Rhode Island Alliance for Retired Americans®

RI ARA

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

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Message from Alliance *for* Retired Americans Leaders

Congress Releases Omnibus Spending Bill

Lawmakers released a $1.7 trillion government spending bill for next year on Tuesday. The legislation provides funding for things that directly impact working and older Americans, including Social Security, Medicare, Medicaid, nutrition programs, and long-term care.

Under the plan, the Social Security Administration will receive $14 billion for operating expenses, a $785 million increase compared to funding for this past year. The Centers for Medicare & Medicaid Services (CMS) will get a total of $4.1 billion, $100 million more than in 2022. $3.7 billion will be allocated to the National Institutes of Health (NIH) for Alzheimer's disease and related dementia research.

The omnibus bill also invests in affordable housing and services that promote senior wellbeing, including $4 billion for the Low-Income Home Energy Assistance Program and $405 million for the Senior Community Service Employment for Older Americans Program. The Administration for Community Living, which oversees community-based services for older Americans, will receive $220 million more for 2023 than it did in 2022. This includes increased funding for Senior Nutrition Programs and for the National Long-Term Care Ombudsman Program.

The bill also provides increased funding for Worker Protection Agencies, most notably the National Labor Relations Board, which has not had an increase in funding since 2010 and has struggled to meet workload demands.

"It's important that our lawmakers invest in workers and seniors," said Robert Roach, Jr., President of the Alliance. "We're glad to see that critical agencies like the Social Security Administration and the NLRB will receive a boost in funding next year."

Many Inflation Reduction Act Provisions Set to Take Effect in January

Rich Fiesta,

On August 16, 2022, President Biden signed the Inflation Reduction Act into law, setting into motion multiple provisions that will bring down skyrocketing prescription drug prices for millions of Americans.

Many of those provisions will begin in January including:

- Insulin co-pays will be capped at $35 per month for Medicare beneficiaries;
- All recommended adult vaccines will be free for Medicare beneficiaries;
- Corporations that raise the price of drugs sold to Medicare faster than the rate of inflation must pay rebates back to Medicare;
- The U.S. Department of Health and Human Services (HHS) must identify the 100 highest-priced drugs and select the first 10 for price negotiation.

In addition, Medicare will begin to cover medically necessary dental procedures beginning in January. Also, over-the-counter hearing aids are available now, following an **Executive Order** signed by President Biden in October.

"It took many years of activism to get here, but in two weeks drug prices will finally begin to come down," said Executive Director Fiesta. "Alliance members should be proud of the role they played in making this a reality."

Kaiser Health News: States Challenge Biden To Lower Drug Prices by Allowing Imports From Canada

By Phil Galewitz

The Biden administration is facing mounting pressure from states to let them import medicine from Canada to help lower prescription drug costs.

Colorado on Dec. 5 became at least the fourth state to seek federal permission to use the strategy, following Florida, New Hampshire, and New Mexico.

President Joe Biden has endorsed the approach, but his administration has yet to greenlight a state plan.

"States have done the work, and the only thing preventing them from going ahead is the Biden administration," said Jane Horvath, a health policy consultant who has worked with states on importation plans.

Health and Human Services Secretary Xavier Becerra told KHN on Dec. 5 that the Biden administration welcomed applications for drug importation programs from Colorado and other states. But he would not pledge that the FDA would rule on any application in 2023. Read more **here**.

OUR ISSUES

Get involved! Here's how you can take action:

Economic Security – Tell Congress to expand our earned Social Security benefits and urge them to require that the Social Security Administration base future COLAs on the Consumer Price Index for the Elderly (CPI-E), which much more accurately reflects the cost of things retirees purchase, including health care and housing.

Retirement Security – Defined benefit pension plans are under attack. Read our fact sheets, attend our local events, and join our lobbying efforts to ensure that America's retirees, their spouses and their partners are able to maintain their standard of living after a lifetime of work. Americans should not fall into poverty as they age.

Health Care Security – Medicare just celebrated its 54th Birthday. Help make sure it lasts another 50 years by sharing your story about what the program has meant to you and your family. Read about the experiences of other Alliance members and educate your children and grandchildren about this American success story, so that Medicare remains strong for them.

ADD YOUR NAME

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

Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381
riarajap@hotmail.com • http://www.facebook.com/groups/354516807278/

What are your Medicare premium and other costs in 2023?

In 2023, the **standard monthly Medicare Part B premium,** which covers medical and outpatient care, is $164.90, a monthly decrease of $5.20 from $170.10, for people with annual incomes of $97,000 or less in 2021. At the same time that your Medicare Part B premium is decreasing, your **Social Security increase** is increasing a **8.7 percent**, providing an average additional $146 a month in benefits.

Social Security benefits in 2023 will be up an average of $1,827 for a single retiree.

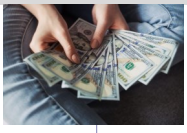
In 2023, people whose modified adjusted gross income from two years ago as reported on their federal tax return–about seven percent of the Medicare population–pay a Medicare Part B premium of:

- **$230.80 a month**, if their income is above $97,000 and no more than $123,000.
- **$329.70 a month**, if their income is above $123,000 and no more than $153,000
- **$428.60 a month,** if their income is above $153,000 and no more than $183,000
- **$527.50 a month**, if their income is above $183,000 and less than $500,000
- **$560.50 a month,** if their income is $500,000 or more

For couples with combined incomes of $366,000 or less two years ago, filing a joint tax return, the premium amount doubles. Couples with annual incomes above $366,000 and less than $750,000 each pay a $527.50 monthly premium. And, couples with annual incomes of $750,000 and above each pay a $560.50 monthly premium. Visit this **CMS web site** for your Part B premium amount if you are filing separate returns.

Medicare Part B annual deductible: $226, a decrease of $7 from the annual deductible of $233 in 2022.

For more than four decades, the Medicare Part B premium (medical insurance) was the same for everyone regardless of income, geography or health status, a quarter of the cost of Part B services. (Medicare Part A, hospital insurance, is premium-free if you have contributed into Social Security



for at least 40 quarters.) In 2007, wealthier people with Medicare began paying higher premiums.

Here are 2023: Medicare Part A costs:

- There is no Medicare Part A premium if you or your spouse have at least 40 quarters of coverage.
- The Medicare Part A premium, if you or a spouse has at least 30 quarters of coverage, is $278 a month; if you don't have at least 30 quarters, the premium is $506 a month.
- The Medicare Part A inpatient hospital deductible is $1,600, in 2023 an increase of $44 from 2022, and coinsurance for hospitalizations after day 60 is $400 a day in a benefit period; coinsurance for lifetime reserve days is $800 a day.
- The Medicare Part A daily coinsurance for skilled nursing facility stays after day 20 is $200, an increase of $5.50 from $194.50 in 2022.

