



### Message from Alliance for Retired Americans Leaders

#### Alliance Marks Scrap the Cap Day

For most Americans, payroll taxes for Social Security are a reality throughout the year. However, for people earning one million dollars or more annually, contributions to



Robert Roach, Jr.  
 President, ARA

Social Security for 2024 will end on March 2. The Alliance drew attention to that fact by marking "Scrap the Cap Day" on Thursday, February 29th, noting on social media that Social Security taxes are only paid on the first \$168,600 of wage income this year and calling for change.

It only took **4 minutes** for Tesla CEO Elon Musk to pay his maximum earnings subject to Social Security taxes. Similarly, the CEOs of many **large pharmaceutical corporations** make millions of dollars a year and have already stopped paying into Social Security. Scrapping the maximum earnings cap would increase the solvency of the Social Security Trust Fund and even allow for an increase in hard-earned benefits.

Many members of Congress recognize the need for action. Some Democrats are proposing legislation that will ensure the Social Security system remains strong. House Speaker Mike Johnson (R-LA) and House

Budget Chair Jodey Arrington (R-TX), however, are demanding the creation of a closed-door, fast-track commission designed to slash Social Security and Medicare without public input. Rep. Arrington has openly demanded this commission as a condition of keeping the federal government funded.

In just the last week, Alliance members have sent more than 20,600 letters to their Senators and U.S. Representative telling them to oppose Fiscal Commission legislation.

"We are the wealthiest nation in the world -- we certainly do not need to cut benefits. We can even afford to

expand Social Security if the wealthiest pay their fair share," said **Robert Roach, Jr., President of the Alliance**. "Scrapping the cap would not only keep the program strong decades into the future but also make the expansion of our hard earned benefits a reality."

Watch the video "**Scrap The Cap, We're Movin' In**"

**Survey: 83% of Americans Believe All Workers Should Have a Pension**  
 Americans are increasingly worried about retirement security, and they see a

return to pensions as a way to address the problem, according to new **research** from the National Institute on Retirement Security (NIRS).

Anxiety over retirement security has steadily increased for Americans. When asked whether the nation faces a retirement crisis, 79 percent of Americans agree that there is a crisis, up from 67 percent in 2020. More than half of Americans (55 percent) are concerned that they cannot achieve financial security in retirement.

Eighty-three percent of Americans say that all workers should have a pension to allow them to be independent and self-reliant in their retirement. More than three-fourths of Americans agree that those with pensions are more likely to have a secure retirement. 0

Additionally, the NIRS report showed that 87% of Americans

believe Congress must act now to shore up Social Security. 0

The unpredictability of life in their later years and the possible need for long term care also came up as concerns in the survey. The report found that 80% of Americans worry about the rising cost of long term nursing care, and 66% have anxiety about rising health care costs in retirement.

"Americans want the certainty that pensions provide. They deliver retirement benefits in the most cost efficient way possible, along with reliable lifetime income," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "In addition, pensions enable employers to recruit and retain workers in an increasingly tight labor market.

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Joseph Peters, Jr.  
 Secretary  
 Treasurer ARA

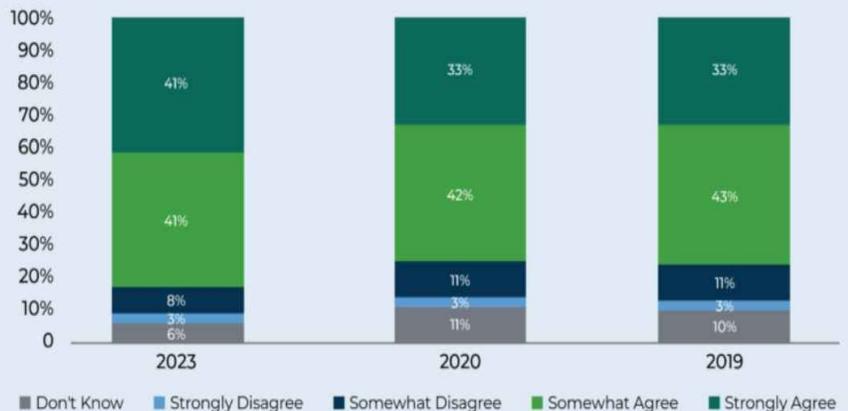
Millionaire earners are about to stop paying into Social Security for the rest of 2024.

It's time for the wealthy to pay their fair share. #ScrapTheCap!



**Figure 6: The vast majority of Americans say all workers should have a pension so they are independent and self-reliant in retirement.**

To what extent do you agree or disagree: I believe that all workers should have access to a pension plan so they can be independent and self-reliant in retirement.



ADD YOUR NAME

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

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# CMS Proposes Significant Policy Changes To Improve Care For Dually Eligible Individuals

For the over **12 million** people dually enrolled in Medicare and Medicaid, known as dually eligible individuals, Medicare is their primary insurer. It mainly pays for medical services, such as hospital care, doctors' visits, and prescription drugs. Medicaid wraps around this coverage, helping with Medicare costs and paying for services Medicare does not, such as long-term care.

People who are dually eligible have diverse needs and circumstances, but nearly all face challenges navigating their coverage since being enrolled in Medicare and Medicaid can mean working with two sets of benefits, rules, processes, and providers.

Like other Medicare enrollees, dually eligible individuals can choose Original Medicare or a private Medicare Advantage (MA) plan. Some who select MA may have access to a Dual Eligible Special Needs Plan (D-SNP), which is an MA plan exclusive to people who are enrolled in both Medicare and Medicaid.

In 2023, **5.2 million** people were enrolled in such a plan. As envisioned, D-SNPs can offer a unique framework to address Medicare-Medicaid

fragmentation issues, as they are required to provide greater coordination of Medicare and Medicaid benefits than other MA plans. A new **KFF brief** highlights 10 things to know about D-SNPs, including trends in enrollment, coverage, and access to care.

**Enrollment and Plan Growth**  
In 2021, nearly 3 in 10 dually eligible individuals were enrolled in D-SNPs, an increase from 20% in 2018. KFF notes this may be due to some extent to an uptick in **automatic enrollment**, and that **proposed** Special Enrollment Periods could further increase D-SNP participation.

Plan availability is also on the rise, perhaps driven by **relatively high** profit margins. In 2022, the average dually eligible individual had access to 10 D-SNPs, compared to 6 plans in 2018. This trend is likely to continue. As covered by **Axios**, a January 2024 **McKinsey report** projects that plans covering dual enrollees "will see a growth rate of greater than 10% between 2022 and 2027, and profits will grow from \$7 billion in 2022 to \$12 billion in 2027."

## Care Coordination and



## Quality

Although enrollment and plan availability continue to expand, **it is not clear** how well D-SNPs coordinate with Medicaid to provide the full range of benefits to dually eligible enrollees. KFF found that fewer than one in ten D-SNP enrollees were in fully integrated plans.

Further, gaps in reporting rules mean little is known about the overall quality of D-SNPs, and the available assessments suggest problems. For example, there are **longstanding concerns** that current quality measures are insufficient, and some studies **report little difference** in care quality between D-SNPs and other methods of care for dually eligible individuals.

