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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Message from the Alliance *for* Retired Americans Leaders

Congressional Democrats' Introduce Freedom to Vote Act

Robert Roach, President, ARA

House and Senate Democrats on Tuesday **reintroduced** an election overhaul package, stressing a contrast with Republicans who, according to House Minority Leader Hakeem Jeffries (NY), are seeking to "turn back the clock" on democracy.

Jeffries was joined by Senate Majority Leader Charles Schumer (NY) and other Democratic leaders at a news conference to discuss the Freedom to Vote Act, which they said would expand voter access, support local election workers and limit the influence of dark money and partisan gerrymandering on elections.

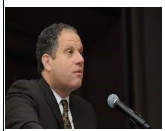
The legislation would set nationwide standards to ensure voting access and expand the availability of early voting, voting by mail and drop boxes. In addition, it would provide funds for states to invest in new and more secure voting systems, stronger cybersecurity measures and additional election workers. It would also implement nonpartisan post-election audits, require super PACs and other political organizations to disclose their donors and prohibit partisan gerrymandering.

A version of the Freedom to Vote Act was introduced in the 117th Congress and passed the House but stalled in the Senate.

The latest measure was unveiled about a week after Republicans had introduced and advanced out of committee their own election package, the American Confidence in Elections Act. Critics argue it would disenfranchise voters of color and allow more dark money in politics while catering to election deniers.

"The Freedom to Vote Act is a key step in protecting our democracy," said **Robert Roach, Jr., President of the Alliance.** "Several state Alliance chapters have had to challenge overly burdensome voting requirements. We clearly need reform."

"Protecting seniors' right to cast a ballot, and having their ballot counted, has long been an Alliance priority," added **Richard Fiesta, Executive Director of the Alliance**. "This legislation will help us achieve that goal. Congress should pass it without delay."



Rich Fiesta, Executive Director, ARA

Ten Prescription Drugs Accounted for More Than One-Fifth of Part D Spending in 2021

Medicare Part D covered more than 3,500 prescription drug products in 2021, with total gross spending of $216 billion, not accounting for rebates paid by drug manufacturers to pharmacy benefit managers (PBMs). According to KFF, formerly known as the Kaiser Family Foundation, **a small number of those drugs represented a surprising percentage of Medicare's spending.**

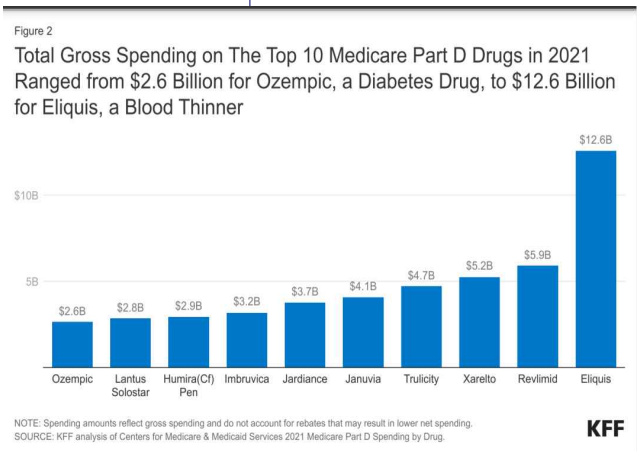
Specifically, the 10 top-selling Part D drugs comprised just 0.3% of covered drugs, yet they made up 22% of total gross Medicare drug spending in 2021. Moreover, the top 100 drugs, representing just 3% of covered drugs, accounted for 61% of total gross spending that year.

Overall, gross Medicare drug spending on the top 10 Part D drugs in 2021 was $48 billion. Eliquis, a blood thinner manufactured by Bristol Myers Squibb, was the top-selling drug, accounting for a quarter of this total, or $12.6 billion. Gross Medicare Part D spending also exceeded $5 billion for both Revlimid, a treatment for multiple myeloma also manufactured by Bristol Myers Squibb, and Xarelto, a blood thinner manufactured by Janssen.

PhRMA, the U.S. Chamber of Commerce, Johnson & Johnson, Merck, and Bristol Myers Squibb have now all sued the Administration in an effort to block drug price negotiation.

"The ten Part D drugs that will be selected for price negotiation for 2026 will be published by September 1, which is nearly upon us," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "We can see from the KFF report that negotiating the prices for ten drugs can go a long way in strengthening Medicare's finances and saving taxpayers billions of dollars."

Joseph Peters ARA Sec.-Trea.



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5 Things Retirees Need to Know About Income Taxes on Social Security Benefits

Will you need to pay tax on your Social Security benefits?

Many people don't realize it, but Social Security benefits aren't necessarily tax-free retirement income. Depending on a few factors, you might have to pay taxes on some of the retirement benefits you receive. It's important to know what to expect before you start collecting your benefits, so here are five key Social Security taxation concepts you should be familiar with.

1. As much as 85% of your Social Security benefits can be taxed

The short version of Social Security taxation is that some Americans must pay tax on Social Security benefits, and it generally only applies to those for whom Social Security isn't their only primary income source.

However, under no circumstances will anyone have to include all their **Social Security benefits** in their taxable income. Even for the highest-income retirees, no more than 85% of Social Security benefits can be taxable.

2. A special income figure is used

When determining if your Social Security benefits are taxable, the SSA uses a figure called "combined income," which is the sum of three numbers:

- Your adjusted gross income, or AGI.
- Any nontaxable interest you receive.
- *Half* of your Social Security benefits.

For example, if you have AGI of $30,000 and you receive $30,000 from Social Security, and don't have any nontaxable interest income, your combined income would be $45,000.

3. The formula to calculate the tax is complicated

Once you have figured out your combined income, there are three different categories you can fall into:

- If your combined income is less than $25,000 (individual filers) or $32,000 (joint filers), your Social Security benefits aren't taxable.
- If your combined income is between $25,000-$34,000 (individual) or $32,000-$44,000 (joint), up to 50% of your benefits can be taxable.
- If your combined income is greater than $34,000 (individual) or $44,000 (joint), as much as 85% of your benefits can be taxable.

The IRS has a worksheet in **Publication 915** that can be used to calculate your exact tax. Having said that, the simple version is that if Social Security accounts for the bulk of your retirement income, it's unlikely that your benefits will be subject to tax. On the other hand, if you have substantial sources of other income, such as 401(k) or IRA distributions, a pension, or lots of interest income, it will probably push your combined income into the taxable realm.

4. Taxes on Social Security benefits help fund the program

Taxation of Social Security benefits began as a result of the 1983 Social Security Amendments as a way to increase the money flowing into Social Security without raising taxes on all Americans. And it remains a significant source of income for the program. In 2022, Social Security brought in $1.22 trillion, and nearly $49 billion of it came directly from the taxation of benefits. Overall, Social Security ran a $22 billion deficit in 2022, but it would have been more than *three times* as much if it wasn't for taxes on higher-income retirees.

5. Some states tax Social Security benefits

So far, we've only discussed *federal* taxes on Social Security benefits, but what about state income taxes?