Extra Help paying your Medicare premiums and out-of-pocket costs: People with low incomes and assets have help paying these costs through the Medicare Savings Program. You should apply through your Medicaid office, if you think you might be eligible.

People with incomes up to 135 percent of the federal poverty level, (the exact amount will be released in 2023) are eligible for **help paying their premiums through Medicaid or a Medicare Savings Program.**

In 2023, for full low-income subsidy (LIS) benefits through the Qualified Medicare Beneficiary (QMB) program, your assets cannot be higher than $9,090 ($13,630 if married). For partial LIS benefits, your assets cannot be higher than $15,160 ($30,240 if married).

That said, if you notify the Social Security Administration (SSA) that you plan to use some of your assets for burial expenses, for full LIS benefits, your assets can be as high as $10,590 ($16,630 if married). For partial LIS benefits, your assets can be as high as $16,660 ($33,240 if married).

Financial Elder Abuse: How Advisors Can Help Protect Clients

One in 10 older Americans experience abuse, and financial abuse is one of the most common forms. According to the National Council on Aging, up to 5 million Americans suffer from financial elder abuse every year, with financial losses of at least $36.5 billion per year.

Though some of these abuses are the work of scammers, they often happen at the hands of trusted family members, friends and caregivers who take advantage of an elder's cognitive decline or other health issues for their own financial gain. This can involve getting elders to sign checks and forms they wouldn't sign otherwise, among other abuses.

Financial elder abuse is pervasive, and **advisors** responsible for the financial well-being of elderly clients are in a position to help stop it. Here are some best practices that can help mitigate such abuses as well as five steps to take to prevent them:

- Recognizing signs of financial elder abuse.
- Reporting suspected financial elder abuse.
- Preventing financial elder abuse.

Recognizing Signs of Financial Elder Abuse

When a **financial advisor** suspects that financial abuse has occurred, there are some ways to confirm it. Identifying an abuse after it has happened may seem like trying to scoop up spilled milk, but early identification can both prevent further losses and help recover what was already taken.

Signs that financial elder abuse is taking place (or has taken place) include:

- Unpaid bills.
- Unusual or unexpected changes in the spending patterns of elders.

- Fraudulent signatures on various forms.
- Elders acting stressed about their money.
- Unexpected transfers of assets or money.

Any of the above is a red flag, and when an advisor discovers a discrepancy, proper checks into the accounts of the elder should be conducted to unearth any abuse. Of course, red flags also mean financial advisors must be extra vigilant and establish guardrails that will alert them to potential or ongoing abuse.

Reporting Suspected Financial Elder Abuse

Even when financial elder abuse has already taken place, advisors can counsel elders to report the case to the police and any other relevant authority. By some estimates, only 1 in 24 cases of financial elder abuse gets reported. Financial advisors should encourage victims to report abuses so the losses can be recovered and further abuses can be avoided.

Furthermore, financial advisors don't need to wait for the crime to happen before they report it. Suspicions of financial abuse can be reported even if they have not yet been confirmed. It is then the responsibility of relevant authorities to act on the report.

Preventing Financial Elder Abuse

An ounce of prevention is worth a pound of cure when it comes to financial elder abuse. Therefore, advisors should also put processes in place that will prevent financial elder abuse:

Cybersecurity Solutions

Products such as Norton's LifeLock, Identity Guard and ID Watchdog, among other **cybersecurity solutions**, can help prevent identity theft, privacy and data breaches, and other threats….**Read More**

Government rules won't curtail Medicare Advantage bad acts without stiff penalties

The Centers for Medicare and Medicaid Services (CMS), the agency charged with overseeing Medicare, recently released a series of **proposed rules** intended to limit harmful behavior in Medicare Advantage. They aim to curtail misleading marketing as well as to eliminate barriers to care. Many of the rules seem good in theory but, even if finalized, unless CMS enforces them and applies meaningful penalties for violating them, it is hard to imagine that they will do much good.

For years, Medicare Advantage plans have been violating rules. They have not covered medically necessary services covered in traditional Medicare, as required; they have overcharged the government for their services; they have failed to disclose complete and **accurate data** that would allow oversight of the quality of care they deliver; they have not maintained accurate provider directories and more. The **HHS Office of the Inspector General, the Government Accountability Office and the Medicare Payment Advisory Commission**, among others, have called out these issues and urged CMS to address them through new policies, greater oversight, and penalties that are meaningful. CMS has done little to call out the bad Medicare Advantage actors and penalize them appropriately, putting people enrolled in Medicare Advantage plans at risk.

For example, for more than ten years, Medicare Advantage plans have overcharged the government billions of dollars a year, with projections that the overcharges will total more than **$600 billion** in the next nine years. And, MA plans have not released the patient data they are required to disclose, Yet, CMS has done little if anything to address their malfeasances and bad acts, endangering the lives of enrollees and draining the Medicare Trust Fund.

You can review the CMS enforcement actions over the last decade **here**. Last month, CMS "punished" Elevance, a Medicare Advantage plan, "for failing to meet its primary responsibility to provide Medicare enrollees with medical services and prescription drug benefits in accordance with Medicare requirements." CMS found that Elevance overcharged its enrollees. The penalty? $38,512.

CMS also punished Humana $131,660. "Auditors found that Humana overcharged enrollees for Part D medications and Part C services. Humana's failures adversely affected (or had the substantial likelihood of adversely affecting) enrollees because they may have experienced increased out-of-pocket costs."

Auditors found that "in 2019 Kaiser failed to reprocess prescription drug claims in accordance with enrollee's LIS levels within 45 days of the receiving complete information regarding the enrollees LIS status. As a result, enrollees were over charged for Part D drugs at the point of sale and Kaiser then failed to ensure refunds were provided to enrollees who overpaid." The penalty? $27.260.

Where are the incentives for insurers offering Medicare Advantage plans to do right by Medicare? Where's the requisite oversight? Where's the punishment for the wrongful behavior? People go to **jail for not paying their medical bills**; they go to jail for years for defrauding the government. It appears that the MA plans can do major harm to Medicare, with impunity.

When will the government stop simply talking the talk and walk the walk?

Non-profit hospital systems compromise patient safety

The **New York Times** reports on how Ascension, a non-profit hospital chain operating in 16 states and serving millions of patients a year, created its own staffing crisis while building an $18 billion reserve and paying its CEO $13 million in 2021. The for-profit hospital chains are behaving no better and could be worse. What's going on?

Most hospitals in the US are non-profit. They don't pay taxes. In exchange, they are supposed to offer charity care and community assistance. But, many are not providing the charitable services expected of them. Staffing is inadequate, often at the poorest hospitals, and **charity care** is hard to come by.

