurers will be able to sell less comprehensive policies.

Nursing homes will have fewer nurses thanks to the Trump tax bill. Understaffed nursing facilities will not be able to meet residents' needs. With fewer staff and less Medicaid revenue, more than 570 nursing homes could immediately close.

Nearly 200 women's health care centers could close because Trump's tax bill defunds Planned Parenthood. Sixty percent of the closures will be in areas serving poorer populations. The lives of one million people are endangered. The effect is a backdoor abortion ban, even in states that permit abortions.

Requirements for states to help people enroll in Medicaid and CHIP are being rolled back. States will be able to make it harder for people with Medicare to enroll in Medicare Savings Programs, which cover their premiums and sometimes their out-of-pocket costs as well.

As of July 4, states no longer have to help people enroll in Medicaid, CHIP or Medicare Savings Programs. Nursing homes do not need nurses on staff 24/7. Planned Parenthood will not receive Medicaid funding.

As of August 25, people will need to jump through more administrative hoops to keep their ACA coverage in 2026. They will need to follow new rules for verifying their income and will have less time to enroll. People with low incomes will no longer have a special enrollment period for enrolling.

As of October 1, states will be able to try to get some of the $10 billion available for rural health. They might have to wait for it though. And, only $5 billion must be distributed to states whose applications are approved. Dr. Oz decides whether the remaining $5 billion is distributed and to which states.

As of December 1, CMS will determine whether and which states get access to the rural slush fund. And CMS must issue rules around reapplying for Medicaid every six months, as now required.

As of January **1**, 2026, no more help for many people with ACA premiums. People will pay an average of $700 more in premiums in 2026. Anyone who gets help with premiums by mistake will be billed for it when they file their 2026 taxes. And people will see higher copayments.

As of October 1, 2026, federal Medicaid funding ends for many immigrants in the US lawfully.

As of January 1, 2027, working families must reapply for Medicaid every six months.

As of January 1, 2028, Medicare cannot negotiate prices of additional drugs treating rare diseases. This will put $5 billion in the pocket of the drug industry and drive up drug prices for people with Medicare with rare diseases.

Also, people with assets of more than $1 million in their homes will not be able to qualify for Medicaid.

And Medicaid dollars are cut 10 percent each year.

And, there's much more. . .

Here's a recap dollar by dollar, directly from the minority staff in Senate Finance:

- Blocking rules to help low-income seniors afford Medicare (Sec. 71101) $1,000,000
- Carrying out bipartisan program integrity in Medicaid (Sect. 71103) $30,000,000
- Adding red tape for people with Medicaid every six months (Sect. 71107) $75,000,000
- Taking Medicaid away from lawfully-present immigrants (Sect. 71109) $15,000,000
- Cutting Medicaid funding for emergency services (Sect. 71110) $1,000,000
- Taking away retroactive Medicaid benefits (Sect. 71112) $10,000,000
- Defunding Planned Parenthood (Sect. 71113) $1,000,000
- Cutting Medicaid funding for states (Sect. 71115) $20,000,000
- Cutting Medicaid funding for states (Sect. 71116) $56,000,000
- Putting needless checks on state flexibility (Sect. 71118) $10,000,000
- Adding red tape and terminating Medicaid for millions (Sect. 71119) (CMS) $200,000,000
- Forcing new copayments on people with Medicaid (Sect. 71120) $15,000,000
- Testing home-based care models for new populations (Sect. 71121) $150,000,000
- $50 billion rural health slush fund5 (Sect. 71401) $200,000,000

Addressing Anxiety and Stress in Seniors

Anxiety and stress are common mental health concerns for seniors, especially as they navigate the often-challenging transitions that occur with aging. Therefore, older adults must access proper support and mental health services to maintain and improve their mental well-being. **Assisted living communities** are critical in providing these essential services, helping seniors effectively manage their stress and anxiety levels.

This article will explore how assisted living facilities can provide mental health services for senior residents. We will cover the different types of support available, how these programs can benefit seniors, and discuss considerations when choosing a community for yourself or a loved one.

