

## November 19, 2023 E-Newsletter



### Message from the Alliance for Retired Americans Leaders

#### Union Voters Lead the Way to Election Victories Across the Country



Robert Roach, Jr.  
President, ARA

Tuesday's elections resulted in major victories for pro-retiree, pro-worker candidates and initiatives in states across the nation, including Kentucky, Pennsylvania, Texas and Virginia. AFL-CIO President Liz Shuler (second from left) in Louisville for GOTV on election day, with Kentucky Alliance president Kirk Gillenwaters and Kentucky Alliance members Kay Tillow and Dale Warren Kentucky Alliance members have worked to support Governor Andy Beshear's



Kentucky Alliance members and A. Philip Randolph Institute chapter members in Louisville volunteered to drive voters to the polls Tuesday.

reelection, with Alliance members appearing in television ads, joining with the Louisville chapter of the A. Philip Randolph Institute to drive

voters to the polls. In Virginia union volunteers knocked on thousands of doors and ensured a pro-worker majority in the House of Delegates and state Senate. And in Pennsylvania, Daniel McCaffery won the vacant seat on the Pennsylvania Supreme Court, once again **bringing** a 5-2 Democratic majority on the state's high court.

In Texas, voters approved **Proposition 9**, which would allow the state to use about \$3.4 billion to fund a cost-of-living adjustment for retired educators with 84% of the vote, the highest yes vote of 14 ballot measures. Texas Alliance members worked all year to ensure the measure passed.

"The labor movement and union retirees are still a force to be reckoned with," said **Robert Roach, Jr., President of the Alliance**. "Tuesday night we were reminded of what we can accomplish by working together and focusing on issues that matter to working people no matter where they live."



AFL-CIO President Liz Shuler (second from left) in Louisville for GOTV on election day, with Kentucky Alliance president Kirk Gillenwaters and Kentucky Alliance members Kay Tillow and Dale Warren

"Alliance members showed up for these elections, and we must carry that momentum

into 2024," added Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "The senior vote will be key, as it is in every election."

#### Republican Presidential Debate Rife With Misinformation on Social Security



Rich Fiesta,  
Executive  
Director, ARA

Social Security was a topic of much discussion during Wednesday night's GOP debate, with several candidates offering responses containing lies or deliberate misrepresentations. Former South Carolina Governor Nikki Haley falsely **stated** that Social Security will be bankrupt in ten years as she defended wanting to raise the retirement age. She has previously said that the U.S. retirement age is **"way too low."** "Nikki Haley is wrong. Social Security will not be bankrupt in

ten years, and there are better solutions than raising the retirement age," said **Richard Fiesta, Executive Director of the Alliance**. "Just by requiring wealthy Americans to pay payroll taxes on wages above \$400,000, we could increase benefits and extend the life of the trust fund."

Former New Jersey Governor Chris Christie **proposed** raising the retirement age for those who are 30-40 years old, not mentioning that every year the Social Security eligibility age is raised translates to about a **7% benefit cut**.

Sen. Tim Scott (SC) said **he would** protect Social Security. However, his **actual plan** is to cut funding for the Social Security Administration and lower taxes for the wealthy. "Former President Donald Trump also **supports** slashing Social Security. In 2020 he said 'we'll be cutting' entitlement programs," said Fiesta. "And when he was a Congressman, Florida Governor Ron DeSantis **voted** to raise the retirement age and privatize Social Security. What you don't hear is the GOP presidential candidates describing any plans to strengthen and expand



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## Seven questions you should be asking this Medicare Open Enrollment period

**During this Medicare Open Enrollment period, ask yourself these seven questions:**

- Q. What's the biggest difference between traditional Medicare and a Medicare Advantage plan?** To ensure you have good coverage for both current and unforeseeable health needs, you should enroll in traditional Medicare. In traditional Medicare, you and your doctor decide the care you need, with no prior approval. And, you have easy access to care from almost all doctors and hospitals in the United States with no incentive to stint on your care. In a Medicare Advantage plan, a corporate insurance company decides when you get care, often requiring you to get its approval first. Medicare Advantage plans also restrict access to physicians and too often second-guess your treating physicians, denying you needed care inappropriately. The less care the Medicare Advantage plan provides, the more the insurance company profits. You will pay more upfront in traditional Medicare if you don't have Medicaid and need to buy supplemental coverage, but you are likely to spend a lot less out of pocket when you need costly care. Regardless of whether you stay in traditional Medicare or enroll in Medicare Advantage, you still need to pay your Part B premium.
- Q. Should I trust an insurance agent's advice about my Medicare**

**options?** No. Unfortunately, insurance agents are paid more to steer you away from traditional Medicare and into a Medicare Advantage plan, even if it does not meet your needs. While some insurance agents might be good, you can't know whom to trust. Keep in mind that while Medicare Advantage plans tell you that they offer you extra benefits, you still need to pay your Part B premium, and extra benefits are often very limited and come with high out-of-pocket costs; be aware that many Medicare Advantage plans won't cover as much necessary medical and hospital care as traditional Medicare. For free independent advice about your options, call the Medicare Rights Center at 1-800-333-4114 or a **State Health Insurance Assistance Program (SHIP)**.

- Q. Why can't I rely on my friends or the government's star-rating system to pick a good Medicare Advantage plan?** Unlike traditional Medicare, which gives you easy access to the physicians and hospitals you use from everywhere in the US and allows for continuity of care, you can't count on a Medicare Advantage plan to cover your care from the health care providers listed in their network or to cover the medically necessary care that traditional Medicare covers. Even if your friends say they are happy with their Medicare Advantage plan right now, they are gambling



with their health care. The government's five-star rating system does not consider that some Medicare Advantage plans engage in **widespread inappropriate delays and denials of care** and other Medicare Advantage plans engage in different bad acts that can endanger your health. So, while you should never sign up for a Medicare Advantage plan with a one, two or three-star rating, Medicare Advantage plans with four and five-star ratings can have very high denial and delay rates.

- Q. If I'm enrolled in a Medicare Advantage plan, can I count on seeing the physicians listed in the network and lower costs?** Unfortunately, provider networks in Medicare Advantage plans can change at any time and your out-of-pocket costs can be as high as \$8,300 this year for in-network care alone. You can study the MA plan literature, and you can know your total out-of-pocket costs for in-network care. But, you cannot know whether the MA plan will refuse to cover the care you need or delay needed care for an extended period. This year alone, dozens of health systems have **canceled their Medicare Advantage contracts**, further restricting access to care for their patients in MA, because MA plans make it hard for them to give people needed care.
- Q. Doesn't the government make sure that Medicare Advantage plans deliver the same benefits as**

**traditional Medicare?** No. The government cannot protect you from Medicare Advantage bad actors. The insurers offering Medicare Advantage plans can decide you don't need care when you clearly do, and there's no one stopping them; they are largely unaccountable for their bad acts. In the last few years there have been multiple **government** and independent reports on insurance company bad acts in Medicare Advantage plans.