## Access to Care

KFF found that contracts containing only D-SNPs deny prior authorization requests at much higher rates than other MA plans, despite receiving fewer requests per enrollee. Here too, data is lacking. Because CMS publishes prior authorization and denial information at the contract level, rather than at the plan level, it is impossible to identify the total number of coverage requests

and denials for D-SNP enrollees. KFF's analysis was limited to contracts containing only D-SNPs, which account for about 19% of total D-SNP enrollment. Most D-SNP enrollees (81%) are in plans that are in a contract with other Medicare plan types.

## Supplemental Benefits

Relatedly, **there is an absence** of comprehensive data on the use of supplemental benefits among D-SNP and other MA enrollees, including whether insurers offer adequate networks to access these services, whether they are of value to plan members, and whether plan **marketing tactics** are appropriate.

The KFF report underscores the opportunities and challenges to improving coverage and outcomes for Medicare-Medicaid enrollees. Policymakers have long expressed interest in doing so, in part because dually eligible beneficiaries have relatively high needs and program expenditures. As plans, enrollment, and costs continue to grow, greater transparency and thoughtful reforms that center the needs of beneficiaries will become ever more urgent. ... **Read More**

# This Social Security Spousal Rule Is Officially Finished in 2024 — But These 3 Strategies Remain

A Social Security **spousal rule** that has been around for decades officially ends this year for everyone except those who turned 70 on Jan. 1, 2024. The rule allows recipients to switch between their benefits and their spouse's to **receive the maximum amount**. But unless you were born before Jan. 1, 1954, you won't be able to take advantage. As MarketWatch reported, under the expired rule, the higher-earning spouse would claim spousal benefits at full retirement age while the other spouse claims their own benefit. The higher earner would then switch to their benefits at age 70, which maximizes the monthly Social Security payment because of the delayed retirement credits. In addition, the lower-earning spouse would be able to claim a spousal benefit or keep their own, depending on which is higher.

## Here are three things you should do:

### Plan Ahead

Making the most of Social Security spousal benefits requires having discussions about who should claim benefits and when. Social Security always pays the higher of the individual's benefits or spousal benefits to the lower earner, MarketWatch reported. Couples looking to claim benefits are advised to create an online account with the Social Security Administration so they can review their estimated benefits at various claiming ages.

"It's critically important for married couples to do Social Security planning," said Matthew Allen, co-founder and chief executive officer of Social Security Advisors, told MarketWatch.

### Avoid Claiming Benefits Too Early

As GOBankingRates



previously reported, the amount a beneficiary receives from Social Security depends on both their work record and when they file. Although full retirement age is now 67 for most workers, you can file a claim to start benefits as early as **age 62**. However, your benefits will be permanently slashed by as much as 30%.

For example, if your full retirement benefit is \$2,000 per month at age 67, by filing at age 62, that monthly amount will drop to just \$1,400. A spouse's Social Security benefit is directly tied to the payout that the primary beneficiary receives. If your spouse files for benefits at age 62, your spousal benefit will be permanently reduced as well.

### But Don't Necessarily Wait Until 70 To File, Either

Normally, the longer you wait to collect Social

Security **retirement benefits**, the bigger your check. Waiting until full retirement age guarantees that you will get the full benefit you are owed, while waiting to age 70 ensures the **maximum benefit**. Just as workers face a reduced Social Security retirement payout if they claim early — such as at age 62 — those who delay their payouts will see them increase.

However, spouses can't take advantage of the age 70 rule because their payout is capped at 50% of the primary beneficiary's full retirement benefit. Even if your spouse waited until age 70 to collect Social Security, your maximum benefit would remain at 50% of the primary beneficiary's FRA benefit amount.

## Why some Medicare Advantage plans will get skimpier and costlier

Medicare Advantage plans may look less enticing to their 31 million beneficiaries next year.

**Medicare Advantage plans**—those aggressively promoted alternatives to traditional Medicare sold by health insurers—may look less enticing to their 31 million beneficiaries next year.

“I think the landscape is going to change. Medicare Advantage will have less perks and be less attractive to people,” says Marvin Musick, cofounder and chief educator of [Medicareschool.com](http://Medicareschool.com) and a **Medicare broker**.

That would be quite a reversal, considering that the 21-year-old Medicare Advantage program has become so popular, more Medicare beneficiaries are now in these plans than in traditional Medicare. **Enrollment** has more than doubled since 2010, according to KFF, a health research firm.

### The vise tightens on Medicare Advantage insurers

But some of the nation’s biggest Medicare Advantage plans are feeling a financial pinch. Consider:

◆ **Humana**, the second-largest Medicare Advantage insurer, recently sharply cut its earnings-per-share projections for 2024 and 2025 citing unprecedented cost surges. A fourth-quarter 2024 loss due to higher Medicare Advantage usage caused its stock price to trade near a four-year low.

Karen Lynch, the CEO of **CVS Health**, which owns **Aetna** (the third-largest Medicare Advantage insurer), said in an earnings call that the Centers for Medicare and Medicaid Services (CMS) proposed 2025 funding level “was broadly consistent with our expectation, which we do not believe is sufficient to cover current medical cost



trends.” The company, which is a sponsor of *Fortune* Well, believes its Medicare Advantage business will be only marginally profitable this year.

◆ On a recent earnings call, the chief financial officer of **Centene**, the sixth-largest Medicare Advantage insurer, said Medicare Advantage “products may be a little bit less attractive for seniors from an industry standpoint if we don’t make a lot of progress on the final rates.”

In January 2024, **Cigna** (the eighth-largest Medicare Advantage insurer) announced plans to **get out of the business**, agreeing to sell its Medicare Advantage plans to **Health Care Service Corp.**, a Blue Cross Blue Shield insurer. Cigna had earlier tried to purchase Humana.

### What’s causing the problems

“The difficulties we’re

seeing are related to a convergence of pressures from the federal government, or CMS, and changing the rules a little bit, says Bradley Ellis, senior director of North American Insurance Ratings for the Fitch Ratings service. He’s talking about CMS’s proposed base payment cut of 0.16% to Medicare Advantage plans.

Another stress for some Medicare Advantage insurers: higher-than-expected utilization rates. This, Ellis noted, has been a response to pent-up demand for elective procedures during the pandemic.

“It started in the second quarter of 2023,” he says. “There had been a lot of the deferred care during the pandemic, when people were resistant to go into medical facilities to have, say, a hip replacement surgery done—out of fear of **contracting COVID-19**.” ...[Read More](#)

## New poll confirms serious access to care concerns in Medicare Advantage

While all insurers offering Medicare Advantage (MA) profit more the less care they deliver, every Medicare Advantage plan is different; we should not generalize about them. We know that access to care can be a serious issue in MA, with some insurers using **artificial intelligence** to deny care, others relying on **prior authorization requirements to delay and deny care** and others offering provider networks that do not meet

enrollees’ needs. A new **Commonwealth Fund** survey confirms that access to care continues to be a far more serious concern for MA enrollees than for Traditional Medicare (TM) enrollees.