- **The Importance of Mental Health Services in Assisted Living Communities**
- **Types of Mental Health Services Offered in Assisted Living**
- **Key Benefits of Mental Health Support for Seniors**
- **Factors to Consider When Choosing an Assisted Living Community**
- **FAQs**

The End of Social Security Checks: What You Need to Know

The transition to **electronic payments** for Social Security and VA benefits is a significant change initiated by an executive order from President Trump. This move aims to enhance efficiency and security, as paper checks are more prone to being lost or stolen. Beneficiaries must switch to digital payment methods like direct deposit or prepaid cards by September 30. Exceptions exist for those without banking access or in emergency situations where electronic payments are impractical.

For the small percentage still receiving paper checks, updating to **direct deposit** is crucial. This can be done through the My Social Security account, contacting the SSA, or coordinating with your bank. Electronic payments are also mandatory for those with federal tax or student loan obligations. This shift is part of a broader effort to modernize federal payment systems and reduce administrative costs.

In a related development, the "One, Big, Beautiful Bill" signed by President Trump introduces changes in the taxation of Social Security benefits. While it doesn't eliminate taxes, it increases the standard deduction and introduces new deductions for seniors. These changes significantly reduce the number of seniors paying taxes on their benefits, from 46% to 12%, though these deductions phase out for higher-income individuals and are set to expire after 2028.

The SSA is also addressing **overpayments**, with plans to recover $72 billion in erroneous payments. Beneficiaries who have received overpayments may see their monthly benefits reduced by half until the debt is settled.

Looking ahead, the long-term solvency of Social Security is a growing concern. The latest SSA report projects that the trust funds will be depleted by 2034, a year earlier than previously expected. This would result in beneficiaries receiving only 81% of their scheduled benefits. Factors contributing to this include an aging population, lower birth rates, and legislative changes affecting benefit eligibility.

The report highlights the need for legislative action to address the program's financial challenges. Potential solutions include benefit cuts, payroll tax increases, or a combination of both to ensure the program's sustainability through 2099. These discussions are critical as the program faces increasing pressure from demographic shifts and economic factors.

Given these uncertainties, it's advisable not to rely solely on Social Security for retirement. Building a personal retirement fund is essential. This can be achieved by maximizing employer-sponsored plans like 401(k)s, opening an IRA, and managing housing expenses to reduce financial burdens in retirement.

Additionally, utilizing health savings accounts (HSAs or FSAs) can help manage healthcare costs, which are expected to rise. These strategies can provide a more secure financial future, complementing Social Security benefits and ensuring a comfortable retirement.

You will be auto-enrolled in Medicare Advantage and locked in for three years under this new bill in Congress

Medicare Advantage could become the default health-insurance program for all older adults.

A recent proposal in Congress would automatically enroll older adults in a Medicare Advantage plan and then lock them into that plan for three years — unless they actively opt for traditional Medicare coverage.

The proposal sponsored by U.S. Rep. David Schweikert, an Arizona Republican, would automatically put people 65 and older into the lowest-cost Medicare Advantage plan in their area starting in 2028. Those enrollees would be unable to change to any other plan for three years.

The proposal, **HR 3467**, does allow people to opt out and choose traditional Medicare, but the process for doing that is not detailed in the bill, and critics said many people may lack the insurance savviness they might need to choose that option.

The bill also doesn't require the private insurers who provide Medicare Advantage plans to keep the same network or cost structure over those three years, said Ari Parker, co-founder of Chapter, a private company that helps people navigate Medicare plans and the author of "It's Not That Complicated," a guidebook to Medicare.

That means an older adult could be locked into a network that becomes more expensive over time or becomes less relevant to them, for instance if the network changes and they lose their doctor, Parker said.

A total of 68.6 million people age 65 and older are enrolled in Medicare plans, with 51.2% of those people enrolled in Medicare Advantage plans, according to the Centers for Medicare & Medicaid Services. The balance of enrollees are in traditional Medicare.