- Q. If I join a Medicare Advantage plan, can I disenroll and switch to traditional Medicare?** You can switch to traditional Medicare each annual open enrollment period. However, depending upon your situation, where you live, your income, your age and more, you might not be able to get supplemental coverage to pick up your out-of-pocket costs and protect you from high costs. What's worse, you could incur thousands of dollars in out-of-pocket costs in Medicare Advantage.
- Q. If I have traditional Medicare and Medicaid, what should I do?** If you have both Medicare and Medicaid, traditional Medicare covers virtually all your out-of-pocket costs. You will get much easier access to physicians and inpatient services in traditional Medicare than in a Medicare Advantage plan if you need costly health care services or have a complex condition.

## Nursing Home Alternatives to Consider

When you're assessing long-term care options, don't discount options besides nursing homes, such as assisted living, home care and continuing care retirement communities.

**Your loved one and aging**  
It's a common scenario: Adult children see an older family

member is no longer able to live independently. Their loved one may have difficulty cooking meals or keeping up with personal hygiene. Maybe they're showing **signs of memory loss** and can no longer **manage technology** or their finances.



Nursing homes are a go-to option for many families. These facilities tend to be for those who need help with **activities of daily living**, such as medication management, feeding and toileting. Residents also have at least one chronic

condition, such as hypertension or arthritis, notes the **National Center for Health Statistics**.

But nursing homes may not be for everyone. Your loved one's functional and medical needs, budget and preferences could dictate an alternative care facility.....**Read More**



## Could weight-loss drugs ultimately reduce health care spending?

Bruce Japsen reports for **Forbes** that weight-loss drugs are costing employers \$324 per worker each year. These costs will only increase as more workers take these prescription drugs, if the government does not step in to rein in drug prices. They will also drive up Medicare costs a lot if Medicare decides to cover drugs for weight loss. (Medicare covers these drugs for people with diabetes.) But, could they also reduce the prevalence of diabetes, heart disease and other costly conditions, driving down overall health care spending?

Right now, Wegovy, Rybelsus

and Saxenda as well as Ozempic are responsible for ever higher insurance premiums, deductibles and copays. Their costs likely will keep going up, as more people take them and their manufacturers raise prices. When will our government step in to negotiate prescription drug prices for everyone or, at the very least, open our borders to prescription drugs from abroad, which are significantly cheaper than in the US.

In 2021, weight-loss drugs contributed to \$96 of insurance costs for each worker. In two years, health insurance costs for



these weight-loss drugs are projected to rise to \$500 per worker.

Competition from new weight-loss drugs should contain costs some. And, indeed, Gina Kolata reports for the **New York Times** that more weight-loss drugs are coming to market. Eli Lilly's Zepbound, tirzepatide, is the latest to receive FDA approval. But, even if these drugs bring down prices a little, these new drugs are sure to drive up demand. Obesity is rampant in the US, affecting 100 million adults.

Time will tell the extent to which these new drugs affect the

overall cost of health care in the US. Zepbound's initial list price for a four-week dose is \$1,060, somewhat less than the price of Wegovy, which is \$1,349. But, these drugs are expected to drive down people's weight by as much as 20 percent, helping to reduce their risk of diabetes, heart disease and other chronic conditions people develop as a result of being overweight. We can only hope that the cost of these drugs will be offset by savings from a reduction in the prevalence of some costly chronic conditions.

## Antipsychotic Drugs in Nursing Homes

The use and ethics of antipsychotic drugs in nursing homes is an ongoing discussion. Learn why these medications are sometimes misused and how can you advocate for your loved one.

Caring for seniors with cognitive impairments who are living in nursing homes can be a challenging endeavor. One particular area of concern is the use of antipsychotic medications in treating older adults with dementia when associated behaviors become difficult to manage.

Sometimes called "chemical straightjackets," antipsychotic drugs are usually used to treat certain mental health disorders, such as schizophrenia or **bipolar disorder**. Overuse or abuse of these medications in seniors without these conditions is what raises a red flag.

The percentage of nursing home patients who receive antipsychotic drugs is **one of the measurements** U.S. News uses in its ratings for **Best Nursing**



**Homes**. For the 2023-2024 rating year, U.S. News's findings comported with those of a 2021 New York

Times **investigation** that revealed at least 21% of nursing home residents, more than 225,000 people in total, were on antipsychotic drugs.

U.S. News data found that at 22% of evaluated nursing homes, at least 1 in 4 residents received antipsychotic drugs. That number suggests excessive use of the medications.

While the Centers for Medicare & Medicaid Services gave 678 of those homes a positive (four- or five-star) rating, none of them received a positive rating from U.S. News.

"(The New York Times) investigation was our inspiration for much of our work around antipsychotics," says Ben Harder, managing editor and chief of health analysis at U.S. News

**Risks of Antipsychotic Use in Nursing Homes.....[Read More](#)**

## Senate panel advances bill to reform PBMs and bring more FTC scrutiny on industry

A key Senate committee advanced legislation to ban pharmacy benefit manager tactics, such as spread pricing and clawback fees, and heighten transparency of the industry.

The Senate Commerce Committee passed the **PBM Transparency Act of 2023** by a vote of 18 to 9 on Wednesday, advancing the reform legislation to the full Senate. Lawmakers said the legislation is meant to address a source of unfair and deceptive practices that increase drug prices.

"This bipartisan bill would not only put a stop to deceptive and opaque pricing schemes that burden consumers with higher prices, it also saves taxpayers \$740 million," said Sen. Chuck Grassley, R-Iowa, one of the original co-sponsors, in a statement. "It's a win-win and

warrants swift approval in Congress."

The legislation would ban the tactic PBMs use called "spread pricing," where the manager charges payers more for a drug than what they reimburse a pharmacy, thus pocketing the difference, a summary of the bill said.

"This practice can result in pharmacies being reimbursed less than their acquisition cost for a drug," the summary said.

It would also ban clawback fees where a PBM attempts to get back part of a payment made to pharmacies or increase fees to offset any changes to reimbursement from federally funded health plans, the committee summary added.

The legislation also seeks to boost transparency for PBMs, including requiring each manager



to file an annual report with the Federal Trade Commission (FTC) on how much each plan paid the PBM for prescription drugs and in turn how much the PBM paid the pharmacy.

The report would also have to detail why a copay or deductible for a consumer increased or the reason pharmacy reimbursement declined. Any PBM that doesn't follow the law could face fines from the FTC and state attorneys general of up to \$1 million.

The FTC has already launched **a comprehensive study of the PBM** industry and has sent subpoenas to six of the industry's major players.

The PBM industry slammed the vote by the Commerce Committee as giving the FTC far too much power.

