Rhode Island Alliance for Retired Americans®

RI ARA

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

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Message from Alliance *for* Retired Americans Leaders

Biden Budget Includes Plans to Further Lower Drug Costs

President Biden proposed a $7.3 trillion fiscal year 2025 budget on Monday that includes tax increases on corporations and high earners and a wide range of efforts to address consumer concerns such as housing and prescription drug costs. During his State of the Union address last Thursday, Biden noted that his budget priorities offer a sharp contrast to his predecessor, who enacted a $2 trillion tax cut in 2017 that disproportionately benefited the top 1% of earners.

Robert Roach, Jr
President, ARA

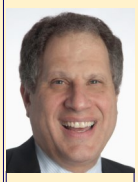
Biden's FY 2025 budget proposes extending Medicare's $2,000 annual cap on out-of-pocket drug costs to people with commercial insurance; extending a $35-per-month cost cap for insulin to the commercial market; and allowing Medicare to negotiate prices for at least 50 drugs per year.

"There is already a $3,200 out-of-pocket cap in place under Medicare Part D this year, and that cap will be lowered to $2,000 in 2025," said **Robert Roach, Jr., President of the Alliance**. "Including Americans with private insurance who are not Medicare-eligible is a logical way to bring drug price relief to even more consumers and their families."

Alliance Members Join Biden Campaign In Battleground States to Focus on Protecting Social Security and Medicare; Trump Talks About Slashing Them

President Biden's reelection campaign is holding **more than 13 press conferences** through Friday across key swing states with local elected officials and seniors, all focused on protecting Social Security and Medicare.

The events follow Donald Trump's Monday interview on CNBC's Squawkbox program, when he told host Joe Kernan that there 'is a lot you can do to cut' Social Security and Medicare. The Biden campaign released a **rapid response** ad reiterating Biden's promise to stop anyone who tries to put Social Security or Medicare on the chopping block or raise the retirement age.



Rich Fiesta, Executive Director, ARA

At an event in Arizona on Tuesday, Arizona Alliance members joined veterans in calling on Arizonans to protect their earned Social Security and Medicare benefits by voting for President Biden for reelection. Also on Tuesday, Michigan Alliance President Jim Pedersen **joined** state representatives Stephanie Young (D-Detroit) and Tyrone Carter (D-Detroit) for a press conference in Lansing, where they called on Michiganders to reject Trump at the polls and reelect President Biden.

"It should not come as a surprise that Trump is joining the growing chorus of Republican extremists who are taking aim at our retirement security," **said** **Richard Fiesta, Executive Director of the Alliance**. "Back in 2020 Trump **said** Alliance members and allies in Arizona Tuesday Michigan Alliance President Pedersen at the podium Tuesday that cutting 'entitlements' would be a second term issue. Every year he was in office Trump **proposed** cuts to Medicare and Social Security. He even called for privatizing Social Security, calling it a **Ponzi scheme**."

On Wednesday, Trump **said**, "'I will never do anything that will jeopardize or hurt Social Security or Medicare."

New Administration Rule Caps Credit Card Late Charges

The Biden Administration announced last week that it would cap the fees credit card companies charge customers when they are late for their payments. Starting this spring, **late charge junk fees will be capped at $8**.

This new rule targeting financial giants will save consumers a projected $10 billion each year. Unless credit card issuers are able to statistically prove their need for higher fees in order to make up for losses, $8 will remain the maximum charge they can impose.

In 2022 alone, credit card companies were able to rake in $14 billion in revenue from late fee charges. This was accomplished by charging an average of $32 per month for late or missed payments to Americans who are in need of savings the most.

Big corporations have exploited extra fees and hidden costs with no accountability in order to overcharge customers. Credit card late fees have risen by nearly 40% from 2015 to 2022.

Republicans like Sen. Tim Scott (SC), a top member on the Senate Banking, Housing, and Urban Affairs Committee, are already kick-starting a process that would allow Congress to review and possibly overturn federal regulations like those targeting junk fees.

In the coming weeks, further actions to combat junk fees will likely be unveiled by the Biden Administration, including a "strike team" run by the Federal Trade Commission and the Justice Department who would tackle anti-competitive pricing tactics in vital consumer areas such as financial services, groceries, housing and prescription drugs. "Reigning in outrageous corporate junk fees is one of the first steps we can take in ensuring a fairer economy," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**.

Joseph Peters, Jr.
Secretary
Treasurer ARA

"Outrageous late fees affect people of all ages and are especially burdensome to those who can least afford them."

ADD YOUR NAME

Get The Message Out:
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Veterans breathe sigh of relief after VA expands access to health care

The early expansion of VA health care benefits is a major win for Pennsylvania veterans who often have to deal with life-altering conditions following deployment.

"I didn't really think about it at the time, but everything kind of hit me when I came back that I kind of had to take it seriously," Jack Stonesifer.

Stonesifer was an 18-year-old freshman at Marshall University when he enlisted in the West Virginia National Guard. He was with the National Guard for many years.

Stonesifer served as an Army paralegal in Saudi Arabia and Kuwait in 2021. Before his deployment, he went for runs every day.

"They always told us that there would be impacts, even if you didn't get hurt. But I honestly never really believed it. I was fit, I was good, in shape," said Stonesifer.

When Stonesifer came home, he realized something wasn't right.

"I'll get winded just walking up a half of a block uphill," he said. "It's a lot tougher for me to keep going. Even just like trying to keep up with my toddler. She's running circles around me."

Every day, he finds it hard to breathe due to respiratory issues. He said the VA helped him quickly set up an appointment for him this month. He has a follow-up for asthma testing.

"I've gotten dizzy, I've had falling spells. I'll have coughing fits or I'll start sweating and kind of getting red in the face. Then I've got chronic fatigue now. I'm always falling asleep," Stonesifer said.

Balancing work and being a husband and father is an everyday battle for him. Memories of terrible sandstorms in Kuwait cloud up in the back of his mind.

"One of the big things that affected me a lot is my breathing, especially after coming back. One of the big things they attribute that to is the sandstorms that we got in Kuwait because of all the contaminated material from the animal feces to the hard lead to anything else in the dessert. Because we'd be breathing that in for a few days," Stonesifer said.

All veterans who were exposed to toxins and other hazards while serving in the military are now eligible to enroll in VA health care. This went into effect under the PACT Act on Tuesday, nearly eight years earlier than originally planned.

"What it does it just makes it a lot easier when submitting a VA compensation claim," Stonesifer said.

He said the early enactment also will help veterans get benefits much quicker, which is crucial to not only his generation of vets.

"For who all became eligible, they finally let the last thousands of WWII veterans. So, that was one thing I was happy they pushed up because of course those gentlemen are dying daily, and of course all the gentlemen in Vietnam. By pushing it up those five years, they'll be able to get that critical VA coverage," said Stonesifer said.

He loved what he was doing for our country, but he didn't know what he was breathing into his lungs would make it difficult for him to catch his breath today.