Ascension operates 139 hospitals. It has been cutting its staff for several years now. Even though it's a non-profit hospital system, its executives worked to improve its "profits." Consequently, patients at some of its hospitals have needed to wait a day just for a hospital bed, and the ratio of patients to aides at one of its hospitals was 32 to one!

Ascension executives used to boast about its staff-cutting, reducing labor costs by $500 million. Despite thousands of complaints from nurses about understaffing, executives refused to hire more staff. Sometimes, nurses were not available to clean or turn patients who were bed-bound or to treat their open wounds.

When the pandemic hit, Ascension was unprepared. It could not take all the patients that needed care. More than a thousand nurse positions were vacant. Emergency rooms were not equipped.

Ascension is not alone among non-profit hospital systems in its desire to limit labor costs in an extreme way. It is one among many non-profit hospital systems that have turned their backs on patient care. The New York Times reports that Providence hospital system also cut staffing significantly, as has CommonSpirit Health, forcing patients to wait extended periods to get needed care. The New York Times investigation focused on two Ascension hospitals that nurses reported put patient safety at risk. Nurses complained formally day after day to no avail. Independent health inspectors cited Ascension for failing to care for patients with bed sores appropriately. At the same time, Ascension's former CEO was earning $11 million a year to run Ascension's investment division.

To keep costs down, Ascension executives gave CEOs at its hospital's financial goals. If they could not meet them, they would not receive bonuses. At the same time, Ascension tried to keep Illinois and Michigan legislators from setting nursing to patient ratios at hospitals. Needless to say, staffing levels at Ascension hospitals were often inadequate to meet patient needs; surgeries needed to be delayed and ambulances could not bring patients to the Ascension hospitals because there was not enough staff to treat them.

Ascension went so far as to replace staff at dozens of its hospitals with 450 "telesitters," robots with video cameras monitored off-site. Off-site staff speak to patients through the telesitters. To make up for inadequate staffing levels, Ascension often expected nurses to work 16 hour shifts and care for more patients than permissible under their contracts.

No one knows how many patients are dying needlessly as a result of Ascension's cost-cutting and inadequate staffing levels. Why would Ascension keep track? Are Ascension's executives looking to sell out to a private equity firm? My bet is that the executives are planning for Ascension to convert to for-profit status and expecting a whopping payout.

2023: Medicare Part D prescription drug coverage and costs

Whether you are enrolled in traditional Medicare or a Medicare Advantage plan, Medicare covers the prescription drugs you get from the pharmacy under Medicare Part D. The vast majority of people with Medicare, 49 million in 2022, are enrolled in a Part D drug plan. Here's what you need to know about Medicare Part D coverage and costs in 2023. Don't assume that your current Part D drug plan will cover your drugs in 2023, even if they did in 2022. Rather, assume that your costs will go up a lot if you didn't check which Part D plan was likely to save you the most money based on your drug needs, during the **Medicare open enrollment period** (October 15-December 7). Each year, these private insurance plans can change dramatically. **Kaiser Family Foundation** reports on your options.

As a general rule, close to three in four people enrolled in traditional Medicare and a Part D plan will pay higher costs the following year, if they do not look at their options and switch plans.

In 2023, there are 16 national Part D prescription drug plans, with monthly premiums ranging from $6 to $111. The average premium is $43, up 10 percent from 2022. AARP offers the highest cost Part D drug plan.

- **Premiums:** Premiums are typically higher for Part D plans offering enhanced benefits, lower cost-sharing and/or low or no deductibles. Standard Part D plans have an average monthly premium of $37. Part D "enhanced" plans that charge no or a low deductible have an average monthly premium of $48 in 2023.
- **Standard deductible:** The standard and highest possible deductible—the amount you must pay before your coverage begins—is $505.
- **If you have traditional Medicare:** You typically will be able to choose among 24 Part D drug plans. Depending upon the state you live in, your options range between 19 and 28.
- **If you are in a Medicare Advantage plan:** You typically will have a choice of around 35 Part D drug plans.
- **Cost-sharing:** For non-preferred brand name drugs, coinsurance could be as high as 40-50 percent and as low as $0 for preferred generics, depending upon the Part D plan you choose. You also are likely to pay 15 -25 percent coinsurance for preferred brand drugs.
- Typically, you'll pay about $1 for preferred generics and $5 for generics. You'll pay around $44 copay for preferred brands, 45 percent coinsurance for non-preferred drugs, and 25 percent coinsurance for specialty drugs.
- **Costs in each coverage phase:** After you have paid your deductible, you are in the initial coverage phase, where you generally will pay around 25 percent of the cost of both brand-name and generic drugs until your drug costs total $4,660. You will then be in the coverage gap phase, where you will be responsible for about 25 percent of the cost of your drugs. Once your out-of-pocket drug costs total $7,400 in the coverage gap phase, you will be in the catastrophic coverage phase . At that point, you will pay no more than 5 percent of the cost of your drugs or $4.15 for each generic and $10.35 for each brand-name drug.
- **If you qualify for a low-income subsidy (LIS) or Extra Help:** You will have lower out-of-pocket costs, depending upon the Part D plan you choose and the drugs you use. Around 13 million people with Medicare qualify for extra help with their prescription drug costs. There are 198 Part D drug plans for which you will not pay a premium. You can also choose a "non-benchmark" plan and pay a portion of the monthly premium.
- **If you need insulin:** The **Inflation Reduction Act** limits your monthly copayment to no more than $35 in all phases of Part D coverage. However, that limit applies only to insulin in a plan's formulary, not all insulin products.
- **If you need a vaccine:** Vaccine costs are covered in full for vaccines that are on the Part D formulary.

Congress should eliminate the cap on Social Security contributions in 2023

In an opinion piece for **Bloomberg News**, Teresa Ghilarducci explains why Congress should eliminate the payroll contribution cap on Social Security. The current cap is $160,200, which means that at least 500 Americans make their full contribution to Social Security in the first few days of this year. Most Americans, however, contribute to Social Security throughout the year.

If Congress lifted the cap on Social Security, not only would it be fairer, but it would strengthen the Social Security Trust Fund significantly. The people who make their full contribution to Social Security in the first days of January can well afford to continue to contribute. They represent only five percent of the population.

How do Social Security contributions work? They are generally split between employers and workers. Each contributes 6.2 percent of their income up to $160,200 in 2023. But, that payroll contribution is not as large as it once was because the 12.4 percent of income contribution does not include non-taxed benefits like health insurance. And, over the last several decades these non-taxed benefits have risen faster than wages.

At this moment, Social Security has enough money in its Trust Fund to pay full benefits until 2033. And, it has never not been able to pay full benefits. But, to keep Social Security paying full benefits, Congress must act.

