Rhode Island Alliance for Retired Americans®

RI ARA

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"Fighting for the future of our members."
"NOW, more than ever!!!"

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Message from Alliance *for* Retired Americans Leaders

White House Releases State by State Fact Sheets on the GOP House's "Default on America Act"

Rich Fiesta, Executive Director, ARA

President Biden invited the "big four" congressional leaders – Senate Majority Leader Chuck Schumer, Senate Minority Leader Mitch McConnell, Leader Jeffries and House Speaker Kevin McCarthy – to the White House next week, after the federal government's debt managers warned Congress of a possible June 1 deadline to raise the statutory borrowing cap.

Ahead of that meeting the White House released **51 fact sheets** highlighting the severe impact of the Default on America Act (H.R. 2811), passed by GOP members of the House of Representatives last week, on Americans in every state and the District of Columbia

Nationally, the legislation would have devastating effects on the American people. For older Americans, it would:

- Worsen Social Security and Medicare Assistance Wait Times for Seniors. People applying for disability benefits would have to wait at least two months longer for a decision. With fewer staff available, seniors would also be forced to endure longer wait times when they call for assistance for both Social Security and Medicare, and as many as 240 Social Security field offices could be forced to close or shorten the hours they are open to the public.
- Jeopardize Food Assistance for Older Adults. House Republicans are threatening food assistance for up to 900,000 older adults with the Default on America Act's harsh new eligibility restrictions in the Supplemental Nutrition Assistance Program (SNAP).
- Raise Housing Costs for Americans. More than 600,000 families would lose access to rental assistance, including older adults, persons with disabilities, and families with children, who without rental assistance would be at risk of homelessness. In addition, about 600,000 people would become uninsured under the House Republican debt bill's plan to impose Medicaid work requirements.

"Congress needs to raise the debt ceiling with no strings attached," said **Richard Fiesta, Executive Director of the Alliance.** "Seniors will not stand for being taken hostage by MAGA Republicans in the House so that the GOP can implement harmful cuts to Social Security, Medicare, Medicaid or critical social programs in exchange for avoiding a default on our financial obligations." Five of the most likely outcomes of the debt ceiling debate and their implications for the country and economy are explained **here**.

Older Americans Month Begins with May Day

Joseph Peters ARA Sec.-Trea.

Older Americans Month Begins with May Day Monday, May 1 was not only the first day of Older Americans Month, it was also May Day, (International Workers' Day). Throughout May, Alliance members across the country are celebrating seniors' contributions to the nation and using the occasion to recognize the power of older adults to influence our communities. President Biden has issued a **proclamation** in honor of Older Americans Month.

May Day is a time to celebrate all workers and the efforts of trade unions and the labor movement. It is also a day of remembrance, since it honors the workers who died during the Haymarket affair bombing in 1886 in Chicago while protesting for an eight-hour workday.

Members of the Texas Alliance (TARA), Young Active Labor Leaders and other activists marked the day by picketing at Starbucks stores across the Dallas metro area. Their signs called for higher wages, the freedom to join a union and other workers' rights.

TARA members pioneered the "flying pickets" tactic at a string of Starbucks, going from one shop to another and quietly leafleting the employees and customers before picketing on the sidewalk outside.

"International Workers' Day is a chance to promote the change we need," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance.** "Legislatively, the best thing we can do as a nation in partnership with local action is to urge Congress to pass the **PRO Act**, introduced by Representatives **Brian Fitzpatrick** (R-PA) and Bobby Scott (D-VA) in the U.S. House as H.R. 20 and by Senator **Bernie Sanders** (I-VT) in the Senate as S. 567. It will make it easier to join or form a union, and that means better wages, health care, pensions and retirement security."

KFF Health News: Biden Administration Issues New Warning About Medical Credit Cards By Noam N. Levey

The Biden administration on Thursday cautioned Americans about the growing risks of medical credit cards and other loans for medical bills, warning in a new report that high interest rates can deepen patients' debts and threaten their financial security.

In its report, the Consumer Financial Protection Bureau estimated that people in the U.S. paid $1 billion in deferred interest on medical credit cards and other medical financing in just three years, from 2018 to 2020…...Read More **here**

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Social Security May Need to Cut Benefits In 2034. Here's What Retirees Must Know

High inflation and rising interest rates made life difficult for many Americans last year, but retired workers on Social Security were hit especially hard. Rising prices eroded the buying power of Social Security **benefits**, and recession fears triggered a sharp decline in the stock market, erasing trillions of dollars from retirement accounts. Fortunately, inflation is now trending downward and the stock market has rebounded from its lows, but the macroeconomic challenges of the past year have created a new problem for Social Security beneficiaries.