The survey of more than 3,200 people with Medicare found that more than one in five people (22 percent) enrolled in Medicare Advantage reported delays in receiving care as compared with



one in eight (13 percent) enrolled in Traditional Medicare.

Wait times to see physicians did not vary between people in Traditional Medicare and people in Medicare Advantage. But, one in three people polled said they waited more than a month to see a physician.

People in MA reported significantly higher financial barriers to care than people in

Traditional Medicare. Twelve percent of people in MA faced cost barriers to care, in the form of either a deductible or a copay, as compared with seven percent of people in Traditional Medicare. The five percent difference is especially telling, given people in MA overall are healthier than people in TM.

Satisfaction was relatively the same for people with Traditional Medicare and Medicare Advantage.

## Her air-ambulance ride wasn’t covered by Medicare. It will cost her family \$81,739

Debra Prichard was a retired factory worker who was careful with her money, including what she spent on medical care, said her daughter, Alicia Wieberg. “She was the kind of person who didn’t go to the doctor for anything.”

That ended last year, when the rural Tennessee resident suffered a devastating stroke and several aneurysms. She twice was rushed from her local hospital to Vanderbilt University Medical Center in Nashville, 79 miles away, where she was treated by brain

specialists. She died Oct. 31 at age 70.

One of Prichard’s trips to the Nashville hospital was via helicopter ambulance. Wieberg said she had heard such flights could be pricey, but she didn’t realize how extraordinary the charge would be — or how her mother’s skimping on Medicare coverage could leave the family on the hook.

**The patient:** Debra Prichard, who had Medicare Part A insurance before she died.

**Medical service:** An air-



ambulance flight to Vanderbilt University Medical Center.

**Service provider:** Med-Trans Corp., a medical transportation service that is part of Global Medical Response, an industry giant backed by private equity investors. The larger company operates in all 50 states and says it has a total of 498 helicopters and airplanes.

**Total bill:** \$81,739.40, none of which was covered by insurance.

**What gives:** Sky-high bills

from air-ambulance providers have sparked complaints and federal action in recent years.

For patients with private insurance coverage, **the 2020 No Surprises Act** bars air-ambulance companies from billing people more than they would pay if the service were considered “in-network” with their health insurers. For patients with public coverage, such as Medicare or Medicaid, the government sets payment rates at much lower levels than the companies charge....[Read More](#)

## Seniors Expect to Run Out of Money as Social Security Drop Forecast

Many seniors expect to run out of money in less than 10 years as economists predict that Social Security will become **insolvent by 2033**.

According to a new survey from MassMutual, 40 percent of near-retirees say Social Security benefits will be their **biggest source of income in retirement**. Despite this, more than one-third say their retirement income would not be enough to last them for more than 10 years.

"Seniors or those nearing their golden years are starting to get a bit apprehensive about would they have enough to make it

through retirement," Nadia Vanderhall, a financial planner at The Brands and Bands Strategy Group,

told *Newsweek*. "Even though people can be within retirement for over 30 years, Americans are living longer while things are becoming more expensive."

The data arrives as economists predict Social Security will become insolvent by 2033 if nothing changes. As more baby boomers retire and fewer young people are entering the workforce, the Social Security program is anticipating benefits



to run out. Beginning in 2033, benefits could be cut by 23 percent without major program changes.

To save benefits, politicians have suggested raising the retirement age, increasing payroll taxes and altering benefit calculations. So far, no strategy has been approved, and future benefits remain in limbo, especially for younger generations paying into it. The Senior Citizens League predicted the cost-of-living adjustment will be only 1.75 percent in 2025, a significant decline from the 3.2

and 8.7 percent increase in 2024 and 2023.

Vanderhall said there's mounting fear about what will happen if Social Security runs out, and that the system will likely go through many changes in the upcoming years, especially as the cost-of-living adjustment fails to keep up with the inflation Americans are facing today.

With no changes enacted, many seniors will find themselves in grave situations as they struggle to make ends meet....[Read More](#)

## Justice Department going after Medicare Advantage fraud

The US Department of Justice has been taking on major enforcement activities to protect people with Medicare and others from health care fraud, something that the Centers for Medicare and Medicaid Services needs to do a lot more of. Noah Tong reports for **Fierce Healthcare** on the more than \$1.8 billion in health-care settlements and judgments the Justice Department has recovered in the last fiscal year.

The Justice Department is able to hold health insurers offering Medicare Advantage plans to account under the False Claims Act. The DOJ recovered \$1.8 billion in federal losses.

Will these DOJ activities move the insurers offering Medicare Advantage plans to provide people with the care they are entitled to and not game the payment system and overcharge the federal government? They should be warned, for sure. As one expert commented, "The [DOJ] press release goes out of its way to signal that Medicare Advantage plans' risk adjustment practices are DOJ's most important healthcare fraud priority. It telegraphs that by making MA risk adjustment the first, and most prominent, specific area it addresses."



Without question, the insurers are taking note. But nothing the Justice Department is doing leaves them with any reason not to continue to delay and deny needed care if they so choose. That's how they maximize profits. And, the Centers for Medicare and Medicaid Services has little way to ensure they cover the Medicare benefits they are required to cover, let alone to warn people enrolled in plans that do not cover these benefits.

And, there's no reason to believe that the same insurers who are gaming the Medicare Advantage payment system are not also gaming the Medicare

coverage requirements. The Office of the Inspector General has said that combating fraud is a challenge because there's no data on denied claims. Why should we trust them when it's in their financial interest to deny and delay care inappropriately?

CMS needs to implement a new MA claims processing system. It needs an independent agency to process all Medicare Advantage claims. Without that, people cannot know whether the Medicare Advantage plan they join will inappropriately deny them the medically necessary care to which they are entitled

## Staffing Shortages at Nursing Homes Continue: Report

Although the pandemic has ended, staffing shortages and employee burnout still plague U.S. nursing homes, a new government report finds.

But the problems didn't end there: The **report**, issued Thursday by the Inspector General's Office at the U.S. Department of Health and Human Services, showed that infection-control procedures were still sorely lacking at many facilities.

Not only that, COVID booster vaccination rates remain far lower than they should be, with only 38% of residents and 15% of staff up-to-date on their shots, according to a recent **KFF report**.

"Just as airplanes cannot be repaired while in flight, nursing home challenges could not be fully repaired during the

pandemic," **Rachel Bryan**, a social science analyst with the inspector general's office, told the *New York Times*. "We feel very strongly that as we come out of emergency mode, we take the time to reflect, learn and take real steps toward meaningful change."

Staffing problems are "monumental," the report said, noting high levels of burnout, frequent employee turnover and the time-consuming burdens of constantly training new employees. For nursing homes, the inability to hire and keep certified nurse aides, food preparation staff and housekeeping workers is tied to federal and state reimbursements that do not cover the full cost of care, the *Times* reported.



The report, based on interviews with two dozen nursing home administrators from across the country, shows that nursing homes are still reeling from the damage inflicted by the pandemic, when shortages of personal protective equipment (PPE) and widespread fear of infection drove away seasoned employees.