Stonesifer is in law school at Duquesne University. With every breath, he's pushing forward with the VA on his side. He said the VA already helps him with quick appointments and provides virtual therapy for mental health.

"I'm hoping that the trend will be greater access and expansion for health care coverage when it comes to veterans, especially when it comes to service-connected disabilities," Stonesifer said. "There's always the chance that some of the guys, some of the people get lost in the cracks and just by expanding that coverage and by getting more people to hopefully use the VA we'll be able to help more veterans and make sure their taken care of," he said.

Social Security chief vows to fix "cruel-hearted" overpayment clawbacks

The Social Security Administration's new chief is promising to overhaul the agency's system of clawing back billions of dollars it claims was wrongly sent to beneficiaries, saying it "just doesn't seem right or fair."

In an interview with KFF Health News, SSA Commissioner Martin O'Malley said that in the coming days he would propose changes to help people avoid crushing debts that have driven some into homelessness and caused financial hardships for the nation's most vulnerable — the poorest of the poor and people with disabilities or persistent medical conditions or who are at least age 65.

O'Malley, **who took office in December**, said that "addressing the injustice we do to too many Americans because of overpayments, the rather cruel-hearted and mindless way that we recover those overpayments," is among his top priorities.

He said he has concrete steps in mind, such as establishing a statute of limitations, shifting the burden of proof to the agency, and imposing a 10% cap on clawbacks for some beneficiaries.

"We do have the ability and we do have the authority to address many of these injustices," he said, suggesting that the SSA won't have to wait for congressional action.

The pledge comes after an **investigation by KFF Health News and Cox Media Group** television stations revealed that SSA routinely reduces or halts monthly benefit checks to reclaim billions of dollars in payments it sent to beneficiaries then later said they should not have received.

In some cases, years passed before the government discovered its mistake and then imposed debts that sometimes have reached tens of thousands of dollars on people who cannot afford to pay. KFF Health News and Cox Media Group discovered that more than 2 million people a year have been hit with overpayment demands.

Most overpayments are linked to the **Supplemental Security Income program**, which provides money to people with little or no income, who are disabled, blind, or at least age 65. Others are connected to the **Social Security Disability Insurance program**, which aids disabled workers and their dependents.

O'Malley said the agency plans to cease efforts to claw back years-old overpayments and halt the practice of terminating benefits for disabled workers who don't respond to overpayment notices because they did not receive them or couldn't make sense of them. "We're not fulfilling congressional intent by putting seniors out of their homes and having them live under a bridge when they didn't understand our notice," O'Malley said.

Denise Woods lives in her Chevy, seeking a safe place to sleep each night at strip malls or truck stops around Savannah, Georgia. **Woods said she became homeless** in 2022 after the SSA — without explanation — determined it had overpaid her and demanded she send back roughly $58,000. Woods didn't have that amount on hand, so the agency cut off her monthly disability benefits to recoup the debt.

The agency later restored some of her benefit allowance: She gets $616 a month. That's not enough to cover rent in Savannah, where even modest studio apartments can run $1,000 a month.

In January, she fell ill and landed in intensive care with pneumonia. "I signed a [Do Not Resuscitate form] and a nurse asked, 'Do you know what this means?'" Woods said. "I told her there was no reason to revive me if my heart stops. They have already ruined my life. I'm beyond exhausted."

After KFF Health News and Cox Media Group published **the series "Overpayment Outrage,"** hundreds of disability beneficiaries came forward with troubling accounts, including how the government sent them overpayment notices without explanation and threatened to cut off their main source of income with little warning....**Read More**

Dear Marci: *Why do my drug costs change throughout the year?*

Dear Marci,

The cost of my medications at the pharmacy has suddenly changed even though I have the same drug plan. What could have caused this?
-Juan (Los Angeles, CA)

Dear Juan,

Good question! Drug costs can change throughout the year depending on which phase of **Part D drug coverage** you're in.

You should know that there are four different phases of Part D coverage:

Deductible Period

- You're in this period until you meet your deductible for the year. Until then, your drugs will cost the full negotiated price. Keep in mind that deductible amounts will vary by plan.

Initial Coverage Period

- Once you meet your deductible, your plan will help pay for your drug costs. You'll have a co–payment and co–insurance determined by your specific plan.

Coverage Gap (aka the Donut Hole)

- When you and your plan's payments towards drug costs have reached a predetermined limit ($5,030 for 2024), you become responsible for paying 25% of the cost of your medications.

Catastrophic Coverage

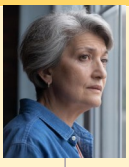
- You enter this period after you reach $8,000 in out-of-pocket costs for your covered drugs. Good news for 2024: in the catastrophic coverage phase, you'll have no cost-sharing for the remainder of the year.
- Out of pocket costs that count towards this limit include your deductible; payments during the initial coverage period; almost the full cost of brand-name drugs during the coverage gap; payments made by others on your behalf (family, charities, etc.); and payments made by **State Pharmaceutical Assistance Programs (SPAPs)**, AIDS Drug Assistance Programs, and the Indian Health Service.
- Costs that don't help you reach catastrophic coverage include your premiums, plan contributions towards drug cots, the cost of non-covered drugs, the cost of covered drugs from out-of-network pharmacies, and the 75% generic discount.

A few things to keep in mind:

- Your plan should track your out-of-pocket spending and include this amount in your monthly statements.
- As of 2025, the out-of-pocket maximum for covered drugs will be $2,000 and there will be no coverage gap.
- Your local **State Health Insurance Assistance Program** can help you determine if you're eligible for programs to help lower your drug costs.

I hope that clarifies things!
-Marci

Is It Possible to Retire on Social Security Alone in 2024?



The average Social Security retirement benefit in 2024 is $1,906 per month, which works out to $22,872 per year. Ideally, that money serves as a supplement to other sources of retirement income, like 401(k) withdrawals and dividends. But is it possible to survive on Social Security alone in 2024?

Social Security is only intended to replace about 40% of income for the average worker. But millions of retirees rely on Social Security for the majority, if not all of their income. Read on to learn about how many seniors are surviving on Social Security alone, as well as some options if you're heading into retirement years without much of a nest egg.

Is it possible to live on Social Security alone?

Living on **Social Security** alone isn't easy, but it's the reality for many seniors in America. According to the Center on Budget and Policy Priorities, roughly 40% of Americans ages 65 and older rely on Social Security for at least half of their incomes. For about one in seven people 65 and older, benefits account for at least 90% of their income.

Millions of workers who aren't yet retired could wind up relying on Social Security as their primary income source. Recent **research by The Motley Fool** found that 25% of workers have no retirement savings.

Heading into retirement with little savings is risky. Though Social Security provides a vital safety net, cost-of-living adjustments generally don't keep pace with the actual living cost increases seniors face each year. That's because the costs of things that retirees spend large amounts on, like healthcare and housing, tend to rise at a faster rate than overall inflation...**Read More**

Social Security's Delayed Retirement Credits End at 70. Will That Change?