Normally, people 65 and older make **choices about their Medicare coverage** each year during open enrollment season, which runs from mid-October until December. During that time, beneficiaries can switch between traditional Medicare to a Medicare Advantage plan, enroll in or change Part D prescription drug plans and add supplemental insurance known as Medigap. Those changes go into effect on Jan. 1 of the following year.

During Medicare Advantage's open enrollment period, which runs from Jan. 1 to March 31 each year, beneficiaries can switch to another Medicare Advantage plan or drop their Medicare Advantage plan and return to original Medicare. Those changes go into effect on the first day of the month following the plan's receipt of the request….**Read More**

Assisted Living vs. Nursing Home Care: How They Differ

Are you attempting to weigh assisted living versus nursing home care as an option for yourself or a family member? Many Americans just like you are doing exactly that. They're looking for clear answers about senior living possibilities and the differences between them. Thankfully, you're in the right spot to find some of those answers.

With help from this article, you can start making informed decisions that result in a comfortable, connected, and care-focused quality of life for you or your loved one. After all, a lot of today's nursing homes and assisted living facilities are warm, homelike communities where older adults enjoy kindness and respect, make new friends, entertain visitors, and pursue satisfying leisure activities.

As you'll soon discover, there isn't just one main difference between assisted living and nursing home care. Rather, each type of senior care community has several special and defining characteristics. In this article, you'll learn more about those differences as they relate to the following aspects:

- **Terminology**
- **Common types of residents**
- **Typical living spaces**
- **Care services**
- **Other kinds of services**
- **Primary caregivers**
- **Cost and payment methods**

Commissions: The main reason you should not trust health insurance agents

I've written before about why **you should not trust health insurance agents**. As is often the case, the answer lies in financial incentives. In Medicare Advantage, insurance agents earn different commissions based on the Medicare Advantage plans they steer you to. If insurers pay them more to steer you to a worse Medicare Advantage plan, they have a powerful incentive to mislead you.

What's worse is that insurers don't pay any commissions for agents to enroll you in traditional Medicare. And, increasingly, they do not pay commissions to sign you up for a stand-alone Part D plan, which most people need in traditional Medicare. Centene stopped paying commissions to insurers who enrolled people in their Part D stand-alone plans in 2024.

To the extent insurers pay commissions for enrollment in Medigap plans–supplemental coverage that fills gaps in Medicare–the commissions are significantly lower than the commissions in Medicare Advantage.

For reasons that I do not understand, the federal government caps commissions that insurers can pay insurance agents but allows insurers to pay different commissions to insurance agents for different Medicare products and Medicare Advantage plans. As a result, increasingly, insurers are reducing or eliminating commissions on certain Medicare Advantage plans–often the best ones–so that agents won't recommend them. And, CMS allows commission changes mid-year.

Adjusting or eliminating commissions mid-year is an insurer tactic that hurts less savvy people with Medicare and that the Centers for Medicare and Medicaid Services should not permit. Rylee Wilson reports for **Becker's Payer Issues** on several insurers that have recently changed their commission structure for Medicare products. For example, UnitedHealth stopped paying commissions on more than 100 of their Medicare Advantage plans, including their PPO plans, which provide coverage outside of your community.

Blue Shield of California similarly stopped paying commissions for some of its Medicare Advantage PPOs earlier this month. Cigna stopped paying commissions for some Medicare Advantage PPOs last year. Elevance and Aetna also ended some commissions.

Dear Marci: Do I need Medigap?

Dear Marci

I have had Original Medicare for a few years. I do not go to the doctor very often, so I have not had to pay much for coverage. I live on a fixed income, and I'm worried about future medical expenses as my health issues start to increase. I want to keep Original Medicare because I have more choice in the providers I can see. Can a Medigap help with out-of-pocket costs, and do I need one?

– Bo (Lovelock, NV)

Dear Bo,

Yes, a Medigap policy can assist with out-of-pocket costs. Below is a detailed breakdown to help you decide if you need one. Medigaps are health insurance policies that work with Original Medicare (not with Medicare Advantage) to cover costs that Medicare doesn't. They are sold by private insurance companies.