The challenges of trying to recruit reliable help have been exacerbated by private staffing agencies that step in quickly but charge nursing homes as much as 50 percent more for workers, the *Times* reported.

**Katie Smith Sloan**, president of LeadingAge, an association of nonprofit nursing homes, told the *Times* that higher federal reimbursement rates would help,

but that mobilizing numerous government agencies would be a better strategy.

For example, she said, the Department of Homeland Security could include nursing aides in the temporary worker visa programs that bring in farm workers from abroad, and the Department of Education, with support from Congress, could make Pell grants available to nursing assistant students and culinary worker trainees.

"This is bigger than CMS," Sloan said, referring to the U.S. Centers for Medicare & Medicaid Services, which oversees nursing homes. "We have to figure out how to creatively apply the things that work to this intractable work force issue."....[Read More](#)

## Five big Medicare access to care issues put vulnerable people at serious risk

The Centers for Medicare and Medicaid Services has issued its annual Medicare Advantage proposed rate notice for 2025 and is seeking comments before it finalizes the rate. It is trying to combat tens of billions of dollars in annual overpayments to Medicare Advantage plans. If not terminated, these overpayments will, over time, destroy Medicare, making it unaffordable for the older adults and people with disabilities who rely on it for their medical care.

What are the big issues with Medicare today:

**Traditional Medicare, which gives people easy access to care from physicians and hospitals across the US, is not an option for people with low incomes** because it lacks an out-of-pocket cap, and Medigap is unaffordable or unavailable to them. MA plans are good while you're healthy, but that's not why we have health insurance. When you develop cancer and other costly conditions, MA plans have powerful financial incentive to stint on care and few restraints. Little accountability. Non-standardized claims processing

and prior authorization rules means inappropriate delays and denials, ineffective CMS oversight and no way to protect people, particularly people with costly conditions, from bad actor plans.

**People cannot make meaningful Medicare choices.** Information is misleading and inadequate to keep people from joining MA plans that impose inappropriate barriers to care and endanger their health when they get sick. CMS tells them they'll get the same benefits in Medicare Advantage as Traditional Medicare. But, it's not true. Some plans have high denial rates, ghost networks, inappropriate prior authorization obstacles, high mortality rates. People can't avoid them. MA plans compete to maximize profits not to promote high value care for those who most need it. CMS can only protect them if there is significantly more MA standardization. Greater standardization of out-of-pocket costs and claims processing would help promote meaningful



choice and appropriate coverage. CMS also needs resources to enable appropriate oversight and enforcement.

**Non-standardized Medicare Advantage administrative processes enable inappropriate care denials:** So long as CMS cannot protect vulnerable individuals from MA plans that delay and deny care inappropriately and that restrict them from seeing good providers, and impose financial barriers to costly care, TM needs to be a meaningful choice. Until Congress acts, CMS should use CMMI, its innovation center, to test a Traditional Medicare model with low out-of-pocket costs and an out-of-pocket limit that is on a more level playing field with Medicare Advantage. If TM is not on a level playing field with Medicare Advantage, Traditional Medicare will disappear, there will be less choice and higher costs for Medicare Advantage enrollees, the vulnerable will be most at risk. To help protect vulnerable MA enrollees CMS should require MA plans to use a

centralized independent agency to do claims processing and prior authorization so that plans compete to deliver better managed and coordinated care, not to avoid covering care for people with complex conditions.

**Delays and denials:** Notwithstanding CMS' efforts to address some of the problems with prior authorization and inappropriate delays and denials of care, proprietary and non-standardized claims processing and prior authorization rules mean inappropriate delays and denials, ineffective CMS oversight and no way to protect people, particularly people with costly conditions, from bad actor plans. Without an independent intermediary to process claims in a timely and standardized manner, vulnerable enrollees have a good chance of not getting the medically necessary care to which they are entitled; and, the bad actor MA plans will go undetected, to the detriment of their most vulnerable enrollees. CMS cannot effectively oversee MA, drive accountability and protect enrollees from bad actors.

## Social Security Faces New Pressure After Seniors Get Shocking Bills

The **Social Security Administration** is facing increased pressure to fix its overpayment problem as millions of **seniors** find themselves with high bills due to the organization's mistakes.

Several lawmakers came together to urge the SSA to fix the system, which often leads to seniors getting hit with tens or hundreds of thousands of dollars in **debt**. Senators Gary Peters and Debbie Stabenow (Michigan) wrote in a letter that the overpayment issues are causing significant hardship for seniors who are unsure how they will ever pay the bills back.

"We have heard from numerous Michiganders regarding the impact unexpected overpayments that were sent by the SSA have caused on some of the most vulnerable beneficiaries of Social Security, who often include the elderly, disabled, retirees, and many who struggle to get by on limited income and resources," the letter reads.

In their letter, Peters and Stabenow requested the SSA look to solve the overpayment problems and find a strategy to prevent such errors in the future.

"Overpayments can pose incredibly difficult hardships on beneficiaries who've committed no wrongdoing and are now responsible for repaying improper payments," the senators wrote. "Because of their devastating impact, it is critical for the agency to improve its processes and controls to reduce the number of overpayments for beneficiaries who rely on these critical benefits."

Seniors, as well as those with disabilities and people living on fixed incomes, have reported anywhere from \$37,000 to \$100,000 and more in overpaid payments, 13 On Your Side reported. And once the SSA realizes its mistake, the seniors who were mistakenly overpaid are suddenly on the line to pay the checks back or end their



benefits altogether until the amount makes up for the overpayments.

The SSA paid out more than \$11 billion in Social Security overpayments in 2022, with the number of overpayment mistakes rising recently. More than 2 million Americans find themselves with an overpayment each year, according to 13 On Your Side.

Overpayments often happen over the span of several years, and by the time the mistake is revealed, it's accumulated to an amount that no recipient could feasibly repay.

"Each person's situation is unique, and the agency handles overpayments on a case-by-case basis," the SSA said in a statement last year. "In particular, if a person doesn't agree that they've been overpaid, or believes the amount is incorrect, they can appeal. If they believe they shouldn't have to pay the money back, they can request that the agency waive collection of the

overpayment. There's no time limit for filing a waiver."

True Tamplin, the founder of Finance Strategists, said the senators' letter could put the pressure needed on the SSA for it to more adequately prevent further overpayment charges from coming to fruition.

"The letter from U.S. senators should definitely add pressure on the SSA to tackle the overpayment issue," Tamplin told *Newsweek*. "It shows that there's political will to address the problem and that it's on the radar of those who can push for changes."

Overpayments can happen for various reasons, whether it's that the SSA miscalculated your benefits or a recipient failed to promptly report an income or household change, according to Michael Ryan, a finance expert who found

[michaelryanmoney.com](http://michaelryanmoney.com)...**Read More**

## Billions in Medicare savings from Medicare drug price negotiation by 2031

A new report from the Center for American Progress (CAP) finds that the Inflation Reduction Act's provision allowing Medicare to negotiate drug prices for its highest cost drugs will reduce drug spending by tens of thousands of dollars a year for millions of people with Medicare and save Medicare millions of dollars a year.