Congress could increase contributions from 12.4 percent to 15.87 percent, a contribution increase of about 1.75 percent for employers and employees, to keep Social Security able to pay benefits for the next 75 years. But, that would be a very heavy and unlikely political lift.

It would be much easier for Congress to eliminate or raise the cap on Social Security contributions. According to the **Congressional Research Service**, if it eliminated the cap, the Social Security Trust Fund would be able to pay full benefits for 35 additional years.

Requiring all Americans to pay into Social Security for the entire year would affect just five percent of the population and would add $150 billion to Social Security's Trust Fund. Of note, Medicare does not have an income cap.

Older Americans rely heavily on Social Security. More than six in ten depend on Social Security for at least half of their monthly income. One in three of them depend on Social Security for 90 percent of their income. Congress must help protect them and eliminate the cap on Social Security contributions.

Dear Marci: How are drug costs changing in 2023?

Dear Marci,

I think my Part D premium is going up in 2023, which I expected. But I've also heard that everyone with Medicare might be saving money on drug costs because of recent legislation. How are drug costs changing in 2023?
-Jean-Claude (New York, NY)

Dear Jean-Claude,

It's true that most people will experience some kind of change to their Part D costs each year. Part D plans can change the drugs they cover, their pharmacy networks, and their costs (such as premiums, copayments, coinsurance charges, and deductibles) from year to year. If you have Medicare prescription drug coverage, often referred to as Part D, your plan should have notified you about any changes in costs for 2023.

This year there are additional changes in Part D costs more generally due to the Inflation Reduction Act (IRA), which is likely the legislation you heard about. While some changes created by the IRA take effect in future years, the following changes take effect in 2023:

Insulin will be more affordable. The IRA limits co-payments to $35 per month for Part-D covered products and for insulin furnished under B, with no deductible for insulin products on your plan's formulary. Currently, over **3 million** Part D enrollees use insulin, and **one in three** people with Part D plans have diabetes. On average, in **2020**, they paid $600 out-of-pocket for insulin. But some had considerably higher costs—25% spent over $800 and 10% spent over $1,300.

Because this change went into effect so quickly, the information about these lower costs was not always included in the Medicare **Plan Finder** tool during Fall Open Enrollment. This may have led some people to enroll in a plan that does not meet their needs. If you discover that you are not in the right plan, you may be able to change plans. Contact 1-800-MEDICARE (1-800-633-4227), your **State Health Insurance Assistance Program (SHIP)**, or the **Medicare Rights Center** if you think this applies to you.

People with Medicare will be able to receive critical vaccines free of charge. The IRA eliminates cost-sharing and deductibles for Part D vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP), such as the shingles vaccine. This policy already applies to **Medicare Part B** and **most private plans**. Its expansion will save you costs and improve your access to necessary preventive care.

This will help the approximately **4 million** Medicare beneficiaries who receive a Part D-covered vaccine each year—including the **3.6 million** who received the shingles vaccine in 2020, at an average cost of over $100. However, it will also reach millions more. **Research** shows Part D immunization rates are well below those for Part B, likely due to cost-sharing. The additional expense is a well-established barrier to beneficiary receipt of recommended vaccines.

You can read more about IRA changes that will take effect in future years **here**.

-Marci

Medicare Advantage plans have major drawbacks

The federal government requires drug advertisements to list all the appropriate dangerous side effects of medications.

Not so with Medicare Advantage plans. Medicare Advantage plans issue a card that looks just like original Medicare card, but it is not.

They advertise freely on TV, radio and print without listing the disadvantages. If they are so wonderful, why do they need to advertise and push so much? Why do they want you to "switch?"

The reason is because these companies make hundreds of billions of dollars from you and from the government (your tax dollars).

We (over 65) are constantly bombarded with picking a Medicare Advantage plan. These plans have many disadvantages over original Medicare, and it is a true case of "buyer beware."

In a nutshell: Advantage plans do not travel. If you get medical service (a visit, a test, a doctor visit) outside your "area," you will be charged substantial "out of network" fees. Tests must be approved by your insurance carrier which is not the case for original Medicare. This means that a test (X-ray, MRI or specialist referral etc.) that your doctor thinks you need may be rejected, and therefore — not paid for — by your "Advantage" plan.

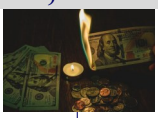
Your regular doctor might not be included among the doctors who are "in network" with the Advantage plan you choose. People who travel a lot, such as "snow birds" should be very, very careful before signing up for an Advantage plan. If you sign up in Florida for instance, you might only be eligible for "emergency" care back here in North Carolina — and if treated for emergency care you might have to "fight" with the insurance company to recognize the care as an "emergency" getting stuck with huge bills after an ER visit.

Medicare Advantage plans, while sometimes saving a healthy patient money, are ripping off the government to the tune of approximately $1,000 per patient per year. This costs the government (therefore your tax dollars) billions of dollars to provide what many consider to be poorer care than original Medicare. ….**Read More**

Hospitals overbill Medicare, driving up costs for everyone

At the end of last year, the HHS Office of the Inspector General (OIG) released **a report** listing its top recommendations to the Centers for Medicare and Medicaid Services (CMS) that CMS has not implemented. Among those is a recommendation to address hospital overbilling, reports Amanda Norris for **HealthLeaders**. Hospital overbilling, both to Medicare and to commercial insurers, drives up costs for everyone.

The OIG reports overpayments of $1 billion from hospitals charging inappropriately for a diagnosis of severe malnutrition in fiscal years 2016 and 2017. We don't know all the other inappropriate diagnosis codes different hospitals are assigning to patients in their care that are driving up Medicare spending and costs to people with Medicare. What we do know is that inappropriate and excessive charges can mean higher coinsurance for patients and higher Medicare costs for taxpayers.



The OIG has found that, overall, hospitals are claiming that their patients in their care are "at the highest severity level," which increases their payments from CMS. The proportion of patients claimed to be "at the highest severity level" has gone up significantly over the last several years. How many of them are at the highest severity level, in fact, is unclear.

OIG made a series of recommendations to address the issue of overpayments to hospitals resulting from inappropriate diagnoses, which CMS has yet to implement. Among those recommendations is that CMS review Medicare Severity Diagnosis Related Groups and other diagnoses that are easily upcoded as well as the hospitals that have disproportionate levels of these codes. CMS did not agree to undertake this effort.

The OIG explains that these reviews are necessary to Medicare's fiscal integrity. They are also necessary to control out-of-pocket costs for people with Medicare, including higher costs for Medicare supplemental coverage.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

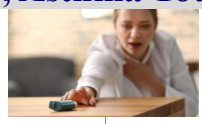
Make Curbing Allergies, Asthma Your New Year's Resolution

Keeping allergies and asthma in check in the new year is a resolution worth keeping.