The good news is that most states don't tax Social Security income – but a few do. As of 2023, **12 states tax Social Security benefits** to one extent or another. Some use the same general guidelines as federal income tax, but others have much lighter taxes. For example, one of the states that taxes Social Security benefits is Colorado, but the tax only applies to people collecting Social Security who haven't turned 65 yet.

The bottom line on Social Security benefit taxation

The important takeaway is that Social Security benefits are taxed more favorably than most other types of income, but contrary to the popular misconception, they aren't necessarily a tax-free source of retirement income for everyone. The taxes you'll pay on your Social Security benefits depend on a few factors, such as your other sources of income, state of residence, and marital status, but it's important to know what to expect before you start collecting your monthly checks.

Medicare Advantage 101: A Policy Series From the Medicare Rights Center

This week, the Medicare Rights Center released ***Medicare Advantage 101***, a new set of fact sheets and videos that delve into the program's history and current status. These resources highlight the importance of strengthening Medicare and the enrollee experience by improving Medicare Advantage (MA) payment accuracy and plan accountability.

People with Medicare can choose to receive their Part A (inpatient/hospital insurance) and Part B (outpatient/medical insurance) benefits directly from Medicare, or from a private MA plan that contracts with Medicare. MA enrollment and costs have **surged** in recent years, along with questions about plan quality, denials of care, transparency, and financing—systemic problems that threaten enrollee health and Medicare sustainability.

A driving premise behind MA was its potential to save Medicare dollars. But it **never has**. Instead, Medicare spending is **higher and growing faster** for MA enrollees than for those with OM. The resulting overpayments reward insurers with greater profits but penalize everyone else. They raise Part B premiums for all beneficiaries, lead to increased costs for taxpayers, and contribute to the erosion of the Part A Trust Fund. Absent correction, these impacts will only deepen.

The *Medicare Advantage 101* series examines these issues and more, laying the groundwork for broad engagement, critical conversations, and needed reforms. Topics include:

Medicare Advantage History: Legislative Milestones

As established in 1965,

Medicare included Inpatient/Hospital insurance (Part A) and Outpatient/Medical insurance (Part B) and paid providers directly on a fee-for-service basis. Together, these two parts are known as Original Medicare (OM). The program has seen many legislative reforms over the years, including the addition of MA (Part C) in 1996. However, private insurers played a role in the lives of Medicare enrollees long before then. In this **fact sheet** and **video,** we trace that evolution.

Comparing Original Medicare and Medicare Advantage

Around half of people with Medicare get their health coverage from Original Medicare (OM) and the other half from MA. Individual needs, preferences, and priorities typically guide these enrollment choices. In this **fact sheet** and **video**, we outline key considerations beneficiaries often keep in mind when deciding between the two coverage pathways.

The Beneficiary Experience with Medicare Advantage Enrollment and Access to Care

In our experience, many people can struggle to choose an MA plan that best meets their needs. For both newly eligible enrollees and those re-evaluating their options, the MA plan comparison process can be complex and burdensome, undermining active, informed coverage choices. Once enrolled, these decisions and MA -specific features—such as restrictions on providers and barriers to services—may limit enrollee access to care in unanticipated and harmful ways. Learn more about the beneficiary experience with MA in this **fact sheet** and **video**….**Read More**

HHS Projects Significant Medicare Beneficiary Savings Under the IRA

The Inflation Reduction Act (IRA) made key changes to improve prescription drug affordability for people with Medicare. Important reforms that are already in place or will be soon include limiting beneficiary insulin costs to $35 per month, making recommended Part D vaccines available at no charge, capping out-of-pocket (OOP) prescription drug costs at $2,000 a year, expanding the full Part D Low Income Subsidy (LIS) to people with incomes at or below 150% of poverty, and redesigning the Part D benefit to eliminate the coverage gap and enrollee coinsurance in the catastrophic phase.

A new report from the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) finds that people with Medicare will see significant savings once these provisions are fully implemented in 2025.

ASPE estimates one out of every three Medicare Part D enrollees, 19 million people, will have their OOP costs reduced by about $400, and some will save even more. Over 8 million enrollees will see a $759 reduction, and nearly 2 million people will save at least $1,000—$2,500, on average—a 66% decrease relative to their current costs.

Callers to Medicare Rights national helpline regularly report struggling to afford the prescription medications they need to maintain their health and well-being. And they are not alone. In 2021, over **5 million** people with Medicare are estimated to have had difficulty paying for their prescriptions, with Black and Latino beneficiaries being disproportionately affected. That same year, nearly **20% of older adult**s said they had not filled a prescription in the past two years, most citing affordability concerns. The IRA's affordability mechanisms will provide much needed relief.

Future ASPE reports may examine other benefits of the IRA's Part D changes, like increased access to needed drugs. **It is anticipated** that under the IRA, people with Medicare will be able to afford prescription medications they previously could not, thereby boosting treatment adherence, improving health outcomes, and reducing the need for—and Medicare spending on—more costly care.

Importantly, other aspects of the IRA, including the inflation rebate cap and drug price negotiation, are expected to generate additional savings for enrollees and taxpayers.

Read the ASPE report, Inflation Reduction Act Research Series: Medicare Part D Enrollee Out-of-Pocket Spending: Recent Trends and Projected Impacts of the Inflation Reduction Act

Read more about the new insulin provisions.

CMS urges states to abide by Medicaid renewal requirements

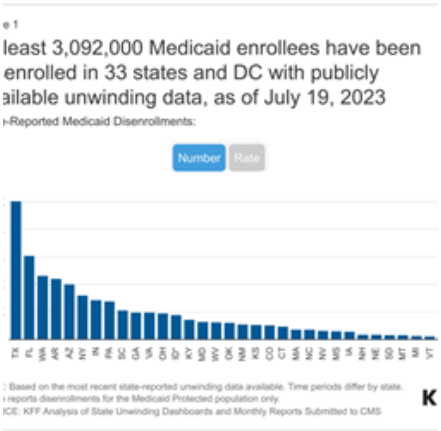
As states continue to work through the lengthy backlog of Medicaid eligibility determinations, federal officials are urging them to do as much as possible to avoid large coverage losses.

Dan Tsai, deputy administrator of the Centers for Medicare & Medicaid Services (CMS) and director of the Center for Medicaid and CHIP Services, told reporters Wednesday that the agency's goal is for states to meet and exceed federal requirements in limiting how many individuals lose healthcare coverage.

"We put out additional policy, levers and strategies for states that all get at reducing procedural termination rates, and our hope … is that all states take up every one of those policy flexibilities," said Tsai during the press conference. "If all states do that, we will see a reduction in procedural terminations, and we will see an increase in the number of eligible people that maintain coverage. That is the bottom line and why we have been urging and partnering with states to … make sure they are following every federal requirement.

"We have been emphasizing it is not enough for states to simply follow federal minimums when it comes to Medicaid enrollments," he added. "We are really asking every state to take up a whole host of policy waivers and strategies."