"The bill would grant the FTC

unprecedented power to pick industry winners and losers, rather than maintaining the agency's focus on the consumer welfare standard, and would set a precedent for allowing the FTC to regulate prices," according to a statement from the Pharmaceutical Care Management Association, = a PBM lobbying group.

The bill's margin of victory and reliance on the FTC could be major headwinds for getting it through Congress.

Sen. Ted Cruz, R-Texas, was reluctant to grant more power to the FTC.

"I am also concerned that additional FTC enforcement actions under this bill could reduce the ability of smaller PBMs to compete and compete effectively," Cruz said during the markup hearing....**[Read More](#)**

## Medicare Advantage plans are not addressing loneliness among their enrollees

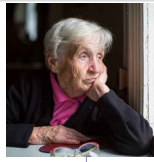
Loneliness is prevalent amount older adults in Medicare Advantage plans, reports Alexa Mikhail for **Fortune**. Most older adults no longer work and have few outlets for social interaction. The government is not addressing their lack of social stimulation. Their Medicare Advantage plans, government health plans administered by corporate health insurers, which are paid to manage their enrollees' health, should be helping to address their enrollees' loneliness.

A survey of 28,000 older adults in Medicare Advantage plans finds that more than half of them (three in five) are lonely or

extremely lonely. Family are often not near by. Friends are often not around. As a rule, their Medicare Advantage plans do not help them.

Consequently, many older adults are at greater risk for a range of health issues, including dementia, depression and anxiety.

What can isolated adults do in an emergency? One in five older adults have no one to turn to in an emergency. Two in five struggle to find social support. Their Medicare Advantage plans do not make it their business to promote social interaction among their enrollees, even though it's an



important way to promote their well-being. Many older adults struggle mentally and physically as a result of social isolation.

They need help taking their medicines and remodeling their homes but they can't get it. They don't have easy and safe access to a bathroom, shower, kitchen and bedroom. They can't get to their doctors' appointments. It's not clear that any Medicare Advantage plans are helping to ensure their enrollees' basic needs are met or even to minimize their risk of falling, even though they are receiving some **\$140 billion in overpayments** each year from the

government.

Half of older adults have annual incomes under \$30,000 and deteriorating health. Loneliness means that they are as much as three times more likely to end up in an emergency room than people who have family or other social companions around to help.

If Medicare Advantage plans were putting their enrollees' needs ahead of their profits, they would be promoting social engagement among their enrollees and otherwise spending money on their enrollees in meaningful ways.

## Who Will Care for Older Adults? We've Plenty of Know-How but Too Few Specialists

Thirty-five years ago, Jerry Gurwitz was among the first physicians in the United States to be credentialed as a geriatrician — a doctor who specializes in the care of older adults.

"I understood the demographic imperative and the issues facing older patients," Gurwitz, 67 and chief of geriatric medicine at the University of Massachusetts Chan Medical School, told me. "I felt this field presented tremendous opportunities."

But today, Gurwitz fears geriatric medicine is on the decline. Despite the surging older population, there are fewer geriatricians now (just over 7,400) than in 2000 (10,270), he noted in a recent **piece in JAMA**. (In those two decades, the population 65 and older expanded by more than 60%.) Research suggests each geriatrician should

care for no more than 700 patients; the current ratio of providers to older patients is 1 to 10,000.

What's more, medical schools aren't required to teach students about geriatrics, and fewer than half mandate any geriatrics-specific skills training or clinical experience. And the pipeline of doctors who complete a one-year fellowship required for specialization in geriatrics is narrow. Of 411 geriatric fellowship positions available in 2022-23, 30% went unfilled.

The implications are stark: Geriatricians will be unable to meet soaring demand for their services as the aged U.S. population swells for decades to come. There are just too few of them. "Sadly, our health system and its workforce are wholly unprepared to deal with an



imminent surge of multimorbidity, functional impairment, dementia and frailty,"

Gurwitz warned in his JAMA piece.

This is far from a new concern. Fifteen years ago, **a report** from the National Academies of Sciences, Engineering, and Medicine concluded: "Unless action is taken immediately, the health care workforce will lack the capacity (in both size and ability) to meet the needs of older patients in the future." According to the American Geriatrics Society, 30,000 geriatricians will be needed by 2030 to care for frail, medically complex seniors.

There's no possibility this goal will be met.

What's hobbled progress? Gurwitz and fellow physicians cite a number of factors: low

Medicare reimbursement for services, low earnings compared with other medical specialties, a lack of prestige, and the belief that older patients are unappealing, too difficult, or not worth the effort.

"There's still tremendous ageism in the health care system and society," said geriatrician Gregg Warshaw, a professor at the University of North Carolina School of Medicine. But this negative perspective isn't the full story. In some respects, geriatrics has been remarkably successful in disseminating principles and practices meant to improve the care of older adults... **Read More**

## Drug prices: Biden v. Trump

Heather Landi reports for **Fierce Healthcare** on how Donald Trump's former Secretary of Health and Human Services, Alex Azar, and Joe Biden's current Secretary of Health and Human Services (HHS), Xavier Becerra, would address high drug prices. Not surprisingly, their views differ significantly.

Azar does not recognize that pharmaceutical companies in the US engage in price fixing. Or, that the pharmaceutical companies often delay the release of new drugs in order to maximize profits on older drugs,

hampering innovation. Or, that it's much easier for people in France to fill their prescriptions than people in the United States because out-of-pocket costs in the US are so high.

Azar does recognize the power of pharmacy benefit managers, PBMs, to drive up people's out-of-pocket costs, but does not suggest a plan to fix that issue. For example, he does not propose removing PBMs from the process of deciding which drugs are covered and at what price to patients.

Last year, Congress passed the



Inflation Reduction Act or IRA, giving Medicare drug price negotiating power for 10 drugs in 2025; the Centers for

Medicare and Medicaid Services have chosen the 10 drugs, based on which cost the Medicare program the most. The IRA also capped out-of-pocket costs for each insulin product people with diabetes use at \$35 a month. And, it imposed an out-of-pocket limit of \$2,000 for drugs covered by Medicare Part D plans beginning in 2025.

President Joe Biden's HHS Secretary Becerra touts

Medicare's drug price negotiation power as an effective way to lower drug costs, pointing out that the IRA now caps the cost of insulin at \$35 per month for seniors who have Medicare.

Of note, the Trump administration had proposed that Part B drug prices—for inpatient drugs—be tied to prices paid abroad for these drugs. That sounds to me as if it would have been a smart move. But, the Biden administration rescinded that proposal, likely under pressure from the pharmaceutical industry.

## Social Security's Max Benefit Is Going Up -- But There's Bad News, Too

Social Security is a lifeline for many retirees, but the average retired worker only collects around \$1,800 per month as of September 2023. That can make it tough to survive on benefits, especially if your savings are falling short.

