



Message from Alliance for Retired Americans Leaders

Pension Spending During Covid Pandemic Provided \$1.3 Trillion to the Economy



Robert Roach, President, ARA

Retirees who spent their public and private sector pension benefits in 2020 generated \$1.3 trillion in total economic

output, supporting nearly 6.8 million jobs across the nation, according to a **report released Wednesday by the National Institute on Retirement Security.** The real



estate, food services, health care, and retail sectors of the economy

saw the biggest employment impacts

The study, entitled Pensionomics 2023: Measuring the Economic Impact of Defined Benefit Pension Expenditures, also found that pension spending added nearly \$157.7 billion to government coffers at the federal, state, and local levels.

"Pension benefits not only provide financial security for retirees, but also boost the economy," said Robert Roach, Jr., President of the Alliance. "At the height of the COVID pandemic, retirees with pensions were able to spend at their normal rate. That spending supported millions of jobs during a time of massive layoffs. In contrast, many retirees relying on 401(k) accounts during that period were afraid to spend their savings, and that added to the

economic turmoil."

A map with downloadable state fact sheets regarding the economic impact of state and local pension plans is available **here.**

Far-right House Members Seek Commitment that New Speaker Will Use Debt Limit to Force Spending Cuts



Rich Fiesta, Executive Director, ARA

Conservative rebels in the House are **demanding** that the next Speaker of the House commit to

opposing a "clean" debt limit increase later in 2023. Their goal is to tie any vote to increase the nation's debt ceiling to deep cuts in domestic spending that could include cuts to Social Security and Medicare

If the maneuver succeeds, it will set up a showdown with Senate Democrats and President Biden and put the country at risk of default.

Rep. Ralph Norman (R-SC) publicly made the threat on behalf of his camp

Wednesday, **telling reporters** that Rep. Kevin McCarthy (R-CA), who is battling to become Speaker, would have to commit to "shut down the government rather than raise the debt ceiling" in order to win their support to lead the House.

Multiple members have **said** the debt ceiling vote should be used to force cuts to Social

Security and Medicare, which President Biden has vowed to oppose. The Treasury Department has not said when exactly the debt limit will expire, but economists estimate it will need to be raised sometime after July.

Rep. Lloyd Doggett (D-TX) said that "there certainly is that danger" that 2023 could turn into a repeat of 2011, when the deadlock over raising the debt limit dragged on for months and took the nation so close to default that Standard and Poor's downgraded America's credit rating.

"Many Republicans have stated that they will force the country to default, setting off a global economic crisis, unless Democrats and President Biden accept changes to Social Security and Medicare," said Richard Fiesta, Executive Director of the Alliance. "The Alliance will do whatever it takes to ensure that does not happen, whoever the new Speaker is."

House Investigation into Alzheimer's Drug Places Blame on FDA, Biogen



Joseph Peters ARA Sec.-Trea.

The Food and Drug Administration's process for approving the Alzheimer's drug Aduhelm, despite great uncertainty about whether it worked, was "rife with irregularities," according to a **congressional investigation.** The report also criticized

Biogen, Aduhelm's manufacturer, for setting an "unjustifiably high **price.**"

The 18-month investigation, initiated by the House Energy and Commerce Committee and House Committee on Oversight and Reform after the FDA approved the drug, strongly criticized Biogen for setting a price of \$56,000 a year for the drug. The inquiry found that Biogen wanted a history-making "blockbuster" in order to "establish Aduhelm as one of the top pharmaceutical launches of all time," even though it knew the high price would burden Medicare and patients. The report included the FDA's own internal inquiry into its Aduhelm review process, which found that FDA officials leading the Aduhelm evaluation did not pay enough attention to dissenting views from the agency's own statistical team, which said there was inadequate evidence that Aduhelm worked.

"It is reprehensible that Medicare premiums increased by 14.55% due in large part to one overpriced and unproven drug," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "Fortunately, the 2023 Medicare premiums no longer reflect a major Aduhelm surcharge."

Joe Biden Wants to Change Social Security: Will the New Congress Help With Reform Efforts?

In November, nearly 66 million Americans, many of whom are aged 62 and over, received a **Social Security benefit**. For the 48.5 million who are retired workers, these payouts are widely viewed as a necessity to cover their expenses.

But despite providing a financial foundation for our nation's retirees, America's top retirement program finds itself in deep trouble. President Joe Biden believes he has the solution that can resolve what ails Social Security, but he's going to need the help of newly elected lawmakers to fix it.

Retired workers could be less than 12 years away from having their benefits cut

For each of the past 83 years, the Social Security Board of Trustees has released a report that's examined the financial status of the program over the short term (the next 10 years) and long term (75 years following the release of a report). The Trustees Report effectively acts as Social Security's balance sheet and allows anyone to see how revenue is collected and where those dollars end up.

In addition to backward-looking financial data, the Trustees Report factors in changing macroeconomic and demographic factors to determine the financial health of Social Security.

The 2022 Trustees Report showed that Social Security had

dug its largest hole yet: an estimated \$20.4 trillion funding shortfall through 2096. For what it's worth, every Trustees Report since 1985 has projected a long-term funding shortfall.

Social Security's increasingly dire financial footing is **primarily a result of demographic shifts**. Examples include historically low U.S. birth rates, a **near-halving in net immigration into the country** over two decades, and growing income inequality, among other factors. With these changes weighing on the worker-to-beneficiary ratio, it would appear the program's financial foundation will only worsen.

Based on last year's projections, the asset reserves for the Old-Age and Survivors Insurance Trust Fund (OASI) are expected to run out in 2034. The OASI is the Trust responsible for paying benefits to 48.5 million retired workers each month, as well as nearly 5.9 million survivors of deceased workers. If this excess cash were to be exhausted within the next 12 years, the Trustees believe an **across-the-board benefit cut of 23%** would be necessary to sustain payouts through 2096. For context, a 23% benefit cut would reduce the average Social Security check by roughly \$420 per month (In January 2023 dollars), or \$5,000 per year.

While Social Security **is in no**



danger whatsoever of becoming insolvent, the size of Social Security checks paid to retired workers 12 years from now is very much in question.

Joe Biden has proposed sweeping reforms for Social Security

In 2020, prior to his election as president, then-candidate Joe Biden released a plan he believed would strengthen Social Security for decades to come. Although there are **four Social Security changes Biden is seeking**, two stand out as key to shoring up the program.

This biggest Social Security change proposed by Biden would tackle income inequality head-on and generate a lot of extra revenue.