Individuals currently enrolled through Medicaid or the Children's Health Insurance Program (CHIP) generally go through annual renewal windows, which were put on pause during the COVID-19 public health emergency. Congress increased the **federal matching rate** for state Medicaid payments during the pandemic so long as states agreed to not drop anyone off Medicaid rolls. Eligibility redeterminations, after Medicaid disenrollments in February 2020, began April 1...**Read More**



J&J sues to block Medicare drug price negotiations

Johnson & Johnson on Tuesday became the latest drugmaker to go to court **to halt** Medicare drug price negotiations established by the Inflation Reduction Act.

Why it matters: The lawsuit increases the odds that negotiated prices won't take effect on schedule, beginning in 2026. And **the filing** in U.S. District Court in Trenton, N.J., also drives up odds of conflicting legal rulings over the law's drug price provisions that could prompt the Supreme Court to review the matter.

- **What they're saying:** J&J, which owns pharmaceutical company Janssen, claims the law is unconstitutional and leaves Janssen with no choice but to withdraw all of its products from Medicare and Medicaid if it wants to avoid the negotiations."That provision is the legal equivalent of a gun to the head because it would require the manufacturer to give up access to nearly 40% of the U.S. health care market," the company wrote.

- "It is akin to the government taking your car on terms that you would never voluntarily accept and threatening to also take your house if you do not 'agree' that the taking was 'fair,'" the company said.
- J&J says Janssen also is being forced to violate its First Amendment rights by being coerced into making false statements and agreeing the price is fair.

J&J is asking the court to declare any agreements Janssen may be forced to sign null and void, and to block the HHS from forcing Janssen to sign the manufacturer agreement.

Catch up quick: HHS will reveal in early September the first 10 high-cost Medicare drugs that will be subject to talks with manufacturers. Discussions will begin in February 2024 and the maximum negotiated prices will be announced in September 2024.

- Johnson & Johnson specifically names Janssen's blood thinner Xarelto as a drug that faces potential negotiation.
- Janssen's antipsychotic medication Invega Sustenna and diabetes drug Invokana have also been named as possible candidates, per a study in the *Journal of Managed Care & Specialty Pharmacy*.
- Merck, Bristol Myers Squibb, the trade group PhRMA, and the U.S. Chamber of Commerce have each challenged the law in other courts.

3 Government Programs That Offer Free Money For Senior Citizens

Most young adults look forward to retirement and the end of the daily grind. In a perfect world, entering retirement means you can relax and take time for the things you enjoy. However, 15% of Americans reported that currently, they have no retirement savings. And with rising inflation, it is becoming even more difficult for the elderly to affordable basic expenses on a fixed income. For those struggling post-retirement, here are 3 government programs that off free money for senior citizens.

3 Government Programs That Offer Free Money For Senior Citizens

With several state and federal programs, the government offers assistance to people with limited resources. Senior citizens are among the most vulnerable, especially as they have higher medical costs and fewer employment options. While Medicare, Medicaid, and Social Security provide some assistance, it isn't always enough to provide the most basic standard of living.

For those in need of immediate cash benefits, here are 3 government programs that offer free money for senior citizens.

Supplemental Security Income (SSI)

The Social Security Administration manages the federal program that pays additional benefits to low-income senior citizens that are blind, disabled, or over 65. Based on figures from 2022, standard payments were $841 for individuals and $1,261 for married couples. If you are eligible, you could receive payments from both SS and SSI.

If you think you qualify, you can call 800-772-1213 with specific questions about your eligibility. However, you will have to apply through your local Social Security Office. But, under special circumstances, some may be able to apply for SSI online.

Veterans Pension

The U.S. Department of Veterans Affairs offers cash benefits for wartime vets and their survivors. If you are disabled or over 65, you are eligible to receive your Veteran's Pension. But, you must meet requirements for years of active service and income limits.

The spouses of deceased veterans may also qualify for the VA Survivor's Pension. Additionally, they can access other benefits through Household Allowance and Aid and Attendance Benefits for financial help. You may be able to afford a healthcare professional who can help with daily activities if their loved ones have lost mental or physical abilities.

To learn more and apply for your Veterans Pension, you'll have to go through the VA website.

Government Grants

Although these programs are open to people of all ages, many government grants offer assistance to low-income families. Though these programs won't send a check to your home, they can provide substantial financial relief.

For example, you may find grants that offer aid through:

- Temporary Assistance for Needy Families
- Individual Development Accounts
- Premium Tax Credit
- American Opportunity Tax Credit
- Earned Income Tax Credit
- Child Tax Credit

Depending on the individual situation, these grants could provide vital funding for senior citizens.

Finding Help for Senior Citizens in Need

Although it may seem hopeless, some resources and programs offer free money for senior citizens with limited resources.

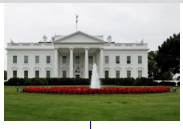
The **BenefitsCheckUp** tool from the National Council of Aging is an excellent resource to help you get started. By entering your zip code, you can find out what state and federal benefits are available where you live. The site also gives more details about the application process and a facts sheet to answer the frequently asked questions.

You can also contact the Area Agency on Aging, a non-profit organization that receives funding from state governments. They may be able to help senior citizens access the services they need and live independently.

White House launches new pandemic office to be led by retired general

The White House on Friday launched an office to prepare for and respond to potential pandemics, to be led by Paul Friedrichs, a military combat surgeon and retired Air Force major general who helped lead the Pentagon's COVID response.

The new Office of Pandemic Preparedness and Response Policy will also take over the duties of President Joe Biden's current COVID-19 and mpox response teams, the White House said.



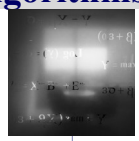
The office will be a charged with "leading, coordinating, and implementing actions related to preparedness for, and response to, known and unknown biological threats or pathogens that could lead to a pandemic or to significant public health-related disruptions in the United States," its statement said.

Biden announced Friedrichs as the office's inaugural director. Friedrichs is currently special assistant to the president and senior director for Global Health Security and Biodefense at the White House National Security Council.

The White House had been expected to cut down its COVID response team after the U.S. government in May ended its **COVID Public Health Emergency**.

Corporate health insurers use NaviHealth algorithms to deny care in Medicare Advantage plans

Beware of corporate health insurers that use **NaviHealth, an AI system tha can inappropriately deny care** to people in Medicare Advantage plans. UnitedHealth, which now owns NaviHealth, and other health insurance companies that rely on NaviHealth in their medical decisionmaking might wrongly deny care to Medicare Advantage enrollees in serious health. Even NaviHealth employees believe NaviHealth denies care to people who should continue to be getting care, reports **Stat News**.



Employees at NaviHealth are complaining in internal communications that insurers are denying care to people who are on IVs in rehab facilities. As Stat previously reported, insurance corporations are using AI–computer programs –to deny care to Medicare Advantage enrollees with serious diseases and injuries. Patients, physicians and NaviHealth workers are "increasingly distressed" that patients are not able to get the care they need as a result of these computer algorithms.

Former medical review employees at NaviHealth say that they were not allowed to use their independent clinical judgment to allow continued stays in rehab facilities when the NaviHealth system said to deny care; they had to follow the algorithms. "That was very different from before we were owned by Optum."