However, it's possible to receive much more than the average amount from Social Security. In 2023, the maximum you can collect is \$4,555 per month -- but that number will be going up next year. While that's a good thing for those nearing retirement, there's bad news, too.

Reaching the maximum Social Security benefit

In 2024, the most you'll be able to collect in benefits is \$4,873 per month -- a whopping \$318 more per month (or nearly \$4,000 more per year) than in 2023. The not-so-good news, though, is that it's becoming even more difficult to achieve the maximum payments.

To earn as much as possible in benefits, you'll need to meet three requirements:

♦ **Work for at least 35 years:** The Social Security Administration calculates your basic benefit amount by taking an average of your wages over the 35 highest-earning years of your career and then adjusting that figure for inflation. If you haven't worked at least 35 full years before you file, you'll receive a smaller benefit amount.

♦ **Wait until age 70 to begin claiming:** Your basic benefit amount based on your earnings is how much you'll receive at your **full retirement age** (age 67 for anyone born in 1960 or later). But to receive as much as possible each month, you'll need to wait until age 70 to begin claiming.

♦ **Consistently reach the wage cap:** The wage cap is the highest annual income subject to Social Security taxes. The closer you get to



this limit, the larger your payments will be. Once you surpass the cap, your income will no longer affect your benefit amount.

Meeting the wage cap, in particular, is tough for many workers. This limit changes from year to year to account for inflation, and in 2023, it's \$160,200 per year. Next year, though, it will be increasing to \$168,600 per year.

To earn the maximum benefit, you'll need to have been consistently reaching the wage cap throughout your career. Because this limit continues to increase every year, it's getting more challenging to achieve this target. Even if you meet the other two requirements for the max benefit, not reaching the wage cap will make it impossible to earn the \$4,873 monthly payments.

What you can do to increase your benefits

Reaching the maximum benefit is tough, and it's only getting tougher -- which can be discouraging for those who will

be depending on Social Security in retirement. The good news, though, is that you can still increase your monthly payments by getting as close as you can to each of the three requirements for the maximum benefit.

For example, maybe you can't work for 35 years or wait until age 70 to begin claiming. But if you can work just one or two years longer or delay Social Security from age 62 to 65, those moves alone could potentially boost your benefits by hundreds of dollars per month. Also, even if you're unable to reach the \$168,600 annual wage cap, increasing your income even a little can still result in larger payments.

Achieving the maximum \$4,873 monthly benefit may not be feasible for most workers, but that doesn't mean you can't get as close as possible. When you know how your benefits are calculated, you can take steps to boost your monthly payments and enjoy a more financially secure retirement.

## Facing Financial Ruin as Costs Soar for Elder Care

Margaret Newcomb, 69, a retired French teacher, is desperately trying to protect her retirement savings by caring for her 82-year-old husband, who has severe dementia, at home in Seattle. She used to fear his disease-induced paranoia, but now he's so frail and confused that he wanders away with no idea of how to find his way home. He gets lost so often that she attaches a tag to his shoelace with her phone number.

Feylyn Lewis, 35, sacrificed a promising career as a research

director in England to return home to Nashville after her mother had a debilitating stroke. They ran up \$15,000 in medical and credit card debt while she took on the role of caretaker.

Sheila Littleton, 30, brought her grandfather with dementia to her family home in Houston, then spent months fruitlessly trying to place him in a nursing home with Medicaid coverage. She eventually abandoned him at a psychiatric hospital to force the system to act.



"That was terrible," she said. "I had to do it."

Millions of families are facing such daunting life choices — and potential financial ruin — as the escalating costs of in-home care, assisted living facilities, and nursing homes devour the savings and incomes of older Americans and their relatives.

"People are exposed to the possibility of depleting almost all their wealth," said Richard Johnson, director of the program on retirement policy at the Urban

Institute.

The prospect of dying broke looms as an imminent threat for the boomer generation, which vastly expanded the middle class and looked hopefully toward a comfortable retirement on the backbone of 401(k)s and pensions. Roughly 10,000 of them will turn 65 every day until 2030, expecting to live into their 80s and 90s as the price tag for long-term care explodes, outpacing inflation and reaching **a half-trillion dollars** a year,

## Denied Insurance Claims Cause Issues for People with All Forms of Health Coverage

A **new survey from KFF** highlights problems people have using their health insurance, with 60% of insured adults reporting that they have had issues, including denied claims and appeals, as well as network inadequacy. The type of insurance matters; those with Medicare or Medicaid fare better than those with other health coverage.

Around 18% of all insured respondents said they faced

denied claims in the past year, with those covered by employer-sponsored insurance over twice as likely to report denied claims than those covered by Medicare. Unsurprisingly, the likelihood of denied claims rose as people used more services; 27% of people with 11 or more provider visits reported denied claims while 14% of those with 2 or fewer visits reported the same. People identifying as LGBT were much



more likely to report a denied claim—30% vs 17%.

Denied claims put people at risk of serious health or financial problems. For example, around a quarter of those who experienced denials said they faced significant delays in treatment, were unable to receive recommended treatment, or experienced a health decline. The financial consequences were even more prevalent, with over half

(55%) of those who faced denied claims paying more than they expected.

As KFF notes, there is no way to know if coverage for these claims was appropriately or inappropriately denied. They also note that people with denied claims report more difficulty understanding their coverage, which may mean they were more likely to submit erroneous claims....**Read More**



## Administration proposes new rule to address myriad problems with Medicare Advantage

The Centers for Medicare & Medicaid Services (CMS) has proposed **a new rule for 2025** with the goal of addressing some of the problems with Medicare Advantage (MA). The rule is intended to **“promote healthy competition”** so that Medicare Advantage plans are not failing to meet people’s needs, as so many of them have in a multitude of ways. The problem is that the proposed rule, like the vast majority of Medicare Advantage rules, has no teeth.

Here are the rule’s major provisions:

The Administration believes that more guardrails are needed to ensure that insurance brokers and agents are not steering people into Medicare Advantage plans that do not meet their needs. Mountains of evidence reveal that many Medicare Advantage plans are inappropriately delaying and denying care and otherwise restricting access to care through limited provider networks and large out-of-pocket costs. No one, including insurance agents, has a clue as to which Medicare Advantage plans to avoid because there is no good data to help people understand which Medicare Advantage plans are the bad actors.

The biggest takeaway of the new proposed marketing “guardrail” is that brokers and agents steer people to the MA plans that pay them the highest commissions. They also steer people away from Medicare supplemental insurance plans,

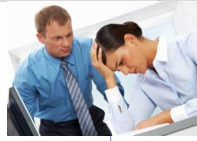
which don’t pay them as high commissions as MA plans. The MA commission is now as high as \$601, with lots of bonuses, and would increase to a fixed rate of \$632 in 2025. Don’t trust the advice of insurance agents!

