Rhode Island Alliance for Retired Americans®

RI ARA

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"Fighting for the future of our members."
"NOW, more than ever!!!"

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Message from Alliance *for* Retired Americans Leaders

House Republicans Discuss Raising Social Security Retirement Age and Cutting Benefits During Hearing


Robert Roach, Jr President, ARA

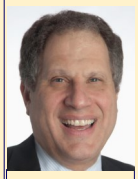
On Tuesday, June 4, 2024, the House Ways and Means Social Security Subcommittee held a **hearing** about the future of the Social Security Trust Fund.

Lawmakers examined options for keeping Social Security fully funded after 2033. House Republicans touted their plan to cut $1.5 trillion in Social Security's funding and raise the retirement age. They also failed to consider solutions that would raise revenue, like lifting the cap on income subject to payroll tax, as viable alternatives. Ranking Member Rep. John Larson (D-CT) and other House Democrats expressed their opposition to benefit cuts, pointing out that "cutting Social Security doesn't solve the problem, it exacerbates it."

A new Gallup poll shows that Americans between the ages of 50 and 64 are extremely concerned about future threats to Social Security and Medicare. More than 80% said they are "worried" or "extremely worried" that Social Security will not be there for them when they are eligible for it, and more than 70% reported having these same thoughts about Medicare.

"Despite Social Security and Medicare being strong and solvent, the future of our benefits are on the ballot this November," said **Robert Roach, Jr., President of the Alliance**. "We must elect pro-retiree candidates to ensure that these earned benefits continue to be there for current and future generations of retirees."

Alliance Celebrates LGBTQ+ Pride Month


Rich Fiesta, Executive Director, ARA

The Alliance wishes all of our members a Happy Pride Month this June!

Many LGBTQ+ individuals **still lack basic federal legal protections** in the workplace. Currently, 16 states have no laws prohibiting discrimination based on sexual orientation or gender identity, putting LGBTQ+ workers at risk of abuse and discrimination. **Pride at Work**, the AFL-CIO's LGBTQ+ constituency group, reminds us that a union contract offers the best protection for these workers. Union contracts are legally binding in every state, and can fill in the gaps for individuals living in states without protections. Pride At Work **even offers model language** for union leaders and workers who want to ensure their contracts are LGBTQ+ inclusive

"Pride month reminds us that all Americans want to live and work without fear of discrimination or dismissal," said Richard Fiesta, Executive Director of the Alliance. "We all must continue our fight for workplace equality without restrictions."

Helping People with Lower Incomes Avoid the Medicare Cliff

The National Council on Aging (NCOA) and the LeadingAge LTSS (long-term services and supports) Center at the University of Massachusetts released a new report on the problems people may face when they lose eligibility for expansion Medicaid because they become eligible for Medicare.

The Affordable Care Act (ACA) gave states the option to expand their Medicaid programs to cover low-income adults aged 19-64 with incomes up to 138% of the federal poverty level (FPL), $20,783 for an **individual in 2024**. To date, **41 states** have adopted the Medicaid expansion, leading to **significant improvements** in health outcomes, economic mobility, and financial security for those enrolled.

But the interaction of expansion Medicaid and Medicare may disrupt some of these gains. People cannot be on both Medicare and expansion Medicaid, which means that when someone with expansion Medicaid becomes Medicare-eligible, they are at risk of losing their Medicaid coverage. This can pose a significant problem because of the differences between the two programs—Medicare has significantly more out-of-pocket costs than Medicaid and does not cover some services that Medicaid programs can, like dental care, home health aides, and over-the-counter medications. Some may purchase supplemental coverage, **such as a Medigap**, but others may find the policies unaffordable. Others may be eligible for different Medicaid programs. For example, those with very low incomes can usually switch to Medicaid for aged, blind and disabled people (ABD Medicaid) or enroll in a **Medicare Savings Program** (MSP). But not everyone will qualify. Most states have **more stringent rules** for these programs than for expansion Medicaid, often with lower income limits and asset tests that require people have minimal savings. In addition, the application processes and other administrative requirements can be overly burdensome, likely causing some who are eligible to miss out. Some people may not even try to sign up because they don't know these programs exist. **MSPs in particular are chronically underenrolled**.

As a result, many who transition from expansion Medicaid to Medicare are left with Medicare alone, leaving them exposed to higher out-of-pocket costs and less comprehensive coverage. This is what's known as the "Medicare cliff."...**Read More**

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SIGN THE GPO/WEP PETITION!!!!!

I Used to Think Social Security Wouldn't Be There for Me in Retirement. Now I Know the Truth

The Motley Fool.

As someone who's been writing about retirement planning for roughly the past decade, it's amusing to me to think back on the days when the only thing I knew about Social Security was that it was some sort of program that paid you benefits when you were older. I didn't learn about the program's many rules and nuances until I started covering the topic extensively.

These days, my Social Security knowledge is far more vast, and I'll bet I could surprise you with some of its **lesser-known rules**. But because I've done so much reading on Social Security, I also have a good grasp of the role the program is likely to play in my retirement.

Social Security isn't going away

When I first started covering **Social Security** (and I'm talking about the very first week I wrote on the topic), I kept seeing warnings about the program going away completely. That was pretty disheartening to read.

Thankfully, I dug deeper. And based on what I know today, I can say with certainty that Social Security is *not* at risk of disappearing completely.

See, Social Security gets the bulk of its funding from payroll taxes. So as long as there's an active labor force, workers will continue to pay Social Security taxes on their wages, and benefits can continue.

In the coming years, Social Security is expected to get less revenue as older workers retire in droves. The program may also need to tap its trust funds to keep up with scheduled benefits.

Once those trust funds run out of money, Social Security may have no choice but to cut benefits to some degree. But the program should still be able to pay retirees the bulk of the benefits they're entitled to. So while it's a good idea to **plan for Social Security cuts**, there's no need to panic that the program is going away completely. That's just not on the table.

What I expect Social Security to do for my retirement

I'd like to look forward to *some* monthly retirement income from Social Security because I've been paying into the program since I started working. I'm confident that Social Security benefits aren't going away. But frankly, I don't expect them to play a huge role in my retirement finances -- and that's actually a good thing.

Even without benefit cuts, Social Security will only replace about 40% of a typical earner's pre-retirement wages. And many seniors need about twice that much money to live comfortably.

I do not want to have to stress about money in retirement. So to that end, I've been working my hardest to pump as much money as I can into various **retirement accounts.**

I live below my means, and have since my career took off so that I'm able to consistently set money aside for the future. My hope is that come retirement, any income I get from Social Security will be money I can use to do things like take vacations or perhaps adopt a few extra dogs (they're my weakness). I don't want to have to count on Social Security to do things like put food on the table or pay the electricity bill.

It helps to get the real story

Social Security really is not in danger of going away completely. I can see why you'd think that, since there's a lot of misinformation out there. Don't feel bad about believing it, since I once did, too.