If you have a Medigap, it pays part or all of certain remaining costs after Original Medicare pays first. These costs can include:

- Deductibles
- Coinsurance
- Copayments

Some Medigaps also cover health care costs that Medicare doesn't cover at all, like limited care received when travelling outside of the country.

Given your concerns about future expenses and your fixed income, a Medigap policy could be beneficial in helping manage your out-of-pocket costs. If you decide to buy a Medigap policy, be sure to do your research. Here are some steps you should take.

- **Understand the best time to buy a policy**: Learn when you have the **right to buy a Medigap without restriction**. This is usually when you are first 65 or older and enrolled in Part B, or when you lose certain types of coverage. At other times, you may be charged more because of health conditions, or companies can refuse to sell you a policy.
- **Compare policies**: There are **10 different standardized policies** in most states, each covering a different range of Medicare cost-sharing. Compare policies to decide which policy is right for you.
- **Compare premiums**: Find out how **Medigap premiums are priced** so you can make cost comparisons. Compare the premium cost to your monthly out-of-pocket costs without a Medigap. Medigap premiums can be high, but they can help you save money if your monthly cost-sharing expenses are higher than the premium.
- **Consider prior medical conditions**: Understand how a Medigap covers **prior medical conditions** to know if any of your medical costs may be excluded from Medigap coverage for a period of time.
- **Prepare questions:** Have a **list of questions** to ask to help you choose a Medigap.

Contact your **State Health Insurance Assistance Program (SHIP)** for assistance with Medigap. For additional information on Medigap policies in your state, you can also contact your **State Department of Insurance**.

Hope this helps!

-Marci

Medicare IRMAA: What You Should Know

In this article, we'll go through the basics of what IRMAA entails and who might be required to pay this additional fee.

Medicare's income-related monthly adjustment amounts (IRMAA) can be tricky to parse. We'll walk through what it means, who qualifies and how it affects your coverage and costs.

What Is IRMAA?

Medicare IRMAA is an income-based surcharge that couples or individuals must pay on top of existing premiums for **Medicare Part B** (coverage for preventive care, visits to the doctor and outpatient care) and **Medicare Part D** (prescription drug coverage).

IRMAA is based on your modified adjusted gross income, also referred to as MAGI, from your tax filings two years prior to your enrollment date. For example, you would qualify for IRMAA in 2024 if your MAGI from your 2022 tax returns meets the 2024 income thresholds ($103,000 for beneficiaries who file individual tax returns and $206,000 for those who file joint tax returns), according to the Centers for Medicare & Medicaid Services. For 2025, those thresholds are predicted to be $105,000 for those filing individual tax returns and $210,000 for those filing joint tax returns.

"I call it the Robin Hood theory because the government takes from the rich, but instead of giving it to the poor, they just use it to fund the Medicare trust fund," says Darren Hotton, a Medicaid services access specialist with S2Tech, which provides Medicaid system development and enhancement services to Medicaid programs in 34 states and Washington, D.C. ….**Read More**

RI ARA HealthLink Wellness News

Please Note: All Articles In This Section Are For Information Only And Not Medical Advice

HealthLink Wellness "Taking Control"

Slower Arm Movement Increases Fall Risk Among Seniors

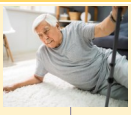
Seniors might be more prone to bone-breaking **falls** because they are unable to react quickly enough to regain their balance, a new study says.

When a person starts to slip and fall, their natural response is to raise their arms in an attempt to restore balance.

But seniors 65 and older throw out their arms more slowly when slipping than young folks, increasing their odds of a tumble, according to results recently published in the journal ***Scientific Reports***.

Worse, this slow response makes it more likely they'll fall to the side and sustain a hip fracture, researchers said.

If these findings are validated, then adding arm exercises to fall prevention programs could help protect older folks from debilitating fractures, senior researcher **Jonathan Lee-Confer**, an assistant professor of physical therapy at the University of Arizona, said in a news release.