The proposed rule also includes better access for people to outpatient behavioral health providers through changes to its network adequacy standards. This year, CMS expanded coverage to marriage and family therapists (MFTs) and mental health counselors (MHCs).

About **400,000 more therapists will be able to treat Medicare patients** if they so choose.

Because reports indicate that Medicare Advantage plans do not often offer easy or **any access to mental health providers**, as required, CMS is setting a special network adequacy standard for Medicare Advantage plans. But, as it is, CMS does not appear to have the resources to assess network adequacy nor does it have the ability to meaningfully penalize MA plans with inadequate networks.

And, the proposed rule seeks to help people with Medicare make good on the “supplemental benefits” that Medicare Advantage plans offer. Reports indicate that many of these benefits go unused because they come with unaffordable out-of-pocket costs or other burdens on enrollees. CMS allows MA plans to offer food vouchers and



transportation services. But, few use them. So, if the rule is finalized, MA plans would have to let enrollees know of the availability of supplemental benefits midway through the calendar year.

CMS states it does not want MA supplemental benefits used as a “marketing ploy,” as they so often are. But, the problem the administration overlooks is that few people will read the notice from their MA plans and fewer still will be able to take advantage of these benefits even if they know about them. Many people with Medicare have serious mental and physical health conditions as well as low health literacy levels that impede their ability to understand Medicare’s complex rules.

To address the disproportionate impact that inappropriate delays and denials of care in Medicare Advantage has on underserved populations, such as people with disabilities, people with Medicaid and people in **Medicare Savings Programs**, CMS has proposed that Medicare Advantage plans analyze their utilization management (UM) policies and procedures from a health equity perspective.

And, CMS’ proposed rule attempts to give Medicare Advantage enrollees faster access to appeals; right now in some cases people in MA plans have far less timely appeals than people in traditional Medicare. This proposed rule is an

improvement that might help a tiny fraction of MA enrollees. The problem is that the overwhelming majority of MA enrollees do not know to appeal MA plan denials and do not appeal.

Lastly, CMS proposes a rule to allow monthly enrollment in MA plans and appears to help insurers push more people with Medicare and Medicaid into an MA plan. That’s insane given all the reports of bad actors in MA and the availability to this population of traditional Medicare with easy access to care and few if any out-of-pocket costs. Thankfully, the rule also gives these “dual eligibles” the ability to switch to Traditional Medicare more easily.

The proposed rule would limit out-of-network cost sharing for D-SNP preferred provider organizations (PPOs) for specific services, beginning in 2026. The proposed rule also would reduce cost shifting to Medicaid, increase payments to safety net providers, expand dually eligible enrollees’ access to providers, and protect dually eligible enrollees from unaffordable costs.

It’s great that CMS is acknowledging many of the major issues with Medicare Advantage. It’s unfortunate that even when it proposes a good rule, the insurers offering Medicare Advantage plans can effectively ignore the rule with impunity, and **many of them do**.

## Caregiving's Financial Toll Is Often Hidden

A growing number of people have become unpaid caregivers for loved ones, and a new report says many are overlooking the financial consequences of their selflessness.

One in five adults now provide uncompensated care to family and loved ones with health problems, according to the **report** from the TIAA Institute and the University of Pennsylvania School of Nursing.

On average, these caregivers are shelling out more than \$7,000 a year, on average, in expenses out of their own pockets on things like housing, health care and transportation.

Nearly half of caregivers say they’ve suffered financially as a result, forcing them to take steps that eat into their own finances. Many feel they have no choice but to withdraw money from savings, take on debt, pay bills late or cut back retirement contributions.

Overall, caregivers have lower levels of financial assets and carry more debt than those who aren’t caring for loved ones, the report found.

For example, one in four caregivers has less than \$1,000 in savings and investments, compared to one in seven for



those who aren’t caregivers. “Although the emotional and physical toll on family caregivers is well recognized, the financial impact of these roles has received less attention,” said **Surya Kolluri**, head of the TIAA Institute.

“The impact on lifetime earnings, savings, Social Security benefits and retirement readiness can be severe,” she said in a news release from the University of Pennsylvania School of Nursing. “Especially today, as people are living longer, caregivers should plan for these costs at various life stages.”

The fiscal impact also extends into the workplace. About three in five caregivers have jobs outside the home, but caregiving typically requires 24 hours a week.

As a result, about 61% of working caregivers said the care they provide has impacted them on the job -- causing them to arrive late, leave early, take time off or retire earlier than planned.

The need for caregivers is also likely to skyrocket, meaning that more Americans will face these financial pressures, the report noted....**Read More**

## Income, Education Can Affect Your Stroke Recovery

Strokes can strike anyone, but income and education may play a role in whether your stroke is fatal or disabling, new research shows.

As reported Nov. 8 in the journal *Neurology*, folks who'd had a stroke were 10% more likely to die or become dependent on someone for their care if they were low-income or less educated.

Study lead author **Anita Lindmark**, of Umeå University in Sweden, said there's long been evidence that people from less advantaged backgrounds are already at higher risk of stroke.

"Our study sought to determine if socioeconomic status plays a

role after stroke," she explained in a journal news release.

"Not only did we find an increased risk of death and dependency on others for those with low education and income levels, we also found that if interventions were put in place to reduce disparities, it could save lives," Lindmark added.

In their research, the Swedish team looked at data on almost 26,000 people in the Swedish Stroke Register who'd experienced a stroke over a two-year period. All of these people had previously lived independently, with no need for assistance in the activities of



daily life.

Of these stroke patients, about 6,800 ended up either dying or requiring assistance within three months of their stroke.

Lindmark's team divided the patients into three socioeconomic groups: Low (low disposable income, only a primary school education), High (college education and relatively high disposable income) and Middle (education/income falling between the prior two categories).

They report significant differences in stroke outcomes based on education/income. While 39% of people in the Low group were either deceased or

dependent on others three months after their stroke, that was only true for 18% in the High group.

Overall, and after adjusting for certain factors, people in the Low group for income/education were 10% more likely to end up deceased or disabled soon after their stroke, compared to folks in the High group.

The exact reasons for the disparity remain unclear, in part because the researchers didn't have good information on the locations in which individuals lived or the level of medical care they had received.

## Food Allergies Might Pose 'Silent' Threat to the Heart

In an unexpected finding, new research suggests that antibodies arising from common food allergies may also raise risks for heart trouble.

These IgE antibodies didn't even have to be present in quantities high enough to produce an actual food allergy to have this unhealthy effect on the heart, noted a team from the University

of Virginia Health (UVA) System, in Charlottesville.

"What we looked at here was the presence of IgE antibodies to food that were detected in blood samples," researcher **Dr. Jeffrey Wilson** said in a UVA news release. "We don't think most of these subjects actually had overt food allergy, thus our story is



more about an otherwise silent immune response to food."