But don't rely on Social Security too heavily for retirement income, either. Instead, save as much as you can so that you don't have to worry about things like benefit cuts or smaller **cost-of-living adjustments** when you deserve to be enjoying your retirement to the fullest.

New Federal Strategic Framework on Aging Policies and Programs

The Administration for Community Living (ACL) within the U.S. Department of Health and Human Services (HHS) recently **published** a **Strategic Framework** for creating a national, multi-sector plan to advance healthy aging and age-friendly communities.

Background

The framework was developed by the **Interagency Coordinating Committee on Healthy Aging and Age-Friendly Communities (ICC)**. Established by the Older Americans Act in 2020, the ICC is led by ACL. Rooted in a commitment to person-centeredness, inclusion, respect, and collaboration, its mission is to foster coordination across the federal government on core aging issues. The ICC received its first federal funding in 2023. With that allocation,

ACL convened leaders and experts across 16 federal agencies and departments to craft the Strategic Framework. The resulting document is "intentionally aspirational and high-level." The ICC notes this is intended to "inspire dialogue… about what it would take to turn its vision, values, and goals into reality."

The ICC plans to build on the framework to create a national plan on aging—a set of policy proposals to bolster care quality, access, and outcomes for older adults. Those recommendations, in turn, will guide the next White House Conference on Aging, set to take place in 2025.

The Framework

The Strategic Framework is divided into four overarching domains. Each has a broad goal and key focus areas: **Read More**

What we don't know about Medicare Advantage

[Editor's note: The following is the response to a request for information about Medicare Advantage data gaps by the Centers for Medicare and Medicare Services, from a coalescence of grassroots organizations and others.]

May 29, 2024

The Honorable Chiquita Brooks-LaSure Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-4207-NC–Medicare Program; Request for Information on Medicare Advantage Data Submitted electronically via https://www.regulations.gov

Dear Administrator Brooks-LaSure and Secretary Becerra,

Thank you for providing us with the opportunity to share our views on Medicare Advantage (MA) data gaps and needs in order to make critical improvements to MA. Like you, our goal is to promote health equity, protect enrollees, and ensure the fiscal integrity of the Medicare program. Right now, with limited, untimely and incomplete MA data, these goals are a pipe dream.

This response to the MA Data request for information is submitted on behalf of the below signed organizations and individuals representing a wide and diverse swath of stakeholders. We believe that critical data gaps today undermine MA accountability and allow bad actors to gouge taxpayers, erode the Medicare Trust Fund, endanger the lives and well-being of older adults, and discriminate against Black, Hispanic, Pacific Islander, low-income and critically ill older adults and people with disabilities….**Read Full Article**

Food prices are soaring as are profits at Walmart and other big food corporations

If you spend any time at the grocery store, you can't help but notice that prices are going up and up and up. The big corporations, like Pepsi and General Mills, say it's all about supply chain issues, while their profits soar. Veronica Riccobene reports for the **Lever** on"What's going on?"

In four years, grocery prices are up 25 percent overall, while shareholders with interests in grocery stores have seen $77 billion in distributions.

In 2022, people typically spent 11 percent of their disposable income on food. The price of a dozen eggs has just about doubled in four years. Food and Water Watch says that an average family of four living thriftily spends 50 percent more today than it did four years ago, $976, up from $654.

More Americans are going hungry. Three and a half million more people are facing food insecurity since the pandemic. Today, about 28 million adults in the US do not have ongoing access to food. Some are calling on President Biden to step in and keep the food companies from driving up food prices. The marketplace is broken.

Companies buy back their stocks to drive up their stock prices. Corporate executives and shareholders benefit. Consumers are hurt.

Tyson Foods' execs and shareholders are some of the big beneficiaries of stock buybacks. Tyson raised the price of meat nearly 30 percent and saw its profit margins more than double between 2021 and 2022. It's operating costs rose, but price increases more than offset those costs—by 33 percent.

According to the Federal Trade Commission, Walmart, Kroger, and Amazon "used rising costs as an opportunity to further hike prices to increase their profits." The price of food and drinks rose seven percent more than their costs.

Walmart raised prices more than 50 percent on some of its generic food brands in the three years between 2020 and 2023. General Mills raised the price of cereal 12 percent in 2023 from the prior year. It also shrunk the amount of cereal in the box to 18.1 ounces from 19.3 ounces.

In addition to raising prices, companies are shrinking the size of their products. They call it "shrinkflation."

As grocery store corporations get larger, they can engage in price fixing. Only about four companies control half the market for nearly 80 percent of groceries sold. Walmart sells nearly 30 percent of all groceries in the US. Costco sells about 7.1 percent of groceries and Kroger sells 5.6 percent. The Federal Trade Commission is now trying to stop a merger between Kroger and Albertsons on antitrust grounds.

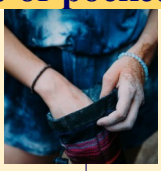
The consolidation is particularly stark among retailers. Just this year, the Federal Trade Commission **sued** to block a $24.6 billion merger between Kroger and Albertsons, alleging it violates antitrust law.

Senator Elizabeth Warren is leading the charge in Congress to stop the grocery store price gouging through the Price Gouging Prevention Act. Her bill would make it a federal offense for corporations to price gouge.

If you use an inhaler, your out-of-pocket costs should come down soon

As of Saturday June 8, many people in the US will pay $35 a month out of pocket for their asthma medications, reports **NBC News.** AstraZeneca and Boehringer Ingelheim have agreed to limit people's out-of-pocket costs for inhalers. GlaxoSmithKline says it will also limit people's out-of-pocket costs but not until next year. The cap does not apply to people with Medicare.

People in other developed countries pay far less than Americans for their inhalers. Americans have been paying 13 times what Brits pay for AstraZeneca inhalers, $645 as compared to $49. Teva charges Americans $286 for their inhalers and Germans $9.



And, we're talking millions of Americans are paying insane costs for inhalers. Twenty-seven million Americans suffer from asthma. Five million of them are children.

Today, even with insurance, many Americans cannot afford their asthma medicines. Costs for insured people with asthma can easily be $350 a month in the US, when you fold in the cost of additional medications such as albuterol.

Black Americans are more at risk than white Americans. Black Americans have far worse health outcomes. Black children with asthma are 4.5 times more likely to end up in the hospital and 7.6 times more likely to die because of their asthma.

If you have insurance: Your pharmacy should adjust the price of your inhalers to $35 a month, if it participates in the pharmaceutical companies' programs.

If you don't have insurance or your pharmacy is not participating in the program: You can visit your drug company's website online and sign up for a $35 copay card.

It's still not clear whether people who use multiple medications for their asthma will have to pay $35 a month for each asthma medicine. Some people need a rescue inhaler in addition to a maintenance inhaler.