As Stat News reports, this is the dark side of AI. Reporters spoke with five former NaviHealth employees, patients, lawyers, experts and reviewed internal communications at NaviHealth. For its part, NaviHealth says its algorithms are merely a guide and NaviHealth does not make coverage decisions. But, how often do insurance company medical review staff not follow the NaviHealth "guide" when the medical evidence suggests patients still need care?...**Read More**

Dear Marci: Will Medicare cover scheduled transportation?

Dear Marci,

I need some help getting to and from treatment I have schedule for next month. Will Medicare cover my scheduled transportation?

-Norman (Riverside, CA)

Dear Norman,

Depending on your circumstances, Original Medicare may cover scheduled/regular non-emergency ambulance transportation if the ambulance supplier receives a written order from your doctor in advance stating that transport is medically necessary. However, Medicare does not cover ambulance transportation just because you lack access to alternative transportation. The order must be dated no earlier than 60 days before the trip.

For example, if you are receiving dialysis treatments, Medicare may cover ambulance services to and from your home to the nearest dialysis facility, if other transportation could endanger your health.

Keep in mind that Medicare does not require a doctor's written order for **coverage of emergency ambulance transportation**.

Keep in mind that Medicare does not require a doctor's written order for **coverage of emergency ambulance transportation**.

In certain states, ambulance suppliers must receive prior authorization from Medicare before providing scheduled, non-emergency ambulance transportation. These states include:

- Delaware
- District of Columbia
- Maryland
- New Jersey
- North Carolina
- Pennsylvania
- South Carolina
- Virginia
- West Virginia

If the prior authorization request is approved, Medicare should cover your ambulance trips so long as the ambulance supplier also receives a written order from your doctor stating that transport is medically necessary. If Medicare denies your request, the ambulance supplier or you should submit a new prior authorization request.

You have the right to appeal denials. Keep in mind that if you choose to receive services after a denial, you may be responsible for the full cost of your ambulance transportation.

If Medicare does not cover the kind of transportation you need, you may have other options. For example, Medicaid may cover some types of transportation that Medicare does not. Additionally, some Medicare Advantage Plans may cover additional types of transportation as a supplemental benefit. You can also contact **ElderCare** or your local **State Health Insurance Assistance Program (SHIP)** to learn about local resources that may be available to you.

I hope this helps!

-Marci

Does Long-Term Care Insurance or Medicare Cover Assisted Living?

Learn about the options for financing assisted living, including long-term care insurance and Medicare coverage.

You just turned 65 and applied for **Medicare**. Now, if you need assisted living, you'll be set, right? Not quite.

Many people assume that Medicare covers **assisted living**, but that misconception can be costly. Knowing the facts about Medicare, Medicaid, long-term care insurance and other coverage options will save you money and grief when it's time to consider assisted living.

What Is Assisted Living, and How Much Does It Cost?

Even if you are healthy today, it's important to plan for the "what ifs." According to the Administration for Community Living, people age 65 or older have a 70% chance of needing some sort of long-term care in their lifetime.

One such option is assisted living. This setting is traditionally designed for those who are still somewhat independent but need assistance with **activities of daily living**, such as bathing, dressing and toileting. Assisted living communities also provide an environment where residents can enjoy socialization, group activities and meals with friends and family. Some communities even allow residents to have pets, as long as they can care for them.

While assisted living provides a homelike, comfortable setting for residents who can no longer live alone but don't need 24/7 care, it can be **pricey**. In fact, the average expense, according to Genworth Financial – a long-term care insurance provider that publishes a **Cost of Care Survey** – is about $4,500 per month. That's a national average, and some locations will cost significantly more.

This baseline fee doesn't include "extras" or unexpected costs, such as additional care fees, medications, housekeeping or cable TV. And costs can climb much higher for luxury communities.

Selecting the right community means considering a range of variables from price to amenities, says Meg Pletcher, vice president at Atria Senior Living, based in Louisville, Kentucky.

"It's important for older adults and their families to talk about their expectations for senior living in advance, do their research and choose the community that meets their needs socially, physically and financially," she explains….**Read More**

Which outpatient drugs are costing Medicare the most?

In a little more than a month, we will know which ten outpatient prescription drugs will be subject to Medicare price negotiation under the Inflation Reduction Act in 2025. (That's if the pharmaceutical companies do not **prevail in their lawsuits** aimed at stopping Medicare drug price negotiation.) The drugs whose prices will be negotiated will be those, covered under Medicare Part D, that are costing Medicare the most.

In 2026, Medicare will negotiate prices for 10 additional drugs. In 2027, Medicare will negotiate prices for 15 additional Part D drugs. In 2028, Medicare will negotiate prices for yet another 15 Part D drugs.

Beginning in 2029, Medicare will negotiate prices for 20 drugs covered under Part D and Part B, which covers inpatient drugs. They must be single-source brand-name drugs, which have been on the market for at least seven years, or biologics that do not have biosimilar options, which have been on the market for at least 11 years.

As with many things, a small number of drugs are responsible for a significant portion of Part D prescription drug spending. Medicare spent $48 billion on the ten drugs with the highest spending in 2021. Half of those drugs are treatments for diabetes: Trulicity, Januvia, Jardiance, Lantus Solostar, and Ozempic. The other half include Imbruvica, a cancer treatment, Humira Citrate-free (Cf) pen, a treatment for rheumatoid arthritis.

Prescription drug prices are soaring, especially for the drugs that Medicare is spending the most on. In the three years between 2018 and 2021, the price of these ten drugs more than doubled. Spending jumped from $22 billion to $48 billion. Total Medicare Part D spending rose from $166 billion to $216 billion.

Twenty-two percent of Medicare Part D spending results from just ten drugs out of a total of 3,500 (0.3 percent) that Medicare covers under Part D. Six-one percent of total spending results from just 100 drugs (3 percent of covered drugs).

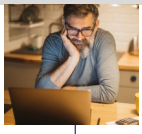
In 2021, Medicare spent $2.6 billion on Ozempic, to treat diabetes for 500,000 Medicare patients, $5 billion on Revlimid, to treat multiple myeloma, and $12.6 billion on Eliquis, a blood thinner….**Read More**

Social Security: Despite 'Overwhelming Bipartisan Support, 'Taxing Rich More To Solve Funding Issues Remains Tense Debate

Coming up with a strategy to **address the looming Social Security funding shortfall** requires agreement on both sides of the political aisle. That's a challenge even in a normal political environment, and it's even more so in today's increasingly partisan climate. But there is one **Social Security fix** that nearly everyone agrees on: hiking taxes on the wealthy to bring in more revenue.

A survey of more than 2,500 register voters conducted last year by the University of Maryland's Program for Public Consultation (PCC) found "overwhelming" bipartisan support for raising the income threshold on wages subject to Social Security payroll taxes. Currently, any wages **above $160,200 are not taxed**. Some lawmakers recommend raising that figure to $250,000 or higher to bring in more revenue.