With 2023 dawning, the American College of Allergy, Asthma and Immunology offers some suggestions for keeping symptoms under control all year long.

"More than 50 million people in the U.S. suffer from allergic conditions," said allergist **Dr. Kathleen May**, president of the ACAAI.

"That's a lot of Americans who need to be mindful of staying healthy to keep symptoms under control," May added in a college news release. "Taking a few moments before the new year begins to consider how you'll keep yourself on top of sneezing and wheezing in 2023 is well worth your investment of time. It's a valuable way to get your year off to a great start."



At the top of the ACAAI tip list: Eat right to avoid food allergens. If you have a food allergy, you already know to steer clear of problem foods. You should also always carry two epinephrine auto injectors with you and make sure they are up to date.

Also, encourage teens and college kids to educate their friends about food allergies, making them allies in safety from anaphylaxis.

Make an appointment to see your allergist if the pandemic has caused you to stay away.

Keep medications current and pay attention to whether your prescriptions are working for your symptoms. An allergist can tailor a plan to fit your allergies and asthma.

The college offers some other recommendations:

Don't smoke. It's bad for your health and that of your child, especially if either of you have asthma. Studies have shown that children with asthma who are exposed to secondhand smoke at home have nearly double the risk of being hospitalized compared to kids with asthma who aren't exposed, the ACAAI said.

Steer clear of fireplace fires and campfires to protect your lungs.

Keep exercising. It's vital to maintaining good health. When you do exercise, use your pre-exercise asthma medication, typically an inhaled bronchodilator.

Warm up and cool down before and after exercise. Wear a mask or loose scarf over your mouth and nose if it's cold and windy outside.

If asthma limits your ability to exercise, ask your allergist about changing medications, the ACAAI recommends.

Congressional Report Slams FDA, Drugmaker Over Approval of Alzheimer's Drug Aduhelm

The U.S. Food and Drug Administration's approval process for the controversial Alzheimer's drug Aduhelm was "rife with irregularities," despite lingering doubts about the power of the pricey medication to slow the disease down, a Congressional report released Thursday claims.

Actions the agency took with Biogen, maker of Aduhelm, "raise serious concerns about FDA's lapses in protocol," the **report** concluded. But the 18-month investigation launched by two congressional committees also took Biogen to task for setting too high a price on the medication.

Company documents showed Biogen officials settled on an annual cost of $56,000 for Aduhelm because it wanted 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 found.

Not only that, Biogen planned to spend up to several billion dollars on an aggressive marketing campaign to target doctors, patients, advocacy groups, insurers, policymakers and communities of color, who were drastically underrepresented in the company's clinical trials of the drug.

The controversy over Aduhelm (aducanumab) stretches back to its June 2021 approval. The Cleveland Clinic and the U.S. Department of Veterans Affairs, among others, decided not to offer Aduhelm infusions following the approval because of the drug's questionable efficacy and risks of brain swelling and bleeding.

Once Medicare sharply limited its coverage of Aduhelm, still expensive after the annual price was halved to $28,800, the drug was essentially sidelined from the marketplace, the *New York Times* reported.

What was so unusual about the FDA's approval process for Aduhelm?

According to the report, an unusual arrangement called a "collaborative workstream" began in July 2019, where FDA officials met repeatedly with Biogen to analyze data from one failed trial and another that seemed slightly successful, helping advise whether the company should seek approval for the drug.

Over the course of 12 months, there were at least 52 meetings, and not all were documented properly under FDA standards, the report added. Also, "there was no official memorialization of at least 66 calls or substantive email exchanges," the report said.

The latest hard look at Aduhelm comes as the FDA is now evaluating two other Alzheimer's drugs for possible approval early next year, including one that Biogen helped develop, the *Times* reported.

In light of that, the report stressed that the agency "must take swift action to ensure that its processes for reviewing future Alzheimer's disease treatments do not lead to the same doubts about the integrity of FDA's review."

In response, the FDA said in a statement that "we fully cooperated with the committees' evaluation and we continue to review their findings and recommendations," the *Times* reported.

But it added that the agency needs to frequently interact with companies during an approval process. "We will continue to do so, as it is in the best interest of patients," the statement said. "That said, the agency has already started implementing changes consistent with the committees' recommendations."

Meanwhile, Biogen defended its drug following the report's release.

"Biogen stands by the integrity of the actions we have taken. As stated in the congressional report, an FDA review concluded that, 'There is no evidence that these interactions with the sponsor in advance of filing were anything but appropriate in this situation," the company said in a **statement**.

Still, members of the investigating congressional committees had harsh words for both the FDA and Biogen, the *Times* reported.

Rep. Frank Pallone (D.-N.J.), chair of the House Energy and Commerce Committee, said in a statement that the report "documents the atypical FDA review process and corporate greed that preceded FDA's controversial decision to grant accelerated approval to Aduhelm."

His committee conducted the investigation with the House Committee on Oversight and Reform, chaired by Rep. Carolyn Maloney (D.-N.Y.). In a statement, she said she hoped the report would be "a wake-up call for FDA to reform its practices and a call to action to my congressional colleagues to continue oversight of the pharmaceutical industry to ensure they don't put profits over patients."

America's Doctors Offer Up Healthy Resolutions for 2023

It's that time of year again, when people gather up their best intentions for living a healthier life and make New Year's resolutions.

Luckily, the American Medical Association (AMA) has some suggestions on which pledges pack the most punch.

Start by being more physically active. Adults should do at least 150 minutes a week of moderate-intensity activity or 75 minutes a week of vigorous-intensity activity, the AMA recommends.

"Many people kick off the start of each new year with big-picture health resolutions — ambitious, immediate lifestyle changes that are very difficult to maintain," AMA president **Dr. Jack Resneck Jr**. said in an association news release. "The good news is that small, positive health choices made right now can have long-lasting effects."

Here are 10 more tips from the AMA:

- Manage your stress with a good diet, at least 7.5 hours of nightly sleep, daily exercise and wellness activities, such as yoga and meditation. Ask for help from a mental health professional when you need it.
- Eat fewer processed foods and sugar-sweetened beverages, especially those with added sodium and sugar. Eat less red meat and processed meats, replacing these with more plant-based foods, such as olive oil, nuts and seeds.
- Drink water in place of sugar-sweetened beverages. Even 100% fruit juices are associated with a higher all-cause mortality risk.
- Alcohol should be consumed only in moderation, with up to one drink per day for women and two for men.
- If you use tobacco or e-cigarettes, talk to your doctor about how to quit. Keep your home and car smoke-free to eliminate secondhand exposure.
- Get your vaccines. The whole family should be up to date on all of their vaccines, including the flu shot and COVID-19 vaccine.
- Stay up to date on screening. Millions of cases of breast, colon and prostate cancers may have been missed because of pandemic-related care disruptions.
- Know your blood pressure numbers. You can better understand what's right for you by visiting **ManageYourBP.org**. Controlling high blood pressure will reduce your risk of heart attack or stroke.
- Also learn your risk for type 2 diabetes. You can do this with a two-minute online self-screening test at **DoIHavePrediabetes.org**. Lifestyle changes made now can help prevent or delay the onset of type 2 diabetes.
- If taking prescription opioids or other medications, follow your doctor's instructions, store them safely to prevent diversion or misuse, and properly dispose of any leftover medication. Always take antibiotics exactly as prescribed.