"We know older adults lose mass in the shoulder muscles used for these types of arm movements," he said. "This is about using physical therapy to extend someone's quality of life.

Falls are the leading cause of nonfatal and fatal injury among American seniors, researchers said in background notes.

For the new study, researchers watched 11 seniors (average age: 72) and 11 young adults (average age: 26) walk around under everyday conditions.

Everyone tended to throw their arms out during slips of similar severity, researchers found.

But seniors were, on average, 58% slower than the young adults, results showed.

Faster, more explosive arm movements helped limit body movement during a slip, with just 1/25 of a second making a major difference in how much people's bodies shifted sideways, researchers added.

"It's actually quite a bit – about an inch to the side," Lee-Confer said. "So if someone is delayed with their arm movement, they are going to fall more toward the side than if they were able to react quickly."

Up until about seven years ago, it was commonly thought that slips caused people to fall backward, Lee-Confer said.

However, new research has found that many people fall to the side, which can increase a senior's risk of a hip fracture, he said.

"When an older adult fractures their hip, it can only be from a sideways fall, not purely backward," Lee-Confer said.

Future research should examine whether dumbbell raises or other arm-strengthening exercises could improve balance reactions to slips, the paper suggests.

Balance-correcting arm movements happen almost as quickly as an automatic reflex, Lee-Confer noted. Having existing strength to draw upon might speed up reaction times.

"I like the idea of being able to give somebody more years of protection from these debilitating injuries," Lee-Confer said.

'Weekend Warrior' Workouts Reduce Diabetics' Risk Of Death

A "weekend warrior" exercise schedule can lower **diabetics**' risk of early death, a new study says.

People with diabetes who get all their recommended weekly exercise in one or two sessions – the "weekend warrior" approach – were 21% less likely to die early from any cause than their counterparts who don't work out, researchers report today in the ***Annals of Internal Medicine***.

They also were 33% less likely to die from heart disease, results show.

"These findings reinforce the importance of flexible physical activity patterns for people with diabetes as they can improve insulin sensitivity and glycemic control — especially for those who face barriers to maintaining regularly routine exercise," concluded the research team led by **Zhiyuan Wu**, a postdoctoral research fellow at Harvard T.H. Chan School of Public Health in Boston.

Exercise guidelines recommend that people get at least 150 minutes of moderate physical activity every week to maintain their health, researchers said in background notes. Moderate activity can include brisk walking, slow bicycling, active yoga, ballroom dancing and general yard work.

However, it's not always easy to find time to work out, researchers said.

"Many people struggle to engage in regular physical activity throughout the week due to time constraints," researchers said. "To overcome this, some condense their recommended (physical activity) into one or two weekly sessions — a pattern known as the 'weekend warrior' approach."

For this study, researchers analyzed data gathered from nearly 52,000 people with diabetes between 1997 and 2018 as part of the National Health Interview Survey conducted by the U.S. Centers for Disease Control and Prevention….**Read More**

Recalled: More Than 67,000 Cases of Deodorant Sold at Dollar Tree, Walmart, and Amazon

More than 67,000 cases of Power Stick deodorant have been recalled due to an undisclosed manufacturing issue.

The recalled deodorants, made by **A.P. Deauville** of Easton, Pa., did not fully comply with federal product safety standards, according to the U.S. Food and Drug Administration (FDA).

In issuing **the recall** earlier this month, the FDA said the regulations are intended to "make sure that a product is safe for use, and that it has the ingredients and strength it claims to have." It did not specify how the products failed to comply, and no risk level has been assigned to the recall, according to *Health* magazine.

The recall applies to:

• Power Stick for Her Roll-On Antiperspirant Deodorant Powder Fresh, 1.8 oz/53 mL. UPC Code 815195019313. NDC: 42913-038-00. Affected lots are 032026B011, 032226B031, 051626C241, 061526C882, 071226D371, 071226D381, 082526E341, 082826E402.