The Motley Fool.

Millions of seniors today collect monthly benefits from Social Security. And for many, those benefits serve as their sole or main source of income.

Clearly, that's not an ideal situation to be in. But it's reality for a lot of seniors who were never able to save for retirement on their own.

Meanwhile, workers who are approaching retirement with little to no savings are often advised to delay their Social Security claims beyond **full retirement age** (FRA). FRA is 66, 67, or somewhere in between, and it's when you're entitled to your complete monthly **Social Security** benefit without a reduction. However, for each year you delay your filing past FRA, your monthly benefits get an 8% boost -- for life.

You can't accrue those delayed retirement credits forever, though. Once you turn 70, you can't grow your monthly benefits any longer. That's why 70 is often referred to as the final age to claim Social Security, even though you *can* sign up after that point.

But will Social Security's delayed retirement credits always end at 70? Maybe not. There are a couple of reasons why lawmakers might consider a change to this rule.

1. FRA could shift down the line

Social Security is facing a funding shortfall that could result in benefit cuts. Lawmakers don't want to see that happen, though, so they've proposed different suggestions for pumping more money into the program.

One idea that's currently on the table is raising FRA from 67 to 68 or 69. That buys the program a little more time before it has to pay out benefits to a large group of workers in full.

But if lawmakers were to increase FRA from 67 to 68 or 69, it would, under the current rules, give people in that boat just a year or two to accrue delayed retirement credits. That's hardly fair. As such, if FRA rises, lawmakers may decide that delayed retirement credits can be snagged until age 71 or 72.

2. Seniors without savings need a financial lifeline

It's not a secret that many older Americans today are approaching retirement with little or no savings. In fact, recent Motley Fool research put the median retirement savings among 55- to 64-year-olds at just $185,000. That's better than nothing, but it's also not a ton of money over the course of what could be 20 years or longer.

In fact, if we were to apply the classic 4% rule to a balance that size, it results in an annual income of just $7,400. Even when added to a Social Security benefit, that's not a whole lot….**Read More**

Can you afford health care in retirement?

DAILY PRESS

At age 65, some couples may need as much as $413,000 to cover health care costs in retirement, according to a January report from the Employee Benefit Research Institute. That's an extreme case, representing two people with high prescription drug costs — but it's not outside the realm of possibility.

"It's one of the most difficult expenses to predict in retirement," says Nancy Nawn, a certified financial planner in Cherry Hill, New Jersey.

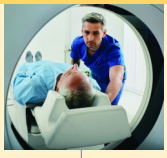
Your costs will depend on your insurance choices, your health, your prescription drugs and your city. (Costs are higher in some places than others.) As you approach retirement, try these tactics to get a handle on future health care expenses.

SAVE TO A HEALTH - SAVINGS ACCOUNT

If you have a high-deductible health plan and access to a health savings account, or HSA, max it out. The money you save is triple tax-advantaged: You pay no taxes on the money you save, the interest you earn or any withdrawals used for qualified health expenses.

"I think most people use them as they go, which is fine too," says Ed Snyder, a CFP in Carmel, Indiana. "But I think there are even more benefits to using the investment account in those (and) letting that money be invested for many years, just like a retirement account."

In 2024, you can save up to $4,150 for an individual health savings account and up to $8,300 for family coverage. If you're 55 or older, you can contribute an extra $1,000. (Note: You can't save to an HSA once you're signed up for Medicare.)



PICK THE RIGHT - MEDICARE PLAN

Once you're 65, advisers typically recommend selecting Original Medicare with Medicare Supplement Insurance, or Medigap. Since Medigap plans cover many out-of-pocket expenses of Medicare, this keeps your monthly health care costs predictable.

Many older adults are attracted to the $0 premiums of most Medicare Advantage plans, but using these private health plans means you may be limited to in-network doctors and hospitals. "I have seen many situations where people wind up needing to go see a provider who doesn't take the coverage, and they pay the full bill themselves," says Melinda Caughill, co-founder and CEO of 65 Incorporated, which offers guidance on Medicare.

Out-of-pocket maximums for Medicare Advantage plans also can be as high as $8,850 per year in 2024, and that doesn't include your Medicare Part B (medical insurance) premiums. That said, if you can't afford a Medigap plan, Medicare Advantage may be the better option. Without Medigap, Original Medicare has no out-of-pocket maximum.

GET HELP WITH TAX PLANNING

If your income exceeds a certain threshold, you will pay more each month for Medicare Part B and Medicare Part D prescription drug coverage (if you have it). This is where it helps to be strategic about your retirement income, making sure you have both pretax and post-tax accounts to pull from as needed. (Pulling from pretax accounts raises your income.)

"If you have saved a lot of money in tax-deferred vehicles, and you haven't planned to do either Roth conversions or spend down that money, you could wind up having a much larger monthly Medicare premium than you think," Nawn says.

PAY DOWN YOUR - MORTGAGE

If you're 62 or older and have at least 50% equity in your home, you may have access to a reverse mortgage later if you really need it. This is a loan or line of credit on your assessed home value — and you don't have to make payments. The loan is repaid when you move out or die.

Reverse mortgages once had a scary reputation, but today's products are safer, Nawn says. "There was abuse many, many years ago," she says. "It's been cleaned up, and it's a really great tool to have in your back pocket."

Keep in mind that reverse mortgages require at least one borrower to live in the home, and they cost more than a traditional home mortgage over time. Work with an adviser who's familiar with the product before you take the plunge.

CONSIDER A HELOC

If you're younger than 62 and you're still working, a home equity line of credit, or HELOC, can provide you with a stream of income to tap later if you need it. (It's easier to qualify for a HELOC while you're still getting a paycheck.)

The catch: Unlike a reverse mortgage, a HELOC requires you to make payments. "At some point in the future, you're going to have to pay it back," Nawn says.

KEEP THINGS IN - PERSPECTIVE

In the end, don't lose too much sleep over the big figures. Consider how intimidating it would be if experts also told you how much you should save to cover 30 years of food or utility bills in retirement. With the right planning, health care costs can be manageable.

"A reasonable cost is about $6,000 a year for an individual, and if you price that out on a monthly basis, it's $500 a month," says Dick Power, a CFP in Walpole, Massachusetts. "That $500 a month typically includes your insurance coverage and your copays."

Concerns Grow Over Quality of Care as Investor Groups Buy Not-for-Profit Nursing Homes

KFF Health News:
*By **Harris Meyer***

Shelly Olson's mother, who has dementia, has lived at the Scandia Village nursing home in rural Sister Bay, Wisconsin, for almost five years. At first, Olson said, her mother received great care at the facility, then owned by a not-for-profit organization, the Evangelical Lutheran Good Samaritan Society.

Then in 2019, Sanford Health — a not-for-profit, tax-exempt hospital system — acquired the nursing home. The covid-19 pandemic struck soon after. From then on, the facility was regularly short of staff, and residents endured long wait times and other care problems, said Olson, a registered nurse who formerly worked at the facility.