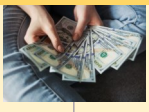
It's great that some pharmaceutical companies have agreed voluntarily to lower people's asthma medicine costs. But, it's terrible policy that pharmaceutical corporations can charge pretty much what they will for their drugs, and we have to rely on their voluntary gestures for our drugs to be affordable. Right now, too many Americans are forced to choose between their child's inhaler and food or rent.

CVS plans to raise Medicare Rx premiums a lot in 2025

In an op-ed for **MarketWatch,** Brett Arens's Roi warns about rising Medicare Part D premiums.

The CFO at CVS is alerting people that Medicare Part D premiums will increase significantly in 2025. How much of that increase amounts to more profits for CVS? It's already profiting from pocketing pharmaceutical company rebates instead of passing them on to its Part D enrollees in the form of lower out-of-pocket costs.

A **series of articles** over the **last few years** highlight **tactics** CVS uses to maximize profits. For example, it sometimes makes its Part D enrollees buy **brand-name drugs,** for which CVS earns more. So, it's no surprise that CVS is planning another premium hike. Premiums will be "much, much higher" says Thomas Cowhey, the CFO.



CVS knocked up Part D premiums 20 percent this past year. This time round, the higher premiums will allow CVS to protect its profits from rising costs resulting from the $2,000 out-of-pocket cap for Part D coverage that goes into effect in 2025.

CVS believes that more people will be filling their prescriptions once Part D has a $2,000 out-of-pocket cap. Costs will no longer be a barrier for some, after they spend $2,000 out of pocket. The question then becomes how many people have $2,000 to spend to reach that out-of-pocket cap when they need to?

As of now, about one in seven people with Medicare say they are not filling their prescriptions because of the cost.

Some analysts believe that the new $2,000 out-of-pocket cap in Part D will steer more people into Medicare Advantage plans. Medicare Advantage plans almost always include prescription drug coverage in their premiums. Medicare Advantage plans are likely to look less expensive than Traditional Medicare, where people would have to buy a stand-alone Part D prescription drug plan.

Medicare IRMAA: What You Should Know for 2024

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.

Medicare can be a complex web, and untangling its various strands to ensure you're getting the most appropriate coverage can be daunting. One thread you might find yourself unsnarling is income-related monthly adjustment amounts, or IRMAA for short.

In this article, we'll go through the basics of what IRMAA entails and who might qualify for this additional fee.

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, doctor visits 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.

"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 former associate director of community health and benefits at the National Council on Aging, based in the Washington, D.C., area.

Who pays IRMAA fees?

Only those **enrolled in Medicare** Parts B and D need to pay IRMAA fees. If you're enrolled in Part A (hospital**, skilled nursing facility** and other inpatient coverage), IRMAA doesn't apply.

Do IRMAA fees apply if I have Medicare Advantage?

Medicare Advantage, also known as Part C, differs from Medicare Parts A and B. Known as original Medicare, Parts A and B are government-funded. With Medicare Advantage, government-approved private insurance companies provide comparable coverage.

If you're enrolled in Medicare Advantage, you are still required to pay for Medicare Part B. If you qualify for IRMAA, then you're paying:

- The monthly Part B premium.
- The IRMAA fee.
- The Medicare Advantage plan's monthly premium.

...**Read More**

Do Seniors Ever Stop Paying Taxes?

When you retire or reach a certain age, there might be certain things you no longer have to do. You might get to skip the commute or qualify for some great discounts. But no matter your age, you don't get to opt out of taxes. It's important to understand why seniors are still taxed, the common taxes seniors pay and how to minimize your tax bill. If you want individualized help preparing for retirement or creating a tax strategy, you can **match with a financial advisor**.

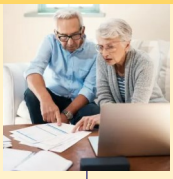
At What Age Can You Stop Filing Taxes?

Taxes aren't determined by age, so you will never age out of paying taxes. Basically, if you're 65 or older, you have to file a **tax return** in 2022 if your gross income is $14,700 or higher. If you're married filing jointly and both 65 or older, that amount is $28,700. If you're married filing jointly and only one of you is 65 or older, that amount is $27,300.

That said, there is one situation in which you can kiss taxes goodbye. If your only income is Social Security payments, you won't owe taxes and you probably won't need to file a tax return.

Common Taxes Seniors Pay

If you're 65 or older, you might also be retired or partially retired and taking distributions from your retirement savings. Retirement savings and **investments** can have more complex tax rules than income, where you often get taxes deducted automatically from each paycheck and a W-2 at the end of each year. Here are some of the more common taxes retirees face and how they work.



Social Security Taxes

If you have significant retirement income other than Social Security, you might have to pay income tax on your Social Security benefits. The percentage of your Social Security benefits that are taxable depends on your combined income. Combined income is defined as your adjusted gross income plus nontaxable interest plus half of your Social Security benefits.

If you file taxes singly and your combined income is $25,000-$34,000, you may owe income taxes on 50% of your **Social Security benefits**. If your combined income is higher than $34,000, up to 85% of your benefits may be taxed.

If you file a joint return and you and your partner's combined income is $32,000-$44,000, you may owe income taxes on 50% of your Social Security benefits. If that number is more than $44,000, 85% of your benefits may be taxed.

Common Retirement Accounts

IRAs, 401(k) plans and other popular retirement savings vehicles have different tax treatments. Generally speaking, some are pre-taxed and some are taxed at withdrawal. For example, IRAs that are funded by money that was already taxed—say you take $1,000 from a paycheck and put it in a Roth IRA—won't be taxed when you withdraw that money in retirement as long as you meet IRS requirements.

On the other hand, 401(k) plans are usually funded with pre-tax money, so you'll usually owe income tax on withdrawals in the year that you take them.

A financial advisor can help you determine the best strategy to minimize taxes in retirement. **Talk to a financial advisor.**

Pension Taxes

Like **401(k) plans**, pensions are usually funded by pre-tax money, so you'll owe federal income taxes on withdrawals in the year you take them. If you take a lump-sum payment rather than annual or periodic payments, you will owe the total tax bill in the year you receive that payment.

In many cases, your employer through which you have the **pension** will withhold taxes as your pension payments are disbursed, which can help mitigate the tax bill.

How to Minimize Taxes as a Senior

While seniors don't get to dodge taxes altogether, there are several ways for you to save on your taxes once you reach a certain age. Here are a few.

- **Take advantage of the tax credit for the elderly**: The Credit for the Elderly and Disabled is worth between $3,750 and $7,500. You can use **the IRS's tool** to see if you qualify and how large a credit you might get. Generally speaking, you have to be 65 or older and make less than $17,500 in adjusted gross income if you're filing singly or as head of household—that limit rises to $20,000 if you're married filing jointly and only one spouse is 65 or older and $25,000 if you're married filing jointly and both 65 or older.
- **Use your bigger standard deduction**: If you're 65 or older and you don't itemize deductions, you are entitled to a higher **standard deduction**. A single filer over 65 gets an extra $1,750 deduction, a couple filing jointly gets an extra $1,400 for each partner who is 65 or older. So if only one spouse is 65 or older, the extra deduction amount is $1,400, but if both are 65 or older, it's $2,800….**Read More.**

If Medicare Advantage can't offer adequate provider networks and accurate directories, why are they in business?