"While these responses may not be strong enough to cause acute allergic reactions to food, they might nonetheless cause inflammation and over time lead to problems like heart disease," said Wilson, an allergy and immunology expert at the

UVA School of Medicine.

All of this could mean trouble for a large swath of the population: According to the researchers, about 15% of adults produce IgE antibodies in response to cow's milk, peanuts and other foods.

Not everyone who produces the antibodies will have a symptomatic food allergy, however....[Read More](#)

## FDA Approves First Vaccine for Chikungunya Virus

The first vaccine to prevent infection with the chikungunya virus was approved by the U.S. Food and Drug Administration on Thursday.

The single-dose shot, known as Ixchiq, is approved for adults who are at increased risk of exposure to the virus.

"Infection with chikungunya virus can lead to severe disease and prolonged health problems, particularly for older adults and individuals with underlying medical conditions," **Dr. Peter Marks**, director of the FDA's Center for Biologics Evaluation and Research, said in an agency [news release](#) announcing the approval. "Today's approval addresses an unmet medical need and is an important advancement in the prevention of a potentially debilitating disease with limited treatment options."

Chikungunya is an emerging

global health threat, with at least 5 million cases of chikungunya virus infection reported during the past 15 years, the agency said. The highest risk of infection is seen in tropical and subtropical regions of Africa, Southeast Asia and parts of the Americas where chikungunya virus-carrying mosquitos are endemic. Unfortunately, climate change has allowed the virus to spread to new parts of the world, the FDA added.

Before 2006, the virus was rarely identified in U.S. travelers, according to the **U.S. Centers for Disease Control and Prevention**, but studies have identified a couple dozen cases in the U.S. travelers between 2006 and 2013. Then, in late 2014, local transmitted cases were reported in Florida, Texas, Puerto Rico and the U.S. Virgin Islands.



People who get sick with chikungunya typically have a fever and can develop joint pain. They may also experience a headache, muscle pain and a rash. For some, the joint pain can be severe and last for years. Among newborns, chikungunya can be a potentially deadly threat, the FDA noted.

Ixchiq contains a live, weakened version of the virus, so it may cause symptoms that mimic an actual infection.

The prescribing information that comes with the vaccine carries a warning that it is not known whether the weakened vaccine virus can be transmitted from a pregnant woman to her newborn, and it is not clear whether the vaccine virus can harm a baby.

Because there's no treatment for chikungunya,

doctors usually tell patients to rest, drink lots of fluids and take over-the-counter medication to manage their fever or pain, the FDA said. But experts noted that a vaccine is the best option for people vulnerable to the virus.

The FDA is requiring that vaccine maker Valneva do a post-market study to make sure there are no serious side effects with the vaccine.

The most common side effects reported in studies submitted for the vaccine's approval included headache, muscle and joint pain, fever, tenderness at the injection site and being tired.

Just 2% of those who got the vaccine had severe chikungunya-like adverse reactions that required medical intervention, the FDA said, and only two of the nearly 3,500 people in the trials had to go to a hospital because of a reaction.

## Majority of Workers at America's Nursing Homes Unvaccinated Against Flu, COVID

Health care workers at America's nursing homes are woefully under-vaccinated for both flu and COVID-19, threatening their own health and that of the frail elderly patients under their care, a new report finds.

Looking at 2023 data collected at nearly 14,000 nursing homes nationwide, researchers found that fewer than one in every four (22.9%) health care workers had received up-to-date COVID vaccines, while less than half (47.1%) had gotten the latest flu shot.

Given the dangers posed by the threat of infectious disease

spreading through nursing homes, "there is a need to promote evidence-based strategies to improve vaccination coverage among health care professionals" working at these facilities, said researchers led by **Dr. Jeneita Bell**. She is with the National Center for Emerging and Zoonotic Infectious Diseases, part of the U.S. Centers for Disease Control and Prevention.

The new report looked at data on staff vaccination rates at U.S. acute care hospitals and nursing homes, gathered from the CDC's National Healthcare Safety Network.



Data was collected on over 2 million health care workers at nearly 14,000 nursing homes nationwide, as well as 8.9 million staffers at over 4,000 hospitals across America.

Health care workers at hospitals had better vaccination rates against the flu in 2023 compared to those working at nursing homes: 81% had gotten the latest shot, Bell's team found.

However, up-to-date COVID immunization was very low among hospital staff, with just 17.2% having gotten the latest vaccines, the study found.

Nursing home staff vaccination

rates were low, and varied widely depending on where in the country the facility was located. For example, almost 41% of workers in nursing homes on the West Coast were up-to-date on their COVID shots, compared to just 17.5% of those in the South.

Similar disparities were seen when it came to vaccination against the flu. In certain southern states — Alabama, Florida, Kentucky, Louisiana and Missouri — less than 10% of staff at acute care hospitals were up-to-date on their COVID shots in 2023, the report found.

## Science Reveals Link Between Obesity, Diabetes & Pancreatic Cancer Risk

Having high insulin levels may be more than tough to manage when you have diabetes: New research shows it also appears to raise the risk of pancreatic cancer.

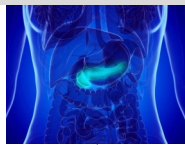
In the study, scientists found excessive insulin levels overstimulated pancreatic acinar cells, which produce digestive juices. This overstimulation triggers inflammation that turns these cells into precancerous cells.

"Alongside the rapid increase in both obesity and type 2 diabetes, we're seeing an alarming rise in pancreatic cancer rates," said co-senior study author **James Johnson**, a professor in the Department of Cellular and Physiological Sciences and interim director of

the Life Sciences Institute at the University of British Columbia (UBC) in Vancouver.

"These findings help us understand how this is happening, and highlights the importance of keeping insulin levels within a healthy range, which can be accomplished with diet, exercise and, in some cases, medications," Johnson said in a university news release.

The study focused on pancreatic ductal adenocarcinoma (PDAC). This is the most prevalent pancreatic cancer. It is highly aggressive with a five-year survival rate of less than 10%. By 2030, PDAC is expected to become the second leading cause of cancer-related



deaths.

The new study sheds light on the role of insulin and its receptors in pancreatic cancer risk.

"We found that hyperinsulinemia [high insulin levels] directly contributes to pancreatic cancer initiation through insulin receptors in acinar cells," said study first author **Anni Zhang**, who recently graduated with a PhD from UBC and now is a post-doc researcher at Stanford University in California. "The mechanism involves increased production of digestive enzymes, leading to heightened pancreatic inflammation."

Knowing this may help guide new cancer prevention strategies, and it may also lead to

treatments that target insulin receptors in acinar cells.

"We hope this work will change clinical practice and help advance lifestyle interventions that can lower the risk of pancreatic cancer in the general population," said co-senior study author **Janel Kopp**, an assistant professor in the Department of Cellular and Physiological Sciences at UBC.