I'm a Social Security Expert: Here's What Your Benefit Should Be in 5 Years



The PCC survey found that making all wages over $400,000 subject to the payroll tax was favored by 81% of voters, including 79% of Republicans and 88% of Democrats. The PCC estimates that doing this would eliminate 61% of the Social Security shortfall due to hit in a decade or so, when the program's **Old Age and Survivors Insurance (OASI) Trust Fund runs out of money**. After that, the program will be solely reliant on payroll taxes, which cover only about 77% of current benefits, for funding .

President Joe Biden's 4-point plan to fix Social Security includes a provision to tax any earned income above $400,000, leaving wages between $160,200 and $400,000 untaxed.

Steven Kull, director at the Program for Public Consultation at the University of Maryland, said raising the payroll tax has gotten "overwhelming bipartisan support," CNBC reported.

Another proposal with wide bipartisan support is reducing Social Security benefits for high earners**.** About eight in 10 **(**81%) voters — including 78% of Republicans and 86% of Democrats — favor reducing benefits for the top 20% of earners. Doing so would eliminate 11% of the shortfall.

Among the lawmakers trying to push through legislation that would raise Social Security taxes on the wealthy is U.S. Senate Budget Committee Chairman Sheldon Whitehouse (D-R.I.). As CNBC reported, Whitehouse has sponsored a bill, the Medicare and Social Security Fair Share Act, that would require wages above $400,000 to be taxed for Social Security.

"Right now, the cap on Social Security contributions means a tech exec making $1 million effectively stops paying into the program at the end of February, while a schoolteacher making far less contributes their share through every single paycheck all year," Whitehouse said.

U.S. Rep. Brendan Doyle (D-Pa.) has introduced a companion version of the bill in the House of Representatives.

But not everyone is convinced taxing the wealthy alone will provide a long-term fix to Social Security's funding problems. As previously reported by GOBankingRates, many high earners might attempt to get around the taxes by putting money into assets not subject to the payroll tax, such as dividend income, capital gains, rental income for non-rental professionals and bond income….**Read More**

Wisconsin Alliance for Retired Americans, Priorities USA File Legal Challenge to Absentee Ballot

On Thursday, the Wisconsin Alliance for Retired Americans, Priorities USA and William Franks, Jr., a board member of the Alliance from Dane County, Wisconsin, filed a legal challenge to three provisions of Wisconsin election law that place unnecessary restrictions on casting absentee ballots. The filing seeks to provide relief to voters impacted by the following restrictions:

The lawsuit challenges barriers to absentee voting in Wisconsin including a requirement that every absentee ballot be signed by an adult witness regardless of whether a voter lives alone, is homebound, or faces other barriers to satisfying the provision. The filing argues that as a result of the unnecessary requirement, the right to vote by absentee ballot is unfairly based on the voter's ability to find a willing third party.

It also challenges a Wisconsin law that has been interpreted to prohibit the use of drop boxes for collecting absentee ballots. Drop boxes have consistently been proven as a secure and convenient way to submit absentee ballots and were widely used without issue in the 2020 election. Despite this, a recent court decision eliminated the use of drop boxes in 2022 which led to a significant increase in late-arriving absentee ballots.

Finally, the suit seeks relief for voters from the arbitrary deadline to cure defects in their ballot.

"Seniors in Wisconsin take their constitutional right to vote seriously. We are also the most likely to need to vote absentee because of health issues or transportation challenges," said Ross Winklbauer, Sr., President of the Wisconsin Alliance for Retired Americans. "We are asking the Court to remove these unnecessary barriers so all voters in Wisconsin, especially older voters, can cast a ballot that will actually be counted." Read the full press release **here**.

Beware experimental Alzheimer's drug trials

Melody Peterson reports for the **LA TImes** on how pharmaceutical companies enlist Californians with Medicare to participate in a clinical trial for **experimental drugs** intended to stave off Alzheimer's. **Ads promote drug trials** for people who are losing their memories, as a way to keep their minds sharp. But, participating in an experimental Alzheimer's drug trial carries serious risks.

The pharmaceutical companies see Alzheimer's drugs as a mega-opportunity to generate outsized profits. The six million person market is huge and only growing. There's little limit on what pharmaceutical companies can charge for these drugs. And, if FDA-approved, Medicare must pay for the drugs. Already, the FDA has approved **Aduhelm** and **Leqembi**, which costs $26,000 a year, even though neither drug shows significant benefits and both can have serious side effects. Now, the race is on to market other drugs. But, the pharmaceutical companies need nearly 60,000 individuals to participate in the clinical trials of the **140 drugs being developed that are still experimental.**

No question that if an Alzheimer's drug works well, it could improve and extend the lives of people with Alzheimer's and, arguably, save the health care system money as well. But, the clinical trials are not designed to treat people, only to test a drug's efficacy. In fact, the trials can severely harm people.

The Leqembi trials were likely responsible for the death of three people, though the drug's manufacturer claims Leqembi was not likely the cause of their deaths. And, four in ten participants in the Aduhelm trials experienced brain bleeding or swelling.

Do trial participants understand that these experimental drugs come with a risk of brain swelling or bleeding? Is there a financial conflict of interest for the trial investigators who could make big money from the experimental drugs when they recruit trial participants? Do they overpromise?...**Read More**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

An experimental Alzheimer's drug outperforms one just approved by the FDA

Patients in the early stages of Alzheimer's may soon have a new option to stave off the loss of memory and thinking.

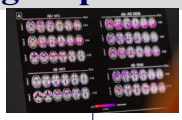
In a study of more than 1,700 people, the experimental drug donanemab slowed the progression of Alzheimer's by about 35%, scientists **reported** at the Alzheimer's Association International Conference in Amsterdam.

The result, **published** simultaneously in the journal *JAMA,* suggests that donanemab is at least as effective as the newly approved drug **Leqembi** (lecanemab), which was found to reduce progression by about 27%.

"This is the biggest effect that's ever been seen in an Alzheimer's trial for a disease-modifying drug," says **Dr. Daniel Skrovonsky**, director of research and development at Eli Lilly, which makes donanemab. The company has submitted the results to the Food and Drug Administration and expects a decision by the end of the year.

But experts caution that donanemab is no cure, and that its benefit amounts to only about a seven-month delay in the loss of memory and thinking.

"I do think that will make a difference to people," says **Dr. Reisa Sperling**, who directs the Center for Alzheimer Research and Treatment at Brigham and Women's Hospital in Boston. "But we have to do better."



Early treatment is key

Donanemab, like Leqembi, is a **monoclonal antibody** designed to remove a substance called beta -amyloid from the brain. Beta-amyloid tends to form sticky plaques in the brains of people with Alzheimer's.

The donanemab study focused on people whose brain scans showed plaques and other changes associated with early Alzheimer's. They had only mild cognitive symptoms.

Even within that group, though, people with more advanced disease saw less benefit from the drug.

"What we saw is that the ability to slow disease progression is strongest if you catch this disease earlier," Skrovonsky says.

The study also suggests that patients may not need monthly intravenous infusions of donanemab for life.

Patients were taken off the drug once the plaques in their brains were mostly gone, usually within a year. The plaques did not reappear during the 18-month study, and the benefit to memory and thinking continued.