People who need health care in Medicare Advantage too often find that the provider directories they rely on when choosing a Medicare Advantage plan are inaccurate. The Senate Finance Committee is looking to address the problem, and the American Medical Association is cheering it on. The fixes are a step forward but should go a lot further. If Medicare Advantage can't offer adequate provider networks and accurate directories, why are they in business?

For the last 20 years, insurers have been able to make their Medicare Advantage provider network directories look far more robust than they actually are, misleading enrollees. The Centers for Medicare and Medicaid Services, CMS, does not begin to have the resources to oversee network adequacy in the more than 4,000 Medicare Advantage plans, let alone protect enrollees when CMS identifies networks that are inadequate. So, insurers have every incentive to have narrow networks and to mislead enrollees.

The MA plans must know who's in their network since they pay these providers. There's no excuse for inaccurate directories. Moreover, the insurers should not be allowed to deceive people by offering different plans with different networks that people cannot distinguish or discriminate against people with low incomes or communities of color by offering them poorer networks than others.

What's wrong in the network directories? A lot. The directories often fail to explain where enrollees can see in-network physicians (yes, the same physician can be in-network at one location and out-of-network at another,) or they claim physicians are in-network when they are not; and, if providers are in-network, the directories often don't indicate that they are not taking new patients. It would be easy to fix the problem with one national government directory that imposed penalties on insurers who did not maintain accurate or complete information. One directory would also make it far easier for people to comparison shop for a Medicare Advantage plan.

CMS proposed **a national provider directory** a couple of years ago, but it has not gone anywhere to date.

But, the insurers oppose a system that would actually help people make informed choices of Medicare Advantage plans. Many in Congress appear to be right there with the insurers. Senator Ron Wyden, who chairs the Senate Finance Committee is trying to end provider directory errors and protect enrollees. Mike Crapo, the ranking Republican on the Committee, claims he is as well. But, what are they doing?

The Finance Committee approved "The Better Mental Health Care, Lower-Cost Drugs, and Extenders Act of 2023," legislation. Some of it is now law. The bill requires Medicare Advantage plans to have accurate and updated provider directories. Though Medicare Advantage plans always have been required to have accurate in-network information, the bill would require more verification. The bill would also protect Medicare Advantage enrollees from the costs of inaccurate directories if they had to pay for out-of-network care when they were led to believe care was in-network. Beginning in 2026, enrollees would only be responsible for the in-network copay.

Joe Biden Wants to Save Social Security by Raising Taxes on the Wealthy. Here's What the Public Thinks About That Idea

The Motley Fool.

Social Security is in trouble -- not to the point where it's at risk of disappearing, but to the point where benefit cuts are a distinct possibility in a little over a decade's time.

In the coming years, **Social Security** is expected to owe more money in benefits than it collects in payroll tax revenue, its main source of funding. That's due to an anticipated mass exodus of older workers -- and a lagging number of incoming workers to replace them.

Social Security can tap its trust funds to keep up with the benefits it owes for a period of time. But once its trust funds run dry, which is expected to happen in **about a decade from now**, benefit cuts may be inevitable.

President Biden, however, does not want to see those cuts happen. Biden has long voiced support for Social Security and has pledged to do what he can to strengthen the program to the best of his ability.

One solution he's introduced to this effect is to increase Social Security taxes on the wealthy. But just how well-received is that idea? Actually, you may be surprised.

There's strong bipartisan support, one survey says

Currently, workers only pay Social Security taxes on their first $168,600 of wages. What Biden wants to do is reintroduce Social Security taxes on incomes above $400,000. So conceivably, under this system, someone earning $450,000 would pay Social Security taxes on their first $168,600, and then pay taxes on an additional $50,000 of income.

Often, proposals of any nature that involve raising taxes tend to be met with pushback. But in a 2022 survey by the University of Maryland's School of Public Policy, roughly 80% of Republicans and nearly 90% of Democrats favored a plan to make all wages over $400,000 subject to Social Security taxes.

So in theory, Biden's proposal has potential. However, it also creates a bit of a problem.

Making higher earners whole

The fact that Social Security does not tax earnings above a certain threshold is said to work to the advantage of higher earners. But there's an important flipside to consider. Social Security also has a **maximum monthly benefit** it will pay retired workers based on the wage cap implemented each year.

To put it another way, this year, someone earning $450,000 will only pay Social Security taxes on their first $168,600 of income. But earnings above $168,600 also won't count toward calculating future Social Security benefits.

If Biden's plan goes through and Social Security taxes are reinstated once wages exceed $400,000, lawmakers will need to figure out how to make things equitable for those who are being forced to hand over that money. It wouldn't be fair to impose an additional tax on higher wages without the promise of a higher monthly Social Security benefit to follow suit.

But if the whole purpose of imposing Social Security taxes on higher earnings is to shore up the program and prevent **benefit cuts,** raising benefits for the wealthy may not achieve that. Of course, lawmakers could also take the "too bad for you" approach and do nothing to raise Social Security's maximum monthly benefit for those being taxed at a higher level. But that changes a core component of the way the program works and truly reads like a penalty on the wealthy.

Let's see what happens

All told, it's interesting to see that the concept of imposing Social Security taxes on higher incomes is well-received across both major party lines. But whether Biden's proposal can actually be made to work is a different story.

For this reason, it's a good idea for current and future retirees to prepare for Social Security cuts as best as they can. That could mean boosting **retirement savings** for those who are still working, or rethinking spending for those who are retired and stand to get hurt financially in the event of a smaller Social Security check.

This Group Is Less Satisfied With Medicare Than Other Enrollees

By and large, Americans love Medicare. But one group of enrollees is a little less thrilled with the program.

The vast majority of people with Medicare for their health care coverage are 65 or older. But there is another, smaller group of Americans who enroll in the program before that age.

As we reported in "**3 Groups Who Can Get Medicare Before Age 65**," these are younger folks who qualify for Medicare due to having a long-term disability, end -stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS).

In 2022, 7.7 million people under the age of 65 — or 12% of all Medicare recipients — fell into this category of coverage.

These are the people who are **less happy with their Medicare coverage**, according to

responses from 3,600 adults in the latest annual KFF Survey of Consumer Experiences with Health Insurance.

While 92% of those over the age of 65 give positive marks to their Medicare coverage, that number dips to 79% for those under the age of 65 with disabilities.

KFF reports that people under the age of 65 who are on Medicare are more likely to report:

- Worse access to care
- More cost concerns

Lower satisfaction with care

Among beneficiaries under age 65 who have disabilities, 70% said they experienced some type of issue with their health insurance over the prior 12 months. Meanwhile, just 49% of those 65 and older report such problems.