In 2023, Social Security's 12.4% payroll tax is applicable to earned income **between \$0.01 and \$160,200**. "Earned income" means wages and salary but **not any sort of investment income**. Approximately 94% of all working Americans earns less than the maximum taxable earnings cap (the \$160,200 figure). For the other 6% of workers, earned income above this \$160,200 level is exempt from the payroll tax.

Joe Biden's proposal would create a doughnut hole between the maximum taxable earnings cap and \$400,000 where earned income would remain exempt, as

well as reinstate the payroll tax on earned income above \$400,000. Since the maximum taxable earnings cap tends to rise over time with inflation, this doughnut hole would eventually close decades down the line. This immediate increase in payroll tax revenue should push back the asset reserve depletion date of the OASI.

The other notable Social Security change President Biden is seeking is the **replacement of the program's measure of inflation**.

Since 1975, the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) has been used to determine Social Security's annual cost-of-living adjustment (COLA). Unfortunately, as its name implies, this is a price-measuring index focused on the spending habits of "urban wage earners and clerical workers." In other words, people who generally aren't receiving a Social Security benefit.

Biden would like to see the Consumer Price Index for the Elderly (CPI-E) used to calculate COLA instead of the CPI-W. The CPI-E specifically tracks the spending habits of older Americans, which would likely provide a larger annual cost-of-living adjustment.

Is a new Congress the recipe Biden needs to reform Social Security?.....**Read More**

The Surprising Truth About the Future of Social Security

There's good news and bad news

Social Security's been a staple of seniors' retirement plans for decades, but whether it'll be around for decades to come is a more complicated issue. A lot of workers believe Social Security won't be there for them when they're ready to retire. This fear isn't without basis but it's also not completely accurate.

Let's look at why Social Security is in danger and what the future of the program could look like.

Social Security is facing a funding crisis. People are worried about **Social Security** running out of money because its costs currently exceed its income, and that has forced

the Social Security Administration to drain the program's trust fund reserves. If nothing changes, the government will reach a point where it's no longer able to pay out all scheduled benefits. The latest estimates place this point at about 2035, though it remains to be seen whether the substantial **2023 cost-of-living adjustment (COLA)** moves this date up.

But even if this happens, Social Security won't end. It has other sources of income that will continue even after the trust funds are depleted. You're probably familiar with the Social Security payroll taxes that all workers pay on the first \$160,200 of their income in 2023. This



automatically comes out of your paychecks, and it helps fund the benefits of seniors on Social Security today.

Some seniors also pay federal (and possibly state) **taxes on their Social Security benefits** if their incomes are high enough. This money also helps fund the benefits of other recipients right now.

Neither of these sources of income is going away, so Social Security will still continue in some form for the foreseeable future. What's less certain is what that future will look like.

What does the future hold for Social Security?

Beginning in 2035, Social Security will only be able to pay

out about 80% of scheduled benefits, and this will drop to 74% by 2096, according to the latest Trustees Report. That means the government would eventually have to slash benefits by up to 26%. But the truth is, it might not come to that.

Politicians on both sides of the aisle recognize that Social Security's funding crisis is serious and requires action. But so far, they haven't been able to agree on how to increase the program's revenue. Some suggested strategies include:

Raising the ceiling on income subject to Social Security payroll tax...**Read More**

Republicans Signal Cuts To Social Security, Medicare With New House Majority

House Republicans are making clear that they intend to seek cuts to entitlement programs like Social Security and Medicare with their new majority in the 118th Congress.

Their plans to target health care programs follow demands from a group of conservatives that helped elect House Speaker Kevin McCarthy (R-Calif.) over the weekend. Those far-right lawmakers have sought across-the-board spending cuts in order to tackle the growing national debt.

But the narrow House GOP majority — McCarthy can afford to lose just four votes on any bill — is far more divided on cuts to defense spending than for entitlement programs.

"I'm all for a balanced budget, but we're not going to do it on the backs of our troops and our military," Rep. Michael Waltz (R-Fla.), a former Army Green

Beret, said Monday during an interview on Fox Business. "If we really want to talk about the debt and spending, it's the entitlements programs."

As part of his **list of concessions** to conservatives, McCarthy reportedly agreed to cap spending for the next year at fiscal 2022 levels, which would amount to **over \$130 billion in cuts** from last month's \$1.7 trillion government funding bill.

Republicans don't plan to alter benefits for current Social Security and Medicare recipients, according to Rep. Chip Roy (R-Texas).

"What we have been very clear about is, we're not going to touch the benefits that are going to people relying on the benefits under Social Security and Medicare," Roy said Sunday on CNN's "State of the Union." "But we all have to be



honest about sitting at the table and figuring out how we're going to make those work, how we're going to deal with defense spending and how we're going to deal with nondefense discretionary spending."

The Republican Study Committee proposed a budget for fiscal 2023 that would gradually increase the eligibility ages for Social Security and Medicare, and change the Social Security benefit formula for people 54 and younger, while not changing it for people closer to receiving benefits.

Democrats are likely to oppose those changes, as well as any cuts to Social Security and Medicare, and an ensuing standoff could result in another government

shutdown. The 2018-2019 lapse in federal funding lasted 35 days after a fight over former President Donald Trump's border policies and immigration.

Rep. Rosa DeLauro (D-Conn.), the top Democrat on the House Appropriations Committee, warned last week that Republicans were "all but guaranteeing a shutdown" by demanding to cap spending at fiscal 2022 levels.

"These types of cuts would harm communities and families across the United States who are already struggling with inflation and the rising cost of living," DeLauro said in a statement. "They put support for our Veterans, law enforcement, small businesses, and military families at risk."

Germans force competition among drug companies; should the US follow suit?

In an article for **Health Affairs**, James C. Robinson argues that the US should take a page from Germany to drive competition among pharmaceutical companies and to lower drug costs for individuals. Medicare and other insurers should pay a fixed fee for drugs with the same clinical benefits, regardless of their cost, and leave it to individuals to decide which drug to get. Ideally, drug manufacturers with costlier drugs would be forced to bring down their prices in order to compete effectively.

It seems insane that drug

manufacturers can charge very different prices for drugs that are similar in effect, and that Medicare and other insurers will pay more for drugs that are no more efficacious than less expensive drugs.

In Germany, when there are three or more drugs that are equally effective, they are treated as if they are in the same therapeutic class. They might be brand name or generic or both. The insurer then pays no more than a particular price for all these drugs, which the insurers



collectively set. Patients have a powerful financial incentive to choose the lowest-priced drugs when they offer similar clinical benefits as the higher-priced drugs. Patients must pay whatever the difference in cost for the higher-priced drugs. Generally, this leads the manufacturers of the higher-priced drugs to reduce their prices.