• Power Stick Invisible Protection Roll-On Antiperspirant Deodorant Spring Fresh, 1.8 oz/53 mL. UPC Code 815195018194. NDC: 42913-039-00. Affected lots are 031726A991, 041226B561, 062026C901, 062026C911, 071026D351, 071026D361, 071326D391, 111626G231.

• Power Stick Original Nourishing Invisible Protection Roll-On Antiperspirant Deodorant, 1.8 oz/53 mL. UPC Code: 815195018224. NDC: 42913-040-00. Affected lots are 101225D781, 032926B281, 032826B221, 041126B531, 062226D011, 070626D301, 070626D333, 111026G051, 111326G091, 111626G221.

Power Stick deodorant is sold at Dollar Tree, Walmart and on Amazon.

Consumers with recalled Power Stick deodorants should throw the product away or return it to the store.

Increasing Walk Cadence Counters Frailty Among Seniors, Study Says

Putting a little more pep in the step could help elderly folks improve their health and remain independent, a new study says. Older adults who slightly increased their **walking** cadence wound up with substantial improvements in physical function, researchers reported July 17 in the journal ***PLOS One***.

Just 14 or more extra steps per minute were enough to make a real difference, results show.

"Even casual walking had positive effects on our study participants," lead researcher **Dr. Daniel Rubin**, an anesthesiologist at the University of Chicago Medicine, said in a news release.

For the study, researchers recruited 102 older people living in 14 independent living retirement communities in the Chicago metro area. Their average age was 79, and all were considered either frail or prefrail.

The team randomly asked 56 of the folks to undertake a regular regimen of walking at casual speeds, and 46 to participate in a high-intensity walking program.

Essentially, the high-intensity walkers were encouraged to amble "as fast as safely possible," Rubin said.

Overall, seniors in the high intensity walking program increased their pace to 100 steps per minute, while casual walkers averaged about 77.

Results showed seniors did better on a six-minute walk test if they increased their comfortable walking cadence by 14 steps per minute.

These sorts of improvements can mean the world to someone struggling with frailty, Rubin said.

"People who haven't experienced frailty can't imagine how big a difference it makes to be able to not get tired going to the grocery store or not need to sit down while they're out," he said.

Based on these results, Rubin's team created a smartphone app called "Walk Test" that can accurately measure walking cadence. The app is specifically designed to be easy for seniors to pick up and use, Rubin said.

"We wanted to make it as low-barrier as possible so it's easy for older adults to use without additional equipment," Rubin said. "The people who need the most help are usually the least well-equipped to get started."

Rubin recommends that seniors measure their usual walking pace to establish a baseline, and then try to increase their pace slightly to a level that's brisker but still comfortable.

Metronome phone apps can help by providing a consistent beat to which seniors can match their steps, maintaining a steady elevated cadence, Rubin added.

Brisk walking also can provide a ton of other health benefits for seniors, noted researcher **David Conroy,** a professor at the University of Michigan School of Kinesiology.

"Physical activity has widespread, multisystem benefits," he said in a news release.

"It increases longevity, reduces risk for many common chronic diseases such as many cancers, cardiovascular disease, and **diabetes**," Conroy added. "It improves brain health, improves cognitive function and reduces risk for **Alzheimer's** disease and **related dementias.** It enhances mental health by reducing anxiety and **depression, improves bone health, and so on."**

And the payoffs come quickly.

"The most noticeable short-term impacts typically involve feeling more pleasant and revitalized, sleeping better, and thinking more clearly," Conroy said.

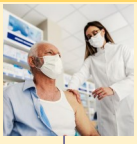
COVID Boosters Protect People With Cancer

Cancer patients can be very vulnerable to a severe COVID infection, but **COVID-19** vaccine boosters can be lifesavers for them, a new study says.

COVID boosters reduced cancer patients' hospitalizations and ICU stays by 29%, researchers report in ***JAMA Oncology***.

Overall, the vaccine boosters prevented one hospitalization or ICU admission for every 150 to 166 boosted patients, researchers found.

"The reduction in hospitalizations was significant, and the number of patients we needed to treat to see a benefit to the boosters is quite low," said senior researcher **Jan Figueiredo,** director of community health and population research at Cedars-Sinai Medical Center in Los Angeles.