On September 1, 2024, the Centers for Medicare and Medicaid Services, which oversees Medicare, will announce the prices it has negotiated with pharmaceutical corporations on ten drugs that treat, among other things, diabetes, kidney disease, blood clots and heart failure.

Beginning in January 2026, the cost of these drugs should drop considerably.

The ten drugs cost Medicare significantly more than other drugs it covers either because they have very high prices or because they are widely used. A total of nine million people currently use their Part D drug benefit to fill their prescriptions for these drugs. These ten drugs represent roughly 20 percent of Medicare's annual drug spending under Part D.

CAP projects that the price of one insulin product, NovoLog FlexPen will fall \$30 a month and the price of one cancer drug, Imbruvica, will fall \$6,548 a



month. The price of Eliquis, which 3.5 million people with Medicare take, could drop by \$123 a

month.

Currently, Americans pay many times more than people in other wealthy nations for several of these drugs. For example, a dose of Stelara, another drug whose price Medicare is negotiating, which treats people with autoimmune conditions, costs \$2,900 in the United Kingdom and \$16,600 in the US. Moreover, Americans paid \$6.5 billion in taxpayer dollars for the development of Stelara.

While Medicare is only negotiating the price of 10 drugs

this year, by 2030 it will have negotiated the price of 80 drugs. CAP estimates that Medicare will save \$25 billion as a result of drug price negotiation in the six years between 2026 and 2031.

Of course, the pharmaceutical companies are trying to block these **price negotiations in the courts**, claiming that the government should not be interfering with the prices private corporations set. What they fail to say is that they developed these drugs with \$11.7 billion in taxpayer dollars, The Lever reports. And, they made \$70 billion on these drugs in 2022.

## Oregon moves toward restricting private equity from owning physician practices

Most states have laws prohibiting corporate interference in the practice of medicine. But, corporations and private equity firms have been getting around these laws, buying up primary care and specialty practices, by enlisting physicians to run their businesses. Amelia Templeton writes for [OPH.org](https://www.oph.org) that Oregon is working to prevent some of this activity because it is benefiting corporations at the expense of patients.

The opposition is fighting back, dragging out the standard arguments that any law preventing corporate ownership

of physician practices will kill innovation and business. The question the Oregon lawmakers must ask is whether concerns about the health and well-being of their constituents resulting from the corporate ownership of medical practices should be paramount.

As it is, nursing homes, health systems and hospitals are not likely to be covered under any new law in Oregon, even though their corporate ownership raises serious patient safety, health care access and health care cost concerns. Corporate owners can



direct physicians to spend less time with patients or to see fewer Medicaid patients. Private equity ownership of medical practices is almost always a short-term play. The private-equity firm takes as much money out of the business as possible or implements ways to generate more revenue and then tries to flip it for a profit. Patient care is at best a secondary concern after profits.

Right now, some types of corporations must abide by a loosely written Oregon law that requires physicians to have a majority stake in any medical

practice that is corporate-owned. Oregon legislators are looking to broaden that to extend to more health care corporate entities. This Oregon law does not apply to hospitals and nursing homes.

If passed, the new legislation would still allow corporate-owned medical practices to exist for the next seven years. After seven years, they would need to have transitioned to a different ownership structure. Sadly, that's plenty of time for the corporate owners to lobby the Oregon legislature to repeal the legislation if it is passed.

## Judge denies AstraZeneca's lawsuit against Medicare negotiation

A judge on Friday granted the federal government's request for summary judgment against AstraZeneca in its lawsuit challenging Medicare negotiation, finding that the drugmaker lacked standing to sue over the program.

In his opinion, U.S. District Judge Colm Connolly found that AstraZeneca had failed to properly establish its standing in filing a lawsuit against the federal government to block Medicare drug price negotiations.

AstraZeneca filed a motion for summary judgment in September asking that the judge find the federal government's definitions of a "qualifying single source drug" and "bona fide marketing" under the Inflation Reduction Act to be contrary to the law.

Drugs chosen for negotiation

could not have any generic competition, like AstraZeneca's diabetes medication Farxiga, which was chosen as one of the first 10. If there was a generic form or biosimilar of a medication that was "bona fide" marketed, then the drug would technically not be eligible for negotiation.

The company sought to block the guidance set by the Centers for Medicare and Medicaid Services (CMS) regarding Medicare negotiation, arguing that it violated the Administrative Procedure Act. It also sought to have the negotiation program itself declared unconstitutional, violating the 5th Amendment.

Connolly made it clear in his ruling on Friday that



AstraZeneca's arguments did not convince him.

The federal judge found he lacked the jurisdiction to hear AstraZeneca's first two claims regarding IRA's definitions of a "qualifying single source drug" and "bona fide marketing." He cited the drugmaker's failure to establish that it had Article III standing to sue, meaning Connolly was not convinced that AstraZeneca was suffering or would soon suffer injury due to the CMS guidance.

The company argued it had standing because the CMS guidance would decrease its incentives to look for other uses of Farxiga in other health conditions.

"A loss or diminishment of an incentive to do something,

however, is not a concrete injury," Connolly wrote in his ruling.

"Were courts to adopt AstraZeneca's 'disincentivizing' theory of standing, they would open their doors to plaintiffs whose only complaint was that they disliked a law or government action. If AstraZeneca had its way, the merits of every 'sin tax' could be challenged in never-ending lawsuits brought by disgruntled smokers, gamblers, oenophiles, and (at least in Philadelphia) soda drinkers," wrote Connolly.... [Read More](#)

## Home Safety Checklist for Seniors

A safe environment and the right support can help you live at home well into your golden years.

Many seniors prefer to live independently at home as long as possible before transitioning to assisted living, nursing homes or other **senior living** accommodations. While living at home, though, these older adults may need to make adjustments to their environment to stay safe. Safety for seniors at home is something to take seriously – about 1 in 4 adults over age 65 fall each year, with more than one-third of those falls resulting in injuries requiring medical treatment, according to the Centers for Disease Control

and Prevention.

Seniors living independently at home are still at risk for falls or nutritional deficiencies. Read on for a comprehensive home safety checklist for seniors.

### Elderly Risk for At-Home Injuries

There are a few key reasons seniors are at risk for at-home injuries, says Macie Smith, a Synergy HomeCare gerontologist and social worker based in Columbia, South Carolina. These include:

- ◆ Lower body weakness.
- ◆ **Vitamin D deficiency**, which causes low bone density.



- ◆ Difficulties with walking and **balance**.
- ◆ Use of **medicines**, like blood thinners, which can affect balance and steadiness.
- ◆ Vision problems.
- ◆ Foot pain, loss of sensation in the lower extremities or poor footwear.

### Home Safety Checklist

It only takes a few small changes to make a safer living environment. Here are some tips.