Now Scandia Village has a new, for-profit owner, **Continuum Healthcare**. Olson said she was reassured when Continuum hired two locals as the facility's new administrator and nursing director.

But Kathy Wagner, a former Scandia Village nursing director, is not optimistic. "The for-profit owner will face the same problems," said Wagner, who is now retired and serves on **an informal task force** that monitors the facility's quality of care. "No one has articulated what the for-profit owner will bring to the table to change the picture."

The sale of Scandia Village this year is part of a trend of for-profit companies, including private equity groups and real estate investment trusts, snapping up struggling not-for-profit nursing homes, many of which were operated for decades by Lutheran, **Catholic, Jewish,** and **other faith-based organizations**

The pace of sales has ticked up, reaching a high last year, **according to Ziegler Investment Banking**. Since 2015, 900 not-for-profit nursing homes and senior living communities nationwide have changed hands, with more than half of them acquired by for-profit operators.

For-profit groups **own about 72%** of the roughly 15,000 nursing homes in the United States, which serve more than 1.3 million residents….**Read More**

Beware of criminals stealing Social Security benefits

Many older adults and people with disabilities rely on Social Security as their sole source of income in retirement. Typically, Social Security deposits their monthly benefit directly into their bank accounts. But, Tara Seigel Bernard reports for the **New York Times** that last year 2,000 people found themselves the victims of criminals who diverted that money into their own bank accounts.

The criminals change the bank account to which Social Security benefits are directed. And Social Security staff say that this is a common crime. Between 2013 and 2018, 21,000 people lost $33.5 million in Social Security benefits to criminals. The government was able to stop $23.9 million in attempted fraud during that same time. Between 2019 and 2023, 7,600 people let the Federal Trade Commission know that criminals had redirected their Social Security benefits.

Don't ever give anyone your Social Security number. Social Security will never ask for it. But, criminals call claiming to work at Social Security or a computer company, a bank, an insurance company, a credit bureau or a doctor's office and persuade people to divulge personal information the criminals can use to steal their Social Security benefits. Criminals then break into people's online Social Security accounts and change all applicable information so that the benefits go to their bank accounts.

Criminals are also claiming benefits of people who have reached retirement age but have not yet claimed benefits.

The Office of the Inspector General suggests that the online Social Security portal is not secure enough. People can verify their identity too easily. Social Security claims to be doing what it can, updating its systems, but the Office of the Inspector General says it needs to do more.

Social Security does write people when there is a change to their account to ensure they authorized it. And, that has helped avoid a lot of fraud.

Consider identifying someone you trust serve as your representative payee with Social Security. You might not need a **representative payee** now, but should you be unable to manage your Social Security account on your own, it's good to have a representative payee in place. A power of attorney will not work with Social Security. You will need a representative payee.

You can lock your Social Security account. Put an **e-services block** on your Social Security account. You will not be able to change any information you provided Social Security online, but neither will anyone else. If you do need to change something, you will need to reach out to your local Social Security office to do so.

You can put a direct deposit block on your account to prevent fraud. Again, this will keep anyone, including you, from changing your direct deposit information online. If you do need to change something, you will need to reach out to your local Social Security office to do so.

Never trust that a caller is from Social Security even if Social Security appears on your phone's caller ID. If the caller presents some issue with your accountant, hang up and call Social Security directly at 1-800-772-1213.

If you are scammed: Call the Federal Trade Commission at 1-877-IDTHEFT (1-877-438-4338) or contact them online **here.**

What do people on Medicare really think about Medicare? New survey reveals challenges and frustrations

Story by Richard Eisenberg

When Americans are asked what they think about Medicare, they generally rate the program highly. But how do people 65 and older who are actually *in* Traditional Medicare or the alternative **Medicare Advantage (MA) plans** from health insurers really feel about it?

That's a somewhat different story, as recent surveys from health researchers at The Commonwealth Fund, KFF, Brigham & Women's Hospital and Retirement Living revealed.

While beneficiaries in Traditional Medicare and Medicare Advantage plans say they're largely happy with each program, they also report challenges and frustrations.

Some Medicare Advantage beneficiaries were disappointed by the realities of major reasons they enrolled in the plans.

One of the surveys' biggest surprises: Although Medicare Advantage plans heavily promote the supplemental benefits they offer and that Traditional Medicare can't—dental, hearing, and vision—a sizable percentage of MA members don't use them

Here's a dive into the survey findings:

Medicare beneficiaries are mostly happy with their health insurance and happier than people with employer-sponsored health coverage. In KFF's **2023 Survey of Consumer Experiences with Health Insurance,** 92% people aged 65+ rated as "excellent" or "good" the overall performance of Medicare's health insurance and the availability and quality of medical providers. By contrast, only 80% of people with employer-sponsored health insurance graded it "excellent" or "good."...**Read More**

Bill in Congress to address burdensome Medicare Advantage prior authorization

A while back now, the House of Representatives passed the **Improving Seniors Timely Access to Care Act**, designed to address problems individuals and hospitals face because Medicare Advantage plans impose burdensome prior authorization requirements, often with little if any medical justification. Unfortunately, it's not clear that the bill will do anything to improve Medicare Advantage insurer behavior and ensure that prior authorization demands are evidence-based and appropriate.

As it is, no matter the legal requirements, insurers can and often do violate many if not most regulations with near impunity. CMS does not have the power to penalize them for so doing or the resources to adequately oversee them. So, any bill without serious penalties for non-compliance is more sizzle than anything meaningful.

The Improving Seniors Timely Access to Care Act lacks teeth. But, beyond its failure to require appropriate punishments on Medicare Advantage plans that impose burdensome and non-medically justified prior authorization (PA) requirements, the bill does not call for some basic fixes to the broken prior authorization system. We need consistent criteria for Medicare Advantage PA requirements imposed by CMS. Proprietary PA lists and policies, which are different for each plan, prevent patients from meaningful Medicare Advantage plan comparisons and impose huge costs on physicians. Physicians need to know what services or procedures will require a PA without having to research which plan the patient has and what that plan's PA list includes or does not include. Today, medical practices are at a loss to know what they will need to do to ensure their patients in different MA plans get the care they need.

PA requirements must be evidence-based, relating to medical necessity; CMS must ensure they are not arbitrary, preventing coverage of medically necessary services. CMS has Payment Advisory Councils across the country, with representation from all specialties, for determining medical necessity of every procedure. It would be easy to add review of PAs to this system to ensure their medical necessity, and then standardize them across plans.....**Read More**

Spousal Social Security Benefits: 3 Things All Retired Couples Should Know

The Motley Fool

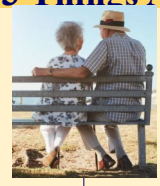
One of the best social programs the U.S. offers is Social Security. For millions of Americans, Social Security benefits make up a lot of their income in retirement and act as a financial safety net. Social Security retirement benefits are well-earned, too. After years of paying Social Security taxes, it's a way for people to benefit on the back end of their careers.