"This research could also pave the way for targeted therapies that modulate insulin receptors to prevent or slow the progression of pancreatic cancer," she said in the release.

The findings were published Oct. 31 in the journal **Cell Metabolism**. [Read More](#)

## Two New Studies Point to the Promise of Gene Therapy for High Cholesterol

Two new gene-editing treatments that target dangerously high levels of cholesterol in people with a genetic predisposition to the condition were found safe and effective in new, groundbreaking research.

While powerful drugs like statins can help manage cholesterol in most people, they can't treat those who have genes that predispose them to heart troubles. But the duo of studies, presented Sunday at the American Heart Association (AHA) annual meeting in Philadelphia, may one day change that.

Both treatments will need years of additional research before the

U.S. Food and Drug Administration would even consider approving them, but that didn't dampen the excitement among heart experts.

"There is no way to categorize this other than revolutionary," **Dr. Hugh Cassiere**, director for critical care services at South Shore University Hospital, Northwell Cardiovascular Institute, in New York, told *NBC News*. He was not involved with either study.

One of the treatments, from Boston-based Verve Therapeutics, uses a gene-editing approach that targets the PCSK9 gene, making a tiny change to the



gene. The effect is akin to a permanent eraser, deleting the gene's ability to fuel a rise in cholesterol levels, Verve co-founder and CEO **Dr. Sekar Kathiresan** told *NBC News*.

In theory, the one-time treatment should last a lifetime.

"Instead of daily pills or intermittent injections over decades to lower bad cholesterol, this study reveals the potential for a new treatment option -- a single-course therapy that may lead to deep LDL-C lowering for decades," senior study author **Dr. Andrew Bellinger**, chief scientific officer at Verve, said in

an AHA [news release](#).

In Verve's [preliminary study](#), most of the 10 patients received doses that didn't make a measurable difference in their LDL levels, but three were given higher doses. In those patients, LDL cholesterol levels were slashed by more than half.

Verve's research was limited to people with a genetic condition called familial hypercholesterolemia, in which cholesterol levels are high from birth. Many of these patients suffer heart attacks in their 30s or 40s... [Read More](#)



## Wegovy Cuts Heart Risks by 20% in Large Trial

In a finding that could change the landscape of heart disease care, the wildly popular weight-loss drug Wegovy has proved its mettle in protecting the heart after lowering the risk of cardiac problems in patients by 20%.

The results from this large, international study had been eagerly awaited by scientists and doctors alike. Why? It is the first to show that Wegovy's therapeutic powers may extend to the cardiovascular system, helping prevent a heart attack, stroke or a heart-related death in people who already have heart disease but not diabetes.

"It moves from a kind of therapy that reduces body weight to a therapy that reduces

cardiovascular events," study author **Dr. Michael Lincoff**, vice chairman for research in the department of cardiovascular medicine at the Cleveland Clinic, told the *Associated Press*.

A high-dose version of the diabetes drug Ozempic, which already has been shown to lower the risk of heart problems in people who have diabetes, Wegovy seems to do the same for heart patients who don't have the blood sugar disease.

**Dr. Francisco Lopez-Jimenez**, a heart expert at the Mayo Clinic, told the *AP* that he believes the new findings will alter heart treatment guidelines and



"dominate the conversation" for years to come.

"This is the population who needs the medicine the most," said Lopez-Jimenez, who wasn't involved in the research.

The results were published Saturday in the *New England Journal of Medicine* and presented simultaneously at the American Heart Association's annual meeting in Philadelphia. Novo Nordisk, which makes both Wegovy and Ozempic, has already asked the U.S. Food and Drug Administration to include the heart benefits on Wegovy's label, as it does on Ozempic's label.

More than 17,500 people in 41 countries were included in the company-funded study. Participants were 45 and older, had a body mass index of 27 or higher and were tracked for more than three years, on average. They took standard heart medications, but they were also randomly assigned to get weekly injections of either Wegovy or a dummy shot.

The study found that 6.5% of those who got the Wegovy shot had a heart attack, stroke or died from a heart-related cause, while 8% of those who received a dummy shot did. That translated into an overall risk reduction of 20%....[Read More](#)

## U.S. Men Are Dying Much Earlier Than Women, as Death 'Gender Gap' Widens

The gap in life expectancy between American men and women is now the biggest it has been since the mid-1990s -- almost six years.

The pandemic and opioid overdoses are key factors in the gender difference in longevity, said researchers from the University of California, San Francisco (UCSF) and Harvard University T.H. Chan School of Public Health.

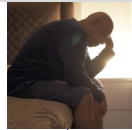
"There's been a lot of research into the decline in life expectancy in recent years, but no one has systematically analyzed why the

gap between men and women has been widening since 2010," said first study author **Dr. Brandon Yan**, a resident in internal medicine at UCSF.

In 2021, the gender gap in life expectancy rose to 5.8 years, its largest since 1996, he and his colleagues report. In 2010, the gap was its smallest in recent history, 4.8 years.

Life expectancy in the United States was 76.1 years in 2021. That's down from 78.8 years in 2019 and 77 years in 2020.

Researchers cited the pandemic



as the biggest factor in the widening gender gap; it took a heavier toll on men. Unintentional injuries and poisonings (mostly drug overdoses), accidents and suicide were other contributors.

Another factor in Americans' shrinking lifespan: so-called "deaths of despair." That's a nod to the rise in deaths owing to such causes as suicide, drug use disorders and alcoholic liver disease. These are often linked to economic hardship, depression and stress.

"While rates of death from drug

overdose and homicide have climbed for both men and women, it is clear that men constitute an increasingly disproportionate share of these deaths," Yan said in a joint news release from UCSF and Harvard.

He and colleagues from around the country used data from the National Center for Health Statistics to zero in on the causes of death that were contributing most to shrinking life expectancy. After that, they examined how much different causes were contributing to the gap....[Read More](#)

## Americans Are Now Getting Far Fewer Opioids for Dental Pain

If you're getting a tooth pulled or having another painful dental procedure, you're much less likely to get opioids than you were just a few years ago, new research reveals.

That's good news because opioid abuse is a major issue in the United States and these drugs aren't necessary for most dental procedures.

But there was a bit of bad news in the findings: Efforts to reduce opioid use in dental care did hit a snag during the pandemic, according to the study authors.

The decline in opioid prescriptions filled by dental patients was much faster in the pre-pandemic years 2016 through 2019, compared with the rate of decline from June 2020 to December 2022.

"These data suggest the dental profession has made major strides in reducing opioid prescribing, but also suggest that progress is slowing," said senior study author **Dr. Kao-Ping Chua**, an assistant professor of pediatrics at the University of Michigan (UM) Medical School.

Dental opioids dispensed to U.S. patients of all ages declined 45% from 2016 to the end of 2022. Still, about 7.4 million dental patients filled opioid prescriptions in 2022.