"This shows a great benefit to our cancer patients and should encourage patients to discuss vaccination with their healthcare providers," she said in a news release.

"Their immune systems can be weakened by their disease and the treatments they receive, which is why major health organizations recommend that these patients be vaccinated against COVID-19," Figueiredo said.

For the new study, researchers analyzed data on more than 161,000 patients treated for cancer in 2022 and 2023 at Cedars-Sinai, Kaiser Permanente Northern California, Northwell Health in New York and the Veterans Health Administration.

Overall, the percentage of cancer patients who got COVID boosters was quite low, Figueiredo said.

By January 2022, 68% had gotten a booster, and only 38% received subsequent boosters that targeted more than one COVID strain.

"Whether this is due to patient concerns about safety or provider uncertainty about whether to administer a vaccine during treatment is not clear," Figueiredo said. "What is clear is that we need to advocate strongly for vulnerable groups, including cancer patients, to receive these vaccines."

This is the largest study to date examining the effectiveness of COVID vaccines and boosters ...**Read More**

FDA Approves Prefilled Syringe Presentation for Shingles Vaccine

The U.S. Food and Drug Administration has approved a prefilled syringe presentation of Shingrix (zoster vaccine recombinant, adjuvanted) for the prevention of shingles (herpes zoster).

The existing vaccine consists of two vials -- a lyophilized (powder) antigen and a liquid adjuvant -- that health care professionals combine prior to administration. The new prefilled syringe simplifies the vaccine administration process for health care professionals. The indications for the prefilled syringe are consistent with existing indications for the vaccine. The prefilled syringe presentation is licensed in the United States for immunization of adults 50 years and older, as well as those aged 18 years and older who are or will be at increased risk for shingles due to immunodeficiency or immunosuppression caused by known disease or therapy.

The approval was based on data showing technical comparability between the new and existing vaccine presentation.

"This new presentation of Shingrix was developed to streamline the vaccination process, supporting health care professionals to provide protection against shingles, a disease that one in three U.S. adults will develop in their lifetime," Tony Wood, chief scientific officer at GSK, said in a statement.

Approval of the prefilled syringe presentation of Shingrix was granted to GSK.

Eggs Guilt-Free For 'Bad' Cholesterol, Experiment Shows

A new egg study has produced sunny-side-up results for the oft-maligned breakfast staple.

Eggs are commonly thought to increase risk of heart disease by raising people's cholesterol levels.

But people who ate two eggs a day experienced reductions in their "bad" LDL cholesterol levels, as long as the rest of their diet remained low in saturated fat, researchers reported in the July issue of the ***American Journal of Clinical Nutrition***.

Indeed, the amount of saturated fat in a person's diet tended to increase their LDL cholesterol levels, not the cholesterol found in eggs, results show.

"You could say we've delivered hard-boiled evidence in defense of the humble egg," senior researcher **Jon Buckley**, a professor at the University of South Australia, said in a news release.

"So, when it comes to a cooked breakfast, it's not the eggs you need to worry about – it's the extra serve of bacon or the side of sausage that's more likely to impact your heart health," Buckley added.

Eggs are a unique food, in that they are high in cholesterol but low in saturated fat, he said.

"Yet it's their cholesterol level that has often caused people to question their place in a healthy diet," Buckley said.

For the new study, researchers recruited 61 adults 18 to 60 with an average LDL cholesterol level of 105.

LDL cholesterol levels above 100 are considered "at risk" for heart disease, and 160 and higher are "dangerous," according to the **Cleveland Clinic.** This type of cholesterol contributes to plaques that can block arteries and cause heart attacks or **strokes**.

Participants took turns cycling through three different types of diets for five weeks each:

- A high-cholesterol, low-saturated fat diet with two eggs a day.
- A low-cholesterol, high-saturated fat diet without eggs.
- A high-cholesterol, high-saturated fat diet that included one egg a week.