Generally, **Social Security** determines someone's monthly Social Security benefit using a formula that considers the 35 years when their earnings were the highest. However, that's not the only way for someone to receive Social Security retirement benefits. You can also claim benefits based on a spouse's earnings record.

For couples considering Social Security **spousal benefits**, here are three things you should know.

1. How Social Security spousal benefits are calculated

For someone to qualify for spousal benefits, they must have been married for at least a year, and they or their spouse must be at least 62 years old or caring for a child who is under 16 or disabled who receives benefits on their record.



Social Security spousal benefits are based on the primary claiming spouse's primary insurance amount. It serves as the baseline. If the person claiming spousal benefits is at full retirement age, they can receive up to 50% of their spouse's primary insurance amount.

For example, if spouse A is the primary claimer and their monthly benefit at their full retirement age is $1,500, spouse B (the person claiming spousal benefits) is eligible to receive up to $750 in monthly benefits. The exact amount will depend on the age at which spouse B claims benefits.

2. The role of your full retirement age

Your full retirement age is among the most important numbers in Social Security (and retirement in general). It's based on your birth year as follows:

Full retirement age plays a key role because monthly benefits are adjusted based on when you claim relative to it.

For the primary claiming spouse (Spouse A in our example), benefits are reduced by 5/9 of 1% each month before their full retirement age, up to 36 months. Each month after that, benefits are further reduced by 5/12 of 1%, with the earliest claiming age being 62. For example, if their full retirement age is 67 and they claim benefits at 62, their primary insurance amount is reduced by 30%.

For those receiving spousal benefits, benefits are reduced by 25/36 of 1% each month before their full retirement age, up to 36 months. Any additional month reduces benefits by 5/12 of 1%. In this case, someone whose full retirement age is 67 and claims spousal benefits at 62 would have their monthly benefit reduced by 35%.

It's important to note that benefits typically increase if you delay them past your full retirement age, but this doesn't apply to spousal benefits.

3. The link between Social Security spousal and survivors benefits

If someone is claiming spousal benefits when their partner passes away, Social Security will convert their spousal benefits to survivors benefits. Survivors benefits allow you to receive up to 100% of your deceased spouse's benefit, including the increased amount they may have received by delaying benefits past their full retirement age.

A widow or widower can begin receiving survivors benefits at age 60 (50 if they have a disability), but the same reduction rules apply if the benefits are claimed before full retirement age. For instance, someone claiming survivors benefits at age 60 would only receive 71.5% of their late spouse's benefit.

You can't receive spousal and survivors benefits at the same time, only whichever is higher. However, since spousal benefits are only up to 50% of the primary claiming spouse's benefit, survivors benefits are typically the higher-paying option.

President's Budget Request Outlines Priorities for Fiscal Year 2025

On Monday, the White House released President Biden's **budget request** to Congress for fiscal year (FY) 2025, which begins on October 1.

Presidential budgets are important policy and messaging tools that articulate the administration's goals and are often used to guide reforms, introduce or refine ideas, and stake out positions. They are typically comprehensive and detailed, including spending levels for nearly every federal agency and activity as well as legislative priorities. This year's budget follows suit, offering both specific ideas and a broad vision for the future.

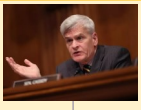
Among the outlined policies are several impacting Medicare and Medicaid. Notably, the FY25 budget recommends significant investments in long-term care, allocating $150 billion over 10 years to Medicaid home and community-based services (HCBS). This funding would help more people remain in their homes and communities, improve the quality of jobs for home care workers, and better support family caregivers.

The budget also addresses Medicare sustainability. It would extend Part A Trust Fund solvency indefinitely, largely through the closure of existing tax loopholes and an increase to the Medicare tax rate on incomes above $400,000 (from 3.8% to 5%). Other notable Medicare policies would help extend benefits and affordability, including a $2.00 cap on certain generic prescriptions, an expansion of Medicare's authority to negotiate prescription drug prices, better coverage for nutrition-based services, increased oversight of nursing homes, and enhanced access to behavioral health care…..**Read More**

Medicare, Medicaid Plans Could Drastically Change

Dual enrollees of **Medicare** and **Medicaid** could see big changes ahead as a bipartisan group of U.S. senators proposed a new law to integrate the two plans in a more seamless program.

Republicans **Bill Cassidy** of Louisiana, John Cornyn of Texas and **Tim Scott** of South Carolina, along with **Democrats** Tom Carper of Delaware, Mark Warner of Virginia and Bob Menendez of New Jersey, this week proposed the Delivering Unified Access to Lifesaving Services (DUALS) Act of 2024 in hopes of improving Medicare and Medicaid for dual eligibles.



"Patients dually eligible for Medicare and Medicaid have much worse outcomes than other groups even though there is a lot more money spent on their care," Cassidy said in a statement. "Making Medicare and Medicaid better work together makes patients healthier and saves money for taxpayers."

Carper said that beneficiaries who are dually eligible for Medicare and Medicaid tend to be some of the sickest and most vulnerable patients, and ending the complexity behind the health care programs is key in the bill.

"We've worked hard over the last three years to draft this legislation, and I'm proud to introduce the product of our years of work today," Carper said.

Cornyn added that Medicare and Medicaid often don't coordinate care for those enrolled in both programs, ultimately leading to poor outcomes for patients and inefficient spending for the health care system….**Read More**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Silent brain changes precede Alzheimer's. Researchers have new clues about which come first

Story by By LAURAN NEERGAARD, AP Medical Write

WASHINGTON (AP) — Alzheimer's quietly ravages the brain long before symptoms appear and now scientists have new clues about the dominolike sequence of those changes — a potential window to one day intervene.

A large study in China tracked middle-aged and older adults for 20 years, using regular brain scans, spinal taps and other tests.

Compared to those who remained cognitively healthy, people who eventually developed the mind-robbing disease had higher levels of an Alzheimer's-linked protein in their spinal fluid 18 years prior to diagnosis, researchers reported Wednesday. Then every few years afterward, the study detected another so-called biomarker of brewing trouble.

Scientists don't know exactly how Alzheimer's forms. One early hallmark is that sticky protein called beta-amyloid, which over time builds up into brain-clogging plaques. Amyloid alone isn't enough to damage memory — plenty of healthy people's brains harbor a lot of plaque. An abnormal tau protein that forms neuron-killing tangles is one of several co-conspirators.

The new research, published in the New England Journal of Medicine, offers a timeline for how those abnormalities pile up.

The study's importance "cannot be overstated," said Dr. Richard Mayeux, an Alzheimer's specialist at Columbia University who wasn't involved in the research.

"Knowledge of the timing of these physiological events is critical" for testing new ways of treating and maybe eventually even preventing Alzheimer's, he wrote in an accompanying editorial.

The findings have no practical implications yet.