That appears to give donanemab an edge over Leqembi, which requires ongoing treatment. But it's still not clear whether donanemab's benefits will persist for years after treatment ends.

"I imagine in the future we'll have this initiation phase where we knock down plaque and then we'll have maintenance therapy," Sperling says.

Both donanemab and Leqembi can cause dangerous swelling or bleeding in the brain.

In the donanemab study, brain scans revealed this side effect in about 25% of patients. About 6% had symptoms, like headache, nausea, and confusion. Three patients died.

A new era for Alzheimer's treatment?

The results with both donanemab and Leqembi provide strong evidence that removing amyloid from the brain can slow down Alzheimer's. That approach, known as the amyloid hypothesis, had been in doubt after dozens of other amyloid drugs failed to help patients.

One reason for the recent success is earlier treatment, Sperling says. Instead of treating patients who've already sustained significant brain damage from Alzheimer's, researchers have focused on people whose brains are still relatively healthy.

Another factor is the way researchers are approaching treatment, Sperling says.

"We've learned to be more aggressive with dosing," she says, which quickly reduces amyloid to very low levels in the brain.

But scientists still aren't sure which forms of amyloid offer the best target.

Single amyloid molecules appear to be harmless. But scientists have learned that when these molecules begin to clump together, they can take on forms that are toxic. Eventually, these clumps end up in plaques between brain cells.

"There's been a debate in our field for 30 years now about whether the plaques themselves are causing the problem," Sperling says. And the results with donanemab and leqembi are unlikely to end that debate.

Donanemab is designed to target plaques specifically. Leqembi is designed to target other forms of amyloid, though it also removes plaques.

Yet both drugs appear to slow down the loss of memory and thinking, in patients with early Alzheimer's.

A **study** Sperling is involved in could help answer the amyloid question by treating people who still have very little plaque in their brains.

"If we see benefit even at that stage," Sperling says, "one might argue it's not just plaque" eroding memory and thinking.

Weekly Insulin Shot Could Be a Game Changer for Those With Type 2 Diabetes

People with type 2 diabetes could soon have access to convenient once-a-week insulin shots that could replace the daily injections now required.

A once-weekly insulin formulation called icodec performed just as well as daily doses of the insulin degludec, phase 3 clinical trial results show.

Icodec now awaits approval by the U.S. Food and Drug Administration based on these results, said lead researcher **Dr. Ildiko Lingvay**, an endocrinologist at UT Southwestern Medical Center in Dallas.

"This is the first product that's been developed as a weekly insulin, so we were, of course, very eager to see how it fares from an efficacy and safety standpoint compared with the current insulin," she said. "And frankly, it's just as good. I think it's going to be a game changer."

More than 37 million Americans -- about 1 in 10 -- have diabetes, researchers said in background notes. About 95% of those cases are type 2 diabetes, in which the body develops insulin resistance.

About a third of people with type 2 diabetes take daily insulin injections to keep their blood sugar in a healthy range, researchers said.

But these daily shots are such a bother that there's an average three to five years of delay before people start taking their needed insulin, increasing the risk of long-term complications like heart disease, nerve damage, vision loss, and foot or leg amputations, researchers said.

"We know it's not fun," Lingvay said. "It's a lot of work for patients. It interferes with their lives. It's complicated, and it comes with all sorts of hassles."

Icodec works as a time-release insulin by adhering to albumin, a protein in blood plasma, she said.

"It goes in the blood and then it attaches to albumin," Lingvay said. "Then it sits in an inactive form circulating around the blood, and it releases at a constant pace throughout the week. You're basically creating a depot of inactive insulin that slowly releases to do its job."

To test its effectiveness, researchers recruited 564 people with type 2 diabetes who'd never been treated with insulin.

They were randomly assigned to….**Read More**

New Drug Could Boost Outcomes for People With Ulcerative Colitis

People living with the pain, bloody diarrhea and sometimes urgent need to use the toilet that comes with ulcerative colitis may soon have a new treatment option that's already been given the go-ahead in Europe.

The drug -- an antibody known as mirikizumab (Omvoh) -- is the first of its kind tested for this condition. It works by blocking interleukin-23, a key protein in triggering and maintaining gut inflammation.

An international team led by researchers at Amsterdam University Medical Centers in the Netherlands tested the drug's safety and effectiveness in trials that included 1,281 adults with moderate to severe inflammation from the disease.

Rates of remission doubled, to as much as 50%, in certain groups.

If approved in the United States, the drug could provide better or safer symptom control in a marketplace of treatments, according to researchers. Among those are the steroid prednisone, anti-TNF inhibitors that suppress the immune system and other medications, including one that blocks two proteins known as cytokines.

The new drug works by blocking a single protein, said lead researcher **Dr. Geert D'Haens**, a professor of gastroenterology at Amsterdam UMC.

"It's very important to patients," he said. "That's the purpose. Restoration of quality of life and normality of life, whatever that may mean, of course."

Experiences with ulcerative colitis vary, with about half of patients having disease that's easy to treat and the others having more challenges in getting symptoms under control, D'Haens said.

Those symptoms can include bloody diarrhea, abdominal pain, anemia, fatigue and, for some, fecal incontinence, the sudden need to empty one's bowels.

Millions of people around the world have ulcerative colitis. Many patients experience an impaired quality of life.

"The most important advantage, I would say, lies in the safety," D'Haens said about mirikizumab.

Some of the other medications available to treat the condition increase the risk of infections and potentially cancer.

Some patients with ulcerative colitis undergo surgery that includes a stoma or a pouch reconstruction.

The condition itself increases the risk of cancer because of chronic colon inflammation.

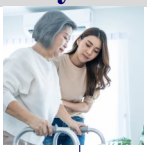
This drug doesn't impact either the liver or kidneys, D'Haens said….**Read More**

Women With Severe Stroke Less Likely Than Men to Be Sent to Stroke Centers

Despite worse symptoms and living about the same distance from comprehensive stroke centers, women with a severe type of stroke are less likely to be sent to these facilities than men, a new study reveals.

Researchers at the University of Texas Health Science Center at Houston found women with what's called a large vessel occlusion acute ischemic stroke were about 9% less likely than men to be routed to comprehensive stroke centers.

These strokes happen when a major artery in the brain is blocked. They account for an estimated 24% to 46% of ischemic strokes, according to the study authors.



"Timely treatment of stroke is incredibly important; the faster a doctor is able to get the vessel open, the better the patient's chance of having a good outcome. These routing systems in hospitals are designed to get patients to the best care as quickly as possible," said study co-author Dr. Sunil Sheth, an associate professor of neurology.

"We don't know exactly why women were less likely than men to be routed to comprehensive stroke centers, but we do know that gender is an implicit bias," Sheth continued in a university news release. "Getting to the granular level of what went into a hospital's routing decision will be very important for future studies."

For the study, the researchers used data on patients with large vessel occlusion acute ischemic stroke from a multi-hospital registry for the greater Houston area from January 2019 to June 2020.

The investigators compared prehospital routing of men and women to centers capable of performing endovascular therapy to remove the artery-clogging clot.