Insurers in Germany are generally able to negotiate additional discounts on a single drug in that class through a

confidential rebate system with the manufacturer of that drug. The manufacturer wins with more business; consumers win with lower prices.

For the German reference pricing system to work best, there need to be several drugs in a class. So, the German government broadened therapeutic classes for biologics and biosimilars, where there are otherwise too few drugs to promote competition....**[Read More](#)**

Nursing Home Red Flags You Should Watch Out for

When comparing nursing homes for a loved one, diligence is key. Be on the lookout for the telltale signs of a poor nursing home facility.

The importance of visiting nursing homes

Choosing **the right nursing home** for yourself or a loved one is a challenging task. You want to find a facility where residents are treated with respect and where the level of care is high. **Nursing home ratings** from federal and state agencies can help you see how different facilities stack up on important measures like

staffing and other issues.

For example, the federally run **Care Compare** website provides tools where you can search by region and view different metrics for nursing homes, long-term care hospitals, in-patient rehabilitation centers and other facilities. The website provides, for instance, a tool that allows you to see the percentage of patients with complications like pressure ulcers or pressure injuries that are new or worsened and compare a particular facility's rate to the national average.



Many state agencies provide similar resources. For instance, the California Department of Public Health provides the California Health Facilities Information Database.

Medicare's Nursing Home Lookup also provides ratings on an array of issues, like staffing and whether a home is meeting state health and safety standards.

But it's still crucial to visit facilities you're considering, says Amy Cameron O'Rourke, a licensed nursing home care administrator with 40 years of

experience in the field. O'Rourke is based in Orlando, Florida, and she's the author of "The Fragile Years: Proven Strategies for the Care of Aging Loved Ones," which was published in July 2021.

"The biggest decision you are about to make is moving to a skilled nursing facility. They'll see you at your most vulnerable state, bathing you, feeding you and helping you get dressed and undressed," she says. "Would you pick a home without seeing it?..."**[Read More](#)**

Traditional Medicare v. Medicare Advantage? Different as night and day

Make no mistake. Traditional Medicare, which is government-administered, and Medicare Advantage, which is administered by corporate insurers, are as different as night and day. But, it's easy to think otherwise, as they both offer Medicare benefits. Here's what you should ask yourself to choose between them:

Can you see the doctors you need to see wherever you happen to be in the US? Only traditional Medicare covers your care from virtually any doctor or hospital in the US. Medicare Advantage plans generally only cover care from a restricted network of doctors and hospitals, often only in your community. When they cover care from health care providers outside of their network, you are often left paying 40 percent of the bill out of pocket.

Will you be covered for all the Medicare services your physicians say you need? Only traditional Medicare covers these services. Medicare Advantage plans often second-guess your treating physicians. Medicare Advantage plans too often inappropriately **delay and deny you needed care**, even though they are supposed to cover the same medically necessary services as traditional Medicare.

Will you face administrative obstacles to care, such as PCP referrals and prior authorization requirements for specialty care? Only traditional Medicare allows you to go straight to the physicians and hospitals you want to use without creating barriers. Medicare Advantage plans too often require you get their permission in order

to get the treatments you need, at times **second-guessing your physicians**. They typically cover 25 percent fewer services than traditional Medicare.

Will your Medicare plan profit from delaying and denying care? Only traditional Medicare gives your health care providers an incentive to provide all the care you need. Medicare Advantage plans receive **a fixed amount from the government to cover your care**, regardless of how much they spend on your care. The less money a Medicare Advantage plan spends on your care, the more money the Medicare Advantage plan has for its shareholders. They profit from delaying and denying care.

Can you limit your out-of-pocket health care costs? Only traditional Medicare provides you with the option of buying **supplemental insurance** to fill gaps in coverage. So, when you need care, you don't have to think about out-of-pocket costs. But, traditional Medicare does not have an out-of-pocket limit, so if you don't have Medicaid, which fills gaps in coverage, or supplemental insurance—which could easily cost \$2,500 a year—your out-of-pocket costs could be substantial. Medicare Advantage has an out-of-pocket limit. But, that limit can be as high as **\$8,300 a year for in-network care alone** in 2023, depending upon the plan you choose. So, when you need care, your costs could be hundreds, if not thousands, of dollars.

How will you get prescription



drug benefits? You can buy a **Medicare Part D prescription drug benefit** if you're in

traditional Medicare for about \$30 a month. If you're in Medicare Advantage, prescription drug benefits are generally included. Either way, Medicare only covers some of the costs of your drugs. You need to check to see whether the plan you choose will cover the drugs you need at a reasonable cost to you.

Do you want "extra" benefits? This is a trick question. Traditional Medicare does not cover vision, hearing and dental care or transportation services and gym memberships. Medicare Advantage often tacks on one or more of these benefits to its package as a way to lure in enrollees. If these are important to you, make sure they are meaningful benefits. Medicare Advantage plans often force you to use a small group of providers for these services as well as to pay substantial amounts out of pocket for them. And, remember that if you need a lot of medical care, Medicare Advantage plans are likely to cover fewer services than traditional Medicare.

Want to know which Medicare Advantage plan is best for you? Throw a dart and say a prayer. Many Medicare Advantage plans have **long histories of engaging in consumer fraud**. A lot of them have been found to persistently inappropriately delay and deny people needed care. A large portion of them do not have cancer centers of excellence in their networks and, if they do, the

networks are always changing. The government is not able to assess meaningful quality differences among them. And, the **five-star rating system is largely a farce**.

Can you save money by joining a Medicare Advantage plan? Yes. You can save on the cost of supplemental insurance and Part D prescription drug coverage. But, if you develop a serious condition and need expensive care, you will likely pay a lot more.

Can you enroll in a Medicare Advantage plan while you're healthy and then switch to traditional Medicare when you need costly care? Theoretically you can. But, in practice, you take a big financial and health risk. Unless you live in Maine, Massachusetts, New York or Connecticut, companies offering Medicare supplemental insurance are not required to sell you coverage to fill gaps in traditional Medicare after you are first eligible for Medicare, except in limited situations. If you can't buy supplemental coverage, you are effectively locked into Medicare Advantage in order to protect yourself financially, because traditional Medicare has no out-of-pocket cap.

Bottom line: If you can afford supplemental coverage in traditional Medicare or have Medicaid, you and your family can sleep well, knowing you will be able to get the care you need, wherever you are in the US, whenever you need it, without worry about out-of-pocket costs. Don't count on that in Medicare Advantage.

The Decision of Where to Seek Care Is Complicated by the Multitude of Options

One evening in February 2017, Sarah Dudley's husband, Joseph, started to feel sick.