More than 6 million Americans, and millions more worldwide, have Alzheimer's, the most common form of dementia. There's no cure. But last year **a drug named Leqembi** became the first approved with clear evidence that it could slow the worsening of early Alzheimer's — albeit for a few months.

It works by clearing away some of that gunky amyloid protein. The approach also is being tested to see if it's possible to delay Alzheimer's onset if high-risk people are treated before symptoms appear. Still other drugs are being developed to target tau.

Tracking silent brain changes is key for such research. Scientists already knew that in **rare, inherited forms of Alzheimer's** that strike younger people, a toxic form of amyloid starts accumulating about two decades ahead of symptoms and at some point later tau kicks in. The new findings show the order in which such biomarker changes occurred with more common old-age Alzheimer's.

Researchers with Beijing's Innovation Center for Neurological Disorders compared 648 people eventually diagnosed with Alzheimer's and an equal number who remained healthy. The amyloid finding in future Alzheimer's patients was the first, 18 years or 14 years prior to diagnosis depending on the test used.

Differences in tau were detected next, followed by a marker of trouble in how neurons communicate. A few years after that, differences in brain shrinkage and cognitive test scores between the two groups became apparent, the study found.

"The more we know about viable Alzheimer's treatment targets and when to address them, the better and faster we will be able to develop new therapies and preventions," said Claire Sexton, the Alzheimer's Association's senior director of scientific programs. She noted that blood tests are coming soon that promise to also help by making it easier to track amyloid and tau.

Colon Cancer Blood Test 83% Accurate in Spotting Tumors

An experimental blood test accurately detected colon cancer in more than 8 in 10 people confirmed to have the disease, researchers report.

The test — which could be an option for people who want to avoid colonoscopy — is intended for people who have no colon cancer symptoms and are at average risk.

"The results of the study are a promising step toward developing more convenient tools to detect colorectal cancer early, while it is more easily treated," said corresponding author **Dr. William Grady**, a gastroenterologist at Fred Hutchinson Cancer Center in Seattle.

Current guidelines recommend regular screening starting at age 45. But only 50% to 60% of people who are eligible for colon cancer screening actually take the tests, Grady said.

"Having a blood-based test for people to take during routine doctor's visits could be an opportunity to help more people be screened," he said in a Fred Hutchinson news release.

More than 7,800 people between the ages of 45 and 84 participated in a multisite clinical trial of the new blood test. The research was funded by Guardant Health, developer of the Shield blood test.

The test detects colon cancer signals in the blood from DNA shed by tumors. Called circulating tumor DNA, or ctDNA, it is also used to monitor for recurring cancer and in other emerging screening tests.

In all, 83% of study participants with confirmed colon cancer tested positive for ctDNA. Seventeen percent had a negative test, meaning the blood test did not show colon cancer even though a colonoscopy did.

Researchers said the test was most sensitive for colon cancers, including those in the early stages, and less sensitive in detecting lesions that could become cancerous.

The findings were reported March 14 in the *New England Journal of Medicine.*

Grady likened the blood test's sensitivity to that of stool-based tests. But he said it is lower than that of colonoscopy, which he considers the most accurate colon cancer screening tool.

"Getting people to be screened for cancer works best when we offer them screening options and then let them choose what works best for them," he said.

Colon cancer is the second leading cause of cancer deaths in U.S. adults, according to the American Cancer Society. It projects that over 53,000 people will die of the disease this year.

While death rates from the disease have dropped among older adults, rates among people under 55 are on the rise. They have risen about 1% a year since the mid-2000s.

"We continue to see younger people getting colorectal cancer, and it's now the third most common cancer for people under the age of 50," Grady said.

More information

The U.S. Centers for Disease Control and Prevention has more about **colon cancer screening tests.**

SOURCE: Fred Hutchinson Cancer Center, news release, March 14, 2024

Drug Combo Marks Advance Against Bladder Cancer

A cancer drug duo more than doubled the survival of people battling the most common form of advanced bladder cancer, trial results show.

Patients who took a combo of meds called EV+P -- enfortumab vedotin and pembrolizumab (Keytruda) -- had an average 31.5 months survival, compared to just over 16 months for those on standard chemotherapy, researchers reported March 7 in the ***New England Journal of Medicine.***

"This is revolutionary for patients," said study co-investigator **Dr. Jean Hoffman-Censit**s. She directs the Upper Tract Urothelial Cancer Multidisciplinary Clinic at the Johns Hopkins Greenberg Bladder Cancer Institute in Baltimore.

"It's a practice-changing study, where we're nearly doubling the overall survival for patients with locally advanced and metastatic urothelial cancer," she said in a Hopkins news release.

Urothelial tumors are the most common form of bladder cancer. According to the American Cancer Society, more than 83,000 new cases of bladder cancer are diagnosed each year and the illness kills almost 17,000 people annually.

The new trial was funded by drug maker Astellas Pharma US. It involved 886 patients with advanced urothelial cancers enrolled from cancer centers in 25 countries. Patients averaged 69 years of age and about three-quarters were men (bladder cancer is much more common in men). During three-week cycles, patients received either the intravenous EV+P regimen or standard chemotherapy (gemcitabine and either cisplatin or carboplatin). Treatment lasted 17 months.

Besides the doubling of overall survival times, there was also a near-doubling of "progression-free survival" -- the amount of time a patient lives without his or her cancer progressing. Patients on EV+P had a progression-free survival averaging 12.5 months, compared to 6.3 months for people on standard chemo.

Onerous side effects occurred less frequent among folks getting EV+P, as well: About 60% of people receiving the newer combo had side effects, compared to just under 70% of those on the older regimen.

While Keytruda has long been FDA-approved to fight a myriad of cancers, enfortumab vedotin (Padcev) only received agency approval for use in urothelial cancers in December.

The drug is an "an antibody-drug conjugate," where an anticancer drug is attached to a monoclonal antibody, which then seeks and destroys tumor cells.

Speaking in a Hopkins news release, Hoffman-Censits said "we're also expanding the patient population who can get treated with this very active therapy because many are not candidates for or could not tolerate the prior standard chemotherapy, which can be incredibly toxic."

Biden Administration Calls for Greater Access to Overdose Antidote

The White House on Wednesday launched a nationwide call for more training and better access to the lifesaving opioid overdose drug naloxone.

Called the Challenge to Save Lives from Overdose, the initiative urges organizations and businesses to commit to train employees on how to use opioid overdose medications, to keep naloxone in emergency kits and to distribute the drug to employees and customers so they might save a life at home, work or in their communities.

"Today, we're calling on organizations and businesses -- big and small, public and private -- across the country to help ensure all communities are ready to use this lifesaving tool to reduce opioid deaths," the White House said in a **fact sheet** announcing the new initiative. "As the drug supply has gotten more dangerous and lethal, we're asking allies to join us because we all must do our part to keep communities safe."