Among 503 patients, about 46% were women. In all, 82% of patients were routed to comprehensive stroke centers.

Compared with men, women with these strokes were older, average age 73 versus age 65. They also had a greater National Institutes of Health Stroke Scale (NIHSS) score, 14 compared to 12. That means their symptoms were worse….**Read More**

How NSAIDs Can Make a C. Difficile Infection Worse

Aspirin, naproxen and other common pain medications known as NSAIDs worsen gastrointestinal infections caused by a bacterium known as *Clostridioides difficile* (C. diff), new research shows.

NSAIDs (nonsteroidal anti-inflammatory drugs) are widely used to ease pain and inflammation. In a new study using mice, researchers set out to find why they exacerbate C. diff, the leading cause of antibiotic-associated diarrhea worldwide.

It appears that NSAIDs disrupt the mitochondria of cells lining the colon, sensitizing them to damage by pathogenic toxins. (Mitochondria are essential components of nearly all cells in the body).

"Our work further demonstrates the clinical importance of NSAIDs in patients with C. diff infection and sheds light on why the combination of these two may be so detrimental," study co-**author Joseph Zackular** said in a news release from Children's Hospital of Philadelphia. He is an assistant professor of pathology and laboratory medicine at the University of Pennsylvania School of Medicine.

C. diff can be difficult to treat and can lead to a wide range of symptoms, from mild diarrhea to complex infection and death.

Past research has shown that NSAIDs like indomethacin, aspirin and naproxen negatively affect the gut, both in patients with C. diff infection and other conditions like inflammatory bowel disease (IBDs, such as Crohn's disease and ulcerative colitis).

Long-term use of these medications can lead to a variety of issues, such as stomach ulcers and bleeding and perforation of the intestinal tissue.

A theory is that this happens because of the effects of NSAIDs on cyclooxygenase (COX) enzymes. While reducing inflammation and pain, the process may impair mucosal function in the upper gastrointestinal tract.

NSAIDs have also been shown to uncouple cellular mitochondrial functions, according to the study.

Researchers in this study used in vitro and mouse models of *C. difficile* infection to test how permeable the colonic epithelial cells are in the presence of a particular NSAID, this time indomethacin.

Led by **Joshua Soto Ocaña**, a graduate student at the University of Pennsylvania, researchers observed that both indomethacin and *C. difficile* toxins increased epithelial cell barrier permeability and inflammatory cell death.

The effect was additive, meaning the combined effect on cell permeability of both toxins and indomethacin was increased compared to each independently….**Read More**

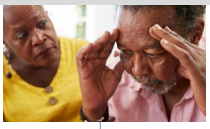
New Opioid Use Raises Death Risk 11-Fold in Those With Dementia

Older adults who begin using opioid painkillers after a dementia diagnosis have a significantly greater risk of death — about 11-fold within the first two weeks, according to new research.

The risk of death continued beyond two weeks, but at a lower rate, said researchers in Denmark. They found a doubled death risk within 90 days of opioid initiation, and said doctors must seriously weigh the risks versus benefits of opioid use in elderly patients with dementia.

The study of all Danes diagnosed with Alzheimer's disease in a 10-year period also found that one-third of patients who began taking opioids died within 180 days of that first dose. About 6% of the non-opioid group died during that time.

"In our study, starting on an opioid after getting a dementia diagnosis was frequent and associated with a markedly increased risk of death, which is worrisome," co-author **Dr. Christina Jensen-Dahm** said in an Alzheimer's Association news release.



"The use of strong opioids has increased considerably over the past decade among older people with dementia. Our study shows the importance of careful evaluation of risk and benefits to the patient when considering initiating opioid therapy among elderly individuals with dementia," said Jensen-Dahm, of the Danish Dementia Research Centre at Copenhagen University Hospital.

When the opioids were fentanyl patches, nearly two-thirds of patients died within the first 180 days versus about 7% of those without opioid prescriptions.

Overall, the researchers found a fourfold increased excess death risk associated with opioids in the first six months even after adjusting for differences between groups.

Guidance from the U.S. Centers for Disease Control and Prevention says opioid therapy should only be considered for pain if benefits outweigh the risks.

"This is particularly important for older individuals with dementia," Jensen-Dahm said. "Opioids are known to have significant side-effects including sedation, confusion, respiratory depression and falls. Older adults with dementia have a severe brain disorder and are often frail. We suspect this is why they cannot tolerate opioids, but we do not know for certain and need to do more research to answer these questions."

Those in the study were 65 and older and diagnosed with dementia between 2008 and 2018. About 42% of them filled a prescription for an opioid.

Strong opioids like morphine and oxycodone (OxyContin) were associated with a sixfold increased death risk. This group also included ketobemidone (Ketogan), hydromorphone (Dilaudid, Exalgo), pethidine (Demerol), buprenorphine (Buprenex) and fentanyl.

"Opioids are very powerful drugs, and while we need to see additional research in more diverse populations, these initial findings indicate they may put older adults with dementia at much higher risk of death," said **Dr. Nicole Purcell**, a neurologist and Alzheimer's Association senior director, clinical practice….**Read More**

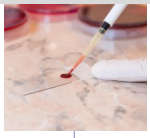
Blood Prick Test for Alzheimer's Shows Promise

A definitive diagnosis of Alzheimer's disease now requires a series of complicated and expensive imaging scans that look for abnormal protein plaques and tangles in the brain.

But in the near future, detecting signs of Alzheimer's could be as simple as taking a finger prick blood test.

Researchers detected key Alzheimer's-related biomarkers in dried blood samples drawn from a finger prick, according to findings presented Wednesday at the Alzheimer's Association International Conference, in Amsterdam.

"The finger prick method is very much a work in progress, but we are encouraged by this preliminary evidence," said lead scientist **Hanna Huber**, a postdoctoral researcher of neurochemistry at the University of Gothenburg in Sweden.



This study, along with two other research efforts featured at the conference, point the way to a future when Alzheimer's can be more easily detected, tracked and treated, experts said.

"There is an urgent need for simple, inexpensive, minimally invasive and accessible diagnostic tools for Alzheimer's," said **Percy Griffin**, director of scientific engagement for the Alzheimer's Association. "A widely available, simple-to-use blood test for Alzheimer's would be a great advance."

The two other studies involved the usefulness of blood samples to diagnose Alzheimer's, and a new test that could more accurately detect the presence of tau protein tangles in the brain.

"These studies are fascinating and the results inspire hope," Griffin said. "They point to a not-too-distant future where multiple tools to aid in early detection and accurate diagnosis are more accessible to all people in all communities."

Alzheimer's disease is defined by two types of proteins that start behaving abnormally in the brain.