He had a high fever, his head and body ached, and he seemed disoriented, she said. The Dudleys had a decision to make: go to the hospital emergency room or to an urgent care clinic near their home in Des Moines, Iowa.

"ERs take five, six, seven hours before you're seen by a doctor, depending on how many people are there," Sarah said. "I know

that I can go to an urgent care clinic and be seen within an hour."

According to court filings, at the clinic, a physician assistant misdiagnosed Joseph with the flu. His condition worsened. A few days later he was hospitalized for bacterial meningitis, and he was placed into a medically induced coma. He had multiple strokes, lost hearing in one ear, and now has trouble processing information. The Dudleys sued over the error



and a jury awarded them \$27 million, though the defendants have asked for a new trial.

Their story reflects a challenge in the American health care system: People who are injured or sick are asked, in a moment of stress, to prudently decide which medical setting is the best place to seek help. And they must make that choice amid a growing number of options.

Landing in the wrong setting can lead to higher and

unexpected medical bills and increased frustration. Patients often don't understand what kind of services different settings provide or the level of care they need, and an uninformed choice is "a recipe for poor outcomes," said **Caitlin Donovan**, senior director at the National Patient Advocate Foundation, a patients' rights nonprofit. **Read More**

Retirement Reboot: What you should know and how to plan ahead

Once you retire, how will you replace your working income to maintain your standard of living? In his new book, Retirement Reboot, Mark Miller offers simple, practical guidance to help ensure that you are prepared for retirement. Miller's book is an excellent primer on the big questions and uncertainties retirees face. And, it offers smart guidance. Here's an overview of many of the topics Miller covers:

1. **Retirement planning:** Make a plan as to how you will have what you need to live on in retirement. Calculate what you spend each year now, how much is non-discretionary and how much is discretionary. Remember that you will likely have swings in your expenses, depending upon your health care needs. As a rule of thumb, people need about 70-80 percent of their pre-retirement income to maintain their standard of living in retirement.
2. **When to retire:** It's a different calculation for everyone, depending upon a number of factors.
3. **When to claim Social Security benefits:** The

longer you can wait before turning 70, the more you will receive. The question is how long you should wait?



4. **What to do about Medicare and health care costs.** Fidelity estimates that a 65-year old will need \$285,000 to cover health care expenses that Medicare does not pay for. Another expert agency estimated that a 65-year old couple will need nearly \$400,000 for medical expenses. Miller explains why, if you can afford it, traditional Medicare is the "gold standard." He advises to be leery of insurance agents who make their living off commissions.
5. **Growing your savings.** Miller offers many tips for investing wisely, including avoiding paying fees, which can seem minor but can amount to a lot of money.
6. **Your home as a source of cash.** You might want to consider downsizing. If not and you need money, you could borrow against your home.
7. **New work options.** Think

outside the box about the jobs you could take on. It's not easy to do, but it's important to keep in mind that your skill set could fit with jobs other than the job you had pre-retirement. You could even become a successful entrepreneur.

8. **Where to live as you age.** Miller advises that you consider the amount and kind of space you will need. For example, should it be single level. How big should it be? How close is it to friends and family, the hospital and medical care?
9. **Plan for long-term care needs.** There's a high likelihood that you will need help with bathing, toileting, dressing, transferring and the like as you get older. Depending upon how much help you need, care can be very expensive. How will you get this assistance?
10. **Take advantage of financial advice.** You should have a formal financial plan for retirement. You want an advisor who has a fiduciary duty to you, putting your needs ahead of his or her income. Miller recommends you get a

Registered Investment Advisor, who charges a fee for his or her services. He suggests the qualities you should look for in a good advisor.

11. **Ways to reduce your taxes.** Miller explains how to time your contributions to different types of accounts and how to coordinate income from retirement savings and Social Security. He also warns about the cost implications for you of large payments, for example, from the sale of a home.
12. **Find purpose in your life.** Look back and ask yourself which activities have brought you the most joy and which the most misery. Focus on what brings you pleasure. Purposeful living has positive physical and mental health benefits.

There's a whole lot more practical guidance in Retirement Reboot. It's chock full of helpful advice that even I have not spent much if any time thinking about. If you have a few hours a week to work your way through the book, you will likely get a nice return on your \$19.95 investment. Pub. date January 10, 2023.

Five tips for talking to the people you love about their health

Many of us want to help our parents or other people we love as they age. But, we have no idea how to help. For sure, **engaging them in conversation is already a big help.** If you want to **talk to your loved ones about their health,** here are five tips for beginning the conversation:

◆ **Don't assume that because your loved ones haven't shared their health concerns with you that they don't have any.** They may not want to waste your time or cause you any worry. And, if your loved one is uncomfortable, or possibly ashamed, sharing private information even with family members, a more successful approach may begin with gentle expressions of support rather than pressure

to accept help.

◆ **Express your support to help them maintain a high quality of life and get everything they need from their doctors.** You could ask them what they have heard about **health buddies,** or a **health care proxy.** Let them know that sharing their concerns with you or a health care buddy they trust can help ensure they get the care they need. If you sense reticence, consider asking an open-ended question, such as, "How can I help you make sure you are getting the care you need from your doctor?" or "What would be the most important thing for me to know about your health?" This might be more helpful than, "Is there



anything I should know about your health." or "Is your doctor taking good care of you?"

◆ If they are living at home independently, remember that **they may be scared to voice their concerns for fear of losing that independence.**

◆ If they are worried about spending money on themselves, keep in mind that **they might not be addressing a health condition because of the cost.** But the **cost of the service may be far less than the risks of not getting treatment.** Let them know that there are often **free and low-cost resources for people with low incomes.**

◆ Finally, explain to them that it's **generally helpful to have a buddy with you at the doctor's office** to hear what the doctor is recommending, take notes, and make sure all important issues are raised, like medication side effects. Remember, everyone's different. Some of us feel our age and some of us feel like we're still in college. Some of us like to talk about our health and some of us keep our conditions to ourselves. Some of us assume that we should have health problems in older age and don't take the time to go to the doctor and some seek treatment whenever they have a new symptom.

FDA Approves 2nd Alzheimer's Drug, Despite Safety Concerns

The U.S. Food and Drug Administration on Friday approved a second Alzheimer's drug, lecanemab, despite reports of rare brain bleeds linked to use of the drug in some patients.

However, the FDA pointed to the drug's benefits, as well.

"Alzheimer's disease immeasurably incapacitates the lives of those who suffer from it and has devastating effects on their loved ones," Dr. Billy Dunn, director of the Office of Neuroscience in the FDA's Center for Drug Evaluation and Research, said in an agency [news release](#). "This treatment option is the latest therapy to target and affect the underlying disease process of Alzheimer's, instead of only treating the symptoms of the disease."