New COVID Pill May Be Improvement Over Paxlovid, Chinese Trial Suggests

COVID-19 patients could soon have a new antiviral pill they can take to guard against severe disease.

The treatment, called VV116, worked as well as Paxlovid in people who were at high risk of severe disease in a phase 3 trial in China.

The trial was a "great success," study co-author Ren Zhao, a professor at Shanghai Jiao Tong University School of Medicine, said in a **news release** announcing the results.

Similar to the antiviral infusion remdesivir, but in pill form, VV116 has not yet been approved by the U.S. Food and Drug Administration.

It may first need more study in a larger, diverse group of patients to look for rare side effects and see how it fares against Omicron variants that have emerged since the trial was conducted, medical experts suggested.

The results of the trial were published Dec. 28 in the ***New England Journal of Medicine***.

"You have a medication that looks to be just as good as Paxlovid, but less cumbersome," **Dr. Panagis Galiatsatos**, an assistant professor of medicine at Johns Hopkins Medicine in Baltimore, told *NBC News*.

The trial found fewer reported side effects for patients, with about 67% of people who took it reporting side effects, compared to 77% of those who took Paxlovid, as well as fewer reactions with other medications such as those that treat insomnia, seizures or high blood pressure.

"It looks like we might have another tool in the toolbox," Galiatsatos noted.

Fewer patients in the trial had elevated levels of triglycerides (fat in blood that increases risk of heart disease or stroke) at 11% compared to 21% with Paxlovid.

Reduced side effects is "a big deal," Galiatsatos said.

In the VV116 trial, more than 380 people took the medication for about five days. A group of similar size took Paxlovid instead….**Read More**

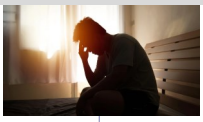
Who Will Respond Best to Ketamine for Severe Depression? New Study Takes a Look

Made infamous as the club drug Special K, ketamine is nowadays being seen as a wonder drug for some folks with hard-to-treat depression.

However, a **new study** finds that some types of patients are more likely to gain a rapid and significant benefit from ketamine than others.

Overall, while most patients did benefit from the drug, about one-third experienced a "rapid improvement" in their depression symptoms, the researchers said. Certain patient characteristics appeared to predict that level of benefit.

"Severely depressed individuals with a history of childhood trauma may have a better likelihood of a rapid and robust response to ketamine," concluded lead researcher Brittany O'Brien, an assistant professor of psychiatry and behavioral sciences at Baylor College of Medicine in Houston.



In 2019, the U.S. Food and Drug Administration approved a ketamine derivative called esketamine (Spravato) for depression that has failed to respond to at least two conventional antidepressants. Given as a nasal spray, esketamine is different from ketamine, which is an injectable anesthetic that can have mind-altering effects.

The new study included nearly 300 people with major depression who were treated with three infusions of ketamine at an outpatient clinic. Participants were 40 years old, on average, and most were men. They had not responded to at least two antidepressants in the past. Mood changes were measured using a standardized depression scale over six clinic visits.

Among the study group, three distinct patterns of response to ketamine were identified by the investigators.

One group was severely depressed before treatment but experienced a rapid and significant symptom improvement. A second severely depressed group received minimal benefit, and third group -- which was less depressed than the other two before treatment -- experienced a more gradual improvement in depression symptoms….**Read More**

Only 1 in 7 Cancers Are Caught Through Cancer Screenings

Just 14% of all cancers diagnosed in the United States are detected through routine screening, a new analysis finds -- pointing to many missed opportunities to catch cancer early.

"It's surprising, but true," said **Caroline Pearson**, senior vice president of the research institution NORC at the University of Chicago, which conducted the review.

Cancer screening, by definition, refers to tests that can detect tumors before they cause symptoms -- giving people the best chance of early treatment and beating the disease. Right now, there are routine screening tests recommended for breast, cervical and colon cancers. Lung cancer screening, meanwhile, is recommended for some smokers and former smokers.

One major reason for the findings is that for most cancers, there are no routine screening tests available. But there are also missed opportunities with the existing ones, according to Pearson.

"For one, screening isn't perfect," she said, so there will always be some early cancers that are missed.

In addition, Pearson said, some cancers will develop in the intervals between screening tests. Mammography screening, for example, is typically done every one or two years, while colonoscopy -- one of the screening tests for colon cancer -- is recommended every 10 years for people at average risk.

But there's also a third reason, Pearson said: Many Americans do not get the recommended cancer screenings.

"Look at something like colorectal cancer, where we have lots of screening options," Pearson said.

Besides a traditional colonoscopy, there is "virtual" CT colonoscopy, as well as various stool-based tests. A recent **report** from the U.S. Centers for Disease Control and Prevention found that 69% of Americans ages 50 to 79 said they were up-to-date with colon cancer screening in 2020.

But that percentage varied widely state to state -- going as low as 58% in California -- and 22% of Americans in the age range for colon cancer screening said they'd never been screened.

Other screen-detectable cancers have similar room for improvement. The CDC says that in 2019, 69% of U.S. women age 40 and older had a mammogram in the past two years, for example.

Getting those rates up, Pearson said, is the most straightforward way to boost the number of cancers detected by screening.

But there's also a need for better screening tests, including methods that are more accessible and less burdensome, according to Pearson.

Researchers are, in fact, working on that. A major goal is to develop a single blood test that can detect multiple cancers, according to **Dr. Ned Sharpless,** former director of the U.S. National Cancer Institute.

"While not market-ready, this concept is currently in development," Sharpless said.

"These simple tests could detect evidence of cancer in blood or other bodily fluids so that the disease can be treated very early, before it spreads," he said.

If such a blood test pans out, Sharpless said, "it could have a tremendous impact on cancer mortality rates."

The NORC **analysis**, which is not published in a peer-reviewed journal, used various data sources to estimate the percent of cancers detected by screening in 2017.

Overall, that figure was 14%. In part, that was because so many cancers lack a screening test: 57% of all cancers diagnosed in 2017 were types that have no routine screening method….**Read More**

Slips, Slides: Winter Injuries Can Be Serious

Wearing proper gear, watching out for snow and ice hazards, and "walking like a penguin" are just some of the tips that can help prevent winter accidents, one medical expert says.