Social Security's OASDI trust fund could be insolvent by 2034

Each year, the Social Security Board of Trustees publishes a report detailing the financial status of the Old-Age, Survivors, and Disability Insurance (OASDI) trust fund -- the source of Social Security benefits. The latest report included some alarming news. The OASDI trust fund is on pace to be depleted by 2034, one year earlier than projected by the previous report.

One reason for the timeline acceleration is the historic **cost-of-living adjustment** (COLA) applied to Social Security benefits in 2023. Beneficiaries got an 8.7% COLA this year -- the largest raise since 1982 -- to keep Social Security income in line with inflation. If the OASDI trust fund is indeed insolvent by 2034, continuing income from payroll taxes will cover just 80% of scheduled benefits at that time, and that figure will drop to 74% by 2097. In other words, Social Security benefits would automatically be cut by at least 20% once the trust fund is depleted.

Social Security benefit cuts are all but guaranteed

Social Security ran a $22 billion deficit in 2022, building on the $56 billion deficit in 2021, and the Board of Trustees says the program will continue to operate at a loss until Congress makes changes. In total, Social Security faces a $22.4 trillion funding shortfall through 2097, and the scope of that financing problem means benefit cuts are all but guaranteed.

History supports that assumption. The Social Security program last ran a deficit between 1975 and 1981, and it essentially broke even in 1982 and 1983. That prompted Congress to pass the **Social Security Amendments of 1983**, legislation that has helped keep the trust fund solvent over the last four decades. The Social Security Amendments of 1983 boosted revenue for the OASDI program by raising the payroll tax rate for self-employed individuals. But the amendments also reduced benefits by delaying **full retirement age** and allowing for federal taxation of Social Security income.

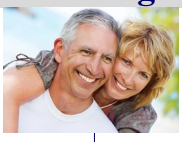
Resolving the current problem will likely involve a similar combination of changes. Some will **boost revenue** for the OASDI program, and others will reduce benefits. But there are a few silver linings for retirees. Congress has never let the Social Security trust fund become insolvent, and many experts believe future enrollees (especially high earners) will bear most of the benefit cut burden.

The longer Congress waits, the more serious the problem becomes

Social Security accounted for nearly 20% of federal spending last year. The sheer scope of the program makes it one of the more politically polarizing issues. Republicans and Democrats view Social Security's financing problem differently, and members of both parties have proposed solutions that attack the issue from different angles, but lawmakers need to find common ground soon. The longer Congress delays making changes, the more drastic the changes will need to be.

According to the Board of Trustees, a benefit cut of 21.3% in January 2023 would have kept the OASDI trust fund solvent through 2097. But if Congress delays until 2034, a benefit cut of 25.2% will be necessary to achieve the same outcome.

One Financial Tip to a Longer, Happier Marriage



The key to a happier and longer marriage may be pooling your money.

Researchers found that couples with joint bank accounts had better relationships, fought less about money and felt better about how their household finances were handled.

"When we surveyed people of varying relationship lengths, those who had merged accounts reported higher levels of communality within their marriage compared to people with separate accounts, or even those who partially merged their finances," said **Jenny Olson**, an assistant professor of marketing at Indiana University's Kelley School of Business. "They frequently told us they felt more like they were 'in this together.'"

The authors recruited 230 newlyweds or engaged couples, following them for two years in their early married life. Each of them began the study with separate bank accounts but consented to potentially changing their financial arrangements.

Study participants had a mean age of 28. None had been previously married. About 75% were white and 12% were Black. One-third of participants had a bachelor's degree and a median household income of $50,000. The couples had known each other an average of five years and had been romantically involved for an average of three years. About 10% had children….**Read More**

Half of Medicare Beneficiaries Are Enrolled in Medicare Advantage

Between 2007 and 2023, the share of Medicare beneficiaries enrolled in Medicare Advantage has increased from 19 percent to 50 percent

Half of all Medicare beneficiaries are **enrolled** in Medicare Advantage, according to the most recent enrollment data from CMS.

The CMS data found that, as of January 2023, 30.19 million of the 59.82 million people with Medicare Part A and B were enrolled in a private Medicare Advantage plan.

Medicare Advantage enrollment has grown every year since 2007 when just 19 percent of all eligible Medicare beneficiaries were enrolled in the private program.