- ◆ **Create a support system.**
- ◆ **Set up grocery delivery.**
- ◆ **Create an emergency response system.**
- ◆ **Safety-proof your general living space.**

- ◆ **Safety-proof your bathroom.**
- ◆ **Safety-proof your kitchen.**
- ◆ **Use technology to your advantage.**
- ◆ **Visit the doctor regularly.** ... **Read More on each of the above Home Safety Checklist**

### The Bottom Line

Taking a few extra precautions to follow an elderly home safety checklist can make your home safer, allowing you to gracefully age in place for as long as possible. If you want to know more about home safety for the elderly, talk with your primary care provider, **senior care provider** or an occupational or physical therapist.

## U.S. Deaths Linked to Alcohol Keep Rising, Especially Among Women

Deaths where alcohol played a key role climbed sharply in recent years, hitting women even harder than men, new government data shows.

Between 2016 and 2021 (the latest numbers available), "the average number of U.S. deaths from excessive alcohol use increased by more than 40,000 [29%], to 178,000 per year," reported a team from the U.S. Centers for Disease Control and Prevention.

Put another way, during 2020 and 2021, an average of 488 Americans died each day from excessive drinking, the report's authors concluded.

The rate of increase appears to

be accelerating: Between 2016 and 2019, deaths where alcohol was a factor rose by 5%, but between 2018 and 2021 they climbed by 23%.

Men continue to lose their lives to alcohol in greater numbers than women, the report found. However, the rate at which women are dying from excessive drinking is rising faster than that of men, the researchers found.

Over the study period, deaths from excessive alcohol use among women rose by about 35%, compared to about a 27% rise among men.

The new data looked at deaths directly linked to drinking --



things like alcoholic liver disease or excessive intoxication -- as well as more indirect causes, such as heavy drinking's role in heart disease and stroke.

Over the study period, death rates rose for most forms of alcohol-related deaths, but "death rates among females [involving alcohol] were highest from heart disease and stroke," noted a team led by CDC alcohol researcher **Marissa Esser**.

Why the steady, steep rise in deaths? According to the researchers, numerous factors may be to blame, including a widening of access to alcohol (for example, home delivery) that

began during pandemic lockdowns.

Binge drinking also seems to be on the rise. For example, "the prevalence of binge drinking among adults aged 35-50 was higher in 2022 than in any other year during the past decade," the CDC team noted.

That rise doesn't bode well for the future, Esser's group warned.

What can be done to turn these trends around? The researchers believe boosting taxes on alcohol and cutting back on the number of outlets licensed to sell beer, wine and liquor could only help.

The study was published Feb. 29 in the CDC journal **Morbidity and Mortality Weekly Report**.

## PSA Test Might Overdiagnose Prostate Cancers in Black Men

A new British study suggests that the prostate-specific antigen (PSA) test, long used to spot prostate cancers, might lead to overdiagnosis in Black men.

Researchers now theorize that Black men may have naturally higher levels of the antigen in their blood than white men, but that it does not indicate any higher risk for prostate cancer.

If Black patients are being overdiagnosed, that could mean that many receive unnecessary follow-up MRIs and onerous prostate biopsies.

"Overdiagnosis of cancer may not sound as worrying as underdiagnosis, but we need to redress the balance in the evidence base to get more precise and accurate prostate cancer diagnosis to avoid unnecessary biopsies which can lead to psychological distress and sepsis," explained study lead author **Dr. Tanimola Martins**, a senior research fellow and lecturer at the University of Exeter.

"We need more research to ensure everyone gets the best diagnosis,



regardless of their ethnicity," Martins said in a university news release. The PSA test was once routinely used by doctors to help diagnose cancers.

However, over time the screen came under fire, because it too often spotted "indolent" tumors that were slow-growing and might be better left untreated.

Currently, the **American Cancer Society** leaves the decision to have a PSA test up to an informed discussion between a patient and his doctor.

In the new study, Martin's team examined the medical records of over 730,000 British men, ages 40 or older. The researchers tracked which of the men were diagnosed with prostate cancer after receiving a test result showing raised levels of PSA.

More than 80 percent of the men had normal PSA levels, the team noted.

However, among men with raised levels of PSA, Black men typically had higher levels than either white or Asian men, the researchers found. ... **Read More**

## U.S. to Strengthen Protections for Air Travelers With Wheelchairs

Air travel can be miserable for people with disabilities, particularly if an airline mishandles, damages or loses their wheelchair in transit.

Now, the Biden Administration has proposed tough new standards for how airlines treat and accommodate people in wheelchairs.

The proposed rules would make mishandling wheelchairs an automatic violation of the Air Carrier Access Act, allowing federal regulators to more easily hold airlines accountable when a person's wheelchair is damaged.

The rules would also mandate better training and improved practices to ensure that disabled passengers receive safe, dignified and prompt assistance at airports. "There are millions of Americans with disabilities who do not travel by plane because of inadequate airline practices and inadequate government regulation, but now we are setting out to change that," **U.S. Transportation Secretary Pete Buttigieg** said in an **announcement** outlining the proposed rule.

"This new rule would change the way airlines operate to ensure that travelers using wheelchairs can travel safely and with dignity," Buttigieg added.

An estimated 5.5 million Americans use a wheelchair, the U.S. Department of Transportation (DOT) said. In 2023, 11,527

wheelchairs and scooters were lost, delayed, damaged or stolen by airlines.

Among its provisions, the new rule would require airlines to:

- ◆ Immediately notify passengers of their options if their wheelchair has been mishandled
  - ◆ Repair or replace damaged wheelchairs
  - ◆ Return a lost wheelchair to the passenger's final destination within 24 hours, by whatever means possible
  - ◆ Make loaner wheelchairs available that fit the needs of the passenger
  - ◆ Promptly assist disabled passengers through the airport terminal and on or off the plane
  - ◆ Conduct annual hands-on training for employees and contractors who physically assist disabled passengers or handle their wheelchair
  - ◆ Provide safe and dignified assistance to all passengers with disabilities
- The rule also calls for



improved performance standards for on-board wheelchairs on twin-aisle aircraft and small aircraft, consistent with existing standards on single-aisle airplanes.

The DOT will take comments on the proposed rule for the next 60 days, following its publication in the Federal Register.

This new proposal follows a rule finalized last September that requires new single-aisle airplanes to be designed with handicapped-accessible bathrooms.

Back then, the DOT also announced an agreement with United Airlines that would require industry-leading actions to improve customer service for wheelchair-bound passengers.

A new feature on United's website will help passengers find flights on airplanes better able to safely store and transport a wheelchair. United will also refund the fare difference if a more expensive flight is needed to accommodate a specific wheelchair size.

The United agreement was prompted by an incident in which a passenger died after her customized wheelchair was damaged during a cross-country flight.

Engracia Figueroa, 51, died after her \$30,000 specialized wheelchair broke in the cargo hold during a United flight home to Los Angeles from Washington, D.C.

Figueroa had to sit in a broken manual wheelchair for nearly five hours at the L.A. airport while United sorted out what had happened, according to Hand in Hand, the domestic employers' advocacy group she represented.