"A variety of injuries can occur during the winter," cautioned **Dr. Mahmood Gharib**, a physiatrist at the University of Minnesota Medical School, in Minneapolis. "If someone slips or falls on icy surfaces, an injury can range from spine and musculoskeletal injuries — such as sprains and broken bones — to head and brain injuries — such as a concussion."

Winter sports are also a common cause of injury, Gharib added, while frostbite and hypothermia are additional concerns.

People should be mindful of slippery or icy surfaces that may be hard to see. Use extra caution near water runoff areas such as downspouts, landscaping, parking ramps and outdoor stairwells because of the possibility of black ice.

Stay on designated sidewalks and avoid taking shortcuts through grass and landscaping, Gharib advised.

"Walk like a penguin," Gharib said in a university news release. This looks like moving slowly and walking flat-footed. Use a wide stance, taking small, shuffle -like steps. Keep your center of gravity over your feet, using your arms for balance.

Dress appropriately, wearing multiple layers for warmth. Wear appropriate footwear to limit slipping….**Read More**

Covid-19 Cases on the Increase

Yes, we are all sick of covid and want to get back to living our lives in a normal way. However, as others have said, covid is not done with us.

Although not nearly as severe as in the past couple of years, covid infections are on the rise. Hospitalizations among seniors are nearing the peak from the Delta surge and rising fast. What's more, the age gap has never been wider. Since October, the Covid-19 hospitalization rate among seniors has been at least four times higher than average.

Even during the first winter surge in 2020, when Covid-19 took a devastating sweep through nursing homes, there was never more than a three-fold difference.

The fact is, between shots and prior infections and combinations thereof, younger people are doing pretty well. But the immune systems of people of advanced age are not as strong.

The current rate of deaths does not come close to what it was in 2020, before the vaccines, or even when the omicron variant took over last winter. But more than 300 residents a week have been dying recently in nursing homes and that number is likely to rise as holiday gatherings and cold weather fuel an uptick in infections.

In the total U.S. population, elderly people have been hit hardest this season, with people 75 and over making up 71 percent of all covid fatalities in November, according to the Center for Disease Control (CDC).

Immunity from the original round of shots has waned over time. The new boosters do not prevent all infections, but they are effective at preventing serious illness, hospitalizations and deaths, according to the CDC. The agency said the bivalent boosters cut the risk of covid hospitalization by at least half.

We urge you, once again, to get your covid booster shot if you have not already done so. There is plenty of the vaccine available and it is as easy as it has ever been to get the shot.

Statins May Lower Risk of Deadly 'Bleeding' Strokes

Statins may do more than help your heart: New research shows the cholesterol-lowering drugs may also lower your risk for a bleeding stroke.

An intracerebral hemorrhage, which involves bleeding in the brain, comprises about 15% to 30% of strokes, according to the American Association of Neurological Surgeons. It is also the most deadly. With this type of stroke, arteries or veins rupture, and the bleeding itself can damage brain tissue. The extra blood in the brain may also increase pressure within the skull to a point that further harms the brain.

"While statins have been shown to reduce the risk of stroke from blood clots, there has been conflicting research on whether statin use increases or decreases the risk of a person having a first intracerebral hemorrhage," said study author **Dr. David Gaist**, of the University of Southern Denmark in Odense.

"For our study, we looked at the lobe and non-lobe areas of the brain, to see if location was a factor for statin use and the risk of a first intracerebral hemorrhage," Gaist said. "We found that those who used a statin had a lower risk of this type of bleeding stroke in both areas of the brain. The risk was even lower with long-term statin use."

The researchers used health records in Denmark, identifying 989 people who had an intracerebral hemorrhage in the lobe area of the brain.

The lobe area includes most of the cerebrum, such as the frontal, parietal, temporal and occipital lobes. The non-lobe area includes the basal ganglia, thalamus, cerebellum and brainstem.

People included in the study had an average age of 76. Researchers compared them to 39,500 people who did not have this type of stroke and were similar in age, sex and other factors.

The researchers also looked at 1,175 people with an average age of 75 who had an intracerebral hemorrhage in the non-lobe parts of the brain, comparing them to more than 46,000 people who did not have this type of stroke.

Statin use was determined using prescription data.

After adjusting for factors like high blood pressure, diabetes and alcohol use, the researchers found that people taking statins had a 17% lower risk of having a stroke in the lobe areas of the brain. They had a 16% lower risk of stroke in the non-lobe areas of the brain.

Lower risk of stroke in both areas of the brain was associated with longer statin use. People had a 33% lower risk of having a stroke in the lobe area of the brain and a 38% lower risk of stroke in the non-lobe area of the brain when using statins for five years.

The findings were published online Dec. 7 in the journal *Neurology*. The study was supported by Novo Nordisk Foundation.

"It's reassuring news for people taking statins that these medications seem to reduce the risk of bleeding stroke, as well as the risk of stroke from blood clots," Gaist added in a journal news release. "However, our research was done in only the Danish population, which is primarily people of European ancestry. More research should be conducted in other populations."

Better Imaging Allows More Women to Opt for Breast-Conserving Surgery

Mastectomy has long been the standard of care for certain breast cancer patients, but it still may be more extensive than many women need, a new study suggests.

Researchers found that many women who have two or even three breast tumors may be able to have breast-conserving lumpectomies instead of having the entire breast removed.

That's because newer, more sensitive imaging techniques have allowed doctors to find tumors so tiny they would not have been seen in the past, the *Associated Press* reported.

The study was presented Friday at the San Antonio Breast Cancer Symposium in Texas. Research presented at meetings is considered preliminary until published in a peer-reviewed journal.

Researchers found that in 200 women who had these types of cases and had lumpectomies followed by radiation, the cancer returned in just 3% of women in five years. That is similar to cancer recurrence rates in previous lumpectomy studies with only one tumor, the *AP* reported.

Patients in the study were ages 40 to 87. Their tumors were less than 5 centimeters in size and were separated by about 2 to 3 centimeters of normal breast tissue.

Some doctors were already offering this alternative, even without available surgery guidelines, said lead researcher Dr. Judy Boughey, of Mayo Clinic in Rochester, Minn.

"This will make them more comfortable with that approach," Boughey told the *AP*. "And I think it will also make patients ask their surgeon, 'OK, I have two sites of disease. Do I have to have a mastectomy? Or can you give me breast conservation?'"

Women who had an MRI before surgery had the best results, the *AP* reported.