According to a summary of the KFF findings: "At least one in five Medicare beneficiaries under age 65 with disabilities who reported problems say they were unable to receive recommended treatment (24%) or experienced significant delays in receiving medical care or treatment (21%), compared to very small shares of those 65 or older who said the same (6% for both)."

Although Medicare offers the same benefits to everyone who is enrolled — regardless of age — KFF speculates that because Medicare was designed for older adults, it might not work as well for their younger counterparts.

Other factors also could be at play. For example, KFF notes that among people with Medicare under age 65 who have disabilities, about half said their physical health is "fair" or "poor." Just 19% of those 65 and older said the same.

In addition, 3 in 10 people with Medicare under age 65 who have disabilities report "fair" or "poor" mental health status. Just 1 in 10 people age 65 and older say the same.

As KFF states in a summary of its findings:

"The higher rate of poorer self-reported health among beneficiar

65 could contribute to a higher rate of health insurance problems."

Regardless of what age you enroll in Medicare, it is important to understand the program's limitations. For more, check out "**Medicare Will Not Cover These 10 Medical Costs**."

Delays, denials, debt and the growing privatization of Medicare

Medicare Advantage enrollees report treatment denials and delays in payment, leading to harmful outcomes in healthcare

Jenn Coffey was sick, on several medications, and in and out of the hospital around 2016 when she made a decision that she has come to regret.

Having fought off breast cancer, the former emergency medical technician faced numerous complications, and was diagnosed with two rare diseases: complex regional pain syndrome and small fiber neuropathy.

"I was terrified," she said. "I went into the hospital as a fully functional EMT and came out in a wheelchair, to go on disability income, and I lost everything. I lost my house, I lost everything."

Coffey, 52, had been selling her belongings and raising money on GoFundMe to cover her medical care.

To make things cheaper, she shifted her disability plan from traditional Medicare – a government-run health insurance program for older and disabled people – to Medicare Advantage, a program under which private health insurers contract with the Medicare program to provide health benefits.

With monthly premiums of **$18.50 per month** on average, Medicare Advantage often looks like a frugal alternative. However, private insurers keep premiums low by limiting providers and using byzantine cost containment tools such as prior authorization.

For Coffey, switching proved more expensive, as her Medicare Advantage provider, UnitedHealthcare, denied requests to cover treatments, medications and infusions she required.

Coffey used to be a Republican state representative in New Hampshire. "I changed a lot over these years," she said. "I used to think we could fix healthcare."

Her experience with Medicare Advantage is not unusual. Private insurers now cover roughly half of the nation's 68 million Medicare beneficiaries. Their dominance of this space has grown rapidly over the past two decades – at the expense of patient care, according to healthcare activists and patients, as corporations often deny medical care directed by doctors.

"I was stunned," said Gloria Bent, of the first time her husband, Gary, was denied coverage for his brain surgery. It was only the start of their issues with Medicare Advantage.

Gary – a retired physicist professor in Connecticut – **fought** two types of cancer over six years, before passing away in March 2023. He had been put on a Medicare Advantage plan as part of his retirement health coverage, through the University of Connecticut….**Read More**

Dear Marci: *Do I qualify for the Medicare Savings Program?*

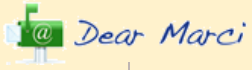
Dear Marci,

I recently got a letter saying that I might be eligible for the Medicare Savings Program. How do I know if I qualify?

– Imani (New York, NY)

Dear Imani,

I'm happy to help with this question! The **Medicare Savings Program (MSP)** can help pay your Medicare costs if you have limited income and savings. States use different rules to count your income and assets to determine if you are eligible for an MSP.



- Examples of income include wages and Social Security benefits you receive.
- Examples of assets include checking accounts and stocks.

Certain income and assets may not count when determining your MSP eligibility. And some states do not have an asset limit.

You'll want to check your individual state's **eligibility guidelines**, but here are typical eligibility limits for some states:

- **Income limits:**
  - Individual- $1,715
  - Couple- $2,320
- **Asset limits**
  - Individual- $9,430
  - Couple- $14,130

If your income or assets seem to be above the MSP guidelines, you should still apply—different counting rules mean that you could still be eligible.

To learn about the eligibility rules for the MSPs in your state, contact your local **State Health Insurance Assistance Program (SHIP)**.

Good luck!

-Marci

RI ARA HealthLink Wellness News

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

HealthLink Wellness "Taking Control"

AI Plus Mammograms Might Boost Breast Cancer Detection

Artificial intelligence (AI) can improve doctors' assessments of **mammograms**, accurately detecting even the smallest breast cancers with fewer scary false positive readings, a new study shows.

AI-assisted mammography detected significantly more breast cancers, with a lower false-positive rate, than doctors assessing mammograms on their own, researchers reported June 4 in the journal *Radiology*.

Nearly 21% fewer women had to come back for a follow-up mammogram when AI helped doctors analyze breast imaging, researchers found.

"We believe AI has the potential to improve screening performance," said researcher **Andreas Lauritzen,** a post-doctoral student at the University of Copenhagen in Denmark.

For the study, researchers had human radiologists read the mammograms of nearly 61,000 Danish women ages 50 to 69 who were screened between October 2020 and November 2021, before AI was available for this purpose.

Then, between November 2021 and October 2022, the team had an AI program perform the first analysis of breast screenings for more than 58,000 women. Mammograms deemed normal by AI were then given a second going-over by human radiologists, to confirm the program's analysis.

Screening assisted by AI detected more breast cancers (0.8% versus 0.7%) and had a lower false-positive rate (1.6% versus 2.4%), results show.

The positive predictive value of AI-assisted screening -- the odds that woman truly had breast cancer after a positive result -- also was higher, 34% versus 23%, researchers found.

AI also helped doctors find more tumors 1 centimeter or less in size, 45% versus 37%.

AI assistance also reduced the reading workload of radiologists by more than 33%, which is important in making mammograms widely available, researchers said.

"Population-based screening with mammography reduces breast cancer mortality, but it places a substantial workload on radiologists who must read a large number of mammograms, the majority of which don't warrant a recall of the patient," Lauritzen said in a journal news release.

However, the researchers said more study is needed to evaluate the long-term outcomes of women, as well as to make the AI even more accurate for individual women.

"Radiologists typically have access to the women's previous screening mammograms, but the AI system does not," Lauritzen said. "That's something we'd like to work on in the future."

Sleep Apnea Could Mean More Hospitalizations

Folks with **sleep apnea** are more likely to require hospitalization for an ailment, a new study shows.

People aged 50 and older with sleep apnea have 21% higher odds of hospitalization compared to those without the breathing disorder, researchers report.

"The findings hold true even after taking into account other factors that may contribute to an increased risk of health service utilization" like excess weight, poor health and depression, said lead researcher **Christopher Kaufmann**, an assistant professor of health outcomes and biomedical informatics at the University of Florida College of Medicine.