Figueroa developed a pressure sore while she waited at the airport, and the sore was made worse by the loaner chair she had to use while she fought with United to replace her broken chair, Hand in Hand said in a **statement** at the time.

"The sore became infected and the infection eventually reached her hip bone, requiring emergency surgery to remove the infected bone and tissue," Hand in Hand said.

Figueroa died Oct. 31, 2021, three months after the July flight in which her wheelchair was broken.

United also agreed to launch a trial program to explore whether medical wheelchairs or other types of chairs can be used to safely accommodate passengers whose personal wheelchairs break during a flight.

## Stationary Bike Workouts Could Help Parkinson's Patients

A bicycle built for two could be a positive prescription for Parkinson's patients and their caregivers, a small, preliminary study says.

Parkinson's patients had better overall quality of life, improved mobility, and faster walking speed after sharing regular rides on a stationary tandem bike with a care partner, researchers plan to report at the annual meeting of the American Academy of Neurology in April.

Care partners also got something out of the rides, reporting improvements in their perceived ability to bounce back or recover from stress, results show.

"A unique cycling program that pairs people with Parkinson's disease with their care partners can improve the physical, emotional and mental

well-being of both cyclists to improve their quality of life," said researcher **Jennifer Trilk**,

a professor of biomedical sciences with the University of South Carolina School of Medicine in Greenville.

Parkinson's is a progressive degenerative disease of the nervous system. Patients become less and less able to control their body, suffering from tremors, leg stiffness, and gait and balance problems.

For the study, patients and caregivers shared a virtual reality ride on a tandem stationary bicycle twice a week for eight weeks. The study included nine Parkinson's patients and their care partners.

"It is just as important that care partners also receive care, so that is why we included them as the



cycling partner," Trilk said in a meeting news release.

During each session, large television screens synced to cycling intensity provided the sense of cycling along real-life scenic outdoor routes.

Because the bike was tandem, care partners were able to help the patients maintain a higher pedaling rate for greater health benefits, researchers said.

Following the series of sessions, caregivers were more likely to agree with statements like, "I tend to bounce back quickly after hard times" and "I usually come through difficult times with little trouble," researchers said.

People with Parkinson's didn't experience a similar improvement in resiliency, but tests showed that they had better

physical function and mobility following the rides.

The patients also felt more capable of dealing with difficulties in daily life, results showed.

"The goal of our small study was to determine if tandem cycling was beneficial," Trilk said. "The next step will be to confirm the results with subsequent studies that would include more participants."

Findings presented at a medical meeting should be considered preliminary until published in a peer-reviewed journal.

## CDC Experts Recommend Seniors Get Another COVID Shot

Even if they got a COVID booster last fall, American seniors should still get a second shot this spring to best protect themselves, U.S. health officials recommended Wednesday.

The latest guidance, voted on by a vaccine advisory panel and endorsed by the U.S. Centers for Disease Control and Prevention, states that a second booster is fine as long as at least four months have passed since your last COVID shot.

"Today's recommendation allows older adults to receive an additional dose of this season's COVID-19 vaccine to provide added protection," CDC Director **Dr. Mandy Cohen** said in an agency **statement** announcing the new recommendation. "Most COVID-19 deaths and hospitalizations last year were among people 65 years and older. An additional vaccine dose can provide added protection that

may have decreased over time for those at highest risk."

The CDC advisory panel's decision followed a debate on whether the wording in the guidance should say older people "may" or "should" get the shots, in an acknowledgement of the public's growing fatigue with anything related to COVID-19, the *Associated Press* reported. Some panel members said the "should" recommendation more clearly encourages doctors and pharmacists to offer the shots.

"I was impressed with data supporting the need for an additional dose of vaccine for those 65 years and older," panel member **Dr. Camille Kotton**, a physician at Massachusetts General Hospital, told the *New York Times*.

"Given the risk of severe, even life-threatening, disease, I would encourage those who are moderately to severely



immunocompromised to take the opportunity for another dose," she added. The CDC stressed that point in its statement.

"Data continues to show the importance of vaccination to protect those most at risk for severe outcomes of COVID-19," the CDC said. "An additional dose of the updated COVID-19 vaccine may restore protection that has waned since a fall vaccine dose, providing increased protection to adults ages 65 years and older."

So far, this season's COVID booster has proved **54% effective against infection** with the predominant COVID variant, known as JN.1.

Many older adults are still protected by the fall shot, which built on the immunity of earlier vaccinations and/or infection, doctors say. Meanwhile, preliminary studies so far have shown no substantial waning

in vaccine effectiveness over six months, the *AP* reported.

Still, immunity fades faster in seniors than in other adults, the *AP* reported. Not only that, but COVID is still a serious disease: There are still more than 20,000 hospitalizations and more than 2,000 deaths each week due to the coronavirus, **according to the CDC**. And people 65 and older have the highest hospitalization and death rates, the **data shows**.

"Adults 65 years and older are disproportionately impacted by COVID-19, with more than half of COVID-19 hospitalizations during October 2023 to December 2023 occurring in this age group," the CDC noted, adding that people who are immunocompromised are already eligible for additional doses of COVID vaccines.

## Say it again: Hearing Aids Can Be Frustrating for Older Adults, but Necessary

By **Judith Graham**,  
KFF Health News

It was an every-other-day routine, full of frustration.

Every time my husband called his father, who was 94 when he died in 2022, he'd wait for his dad to find his hearing aids and put them in before they started talking.

Even then, my father-in-law could barely hear what my husband was saying. "What?" he'd ask over and over.

Then, there were the problems my father-in-law had replacing

the devices' batteries. And the times he'd end up in the hospital, unable to understand what people were saying because his hearing aids didn't seem to be functioning. And the times he'd drop one of the devices and be unable to find it. How many older adults have problems of this kind?

There's no good data about this topic, according to Nicholas Reed, an assistant professor of epidemiology at Johns Hopkins Bloomberg School of Public



Health who studies hearing loss. He did a literature search when I posed the question and came up empty.

Reed co-authored the most definitive study to date of hearing issues in older Americans, published in *JAMA Open Network* last year. Previous studies excluded people 80 and older. But data became available when a 2021 survey by the National Health and Aging Trends Study included hearing assessments conducted at

people's homes. The results, based on a nationally representative sample of 2,803 people 71 and older, are eye-opening. Hearing problems become pervasive with advancing age, exceeding 90% in people 85 and older, compared with 53% of 71- to 74-year-olds. Also, hearing worsens over time, with more people experiencing moderate or severe deficits once they reach or exceed age 80, compared with people in their 70s. Read more **here**.

## Over 1 Billion People Are Now Obese Worldwide

More than 1 billion adults and children around the world are now obese, a new global analysis estimates.

Nearly 880 million adults now are living with obesity, as well as 159 million children, according to the report published Feb. 29 in *The Lancet* journal.

Obesity rates for kids and teenagers quadrupled worldwide between 1990 and 2022, rising from 1.7% to 6.9% for girls and 2.1% to 9.3% for boys.

Meanwhile, adult obesity rates more than doubled during the same period, researchers found.