Lecanemab, made by Eisai and marketed by Biogen as Leqembi, will be only the second Alzheimer's drug to receive the FDA's blessing in the past 18 months; the agency's speedy [approval](#) of the drug Aduhelm in June 2021 generated controversy in the medical community over its lack of

effectiveness, brain bleed concerns and hefty price tag.

But Alzheimer's experts said the story is somewhat different with Leqembi.

"Unlike Aduhelm, which had an incomplete data set and where clinical trial data failed to demonstrate a definitive slowing in cognitive decline, lecanemab showed statistically significant slowing in cognitive and functional decline, as well as reduction of brain amyloid levels, and downstream beneficial effects on other markers of neurodegeneration," [Dr. Sarah Kremen](#), who leads the Alzheimer's Disease Clinical Trials Program at Cedars-Sinai in Los Angeles, said in a statement.

"We need — and are on the way to having — multiple drugs we can combine to personalize treatments to match each patient's Alzheimer's pathology, which will have a much greater impact on slowing the disease," [Dr. Howard Fillit](#), co-founder and chief science officer



of the Alzheimer's Drug Discovery Foundation, said in a statement.

"Today's news is incredibly important and a source of optimism not only for patients, but also for the medical and research community," said Fillit. "It shows us that our years of research into what is arguably the most complex disease humans face is paying off."

Still, Leqembi has been linked to two deaths from brain bleeds among people who used it in trials.

And not every patient would stand to benefit from Leqembi, stressed the Cleveland Clinic's [Dr. Babak Tousi](#). He led the portion of the clinical trial that was conducted at the Cleveland Clinic, in Ohio.

"The trial was designed for patients in the earlier stage of Alzheimer's disease, people with mild cognitive impairment or early stage of dementia," Tousi noted. "It will probably be for people who have early stage of disease, with no to minimal assistance needed for activities of daily living."

The results of the 18-month

trial, which involved about 1,800 patients, gained wide attention when they were published Dec. 1 in the [New England Journal of Medicine](#), Tousi noted.

In the trial, early-stage Alzheimer's patients who took Leqembi showed a 27% reduction in their mental decline compared to patients in the placebo arm of the trial. The drug's users also showed less evidence of amyloid protein plaques in their brain compared to non-users.

"Lecanemab clearly did what it was designed to do — it removed amyloid plaque," said Tousi, who heads the Clinical Trials Program at the Cleveland Clinic Center for Brain Health. "The results demonstrated all the downstream effects we hoped would happen in terms of reduction of biomarkers and less clinical decline on several functional and cognitive measures. So, this difference will likely translate to a longer period of independent living for patients."...[Read More](#)

AHA News: New Year, Healthier You? Here's How to Gradually Improve Your Eating Patterns

Losing weight is a popular New Year's resolution. But people often fail to keep this commitment or quickly gain back the pounds.

Instead of jumping on the latest fad diet, experts advise improving the nutritional quality of what goes into your body. A gradual shift to healthier eating is more likely to stick and can reap long-lasting rewards, such as better heart health and a lower risk of dying from heart disease or stroke.

"Rather than taking things out of your diet, I try to encourage people to think about adding things in that give them better nutrition," said Alexis Newman, a registered dietitian based in Philadelphia. "I stray away from the diet mentality because research shows dieting doesn't work."

Newman said she encourages her clients to add more fruits and vegetables to their diets, along with fiber from whole grains, such as brown rice, and plenty of water for hydration.

These foods are found in eating patterns such as the Mediterranean diet and Dietary Approaches to Stop Hypertension, or DASH diet. The American Heart Association recommended both in its 2021 scientific statement on dietary guidance. Both emphasize whole grains, plant-based or other healthy proteins from fish, seafood and lean meats, liquid plant oils and minimally processed foods. And they encourage minimal consumption of foods and beverages with added sugar and salt.



Research shows people who follow such heart-healthy eating patterns have a cardiovascular mortality rate up to 28% lower than those who don't.

Dr. Anne Thorndike, a member of the dietary guidance writing committee, said people can include healthier choices without giving up favorite foods or important family or cultural staples.

"If I tell you that you can never have something again, the only thing you're going to want is that thing," said Thorndike, director of the cardiac lifestyle program at Massachusetts General Hospital and an associate professor at Harvard Medical School in Boston.

"You don't have to give something up completely," she said, especially dishes that are

part of special occasions. "Enjoy it once and be done with it. Don't eat the leftovers for five days in a row."

And don't think eating healthier has to mean giving up taste, she said. "You should never eat things you don't like. It's not worth the extra calories. If a cracker tastes like cardboard, don't choose that cracker."

Look for variety, Thorndike said, and don't be afraid to try new things.

"I have patients who say, 'I like bananas,' and they eat bananas every day," she said. "Try an apple, an orange, some grapes. And don't forget the vegetables. They are a key component. Choose a variety of colors — green, orange, yellow, red."...[Read More](#)

Suicidal Service Members With Guns at Home Often Keep Feelings Secret

Military service members who conceal their suicidal thoughts are also more likely to store their guns unsafely, a new study reveals.

"These findings highlight a real problem with our suicide prevention system," said **Michael Anestis**, lead author of the study and executive director of the New Jersey Gun Violence Research Center at Rutgers University in New Jersey.

"We know that firearms account for the large majority of suicide deaths within the military and that unsecured firearms at home dramatically increase the risk for suicide," Anestis said in a Rutgers news release.

"Here, we found that suicidal service members less likely to be seen as high risk — those that hide their thoughts from others and avoid behavioral health care

— tend to be the service members with the most ready access to their firearms," he added.

For the study, the researchers surveyed more than 700 gun-owning service members. These included active-duty service members throughout all military branches and those in the National Guard and Reserves.

The investigators focused on 180 service members who had experienced suicidal thoughts within the past year and another group of 85 service members who had experienced suicidal thoughts in the past month.

Surveys asked whether they had ever told anyone about their suicidal thoughts, if they had attended any behavioral health sessions within the past three months and the specific ways



they store their personal firearms. The researchers found that service members with undisclosed past-year suicidal thoughts stored their guns at home more often and with a locking device in place less often compared to those who had shared their suicidal thoughts with others.

The research team also found that those with past-year suicidal thoughts who hadn't attended any recent behavioral health sessions stored their firearms without locking devices more often.

However, they also stored their guns loaded less frequently.

Those who had experienced undisclosed suicidal thoughts in the past month used locking devices less frequently. Those who had avoided behavioral health also used locking devices

less frequently but were less likely to store firearms loaded.