In the last five years, the share of beneficiaries enrolled in Medicare Advantage increased from 37 percent in 2018 to **48 percent in 2022** and finally to 50 percent in 2023.

Part of this growth may be attributed to the supplemental benefits the program offers, including vision, hearing, and dental services. Additionally, Medicare Advantage plans may lead to lower out-of-pocket spending compared to traditional Medicare without supplemental coverage.

A survey from the Commonwealth Fund found that almost a quarter of Medicare Advantage beneficiaries **chose the private program because of the additional benefits** that traditional Medicare does not offer. The survey also revealed that one in five beneficiaries enrolled in Medicare Advantage because of the out-of-pocket spending limits.

Medicare Advantage's popularity may also be growing due to the simplicity of not needing a separate Part D prescription drug plan or supplemental coverage, the KFF policy watch noted.

Medicare Advantage beneficiaries tend to report high satisfaction with their plans. Last year, overall **member satisfaction** was 809 on a 1,000-point scale, according to the JD Power 2022 US Medicare Advantage Study.….**Read More**

‘Big Trouble’: Medicare Advantage Rates Strain SNF Margins, Deepen Sector’s Pain

As Medicare Advantage continues to penetrate the nursing home market, leaders say that MA plans are depressing margins amid higher costs to run operations. This might lead some operators to contemplate closing, while others will be wiser to hire staff in designated roles to help them negotiate better rates – and exclusions – for managed care contracts.

Data confirms that managed care rates are bringing down margins in the space, with MA plans paying one-quarter to one-third less to SNFs than traditional Fee-for-Service (FFS) Medicare, according to statistics put out by the National Investment Center for Seniors Housing & Care (NIC) and **published** in a Forbes piece by Howard Gleckman, also a senior fellow in the Urban-Brookings Tax Policy Center at the Urban Institute, where he edits the fiscal policy blog *TaxVox*.

Traditional Medicare amounts to nearly $600 per resident day in revenue, while managed Medicare is paying out only $468 per day, NIC data shows.

“It takes your breath away a bit, and it has consistently happened … it definitely hits the bottom line,” said Susie Mix, CEO of California-based Mix Solutions, Managed Care & Contract Consulting.

Zimmet Healthcare Services Group **collected its own data** on the FFS Medicare attrition rate – or MA payment shortfall relative to FFS – finding a staggering 40% shortfall, while per admission revenue trails FFS by up to 70%.

The Centers for Medicare & Medicaid Services (CMS) surprisingly doesn’t collect data on Medicare Advantage, according to Marc Zimmet, CEO of Zimmet. The data analytics group collected claims data for at least 1,500 admissions between July 1, 2021 and June 30, 2022 for this particular study. “Medicare Advantage is cannibalizing Medicare Fee-for-Service,” said Zimmet. “I think it’s really important to say that Medicare is what subsidizes Medicaid, and as facilities have less and less [FFS] and more and more Medicare Advantage, that puts more pressure on the Medicaid program.”

As revenue makeup continues to shift, states must get involved with some provider protections, Zimmet added.

These protections would help alleviate the rising cost of care and operating expenses from such initiatives as wage increases and safety protocols that have been in place since the pandemic, among other factors….**Read More**

What we don’t know about Medicare Advantage plans

The **Kaiser Family Foundation** just released a report detailing the many data gaps in Medicare Advantage–the corporate health plan option administered by private health insurers. This missing data is needed to assess Medicare Advantage plan performance and value. The government requires relatively little data from the Medicare Advantage plans and does not make much of it available for public scrutiny. Moreover, some of the required data is inadequate or incomplete, yet the Centers for Medicare and Medicaid Services, which oversees Medicare, rarely holds the Medicare Advantage plans accountable for failing to provide accurate data. Most of the data needed to evaluate Medicare Advantage plans is not required but should be.

Here are some of the questions for which we have no answers:

- Which plans have the highest rates of denials and which have the lowest?
- Which plans have the highest rates of prior authorizations and for which types of services?
- How quickly do Medicare Advantage plans respond to prior authorization requests?
- Why do Black Medicare Advantage enrollees disenroll from Medicare Advantage plans and why do white enrollees disenroll?
- What share of enrollees use the “extra” Medicare Advantage benefits and what is their income, ethnicity and health status?

The Centers for Medicare and Medicaid Services (CMS) does not have the answers to any of these questions. Without the answers, how can anyone assume that any particular Medicare Advantage plan offers value. For example, CMS does not require the Medicare Advantage plans to report the types of services for which there are high levels of prior authorization requests and denials or characteristics of the subpopulations denied prior authorization.