Obesity increased more than twofold in women (8.8% to 18.5%) and nearly tripled in men (4.8% to 14%).

"It is very concerning that the epidemic of obesity that was evident among adults in much of the world in 1990 is now mirrored in school-aged children and adolescents," said senior study author Majid Ezzatti, chair of global environmental health at Imperial College London.

These figures outstrip predictions made by the World Obesity Federation, which had



predicted that 1 billion people globally would be living with obesity by 2030 in its **World Obesity Atlas 2022**.

Essentially, the globe had already surpassed that mark by the time of the atlas' publication, according to the new study.

Obesity is now the most common form of malnutrition in most countries, researchers said.

That's because the proportion of adults who are underweight declined by more than half between 1990 and 2022, and by one-fifth in girls and more than

one-third in boys.

More than 1,500 researchers contributed to the study, which looked at body mass index for more than 220 million people representing more than 190 countries.

In the United States, the obesity rate increased from 11.6% to 19.4% between 1990 and 2022 for girls and from 11.5% to 21.7% for boys.

About 44% of American women and 42% of American men are now obese, up from 21% and 17% two decades earlier, researchers report... **Read More**

## Impaired Sense of Direction Could Be Early Alzheimer's Sign

Middle-aged folks who have difficulties navigating their way through space could be at higher risk of developing Alzheimer's disease years later, a new study finds.

"Very early symptoms of dementia can be subtle and difficult to detect, but problems with navigation are thought to be some of the first changes in Alzheimer's disease," noted **Dr. Richard Oakley**, associate director of research and innovation at the Alzheimer's Society.

He wasn't involved in the new British research, although the society did help fund the study.

"One in three people born today will go on to develop dementia," Oakley added, "and early and accurate diagnosis of the diseases that cause the condition are vital for people to access the right support, plan for the future and receive appropriate treatment."

The study involved 100 middle-

aged people (ages 43 to 66), none of who had any of the standard symptoms of Alzheimer's disease.

At the time of the study, they were all about 25 years younger than the expected age of Alzheimer's onset. However, the participants were all thought to be at heightened odds for the illness due to factors such as genetics, family history or lifestyle.

Researchers at University College London (UCL) had the participants strap on a virtual reality (VR) headset and then "navigate" their way through a virtual environment.

Folks already known to be at higher Alzheimer's risk, but with no symptoms and with good scores on other cognitive tests, tended to perform poorly on the VR test, the researchers found.

The effect seemed much stronger in men than women.

The findings, published Feb. 29 in *Alzheimer's & Dementia: The*



*Journal of the Alzheimer's Association*, suggest that troubles with direction and moving through complicated spaces may be a harbinger of dementia.

"Our results indicated that this type of navigation behavior change might represent the very earliest diagnostic signal in the Alzheimer's disease continuum -- when people move from being unimpaired to showing manifestation of the disease," said study lead author **Dr. Coco Newton**, now at UCL's Institute of Cognitive Neuroscience. She carried out the work while at University of Cambridge.

The gender differences were intriguing, Newton added in a UCL news release, highlighting "the need for further study of the differing vulnerability of men and women to Alzheimer's disease and the importance of taking gender into account for both diagnosis and future treatment."

Senior study author **Dennis Chan** said the VR test used in the study might someday become a standard way of assessing who's at risk of Alzheimer's disease.

Such testing might "improve detection of the clinical onset of Alzheimer's disease, critical for prompt application of treatments," he said.

Still, Oakley cautioned that "this innovative technology is a long way from becoming a diagnostic test."

However, "it does provide more evidence about the role of navigational abilities as an early sign of Alzheimer's disease," he added. "More work is needed to develop this technology, but it will be exciting to see how this research may offer a way to spot disease-specific changes early and help people living with dementia in future."

## High levels of niacin linked to heart disease, new research suggests

High levels of niacin, an essential B vitamin, may raise the risk of heart disease by triggering inflammation and damaging blood vessels, according to new research.

The report, published Monday in *Nature Medicine*, revealed a previously unknown risk from excessive amounts of the vitamin, which is found in many foods, including meat, fish, nuts, and fortified cereals and breads.

The **recommended daily allowance of niacin** for men is 16 milligrams per day and for women who are not pregnant is 14 milligrams per day.

About 1 in 4 Americans has higher than the recommended **level of niacin**,

said the study's senior author, Dr. Stanley Hazen, chair of cardiovascular and metabolic sciences at the Cleveland Clinic's Lerner Research Institute and co-section head of preventive cardiology at the Heart, Vascular and Thoracic Institute.

The researchers currently don't know where to draw the line between healthy and unhealthy amounts of niacin, although that may be determined with future research.

"The average person should avoid niacin supplements now that we have reason to believe that **taking too much niacin** can potentially lead to an increased risk of developing cardiovascular



disease," Hazen said. Currently, Americans get plenty of niacin from their diet since flour, grains and cereals have been fortified with niacin since the 1940s after scientists discovered that very low levels of the nutrient could lead to a potentially fatal condition called pellagra, Hazen said.

Prior to the development of **cholesterol-lowering statins**, niacin supplements were once even prescribed by doctors to improve cholesterol levels.

To search for unknown risk factors for cardiovascular disease, Hazen and his colleagues designed a multipart study that included an analysis of fasting blood samples from 1,162 patients

who had come into a cardiology center to be evaluated for heart disease. The researchers were looking for common markers, or signs, in the patients' blood that might reveal new risk factors.

The research resulted in the discovery of a substance in some of the blood samples that is only made when there is excess niacin.

That finding led to two additional "validation" studies, which included data from a total of 3,163 adults who either had heart disease or were suspected of having it. The two investigations, one in the U.S. and one in Europe, showed that the niacin breakdown product, 4PY, predicted participants' future risk of heart attack, stroke and death.

## New heart syndrome identifies link among obesity, diabetes and kidney disease

For the first time, the American Heart Association has defined cardiovascular-kidney-metabolic syndrome, or CKM.

As more Americans are being diagnosed with multiple chronic health problems at younger ages, for the first time, the American Heart Association is identifying a new medical condition that reflects the strong links among obesity, diabetes and heart and kidney disease.

According to an advisory released Monday, the goal in recognizing the condition — cardiovascular-kidney-metabolic syndrome, or CKM — is to get earlier diagnosis and treatment for people at high risk of dying from cardiovascular disease.

"Reducing the pipeline of individuals progressing to heart disease is our primary goal," said the lead author of the advisory



and an accompanying statement, Dr. Chiadi E. Ndumele, the director of obesity and cardiometabolic research in the division of cardiology at Johns Hopkins University.

Right now, "we're seeing the health consequences of all these conditions interacting and leading to earlier presentations with heart disease," Ndumele said. Naming

and describing CKM are "really a paradigm change."

Increasing evidence shows how metabolic risk factors such as abdominal fat, high blood pressure, high cholesterol and high blood sugar can negatively affect other organs in the body.

Dr. Pam R. Taub, a cardiologist, agreed that the new approach may be a "game changer" in how doctors treat patients...**Read More**