"What this tells me is that we have to move beyond only trying to prevent suicide once we already know somebody is at risk," Anestis said. "If we keep doing that, we will keep missing a large portion of those at greatest risk. We need to find ways to encourage secure firearm storage — locked and unloaded and away from home during times of risk — throughout the entire firearm-owning community and particularly within the military."

The study was funded by the Military Suicide Research Consortium. The findings were published online Jan. 9 in the journal ***Suicide and Life-Threatening Behavior***.

[988 Suicide & Crisis Lifeline](#)

Emergency Care Vs. Urgent Care: What's the Difference?

If you're sick or have been injured, you might not know whether the emergency room or urgent care is the right place to be treated.

The American College of Emergency Physicians (ACEP) offers some general advice, so you don't have to wonder where to go when immediate medical attention is needed.

"The emergency department is the best option for concerning symptoms, severe illness or injury, and we're open 24/7, 365," said ACEP President **Dr. Christopher Kang**. "Emergency

physicians are ready to help anyone who needs them — we are trained to treat every kind of medical emergency."

Emergency departments have advanced medical equipment and are staffed to handle more complex care for severe health issues, the ACEP said in a college news release.

The most common reasons to seek emergency care include trouble breathing, chest pain, uncontrolled bleeding, seizures, severe abdominal pain, head injuries, sudden severe headache



or dizziness, and sudden confusion or disorientation.

Emergency physicians can evaluate and manage any mystery injury or ailment.

Urgent care is a vital part of the health care system, the ACEP noted, and is a good option for minor medical issues, especially after-hours or on weekends when you can't see your primary care doctor.

Urgent care tends to be the right choice for a modest cough, runny nose, sore throat, rashes, minor cuts, upset stomach, minor

bone fractures, pink eye and other seemingly mild symptoms.

Most urgent care centers are not equipped to substitute for emergency care, the ACEP said.

Emergency departments are required by law to treat or stabilize anyone who seeks emergency care, regardless of their ability to pay or insurance status. Urgent care centers tend to accept health insurance, but require payment when services are delivered....[Read More](#)

Coping With Nicotine Withdrawal Symptoms

Giving up nicotine can be a brutal experience that can include everything from physical symptoms, such as headache and nausea, to mood issues, including irritability, anxiety and depression.

Yet, it is still possible to get through nicotine withdrawal symptoms with a good plan and specific tools, according to a smoking cessation expert, who offered some suggestions for coping with nicotine withdrawal symptoms.

"Nicotine is highly, highly

addictive," said **Emma Brett**, a staff scientist at University of Chicago Medicine and a group lead in the Courage to Quit program. "Nicotine affects the brain, blood vessels, metabolism. There are effects all throughout the body."

Quitting requires an adjustment period, she stressed.

Most commonly, withdrawal symptoms happen in the first week after quitting, peaking at about day three or four, Brett said. Some may experience



nicotine withdrawal symptoms for weeks. Some may have few symptoms at all.

Using nicotine replacement aids

Nicotine replacement products can be helpful to get someone through those initial days, weeks or months.

"We know from the research that when people quit and use something like a patch or lozenge or gum, that can almost double the success rate of a quit attempt," because you're still

getting some nicotine, just it's delivered in a safe way versus the combustion of a cigarette, Brett said.

She suggested staying on the products until having a high confidence you won't relapse.

These products deliver measured doses of nicotine, according to the **National Cancer Institute** (NCI), which lists five types that are approved by the U.S. Food and Drug Administration....[Read More](#)

Millions Could Lose Medicaid by April as Pandemic Rules Ease

Millions of Americans are about to lose Medicaid coverage that they gained — and maintained hassle-free — through the pandemic.

The end-of-year spending bill that Congress passed will "unwind" a continuous Medicaid enrollment requirement that states had to honor to get additional federal pandemic funds, explained **Jennifer Tolbert**, director of state health reform for the Kaiser Family Foundation (KFF).

"Essentially, if states took the enhanced federal funding, they were prohibited from disenrolling anyone from Medicaid, beginning in March of 2020," Tolbert said.

As a result, Medicaid enrollment swelled by about 20 million people during the pandemic, as people who otherwise would have lost eligibility remained enrolled, KFF **estimated**. Currently there are nearly 84 million people with

Medicaid coverage.

But starting on April 1, states can begin shedding their Medicaid rolls of people who no longer qualify, under the spending bill passed in December.

The U.S. Department of Health and Human Services (HHS) has estimated that about 15 million people are at risk of losing their Medicaid coverage, Tolbert said.

Many of these are folks who should have lost their coverage due to changes in their lives, except for the pandemic-era protections, Tolbert said.

"Maybe they got a new job that came with more income, or they had a change in family circumstances," Tolbert said.

But HHS has estimated that almost 7 million out of the at-risk 15 million might lose coverage due to bureaucratic snafus or procedural snags, even though they still qualify for Medicaid, Tolbert said.



For example, their state's Medicaid program might not be able to find them and get the information

needed to maintain their enrollment, said **Eric Roberts**, an assistant professor of health policy and management with the University of Pittsburgh School of Public Health

Make sure your Medicaid info is up-to-date

"People might have changed addresses. They might have changed their cellphone number," Roberts said. "Things like not getting mail at the address that was last registered in your Medicaid application forms, or not knowing how to provide updated documentation about income, could all present challenges to completing recertifications."

Some states are more eager to start shedding Medicaid recipients than others.

"Red states are probably going to be less lenient than blue states — at least that's the expectation,"

Roberts said.

The U.S. Centers for Medicare and Medicaid Services (CMS) "has recommended that states take a full year to complete this unwinding process and conduct redeterminations on everyone involved in the Medicaid program," Tolbert said. "CMS requires that before anyone is terminated from coverage, the state has to do a full redetermination of eligibility for that individual."

However, some states like Ohio have already said they plan to speed their shake-up of the Medicaid rolls, Roberts noted.

"Look for states that were less partial to Medicaid expansion in the first place, or that may be undergoing fiscal pressures themselves — the economy is starting to slow down, state revenues are starting to slow down," Roberts said. "There may be some fiscal pressures for those states to accelerate the unwinding."

How a 'Dry January' Could Help Your Health

Having a "dry January," or giving up alcohol for the first month of the year, is a trend.

And it's not a bad idea, according to a drug and alcohol rehab counselor with Cleveland Clinic in Ohio.

Not consuming alcohol can have many health benefits, said **Alan Berki**, from sleeping better and having more time for other hobbies to saving money.

"The condition of your skin, the increased amount of energy

that you have, if you're not replacing the alcohol with candy or sweets — because you may start to crave those a little more if you stop drinking — you'll definitely experience weight loss," Berki said.