The insurers offering Medicare Advantage plans also do not have to distinguish among the plans they offer when they provide data to CMS. So, if some of their plans have particularly high denial rates and others low rates, CMS would not know.

Bottom line: There is no way for people to make an informed choice about a Medicare Advantage plan.

Escort requirements keep people from receiving medical procedures

Paula Span reports for the **New York Times** on outpatient procedures that require patients to have someone to escort them out of the doctor’s office. Even when they need a procedure, sometimes patients must forego care because they have no one to escort them out of the doctor’s office afterwards. These escort requirements keep people from receiving needed medical care.

There are a range of outpatient procedures for which some physicians require you to have an escort. For example, if you need a colonoscopy or cataract surgery, to name two procedures that require anesthesia, you might not be able to get an appointment if you don’t have an escort to pick you up after the service. Without the name and contact information for your escort, doctors might not allow you to schedule these procedures.

Easy access to transportation home after a procedure is not enough. Some physicians require people to have someone to get them from the doctor’s office to the taxi or car and then from the taxi or car into their homes. The concern is that the patient might have a bad reaction to the anesthesia and end up in a stupor or vomiting or totally disoriented.

Not every doctor requires an escort. But, some doctors. One person enrolled in an Aetna Medicare Advantage plan could not find a doctor to perform a procedure he needed unless he had an escort. But, he did not have one, and Aetna won’t cover the cost of the medical escort.

An escort requirement is a big issue for many people who live alone and don’t have people to turn to for help. They might need a procedure for their health and well-being. But, for their safety, they also might need an escort.

Is there a way to avoid having an escort? You should ask your health care providers whether they will allow you to wait in their offices for several hours after a procedure in lieu of having an escort. Sometimes they will.

How to get an escort? You might try contacting your local church or religious institution. Or, if you’re up to it, look into volunteering in your community for credits. Organizations like TimeBank allow you to bank credit from your own volunteering to enable you to get a volunteer to escort you home from the doctor.

Medicare Rights Seeks to Boost Automatic Enrollment in Medicare Savings Programs

Many of the millions of low-income older adults and people with disabilities who are eligible for **Medicare Savings Programs (MSPs)** don't know about them or how to apply. These programs help pay for Medicare premiums and other out-of-pocket expenses, providing crucial assistance to those who may be struggling to make ends meet. To get the word out about these vital programs, we teamed up with AARP New York to contribute to **a report** by Professor Teresa Ghilarducci of The New School's Schwartz Center for Economic Policy Analysis.

The report also highlights the importance of data matching, which is using existing information from other programs like Medicaid to automatically enroll people in MSPs. Further illustrating the effectiveness of data matching, **help was expanded** to an additional 82,000 Medicare-eligible individuals in New York State in February 2023. These individuals were identified by having Medicaid and were enrolled in the MSP in a move Medicare Rights has long held as a priority. This guarantees that over $13 million in Part B premium payments will arrive directly in beneficiaries' Social Security deposits every month.

We're also excited to share some more good news from New York, where **MSP income limits have increased this year.** Thanks to our outreach efforts and dedicated staff and counselors, we have helped more than twice as many clients apply for MSPs this year compared to last year.

At Medicare Rights, we believe every person with Medicare deserves access to affordable health care. That's why we urge all states to follow New York's example and make it easier for people to enroll in MSPs.

Learn more ways to improve the MSP by reading our fact sheet ***Protect and Strengthen Medicare: Improving Medicare Savings Programs.***

The health care dangers of a debt default

By **maya.goldman@axios.com**

If the federal government breaches the debt ceiling, Medicare wouldn't be able to pay providers — and states wouldn't get their federal Medicaid funding, experts tell Axios.

Why it matters: Losing out on those payments, even for a short time, could be disastrous for providers' bottom lines — and the effects could trickle down to patients.

What they're saying: "There is no separating the failure to raise the debt limit from health system collapse," said Sara Rosenbaum, a health law and policy professor at George Washington University.

- An extended default could have broad consequences for Americans' health care, potentially reaching not just Medicare and Medicaid, but the Affordable Care Act as well — and making providers more reluctant to treat Medicare and Medicaid patients.
- "Get your health care now. Don't wait until June 1," Rosenbaum said. "My message to the world is, don't wait on that orthopedic surgery."
- Because the U.S. hasn't defaulted on its debt before, it's difficult to predict specific impacts, said Bill Hoagland, senior vice president at the Bipartisan Policy Center and a former Senate Budget Committee staff director.
- "But every indication [is] this would be extremely disruptive," he added.