Sleep apnea occurs when the upper airway collapses during sleep, cutting off breathing and causing a person to fitfully wake up throughout the night.

Untreated sleep apnea has been linked to health problems like high blood pressure, heart disease, heart rhythm problems, stroke and type 2 diabetes, researchers said.

For this study, they analyzed data from more than 20,000 participants in the Health and Retirement Study, an ongoing project tracking the health problems of aging.

Participants were surveyed about their sleep disorders, including sleep apnea, in 2016. About 12% said they had been diagnosed with sleep apnea.

Two years later, the participants were asked about hospitalizations and use of health services.

The results, which were published recently in the journal ***Sleep*** and presented Monday at the annual meeting of the Associated Professional Sleep Societies in Houston, show that treating sleep apnea can keep older adults out of the hospital, Kaufmann said. Still, such research is considered preliminary until published in a peer-reviewed journal.

"Addressing sleep apnea can not only improve individual health outcomes but also alleviate the strain on health care resources, leading to more efficient and effective health care delivery," Kaufmann said in a meeting news release.

FDA Panel OKs New COVID Vaccine for Fall

A U.S. Food and Drug Administration advisory panel on Wednesday recommended updating the formula for COVID vaccines ahead of a fall campaign that will encourage Americans to get the latest shots.

The unanimous vote recommends that vaccine makers tailor the next vaccine to target the JN.1 variant, which dominated infections in the United States last winter, the *New York Times* reported. However, JN.1 has been overtaken by **descendants** known as KP.2 and KP.3 this spring.

The FDA is expected to formally recommend a new variant target for vaccine makers in the coming weeks, the *Times* reported.

Dr. Peter Marks, who oversees the FDA's vaccine division, urged the committee to consider encouraging the mRNA vaccine makers to focus on the latest versions of the virus, and not the JN.1 variant, the *Times* reported.

"We always say we shouldn't be chasing strains, but we're paying an incredibly high premium for mRNA vaccines to be able to have the freshest vaccines," he said, referring to the technology used by Moderna and Pfizer.

"If this evolves further in the fall, will we regret not having been a little bit closer?" Marks asked.

But **Dr. Sarah Meyer**, a senior vaccines official at the U.S. Centers for Disease Control and Prevention, said that aiming at JN.1 was more appropriate because it was "further up on the tree" in the evolution of the coronavirus, possibly allowing the vaccines to better cover future mutations in the virus, the *Times* reported.

The panel's decision mirrors guidance from a World Health Organization expert committee that **recommended** in April that COVID vaccines switch to a JN.1 formulation.

Representatives of Moderna and Pfizer said that the companies would be ready to produce either version of the vaccine, the *Times* reported….**Read More**

Telehealth for Cancer Care Helps Patients, Planet

Telemedicine visits for **cancer care** could help save the planet while also making things easier on patients, a new study has found.

Nationwide, cancer care could generate 33% less greenhouse gas emissions if it shifted to telemedicine from the traditional model of in-patient care, researchers reported June 3 in the journal ***JAMA Oncology***. The findings were simultaneously presented at the American Society for Clinical Oncology (ASCO) annual meeting in Boston.

"While health care in the United States provides health benefits to many people, it generates substantial amounts of greenhouse gas emissions that drive climate change and inadvertently harm health," said co-lead researcher **Dr. Andrew Hantel**. He's a faculty member of leukemia and population sciences at Dana-Farber Cancer Institute in Boston.

For the study, researchers calculated the amount of carbon dioxide emitted each day at Dana-Farber during two time periods -- between March and December 2020, when the pandemic prompted a shift to telemedicine, and from March 2015 to February 2020, when most visits occurred in person.

Emission sources were as varied as driving to the hospital, taking an elevator, using the bathroom, rubbing with hand sanitizer and using the computers and lights and equipment in the clinic, researchers said.

Emissions of carbon dioxide were 81% lower during the telemedicine period than the in-person period, they found.

Extrapolating that across the entire United States, researchers estimated that carbon dioxide emissions for cancer care could have been reduced by 33% during the pre-pandemic period.

The more modest decline nationwide is based on the fact that people elsewhere in the United States have to travel further to receive cancer care, particularly if they have rare cancers, Hantel said.

Extending telemedicine for cancer care will involve a delicate balancing act, Hantel said.

"On the plus side, they can increase the reach of expert care while reducing travel, time and cost for patients," Hantel said in a Dana-Farber news release. "But they also have the potential to add rather than replace visits, which may be difficult for older adults and those without good internet connections, and in some cases may reduce clinicians' ability to appropriately diagnose and treat."

"Our findings add another layer to this conversation, showing that emissions reduction is an additional benefit of this approach to care," Hantel added.

Energy Drinks Tied to Cardiac Arrest in People With Genetic Heart Conditions

Energy drinks might contribute to sudden cardiac arrest in people with genetic heart diseases, a new study warns.

The study focused on seven patients who had consumed one or more energy drinks just before their cardiac arrest, out of a group of 144 cardiac arrest survivors treated at the Mayo Clinic.

"Although the relative risk is small and the absolute risk of sudden death after consuming an energy drink is even smaller, patients with a known sudden death predisposing genetic heart disease should weigh the risks and benefits of consuming such drinks in the balance," said lead researcher **Dr. Michael Ackerman**, a genetic cardiologist at Mayo Clinic.

Energy drinks contain between 80 milligrams (mg) to 300 mg of caffeine per serving, compared with the 100 mg found in an 8-ounce cup of coffee, researchers noted. They also contain other stimulants like taurine and guarana that aren't regulated by the U.S. Food and Drug Administration.

Doctors think these energy drink ingredients could alter heart rate, blood pressure and heart muscle function in a way that could lead to **heart rhythm** problems, ultimately causing the heart to suddenly stop.

The new study was published June 6 in the journal ***Heart Rhythm***.

Looking at the seven patients in the study, Ackerman did note that other factors likely contributed to their cardiac arrest. These include sleep deprivation, dehydration, dieting or extreme fasting and use of drugs that interfere with heart rhythm.

"As such, unusual consumption of energy drinks most likely combined with other variables to create a 'perfect storm' of risk factors, leading to sudden cardiac arrest in these patients," Ackerman said in a journal news release.

In an accompanying editorial, Italian cardiologist **Dr. Peter Schwartz** said it's "common sense" to consider energy drinks a potential contributor to cardiac arrest.

"Critics might say of these findings, 'it's just an association by chance.' We, as well as the Mayo Clinic group, are perfectly aware that there is no clear and definitive evidence that energy drinks indeed cause life-threatening arrhythmias and that more data are necessary, but we would be remiss if we were not sounding the alarm," said Schwartz, director of the Cardiovascular Genetics Laboratory at the IRCCS Istituto Auxologico Italiano in Milan.