Naloxone, sometimes sold under the brand name Narcan, is a medication that can rapidly reverse the effects of an opioid overdose. **Research** has shown that using the nasal spray doesn't call for medical expertise and requires only minimal training.

In March 2023, the U.S. Food and Drug Administration **approved** an over-the-counter Narcan spray, following that in July with the approval of the first generic nasal spray. Americans can now buy the sprays at pharmacies, grocery stores and vending machines.

Still, public health officials say naloxone can be hard to find and the price can be prohibitive for some, *CNN* reported.

Organizations that have already answered the White House challenge include the American Library Association, which is providing libraries with overdose response training for staff members and the public, as well as supporting the distribution of naloxone and overdose aid kits to the public, the White House said.

Meanwhile, Southwest Airlines has put naloxone in emergency medical kits on 65% of its planes and plans to stock 100% of its medical kits by the end of the year.

The need for naloxone is great: Overdose deaths spiked 30% between 2019 and 2020 and another 15% between 2020 and 2021, **according to the U.S. Centers for Disease Control and Prevention,** and synthetic opioids like fentanyl fueled the increase.

And provisional **data** published by the CDC in February suggests 2023 will be no different: More than 111,000 people died from a drug overdose in the 12-month period ending last September. Synthetic opioids, primarily fentanyl, were involved in more than two-thirds of those deaths.

Would you want to know the "age" of your heart?

Alex Janin writes for the **Wall Street Journal** on how, before long, you might be able protect yourself from some serious health conditions by knowing the "age" of your organs. Would you want to know the "age" of your heart?

Did you know that while you might be 65 based on your birthday, your pancreas could be 70 and your heart 55? Apparently, researchers say that we can have an organ that is considerably older than our actual age. If so, that could increase our odds of getting certain diseases.

If you heart or artery or brain or pancreas are "older" than you are, you have a higher risk of dying sooner. So, if you knew your heart were older, theoretically you might be able to act in ways that reduce your chances of **heart disease**. Similarly, if your brain were older, theoretically you might be able to act in ways that reduce your chances of **dementia**.

To be clear, it's still not possible to know the age of your various organs. It takes identifying the proteins in different organs and then using blood samples to determine the level of these proteins, which are different as you age. And, the science is not definitive at this point.

Moreover, even if it were possible to determine people's organ ages, the next question becomes what to do about older organs. And, that's not always clear. What we do know is that it's not unusual for people to have organs that are "older" than their chronological age. About one in five people apparently do.

Women beware! You could have heart disease and not know it

Precautions Needed When Folks Taking Ozempic, Wegovy Undergo Anesthesia

Nurses who specialize in anesthesia have issued **new guidelines** to reduce the risk that patients taking weight-loss drugs like Ozempic or Wegovy throw up during surgery.

"These medications have exploded in popularity," said **Micah Walden**, of the American Association of Nurse Anesthesiology (AANA) Practice Committee. "This means additional preparation for patients, anesthesia providers and the surgical team to help minimize risks of complications during a procedure."

Because general anesthesia can cause nausea, patients are usually asked to fast before surgery. But a study published last week in the journal ***JAMA Surgery*** found these weight-loss drugs — called **GLP-1 receptor agonists** — slow digestion, so it takes longer for food to leave the stomach. That increases a patient's risk of vomiting or aspiration while under anesthesia.

GLP-1 agonists like **Ozempic**, **Wegovy** (semaglutide), **Saxenda** (liraglutide) or Zepbound (tirzepatide) were originally designed to manage type 2 diabetes, but they have become a popular way to lose weight. They make patients feel full sooner, so they eat less.

As a precaution, the AANA committee said providers may need to do extra screenings such as an ultrasound of the patient's stomach before surgery. If the examination indicates that the stomach is not empty or the imaging is inconclusive, the surgical team may consider delaying an elective surgery or proceeding as "full stomach" to reduce the risk of vomiting and aspiration while the patient is intubated for anesthesia care, the committee said.

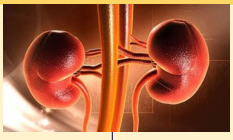
As they developed their recommendations, members of the practice committee said they considered the length of time various GLP-1 medications continue to affect patients.

They recommend withholding medication for a week before surgery if patients take a weekly dose. Those on a daily dose should not use the medication on the day of procedure, the recommendations advise.

The recommendations were published March 12.

"Open communication between patients and the surgical team is important to recommendations for withholding GLP-1 agonist medications prior to surgery," Walden said in an AANA news release. "As providers, we take that information into account to perform an individualized, case-by-case assessment and create a care plan that will keep the patient safe and comfortable before, during and after the procedure."

Weight-Loss Surgery Could Be Lifesaver for Folks Needing New Kidneys



Weight-loss surgery may help patients struggling with obesity and kidney failure become eligible for a lifesaving transplant, researchers report.

Obesity is a key reason why some kidney patients are turned down for a transplant.

But weight-loss surgery "not only helps in reducing the patients' weight to a level where they can safely receive a transplant, but also addresses the broader issue of health care disparities, particularly affecting Black and lower-income individuals," said corresponding author **Dr. Anil Paramesh**. He directs kidney and pancreas transplant programs at Tulane University School of Medicine in New Orleans.

Paramesh was part of a study jointly led by specialists in weight-loss and transplant surgery. It followed 183 patients with end-stage kidney disease from January 2019 to June 2023.

Thirty-six underwent **weight-loss surgery** and 10 then received kidney transplants.

On average, patients who had both procedures had a 27% reduction in body mass index (an estimate of body fat based on height and weight) when they got their transplant. They also had better control of their high blood pressure and diabetes.

With these gains, transplant prospects were significantly better.

The findings were published March 12 in the ***Journal of the American College of Surgeons***.

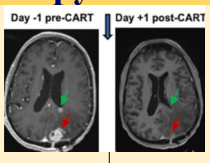
"We've seen that bariatric surgery is not just about weight loss; it significantly improves other serious conditions like diabetes, high blood pressure and sleep apnea," Paramesh said in an American College of Surgeons news release.

While the program offered a path forward for patients who would otherwise have been deemed ineligible for a transplant, Paramesh noted the program had a high drop-off rate. Some patients were unable to undergo surgery, others were unwilling to do so.

In addition, some had complications such as low blood pressure after their weight-loss surgery.

"Our findings indicate a pressing need to enhance patient education and support, making sure that potential candidates understand the benefits of weight-loss surgery and its role in improving their eligibility for transplant," Paramesh said.

New Immune-Focused Therapy Shrinks Aggressive Brain Tumors



Delivering dual-targeted, immune-focused CAR T cancer therapy via a patient's spinal fluid quickly shrank deadly brain tumors, researchers report.

CAR T therapy harnesses the power of the patient's immune system T-cells, which are reprogrammed to seek and destroy a specific protein found on cancer cells.

However, in the new trial -- focused on patients with deadly glioblastomas (GBMs) -- CAR T focused on *two* protein targets, giving tumor cells even fewer places to hide.