Early in Alzheimer's, amyloid beta protein starts to form plaques in the brain. As the disease progresses and cognitive symptoms arise, tau proteins begin twisting into tangles. Currently, the gold standard way to see if a person's brain contains plaques or tangles is through imaging scans, said Dr. Randall Bateman, a professor of neurology at Washington University School of Medicine in St. Louis and co-senior researcher of the tau test study. But these plaques and tangles shed protein fragments into cerebrospinal fluid, which can then eventually make their way into a person's bloodstream, Bateman said….**Read More**

Experimental Shot Given Every Six Months Controlled High Blood Pressure in Early Trial

Every day, millions of people must take one or more pills to control their blood pressure and reduce their risk for heart attack or stroke, but if new research pans out, some may be able to scrap their pills for a twice-yearly shot with the same benefits.

Given as a shot every six months, zilebesiran suppresses the gene that produces a hormone called angiotensin that causes blood vessels to contract. This contraction causes blood pressure to rise.

The new shot isn't ready for prime time yet, but phase 2 trials are underway.

"This approach offers the potential for sustained reduction in blood pressure that may obviate the need for daily pills in select patients and may help overcome some of the challenges with adherence that compromise our ability to effectively treat high blood pressure," said lead author **Dr. Akshay Suvas Desai**, medical director of the Cardiomyopathy and Heart Failure Program at Brigham and Women's Hospital in Boston.

Many people with high blood pressure miss or skip pills because they are overwhelmed and don't necessarily feel sick, among other reasons.

For the study, 107 people with high blood pressure received either varying doses of zilebesiran as a shot, or a placebo injection, and were then followed for 24 weeks….**Read More**

Steer Clear of UTIs This Summer

Dehydration brings lots of risks — including urinary tract infections (UTIs).

An expert offers some tips for avoiding these painful infections without sacrificing summer fun.

"Patients can experience more UTIs during the summer due to inadequate fluid intake, especially in the historic heat waves we've been experiencing," said **Dr. Maude Carmel**, a urology specialist at UT Southwestern Medical Center in Dallas. "Dehydration is a leading risk factor for UTIs," she added in a center news release.

To help reduce your chances of getting a UTI in the summer, Carmel recommends staying hydrated by drinking at least two liters (68 ounces) of fluid every day.

Urinate frequently — go to the bathroom at least every three hours, she advised. Also, avoid constipation, and urinate after intercourse.

While cranberry supplements can reduce some risk of infection, cranberry juice is too diluted to treat UTIs, Carmel noted.

Signs of a urinary tract infection can include burning sensation or pain with urination, increased urinary frequency, urinary urgency and blood in the urine.

Many other conditions can mimic the symptoms of a UTI, but the infection can be diagnosed with a urine culture. A urinalysis, or dipstick test, is not enough, said Carmel, an associate professor of urology.

Someone experiencing symptoms that suggest UTI should see a primary care physician. A urologist can help narrow down the cause of frequent UTIs, about more than three a year, with additional testing and by assessing other risks.

Being mildly overweight in older age has its benefits

Judith Graham writes for **CNN** on the advantages and disadvantages of being mildly overweight in older age. Surprisingly, experts report that some additional weight has its benefits. Of course, there are drawbacks to carrying extra fat as well.

Millions of older Americans are mildly overweight–they are carrying 10 to 15 more pounds than they weighed before having kids, slowing down on physical activities, or developing chronic conditions. But, those extra pounds might not mean they should be taking Ozempic or otherwise focused on losing weight.

Too much excess fat can jeopardize your health and promote heart disease, diabetes and other chronic conditions. And, it's never healthy to gain weight quickly. But, there's plenty of evidence showing that 10 to 15 pounds of added weight can protect people when they fall and provide energy to people getting debilitating medical treatment, such as chemotherapy.

As we grow older, we naturally tend to lose muscle and gain fat. And, when we gain fat, it tends to come in our stomachs as opposed to under our skin. Experts say that this fat in our abdomens is unhealthy and can lead to all sorts of chronic conditions. Adding fat in your hips and rear end is much less concerning.

Keep active: It's important to walk quickly enough to get your heart-rate up for least half an hour five days a week. It's also important to lift weights at least two times a week. In fact, physical activity can be more important than losing weight if you don't have a lot of fat around your middle.

If you continue to eat as you always have and reduce your physical activity, you will gain weight. Yet, the vast majority of people over 65 stop physical activity when they are not working.

If you are even somewhat overweight, it's particularly important to engage in some exercise. Otherwise, you lose your muscle mass and strength. And, then you are likely to become disabled or otherwise physically harmed and you jeopardize your independence.

What happens to muscle when you lose weight? You lose both muscle (25 percent) and fat (75 percent) when you lose weight. So, it's best to exercise more, rather than eat less, if you want to lose weight.

Carrying a few extra pounds can put you at the lowest risk of death. Of note, **some studies** have found that older people who are considered to be of healthy weight are at the highest risk of death. According to the WHO, "being overweight may be beneficial for older adults, while being notably thin can be problematic, contributing to the potential for frailty.

It matters what you eat: Eat a plant-based diet to the extent possible, with lots of legumes, nuts, vegetables and fruits. Limit your fat intake and stick to fatty foods that have unsaturated fats, if you can.

AHA News: Warnings – And Hope – From New Heart Disease Treatment Guidelines

New guidelines detailing how to care for people with heart disease come with some easy-to-grasp warnings for patients.

The chronic coronary disease guidelines from the American Heart Association and American College of Cardiology, published Thursday in the AHA journal Circulation, are no incremental update, said Dr. Salim Virani, chairperson of the expert panel that rewrote them.

"It's actually a new guideline in that everything that needed to be evaluated in terms of evidence was reviewed, and all the recommendations were rewritten," said Virani, vice provost of research and a professor of medicine at Aga Khan University in Karachi, Pakistan.

Coronary disease includes various conditions that trace back to the buildup of plaque in artery walls that limits blood flow to the heart. That includes coronary artery disease, angina, heart attack and care after a procedure to open a blocked heart artery.

The guidelines cover topics ranging from exercise to cholesterol management to bypass surgery. "This is pulling everything together as a one-stop shop for providers who take care of these kinds of patients," said Dr. Kristin Newby, the writing panel's vice chairperson.

From that "one-stop shop," here are six warnings for people with coronary disease – plus an overall message to embrace.

Avoid trans fat

"Trans fats aren't good for anybody," said Newby, a professor of medicine and cardiology at Duke University in Durham, North Carolina. But people with coronary disease need to be extra careful.

Of all the fats and oils used in cooking, Newby said, trans fats are the most likely to cause plaque in the arteries. In people with existing disease, trans fat has been linked to higher risk of heart attack and stroke, higher death rates from those problems, and higher risk of premature death.

Artificial trans fats are liquid oils that have been turned into a solid. Margarine and shortening are common examples. The Food and Drug Administration has banned food manufacturers from using a once-common source of trans fat: partially hydrogenated vegetable oils. But in some places, trans fats still show up in restaurant deep-fat fryers and elsewhere.

Trans fats also occur naturally in beef, lamb and butterfat, but the guidelines say these pose less risk than artificial trans fats.

Companies are allowed to say a food is free of trans fats even if they have as much as half a gram. To avoid trans fats, check nutrition labels and skip fried food, processed baked goods and refrigerated dough. And look for terms such as "partially hydrogenated oils" in the ingredients list….**Read More**