"To date, no studies have directly compared the effects of a high-cholesterol, high-saturated fat diet, as is common in Western diets, with a high-cholesterol, low-saturated fat diet or a low-cholesterol, high-saturated fat diet," researchers noted in their report….**Read More**

Urgent Care Often Hands Out Inappropriate Prescriptions, Study Finds

Urgent care clinics are handing out fistfuls of **antibiotics**, steroids and opioids for conditions these drugs won't help, a new study says.

"Previous studies had shown that patients continue to receive antibiotics for diagnoses where they may not be indicated, such as for a viral respiratory infection, especially in urgent care settings," said co-lead researcher **Dr. Shirley Cohen-Mekelburg,** an assistant professor of internal medicine at the University of Michigan Medical School.

"Our findings reveal that this trend of inappropriate prescribing includes other classes of drugs — including glucocorticoids — and a variety of conditions," Cohen-Mekelburg added in a news release.

For the study, published July 22 in the ***Annals of Internal Medicine***, researchers analyzed health care data for more than 22.4 million urgent care visits that occurred between 2018 and 2022.

More than 12% of those visits resulted in a prescription for antibiotics, 9% in a steroid prescription and 1% in a scrip for opioids.

The research team then looked to see how many prescriptions were handed out for health conditions the drugs aren't meant to treat.

Among the inappropriate prescriptions, researchers found:

- Antibiotics prescribed for more than 30% of patients with ear infections, nearly 46% of patients with urinary symptoms and 15% of patients with bronchitis.
- Steroids prescribed for nearly 24% of patients with a sinus infection, 41% of patients with bronchitis and 12% of patients with upper respiratory infections.
- Opioids prescribed for nearly 5% of patients with muscle pain, more than 6% of patients with abdominal pain or GI symptoms and 4% of patients with sprains or strains.

These results jibe with recent studies showing that urgent care is the most common type of health care visit to result in inappropriate prescriptions for antibiotics to treat viral respiratory infections, researchers said.

The drugs are likely being handed out because the urgent care staff doesn't know better, patients are demanding specific meds and no one is providing back-up support for decisions about prescribing, researchers said….**Read More**

Heart-healthy Behaviors Benefit Much More Than the Heart

Getting regular physical activity, eating a healthful diet, and engaging in other heart-friendly behaviors provides benefits that extend well beyond the heart, a new study shows.

Such **heart-healthy behaviors** can also enhance brain function, vision, hearing and muscle strength, and reduce the risk of chronic diseases, including cancer and dementia, according to research published in the ***Journal of the American Heart Association***.

"While we recently learned that heart-health and brain health are closely tied, in this review we found that almost every organ system and bodily function from head to toe benefit from a heart-healthy lifestyle," study author **Liliana Aguayo**, research assistant professor of global public health at Emory University in Atlanta, said in a news release.

For the study, researchers reviewed nearly 500 studies examining the impact of the American Heart Association's Life's Simple 7 metrics on health and well-being.

The seven metrics include not smoking, healthy eating, regular physical activity, maintaining a healthy weight, as well as managing blood pressure, cholesterol and blood sugar. (The updated Life's Essential 8 also includes sleep.)

Folks who ticked more of these boxes were likely to maintain their brain and lung function, vision and hearing, and keep their teeth and muscle strength as they age, the researchers reported.

In addition, people who practice more heart-healthy behaviors had lower levels of the stress hormone cortisol and were less likely to have chronic ailments, including the lung disease COPD, cancer, pneumonia, Alzheimer's disease, dementia, fatty liver disease, type 2 diabetes, depression and kidney disease, the study showed.

What's more, these folks also reported a better quality of life and a lower risk of adverse pregnancy outcomes, breathing problems during sleep, metabolic syndrome, erectile dysfunction, disability and mobility problems, and premature death from all causes.

Another bonus: People who engaged in more heart-healthy behaviors also had lower medical costs.

Researchers said the findings emphasize the importance of understanding how even minor changes in lifestyle can have a big payoff for health.

They added that more study is needed in underrepresented groups, including pregnant women and kids.