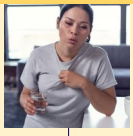
Very Early Menopause Could Raise Odds for Breast, Ovarian Cancers

Menopause before the age of 40 could raise a woman's long-term risk for breast or ovarian cancers, new research suggests.

Besides that, "there is also higher risk of breast, prostate and colon cancer in relatives of these women" noted study author **Dr. Corrine Welt**. She's chief of endocrinology, metabolism and diabetes at the University of Utah Health in Salt Lake City.

Menopause before the age of 40 is rare, and is sometimes clinically known as "primary ovarian insufficiency" -- a shutdown of normal ovarian function prior to a woman's 40s.

In the new study, Welt's team tracked the health histories of 613 Utah women with primary ovarian insufficiency and 165 women who experienced early menopause. The researchers looked at the women's medical histories between 1995 and 2021.



Women who underwent early menopause experienced double the odds for a breast cancer versus women who went through menopause at a more typical time, the research showed.

The risk for ovarian cancer nearly quadrupled in the early menopause group, Welt's group added.

They also looked at genealogy information from the Utah Population Database to find the relatives of each of the women, and their medical histories.

Risks for breast cancer jumped by 30% among second-degree relatives (i.e. aunts, uncles, grandparents, nieces or nephews, etc.) of women who underwent very early menopause, the researchers found.

Second-degree relatives also had a 50% higher risk of getting ovarian cancer.

Men were also affected: Prostate cancer risk rose by up to 60% among first-, second-, and third-degree relatives (i.e., great grandfathers, first cousins), the study found.

Welt said that women who find themselves in a higher cancer risk bracket should undergo regular screening.

The findings were presented Monday at the Endocrine Society's annual meeting in Boston. Such research should be considered preliminary until published in a peer-reviewed journal.

"Women who have infertility from low egg numbers or experience early menopause should make sure they are regularly screened for breast cancer, especially if they have family members with cancer," Welt advised in a meeting news release. "Doctors who practice general medicine, gynecology and fertility treatment should be aware that early menopause increases risk for a number of diseases, and they should now be aware that breast cancer may be one of these diseases to watch for."

Wegovy, Ozempic May Help Curb Alcohol Dependence

Could the blockbuster GLP-1 meds like Wegovy and **Ozempic** have a role to play in helping people cut down on problem drinking? A new study suggests so.

Researchers at Case Western Reserve University in Cleveland report that obese folks with drinking issues who took the drugs to shed pounds had an up to 56% reduction in re-occurrence of alcohol use disorder over one year later, compared to those not using the meds.

"This is very promising news in that we may have a new therapeutic method to treat alcohol use disorder," said lead researcher **Rong Xu**. She's a professor of biomedical informatics at the Case Western's School of Medicine.

Prior data has suggested that something about GLP-1 diabetes/weight-loss drugs can have the effect of curbing excess drinking.

And the Case Western team have already shown that **semaglutide** (Ozempic/Wegovy) can have other unexpected health benefits.

"In January we showed that semaglutide is associated with a decrease in suicidal thoughts, and in March, we demonstrated that semaglutide is also associated with a reduction in both new diagnoses and recurrence of cannabis use disorder," Xu noted in a university news release.

So what about alcohol intake?

In the new study, Xu's team pored over the electronic health records of nearly 84,000 patients with obesity.

Compared to people who weren't taking semaglutide, those who took the med saw a decline in the incidence of new-onset alcohol use disorder or recurrent alcohol use disorder, by anywhere from 50% to 56%.

Similar results were found among a set of over 600,000 people who were taking semaglutide for diabetes, the Cleveland group said.

The findings were published May 28 in ***Nature Communications***.

"While the findings are promising and provide preliminary evidence of the potential benefit of semaglutide in alcohol use disorder in real-world populations, further randomized clinical trials are needed to support its use" to help curb drinking, Xu said.

High-Salt Diets Might Raise Eczema Risk

Doctors already warn folks off salt due to its heart risks, but new research suggests sodium isn't helping your skin either.

Researchers found that as daily **salt** intake rose, so did the odds for the skin disorder eczema, also known as atopic dermatitis.

"Restriction of dietary sodium intake may be a cost-effective and low-risk intervention for atopic dermatitis," concluded a team led by **Dr. Katrina Abuabara,** associate professor of dermatology at the University of California, San Francisco (UCSF).

The data came from on an ongoing British research database called the UK Biobank, involving almost 216,000 people aged 37 and older at the time they were recruited into the study.

As part of the Biobank effort, people were asked to provide a urine sample, which could then be used to gauge a person's sodium intake.

About 5% of the people in the Biobank had a diagnosis of eczema.

The average person's 24-hour "urine sodium excretion" was about 3 grams, but the study found that folks' daily excretion of sodium went up by just 1 gram, their odds for a flare-up of their eczema rose by 22%. The effect seemed stronger among women than men.

People whose urine sample suggested high salt intake faced an 11% higher odds of severe eczema, the researchers said.

On the other hand, folks who stuck to health guidelines when it came to limiting salt intake had a 12% lower odds of eczema , the team noted.

The study was published June 5 in the journal ***JAMA Dermatology***.

Abuabara's team noted that salt's link to eczema isn't a new discovery. In fact, "reduced sodium intake was recommended as a treatment for atopic dermatitis more than a century ago," they wrote in a journal news release.

They stressed that the study wasn't designed to prove cause-and-effect, and its possible that folks who like salt might be eating other foods that put their skin at risk.

"However, our findings are consistent with literature showing that excess dietary sodium can be stored in the skin," the researchers wrote.

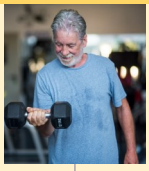
Sodium has also been cited as playing a role in inflammatory processes that might help drive eczema.

Whatever the reasons driving the link, the researchers say it might not hurt to put that salt shaker down.

"Most Americans eat too much salt and can safely reduce their intake to recommended levels," Abuabara said in a UCSF news release. "Eczema flares can be difficult for patients to cope with, especially when they are unable to anticipate them and don't have recommendations on what they can do to avoid them."

"Our study opens the potential for future studies on restriction of dietary sodium intake as an intervention for atopic dermatitis that would be cost-effective, low risk and widely available," the research team said.

Have High Blood Pressure? Weekly Workout May Lower Risk to Your Brain



Vigorous exercise more than once a week can lower the risk of dementia for people with high blood pressure, a new clinical trial shows.

People who engaged each week in vigorous physical activity had lower rates of mild cognitive impairment and dementia despite their high blood pressure, according to results published June 6 in ***Alzheimer's & Dementia: The Journal of the Alzheimer's Association,***

Examples of vigorous activity include hiking uphill, running, fast bicycling, swimming laps, aerobic dancing, jumping rope and heavy yardwork, according to the American Heart Association.