One group should not take part, Berki cautioned. Those are heavy drinkers, who should talk with their doctors first because withdrawal symptoms can be uncomfortable and possibly



deadly.

For those who are not heavy drinkers, Berki suggested this time could be a good opportunity to reflect on drinking habits and write down goals.

When not giving up drinking, men should consume no more than two drinks and women should only have one on days when alcohol is consumed, according to **government dietary guidelines** for

Americans.

Be sure to have social support and avoid temptations, Berki added in a clinic news release.

"The number one thing to do is if they're trying to do a dry January and they truly don't want to drink, the best thing to do is to avoid the situations, so if at all possible not hang out in bars, or nightclubs, or go to parties where there is going to be heavy alcohol use," he advised.

What Are Quit-Smoking Programs and How Can They Help You?

Sometimes it really does "take a village" to help you meet life's challenges, and quitting smoking can be one of the toughest challenges out there.

That's why specially designed smoking-cessation programs can make all the difference, experts say.

Many programs employ a combination approach, one that treats the physical *and* the psychological addictions you're trying to break.

Dr. Amit Mahajan, a volunteer medical spokesperson for the American Lung

Association (ALA), says proven ways to help people quit often include professional counseling — including psychotherapies such as cognitive behavioral therapy.

Such therapies are typically given alongside nicotine replacement patches and gums (to help ease cravings), and/or addiction-counteracting drugs, such as Chantix and bupropion (Wellbutrin).

Programs that offer up these combo strategies have a higher likelihood of success, Mahajan



said.

"At the end of the day, the data is pretty clear that if there's behavioral

therapy combined with pharmacotherapy medications, that is the best option for smokers who want to quit and people who've already tried and were unable to quit," he said.

Breaking free

The ALA offers up its own program, called **Freedom From Smoking**. First begun in 1975 and then updated and refined ever since, the program helps overcome the physical, mental

and social aspects of addiction. It even offers up an **online quiz** that folks can take to confirm that they're mentally ready to try quitting.

People who use the program are six times more likely to be tobacco-free one year later, compared to those who try quitting on their own, the ALA says. When used in combination with cessation medications, up to 60% of participants report quitting by the end of the program... **Read More**

What Is Glaucoma, and How Can You Prevent It?

A comprehensive eye exam could be the key to determining if you have glaucoma, a silent thief of sight.

Glaucoma is a group of eye diseases that affect the optic nerve, and the leading cause of preventable blindness, according to [The Glaucoma Foundation](#).

But most people are unaware of their risk.

Glaucoma affects about 80 million people worldwide, and that number is expected to reach almost 112 million by 2040.

The condition can run in families. It disproportionately

affects people of color.

Most people are diagnosed after age 40, and at least half of

glaucoma patients had no symptoms until their vision was already significantly damaged.

As many as 1.5 million Americans are unaware that glaucoma is silently damaging their optic nerves right now, according to the foundation.

High-risk factors for glaucoma include a family history of the disease and being over age 40. Having a family member with glaucoma doesn't necessarily



mean you'll get the disease, however.

The most important risk factor is having abnormally high intraocular pressure (IOP), the foundation explained in a news release.

Being of African, Hispanic and Asian descent also increases the risk. People with African and Hispanic ancestry have a greater tendency for developing primary open-angle glaucoma. People of Asian ancestry are more apt to develop angle-closure glaucoma and normal-tension glaucoma.

Other risk factors include

diabetes, nearsightedness, previous eye injury, extremely high or low blood pressure, thin central corneas, and long-term use of steroids and cortisone.

The foundation urges everyone under age 40 to have a comprehensive eye exam every three to four years. Those with a risk factor and all folks over 40 should get their eyes checked every 18 to 24 months.

Glaucoma can't be cured but can be managed if it is detected and treated early.

Why Can't I Lose Weight?

You've cut back on your eating, started an exercise routine and just can't seem to lose weight. What's going on?

It could be a number of issues that are causing you to ask yourself, "Why can't I lose weight?" The good news is that you can work through them.

"It's very complicated, which is what people need to remember. It's not a simple task to say I'm going to lose weight and it happens," said [Connie Diekman](#), a nationally known food and nutrition consultant and

former president of the Academy of Nutrition and Dietetics. "So, give yourself a break."

When it comes to eating, food choices, portion sizes and intent — whether you're eating because you're hungry or in an attempt to fill an emotional need — all play a role, Diekman said. Of course, exercise has its place.

Not to be discounted is the significant role that biology and genetics play.

"Not everyone can achieve the



weight loss they want to achieve. In other words, our bodies sometimes are smarter than we are," Diekman said.

That doesn't mean that everyone can't achieve what is a healthy weight for them by understanding what they can control.

Typically, weight gain or loss is a calculation of energy intake and expenditure, but being overweight or obese is more complex, with genetics, behavior and environmental factors

contributing, according to the [National Library of Medicine](#).

Weight loss isn't a specific diet but a lifestyle of healthy eating patterns, regular activity and stress management, according to the [U.S. Centers for Disease Control and Prevention](#).

Losing even a modest amount of weight, 5% to 10%, can improve blood pressure, blood cholesterol and blood sugar, according to the CDC...[Read More](#)

AHA News: Report Highlights Lack of Medical Worker Diversity – And How to Fix That

Racial and ethnic diversity among medical workers is critical to Americans' health, but more needs to be done to recruit, train and support those professionals, a new report says.

The report, published Thursday in the American Heart Association journal *Circulation: Cardiovascular Quality and Outcomes*, describes barriers to a diverse workforce, highlights statistics on the problem and suggests ways for leaders to reshape the system to address it.

At its core, the issue is about caring for people, said first author Dr. Norissa Haynes, an assistant professor of medicine at Yale University in New Haven, Connecticut. "Having a diverse workforce, and having a physician who understands your lived experience, improves patient care and health outcomes." That's especially important in cardiology, she said,

given that cardiovascular disease disproportionately affects underrepresented racial and ethnic groups.

The report, which grew from an expert roundtable held by the Association of Black Cardiologists in 2021, says that although Black and Hispanic people account for about 13% and 17% of the population, respectively, those groups comprise only about 5% and 6% of practicing physicians. Among cardiologists who treat adults, 5% are Hispanic, and 2.7% are Black.

It's "quite rare" to have a physician from an underrepresented group, especially a cardiologist, said Haynes, who is Black. "I can't tell you the number of times when I've been told by patients that they're so happy to see me. That they're proud of me. It's



really an anomaly for them."