Patients were not randomly assigned to lumpectomy or mastectomy, because finding women willing to do that would be nearly impossible and impractical, Boughey said….**Read More**

Antibody Treatment Makes Inroads Against Multiple Myeloma

An experimental immunotherapy appears highly effective in attacking bone marrow cancer, with nearly three in four patients responding to the treatment, new clinical trial results show.

The drug, talquetamab, works by binding to the body's immune cells as well as to **multiple myeloma** cancer cells.

The therapy -- called a bispecific antibody -- directs white blood cells to attack and kill multiple myeloma cells. Researchers described the strategy as bringing your army right to the enemy.

In phase 2 clinical trials, about 73% of patients were helped by the drug, researchers reported over the weekend at an American Society of Hematology meeting. A phase 2 trial reveals more about the safety and effectiveness of a treatment.

The trial included nearly 300 patients whose multiple myeloma had returned despite treatment with at least three different cancer drugs.

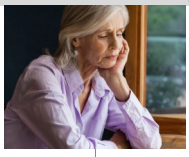
More than 30% of patients who responded to the drug appeared to be cancer-free following treatment with talquetamab, researchers report. Another 60% of those who responded had a very good response, where their cancer was substantially reduced.

It took a little over a month for patients to respond to the drug, and the average duration of response to date is more than nine months, researchers said.

Multiple myeloma patients whose cancer returns after standard and targeted treatment tend to have a poor prognosis. But talquetamab targets a different receptor on the cancer cells from other myeloma drugs, offering fresh hope to those patients, researchers said.

"This means that almost three-quarters of these patients are looking at a new lease on life," said lead researcher **Dr. Ajai Chari**, director of clinical research in the Multiple Myeloma Program at Mount Sinai's Tisch Cancer Institute in New York City…..**Read More**

Broken Hearts: Loneliness Could Raise Danger From Cardiovascular Disease



For people with heart disease, new research suggests loneliness, social isolation and living alone can shave years off your life.

This trio puts people with established cardiovascular disease at greater risk of premature death, according to the international study. Cardiovascular disease refers to heart disease and stroke.

"Social health factors such as loneliness and social isolation have gained a significant amount of attention recently and are really important to think of within the context of cardiovascular health," said lead author Róisín Long, a clinical psychologist and a doctoral candidate at University of Limerick in Ireland.

"What was unclear is to what degree they impact how long people live when they have been diagnosed with cardiovascular disease," Long said in a university news release.

"Our review found that each of these factors are critically important to consider in the treatment of cardiovascular disease, as increased levels of loneliness, social isolation and living alone appears to lead to premature death," Long added.

There are likely several reasons for this, Long added, ranging from support from another person to how an individual biologically responds to stress.

For the report, researchers reviewed 35 studies done in Europe, North America and Asia over many decades.

The effects of living alone appeared stronger in European countries. This may be a reflection of the large number of people living alone in parts of Europe, according to the study.

"While supporting public health concerns surrounding loneliness and social isolation, the study points to the need for rigorous research in this area across a greater range of geographical regions," the researchers concluded.

The findings were published in the January 2023 issue of the journal ***Psychosomatic Medicine.***

Study Shows Hearing Aids Can Reduce Risk of Dementia

As we age, seniors face the reality that dementia is a possibility and that, in some respects, whether we get it or not is out of our hands. Simply getting older is the biggest risk factor, followed by genetics.

The good news is that there are factors we *can* address, like diet, lifestyle and managing blood pressure, cholesterol, and diabetes.

But a study published earlier this month in the journal *JAMA Neurology* looked at hearing loss, which is found in about two -thirds of adults over 70.

The analysis of 31 other studies concludes that, for people with hearing loss, hearing aids reduce their risk of long-term cognitive decline by 19%.

However, there are a few caveats because this study relies heavily on observational research. Other research has shown that hearing is the biggest *modifiable* risk factor.

Researchers say there are three theories that could explain the connection between hearing loss and dementia.

The first is reduced socialization.

People who have hearing loss tend not to listen to radio, TV or other media programs that are educational and can stimulate the mind. Many tend not to go out and socialize as much so they are not having as much cognitively stimulating conversation.

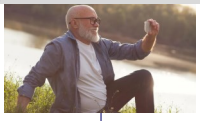
The second explanation is increased cognitive load. Because of changes within the ear, the brain is getting a garbled signal that takes more effort to process, effort that should be spent forming a memory or understanding meaning.

Finally, the experts say parts of the brain associated with sound, speech and memory formation actually shrink in people with hearing loss.

A major problem in dealing with hearing loss has been the lack of access to care and the high prices for hearing aids that many seniors cannot afford. However, the new availability of over-the-counter hearing aids could have a dramatic impact on that.

There is a stigma, as well. People associate hearing aids with old age. But for a generation of baby boomers, they can be key to staying vibrant and healthy.

Time Spent in Nature Appears to Slow Parkinson's, Alzheimer's



Living in an area with easy access to parks and rivers appears to slow the progression of devastating neurological diseases, such as Alzheimer's and Parkinson's.

That's the conclusion of a **new study** based on more than a decade and a half tracking disease risk among nearly 62 million Americans 65 years old and up.

"Prior research showed that natural environments -- such as forests, parks and rivers -- can help to reduce stress and restore attention," noted lead author **Jochem Klompmaker**, a postdoctoral research fellow at Harvard T. H. Chan School of Public Health in Boston. "In addition, natural environments provide settings for physical activity and social interactions, and may reduce exposure to air pollution, extreme heat and traffic noise."

To build on such observations, his and his colleagues looked at hospital admissions for Alzheimer's and related dementia, as well as Parkinson's disease.

By focusing on hospital admission, Klompmaker stressed that his team was *not* assessing the initial risk for developing either disease. Instead, researchers wanted to know if increased exposure to nature lowered the odds that either disease would progress quickly.

And on that front, Klompmaker said, researchers observed significant protective links: The greener an older individual's surrounding environment, the lower their risk of hospitalization for either neurological illness.

The finding could have bearing on millions of Americans, given that Alzheimer's and Parkinson's are among the most common neurological diseases in the United States.

To explore the potential protective benefit of nature, researchers focused on seniors on Medicare living in the U.S. mainland between 2000 and 2016.

About 55% were women, and about 84% were white people. All were 65 to 74 years of age when they entered the study pool…

Over the study's 16 years, nearly 7.7 million were hospitalized for Alzheimer's or other forms of dementia, and nearly 1.2 million were hospitalized for Parkinson's.

Throughout, researchers stacked each patient's ZIP code up against several types of geological survey data that collectively tallied a region's overall "greenness." That data included the amount of vegetation present, as well as the percentage of land devoted to parks and waterways.

In the end, the green number-crunching yielded mixed results.

On one hand, the team found no evidence that patients living in areas with more parks and waterways had lower risk for being hospitalized with Alzheimer's....**Read More**