MRI brain scans of all six patients enrolled in the trial showed rapid tumor reductions occurring within a day or two of treatment.

In some cases, those reductions have continued for months, said the team from the University of Pennsylvania.

"We are energized by these results, and are eager to continue our trial, which will give us a better understanding of how this dual-target CAR T cell therapy affects a wider range of individuals with recurrent GBM," said **Dr. Donald O'Rourke**, whose lab at UPenn developed the technology.

Glioblastomas are the most common and most aggressive forms of adult brain tumors, with an expected life span after diagnosis of just 12 to 18 months.

Certain treatments -- surgery, radiation and chemotherapy -- might beat back the tumor for a while, but recurrence is common and when that happens, death typically comes within a year.

CAR T therapy has long been used successfully to fight blood malignancies, the researchers noted, but solid tumors have been much tougher targets.

"The challenge with GBM and other solid tumors is tumor heterogeneity, meaning not all cells within a GBM tumor are the same or have the same antigen that a CAR T cell is engineered to attack," lead investigator Dr. **Stephen Bagley** explained in a UPenn news release. "Every person's GBM is unique to them, so a treatment that works for one patient might not be as effective for another."

He added that glioblastomas are also adept at evading immune system cells -- even the reprogrammed cells that are used in CAR T.

"Our challenge is getting our treatment around the tumor's defenses so we can kill it," said Bagley, an assistant professor of hematology-oncology and neurosurgery at UPenn...**Read More**

Vitamin D Plus Calcium: Good News, Bad News for Older Women

Women who've gone through menopause and hope that supplemental vitamin D plus calcium might shield them from disease may be disappointed by new data.

A follow-up analysis of data from the landmark Women's Health Initiative trial found the supplement combo lowered a woman's long-term odds of dying from cancer by 7%.

However, it also raised her odds of fatal heart disease by 6%.

The bottom line: there was "no net effect on all-cause mortality" among older women who took the supplement combo, the study authors said.

It's possible "that calcium supplements may increase calcification of coronary arteries, thus increasing cardiovascular disease mortality," said a team led by **Cynthia Thomson**, a professor of health promotion sciences at the University of Arizona in Tucson.

The findings were published March 11 in the ***Annals of Internal Medicine***.

For years, many older women have popped a combination of calcium plus vitamin D to help strengthen their bones. Many may also wonder if the supplements cut their odds for two major killers, heart disease and cancer.

The **Women's Health Initiative** began enrolling tens of thousands of women as far back as 1991, and has tracked their health outcomes over subsequent decades. In 2006, the first (seven-year) findings on the effects of calcium/vitamin D supplementation on women's health were announced; the results were "largely null," Thomson's group noted.

Could that result have changed decades later?

To find out, the Arizona team crunched the WHI numbers for outcomes more than 22 years on.

They found no overall benefit in terms of deaths to older women from any cause.

There was a slight benefit when it came to reducing a woman's odds for fatal cancers, but that was offset by a slightly heightened risk for heart-related death.

Besides those findings, daily calcium/vitamin D supplementation also resulted in higher kidney stone risk for older women, the researchers noted.

The daily supplement doses used by women in the WHI included 1,000 milligrams of calcium and 400 IU of vitamin D.

Overall, "calcium and vitamin D supplements seemed to reduce cancer mortality and increase cardiovascular disease mortality after more than 20 years of follow-up among postmenopausal women, with no effect on all-cause mortality," Thomson's group concluded.

Shortage of Primary Care Doctors Could Bring Crowded ERs: Study

Americans living in areas where primary care doctors and nurse practitioners are in short supply face a greater risk for emergency surgeries and complications, new research shows.

They're also more likely to wind up back in the hospital after they've left it.

That's because serious health issues don't get addressed until they become emergencies, said lead study author **Dr. Sara Schaefer**, a resident in the University of Michigan's Department of Surgery.

"The role of the primary care provider in identifying a potential issue, and referring a patient for diagnostic imaging and surgery, can make a major difference in addressing an urgent problem before it becomes an emergency," she explained in a university news release.

For the new study, her team looked at data for Medicare patients in areas where the federal government has identified a shortage of primary care providers.

Patients had operations for three conditions where timing is critical: colectomy to remove a cancer from the colon; hernia repair; and repair of aneurysms in the the body's largest blood vessel, the aorta.

Nearly 38% of those in areas with more severe shortages required emergency surgery, compared with 30% of those in areas with the least severe shortages, the study found. They also had a higher risk for serious complications (15% versus about 12%), and hospital readmission (nearly 16% vs. 13.5%).

The study found no difference in patients' risk of death based on provider shortage rates, but researchers did find that the risk of premature death was higher for those living in areas with shortages.

Nearly 6 in 10 census tracts classified as having a shortage of primary care providers were in rural areas.

The findings were published in the March issue of the journal ***Health Affairs***.

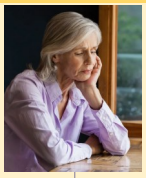
Schaefer said the study holds an important message for people living in shortage areas: Find a primary care provider for regular care, even if getting an appointment takes awhile. It's also important to pay attention to new symptoms, she added, and to know how escalate a concern with your regular provider.

She said surgeons need to realize that some patients are undergoing urgent or emergency operations because they lack regular primary care.

Schaefer called on surgeons to work with their patients while they're in the hospital to make sure they have a primary care provider going forward.

"The role of the primary care doctor as a partner in care of our surgical patients cannot be overstated," she said.

Depression May Be Tougher on Women's Hearts Than Men's



Researchers are zeroing in on the reasons why women who battle depression may be more likely than men to develop heart disease.

A study published March 12 in the journal *JACC: Asia* underscores the need to tailor prevention and management strategies according to sex-specific factors, researchers said.

This "may help in the development of targeted prevention and treatment strategies" for the heart health risks faced by depressed patients, said corresponding author **Dr. Hidehiro Kaneko**, an assistant professor of medicine at the University of Tokyo in Japan.

Depression in the third-leading cause of disease worldwide. It has been linked to an increased risk of heart problems including heart attack, angina, stroke and death.

Women who are depressed are at a greater risk of heart problems than their male peers with depression, but the reasons have not been understood.

For this study, Kaneko's team evaluated data from nearly 4.2 million people who were listed in a Japanese health claims database between 2005 and 2022. Of those, nearly 2.4 million were men.

Researchers looked at participants' weight, blood pressure and fasting laboratory test results at their initial exam. Those with depression had previously received that diagnosis.

Researchers found that women with depression were more likely than men to have one of the heart problems investigated — heart attack, stroke, angina, heart failure and atrial fibrillation.

Researchers suspect women may experience more severe and persistent depression symptoms than men. Those symptoms may accompany critical periods of hormonal changes, such as pregnancy or menopause.

When women are depressed, researchers said, they are more likely to develop traditional risk factors for heart disease, such as high blood pressure, diabetes and obesity.

Genetics and hormonal differences may also contribute to women's heart disease risk….**Read More**