It's more than a matter of pride, said the report's senior author, Dr. Michelle A. Albert, president of the AHA and immediate past president of the Association of Black Cardiologists.

Albert pointed out that cardiovascular disease is the world's No. 1 killer. That makes cardiology workers "extremely important" to global health, said Albert, the Walter A. Haas endowed chair of cardiology and a professor of medicine at the University of California, San Francisco.

Many cardiovascular disease risk factors have socioeconomic roots. When treating a condition, Albert said, "a lot of times there are many other issues that are on the table," such as whether the patient can afford transportation to a medical center. Her own

experiences growing up in Guyana and Brooklyn make her sympathetic, she said.

Having medical workers whose own lived experiences inform care will be vital to solving health disparities in a diversifying America, according to the report.

Dr. Gladys Velarde, a cardiologist and professor of medicine at the University of Florida College of Medicine-Jacksonville, said a physician who shares an understanding of a patient's cultural traditions around favorite foods, for example, could offer guidance on how to make them healthier. Or it might help a doctor grasp that a patient who has been told to exercise more might not have a safe place to walk — but might know where they could go salsa dancing as an alternative, said Velarde, who consulted on the report...[Read More](#)

Is Your Specialist Friends With Your Primary Care Doctor? You May Get Better Care

Patients might be happier with their care when their physician trained with the specialist they're referred to, a new study suggests.

Researchers found that when patients saw a specialist, they generally gave better ratings to their care if that doctor had gone to medical school with their primary care provider. On the whole, they said those specialists take more time to talk with them, give clear explanations, and involve them in health care decisions.

If that sounds puzzling, the researchers said the explanation may be fairly simple: Doctors are just like everyone else, and up their game when their peers are "watching."

"Doctors are people, too, and most of us want to perform at our best in front of a familiar, respected peer," said senior researcher **Dr. J. Michael**

McWilliams, of Harvard Medical School and Brigham and Women's Hospital in Boston.

"It makes you feel good if you're able to excel in those situations," he said.

Of course, no one expects primary care doctors to refer patients only to their old medical school friends. But McWilliams said the findings raise questions about how to better encourage peer relationships and accountability among doctors, and whether that can improve patients' care.

Traditionally, efforts to boost the quality of patients' care have focused on financial incentives. But that doesn't cut it when it comes to individual physicians, according to McWilliams.

"When we think about how to motivate doctors, we need to think about what motivates



humans," he suggested. The study, published online Jan. 3 in **JAMA Internal Medicine**, used

electronic health records from more than 8,600 patients in the same large health system. All were referred to a specialist by their primary care doctor at some point between 2016 and 2019.

In about 3% of those visits, the primary care doctor and specialist had trained at the same medical school at the same time. That served as a "predictor" of whether the doctors knew each other, McWilliams said. However, it's not certain that they did.

Despite that, the researchers did find that patients reported different experiences when their specialist had "co-trained" with their primary care doctor.

On average, they gave a 9-percentage-point higher rating to the quality of their care, versus

other patients. That's the difference between a specialist being average or near the top of the heap, the researchers said.

Overall, those patients were happier with intangibles, like their specialist's friendliness, and were more likely to feel the doctor explained things clearly and involved them in decision-making.

Beyond that, there were some signs that those specialists altered objective aspects of care: They were more likely to prescribe medications than specialists who did not co-train with the referring doctor.

However, that's not necessarily a good thing, said Dr. Don Goldmann, chief scientific officer emeritus of the nonprofit Institute for Healthcare Improvement, in Boston....**[Read More](#)**

More Orthopedic Physicians Sell Out to Private Equity Firms, Raising Alarms About Costs and Quality



Dr. Paul Jeffords and his colleagues at Atlanta-based Resurgens

Orthopaedics were worried about their ability to survive financially, even though their independent orthopedic practice was the largest in Georgia, with nearly 100 physicians.

They nervously watched other physician practices sell out entirely to large hospital systems and health insurers. They refused to consider doing that. "It was an arms race," Jeffords said, "and we knew we had to do something different if we wanted to remain independent and strong and offer

good quality of care."

So, in December 2021, Resurgens sold a 60% share in United Musculoskeletal Partners, their own management company, to Welsh, Carson, Anderson & Stowe, a large New York-based private equity firm known as Welsh Carson. Although details of the sale were not disclosed, physician-shareholders in **deals like this** typically each receive a multimillion-dollar cash payout, plus the potential for subsequent big payouts each time the practice is sold to another investor in future years.

Orthopedic surgeons, long seen as fiercely independent, are

rapidly catching up with other specialist physicians, such as **dermatologists** and **ophthalmologists**, in selling control of their practices to private equity investment firms. They hope to grab a bigger chunk of the surging market in outpatient surgery and maintain their position as one of the highest-paid specialties in medicine — **\$633,620 was the average compensation for orthopedists in 2021**. For older doctors, the upfront cash payout and the potential second payout when the business is flipped offers **the promise of a posh retirement**. Proponents say private equity

investment has the potential to reduce total spending on musculoskeletal care and improve quality by helping physicians move more procedures to **cheaper outpatient surgery centers**, which have less overhead. It also could help the doctors shift to **value-based payment models**, in which they charge fixed amounts for whole episodes of care, such as total joint replacements and spine surgeries — receiving bonuses or penalties from insurers based on cost and quality performance....**[Read More](#)**

Does Your Home Have Dangerous Levels of Cancer-Causing Radon?

People should test for the naturally occurring radioactive gas radon in their homes to help prevent ill health, the American Lung Association urges.

In some areas, like the state of Connecticut, radon was found to be present at high levels in a quarter (26%) of all homes.

Radon is emitted from the ground and can enter a house through floor cracks, basement walls and foundations.

Exposure to radon is the

second-leading cause of lung cancer in the United States and it is the leading cause in people who've never smoked. It's responsible for an estimated 21,000 U.S. lung cancer deaths each year, the ALA said.

"Since radon is odorless, tasteless and colorless, the only way to detect radon in your home is to test the air," said **Ruth Canovi**, director of advocacy for the lung



association. "Radon Action Month is the perfect time to learn more about this

dangerous gas and take action to protect yourself and your loved ones," Canovi said in an association news release.

The U.S. Environmental Protection Agency (EPA) sets an action level of 4 picoCuries per liter or pCi/L for radon.

Anyone with a radon level that high should have a professional

install a mitigation system in their home, according to the EPA.

Both the EPA and the lung association recommend doing so if levels are greater than 2 pCi/L.

A radon mitigation system seals cracks and openings and includes a vent pipe and fan that collects radon gas from under the foundation and vents it outdoors.

Your state's radon program can provide a list of certified radon mitigation professionals