"We know that physical exercise offers many benefits, including lowering blood pressure, improving heart health and potentially delaying cognitive decline," said lead researcher **Dr. Richard Kazibwe**, an assistant professor of internal medicine at Wake Forest University School of Medicine in Winston-Salem, N.C.

This new study offers an idea of how much exercise is needed to reap these benefits, Kazibwe added.

The clinical trial involved more than 9,300 participants with high blood pressure aged 50 and older, recruited from about 100 hospitals and clinics throughout the United States.

Early results published in 2019 showed that tight control of blood pressure significantly reduced the risk of developing mild cognitive impairment, a precursor of early dementia, researchers said.

For this new report, researchers analyzed the effect of exercise on brain health in these folks.

Nearly 60% of study participants reported vigorous physical activity at least once a week, even among those 75 and older, Kazibwe noted.

"It is welcome news that a higher number of older adults are engaging in physical exercise," Kazibwe said in a Wake Forest news release. "This also suggests that older adults who recognize the importance of exercise may be more inclined to exercise at higher intensity,"

However, the protective impact of vigorous exercise on brain health was more pronounced for those younger than 75, results showed.

Service Dogs Work Wonders for Veterans With PTSD: Study

Military veterans often struggle with their mental health once their service ends, but the first clinical trial of its kind has found that having a service dog helps lower the risk of PTSD for these former soldiers.

Veterans paired with a service dog had 66% lower odds of a PTSD diagnosis, compared to a control group of vets still waiting for a service dog, researchers reported June 4 in the journal *JAMA Network Open*.

These vets also experienced lower anxiety and **depression** levels, as well as improvements in most areas of emotional and social well-being, researchers found.

"This research reinforces what we have been studying for almost a decade -- that service dogs are linked to significant benefits for many veterans suffering from PTSD and other invisible wounds of war," said lead researcher **Maggie O'Haire**, associate dean for research at the University of Arizona College of Veterinary Medicine.

"Service dogs are more than pets — they can be essential partners in helping veterans readjust and thrive after they return from service," O'Haire said.

For the study, researchers tracked more than 150 military veterans over three months. Vets received their dogs through the program K9s For Warriors, the nation's largest provider of trained service dogs for military veterans.

Most of the dogs provided by K9s For Warriors are rescues, researchers noted. The program trains them, on average, for six months, then pairs them at no cost with veterans who are struggling emotionally and at great risk of suicide.

It's estimated that nearly 20 veterans die by suicide every day, and that more than 1 million vets suffer from PTSD, traumatic brain injury or military sexual trauma, researchers said.

"Having paired more than 1,000 service dogs with veterans, our work has clearly demonstrated that these dogs are lifesaving and life-transforming. These dogs have enabled our Warriors to better connect with family, friends and their community and to begin living the life they previously didn't think was possible," said **Kevin Steele,** chief program officer at K9s For Warriors.

"The results of this study further prove what we do here at K9s works, and we continue to have the research to back up the success of our program," Steele added in a K9 for Warriors news release.

Few Heart Attack Survivors Get Expert Advice on Diet

Less than one-quarter of people who survive serious heart conditions receive the dietary counseling needed to protect their future health, a new study finds. Only about 23% of people treated for major illnesses like **heart attack** and heart failure receive counseling on their diet within three months of hospitalization, researchers reported recently in the ***Journal of the Academy of Nutrition and Dietetics.***

"Nutrition counseling may reduce the risk a person has for cardiovascular episodes and disease, yet our research shows that the vast majority of patients, who are all at risk after significant heart events, are not receiving this essential education," said senior researcher **Dr. Brahmajee Nallamothu**, a professor of internal medicine-cardiology at the University of Michigan Medical School.

For the study, researchers tracked nearly 150,000 patients seen for serious heart problems at hospitals across Michigan between late 2015 and early 2020.

Most of the patients who did receive dietary counseling got it as part of a cardiac rehabilitation program. Only 20% to 30% of eligible patients take advantage of such rehab, researchers noted.

Outside of cardiac rehab, doctors offered dietary counseling just 5% of the time.

It might be that the doctors don't have the time to offer diet advice, or don't consider themselves expert enough to provide good counseling, researchers said.

"When patients receive this education, we have seen tremendous results -- some have cut cholesterol levels in half within weeks," said lead researcher **Dr. Eric Brandt,** director of preventive cardiology at the University of Michigan's Frankel Cardiovascular Center.

"However, physicians are often limited by time required to manage other aspects of a patient's condition," Brandt said in a university news release. "Additionally, most cardiologists do not receive sufficient education to provide the dietary advice themselves."

Women, seniors older than 65 and patients with chronic kidney disease were less likely to receive dietary counseling, researchers found.

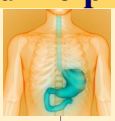
Patients with private insurance were most likely to receive such counseling, followed by Medicare and Medicaid patients, results showed….**Read More**

Chemo Before, After Surgery Could Help Those Battling Esophageal Cancer

People battling advanced esophageal cancers should get doses of **chemotherapy** both before and after tumor-removing surgeries, a new study suggests.

"There is considerable disagreement as to whether giving all adjuvant [chemo] therapy upfront versus 'sandwich' adjuvant therapy before and after surgery is the better standard of care" for people whose tumors can be removed with surgery, explained researcher **Dr Jennifer Tseng**, of Boston Medical Center.

She wasn't involved in the new trial, but said that "this randomized clinical trial from Europe answers that question for patients similar to those in enrolled in the trial: preoperative plus postoperative chemotherapy provides better outcomes."



The findings were presented Sunday at the annual meeting of the American Society of Clinical Oncology (ASCO), in Chicago.

According to the **American Cancer Society**, more than 22,000 Americans will be diagnosed with esophageal cancer this year and over 16,000 will die of the illness. Esophageal cancer is much more common among men than women.

The question of when to administer chemotherapy for esophageal cancer has been a matter of debate.

The new trial was led by **Dr. Jens Hoeppner** of the University of Bielefeld, in Detmold, Germany. His team focused on 371 people with esophageal cancers that hadn't spread beyond the esophagus but had tumor sizes large enough to be considered advanced. All of patients underwent surgery to help remove the tumor.

About half of the patients received chemotherapy only before their surgery, while the other half got chemo before and after their surgery.

Tracked for an average of more than four-and-a-half years following their surgery, the trial found that fewer patients died in the "before-and-after" arm of the trial versus the "before-only" arm -- 3.2% versus 5.6%, respectively.

At the three-year mark, patients who'd gotten chemo before and after surgery had a 30% lower risk of dying than those who only got chemo before, the researchers said. Complete regression of the original esophageal tumor was also more likely in the before-and-after group.

Patients who got the chemo twice lived an average of 66 months, versus just 37 months for those who only got chemo prior to surgery.

According to Hoeppner, the study shows that chemo before and after surgery should be recommended, "in order to optimize the chance of curing their tumors in the long term."

Because these findings were presented at a medical meeting, they should be considered preliminary until published in a peer-reviewed journal.