Those prescriptions for teens and young adults, at especially high risk related to opioids, did keep declining rapidly even after the early pandemic pause. For other groups, the rate of decline slowed after June 2020.



If the pace of decline had continued, 6.1 million fewer dental opioid prescriptions would have been dispensed between June 2020 and December 2022.

American dentists and oral surgeons were still prescribing opioids in late 2022 at four times the rate that another study showed British dentists were prescribing in 2016, according to researchers.

"We know from research that dental pain in most patients can be controlled with non-opioid medications, avoiding the risks of opioids," study co-author **Dr. Romesh Nalliah**, associate dean for clinical affairs at the UM School of Dentistry, said in a university news release. "While it's reassuring that dental opioid prescribing is declining, the

recent slowing in the decline suggests the dental profession must redouble its efforts to reduce unnecessary opioid prescribing."

It's possible the reason for the slowing of the decline was that dentists may have been more likely to prescribe opioids just in case they were necessary, out of concern that patients couldn't easily follow up with their dentist during the pandemic, Zhang suggested.

For this study, researchers used data from a company called IQVIA that tracks prescriptions dispensed at 92% of U.S. pharmacies. The researchers excluded data from March through May of 2020, during a pandemic pause in routine dental care....[Read More](#)

## Special Toothpaste Might Curb Peanut Allergy in Adults

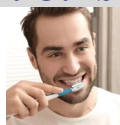
Researchers are testing a toothpaste that aims to let patients who are sensitive to peanuts and other foods simply brush their allergies away.

Doctors already treat some food allergy patients with oral immunotherapy — feeding them tiny, portioned and gradually increasing bits of their allergen under supervision for some time.

The new strategy is a twist on that. Called oral mucosal immunotherapy (OMIT), it relies on the lining of the mouth, which has a lot of immune response cells, to desensitize patients.

All they have to do is brush with a specially formulated toothpaste containing peanut protein. Called INT301, it's dispensed in a metered dose and cleans the teeth at the same time.

"The immunotherapy is conveniently administered by just brushing your teeth once a day so you don't have to get an injection," said researcher **Dr. William Berger**, a pediatric allergist at CHOC at Mission Hospital, Mission Viejo, Calif. "You don't have to eat something. You don't have to prepare



something. You just get up in the morning just like you normally would do and brush your teeth."

Berger is scheduled to present his findings Saturday at a meeting of the American College of Allergy, Asthma and Immunology in Anaheim, Calif. Research presented at meetings is typically considered preliminary until published in a peer-reviewed journal.

To test the treatment, he and his team enrolled 32 adults ages 18 to 55 who had a peanut allergy. Over 48 weeks, some

used the actual toothpaste, in increasing strengths. Others were given a placebo.

Researchers said everyone given the peanut toothpaste consistently tolerated the pre-specified highest dose. No systemic reactions, either moderate or severe, were seen.

For participants who had non-systemic reactions, most were oral itching that was mild and temporary.

"In our study, we had really excellent safety data," Berger said....[Read More](#)

## People's Heart Health Improves in More 'Flexible' Workplaces

A kinder, more thoughtful workplace can lead to better heart health among older employees, a new study finds.

Older workers' heart health risk factors decreased significantly when their office employed interventions designed to reduce work-family conflicts, researchers report in the Nov. 8 issue of the *American Journal of Public Health*.

Specifically, their heart risk factors reflected those of people 5 to 10 years younger when their workplace culture provided them better flexibility and support.

"The study illustrates how working conditions are important social determinants of health," said co-lead researcher **Lisa Berkman**, director of the Harvard Center for Population and Development Studies.

"When stressful workplace conditions and work-family conflict were mitigated, we saw a reduction in the risk of cardiovascular disease among more vulnerable employees, without any negative impact on their productivity," Berkman added in a Harvard news release. "These findings could be particularly consequential for low- and middle-wage workers who traditionally have less control over their schedules and job demands and are subject to greater health inequities."

For the study, researchers worked with two companies -- an IT company with 555 participating employees and a long-term care company with 973 participating employees.



The researchers trained company supervisors on strategies that support employees' personal and family lives. Teams of supervisors and employees also attended hands-on trainings to identify new ways to increase employees' control over their schedules and workflow.

The workplace changes didn't have a significant effect on all employee's heart health risk factors, researchers found.

But there were significant improvements for workers who entered the study with high heart risk scores.

Those employees at the IT company saw a reduction in their heart risk scores equivalent to 5.5 years of age-related changes, researchers found.

Results were even more striking at the long-term care company, where employees saw a reduction equivalent to 10.3 years.

Age also played a role. Employees over 45 with higher heart risk scores were more likely to see an improvement than younger workers.

"The intervention was designed to change the culture of the workplace over time, with the intention of reducing conflict between employees' work and personal lives and ultimately improving their health," said co-lead researcher **Orfeu Buxton**, director of the Sleep, Health & Society Collaboratory at Penn State University. "Now we know such changes can improve employee health and should be more broadly implemented."

## Major Study Confirms Salt's Deadly Effect on Blood Pressure

Cutting out just one teaspoon of salt every day lowers blood pressure almost as much as medication does, new research shows.

Investigators said theirs is one of the largest studies ever to include people taking high blood pressure meds in a look at the effect of reducing dietary intake of sodium.

"We found that 70-75% of all people, regardless of whether they are already on blood pressure medications or not, are likely to see a reduction in their blood pressure if they lower the sodium in their diet," said study co-author **Norrina Allen**, a professor of preventive medicine

at Northwestern University Feinberg School of Medicine in Chicago.

She said researchers previously didn't know if people already on blood pressure meds could lower their blood pressure even more by reducing their sodium intake.

In the study, middle-aged to elderly participants reduced their salt intake by about 1 teaspoon a day.

"The result was a decline in systolic blood pressure by about 6 millimeters of mercury (mm Hg), which is comparable to the effect produced by a commonly utilized first-line medication for



high blood pressure," said co-principal investigator **Dr. Deepak Gupta**, an associate

professor of medicine at Vanderbilt University Medical Center, in Nashville, Tenn. Systolic blood pressure is the pressure in your arteries as your heart beats. It's the first number in a blood pressure reading.

High blood pressure is a leading cause of illness and death worldwide. The added pressure on arteries can trigger heart failure, heart attacks and strokes. It affects the heart's ability to pump blood effectively, Allen said.

The study included 213 men

and women, from 50-somethings to those in their 70s. They were randomly assigned to follow a high-sodium (2,200 milligrams (mg) per day on top of their usual diet) or a low-sodium diet (500 mg in total per day) for one week. Then, they switched and followed the other diet.

Before each study visit, participants wore blood pressure monitors and collected their urine for 24 hours.

Compared to their usual diet, 72% of participants had lower systolic blood pressure when they followed the low-sodium regimen....[Read More](#)