People who get their health coverage through the Affordable Care Act would feel the effects too, Hoagland said — because the government wouldn't be able to pay subsidies for Marketplace insurance premiums if it defaults.

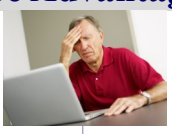
The big picture: Public insurance — including Medicare, Medicaid, CHIP, and Veterans Administration and Department of Defense programs — paid for 42.5% of national health expenditures in 2021, **according** to the Kaiser Family Foundation.

What to watch, if President Biden and House Speaker Kevin McCarthy don't get it together pretty soon:…...**Read More**

You still can't trust Medicare Advantage plan provider directories

Back in 2019, I wrote a post for Just Care on why **you can't trust Medicare Advantage plan provider directories.** Unfortunately, you can't trust **their ads**, their **sales agents**, the **quality of the health care providers** in their networks or their coverage policies either, so you are throwing darts when choosing a Medicare Advantage plan. What's particularly disturbing is that notwithstanding years of oversight showing untrustworthy provider directories, these directories remain untrustworthy, and CMS, which oversees Medicare Advantage, has done little to hold Medicare Advantage plans to account for their failure to keep their directories accurate.

The Senate Finance Committee is looking into what are called "ghost networks," provider directories with names of providers who are not available to provide care. It issued a report on ghost networks for mental health providers.



No one knows for sure how common these ghost networks are, but Senate Finance Committee Majority staff found significant errors in a secret shopper study of mental health providers in Medicare Advantage plans. Out of 120 calls staff made, they were only able to make appointments 18 percent of the time. The inaccuracy rate was more than 80 percent, with the vast majority of providers either not able to be reached, out of network, or not taking new patients.

Some plans did better than others and availability was better in some states. But, in Oregon, staff could not make an appointment at all. In Colorado, they were able to make an appointment half the time. In some cases though, appointments were available many months down the road. Moreover, some offices required additional information before scheduling an appointment; Senate Finance staff could not confirm whether appointments would be scheduled once that information was provided. If not, the provider directories would only have been accurate 13 percent of the time.

Unfortunately, it appears that Senate Finance is suggesting minor steps to correct what can be a huge issue for Medicare Advantage enrollees in need of critical care. Rather than recommending an open network in any MA plan with inaccurate provider directories–the only fair solution to ensure MA enrollees access to needed care–they want more CMS oversight and financial penalties. Inexplicably, Senate staff fails to acknowledge in its report that CMS has been admonished several times over several years to ensure provider directory accuracy with no success. Fool me once . . .

Given mental health parity laws and the fact that one in five adults–nearly 60 million Americans–have a diagnosable mental health illness, access to mental health providers should be easy. Without treatment, people often suffer considerably and can become increasingly ill or even die.

In their report, staff did not name the MA plans they looked into, let alone the names of the worst actors, which would be helpful information for people deciding among MA plans, particularly people with mental health needs. How is it that we know more about differences among restaurants and refrigerators than we do about Medicare Advantage plans?

Many retirees aren't prepared for how Medicare costs 'can add up'

Most Americans don't have a clue about what their health care expenses will add up to in retirement. Many may even think once they reach age 65, Medicare will cover most, if not all, of their medical bills.

In 2019, half of the 35 million older adults and younger persons with disabilities with traditional Medicare spent at least 16% of their income on out-of-pocket health care costs, according to the report. Overall, for the annual period reviewed, people with traditional Medicare spent an average of $6,663 on insurance premiums and medical services.

The annual out-of-pocket medical expenditures that many older Americans face in retirement underscores the need for workers to double-down either on ways to cut those costs or tap every tool to save up enough to cover future health care bills that may be considerably higher than expected.

"Contrary to a common belief, Medicare does not cover all health care–related expenses," said Claire Noel-Miller, a senior strategic policy advisor at the AARP Public Policy Institute and writer of the report, who examined data from the 2019 Medicare Current Beneficiary **Survey**. "And costs can add up."

No maximum limit to traditional Medicare out-of-pocket expenditures

The main culprit for the pricey healthcare tab: no cap on the amount someone might shell out in yearly outlays for expenses not covered by Medicare.

"Even though the program offers fairly comprehensive coverage, traditional Medicare does not have a maximum limit on what people have to spend out-of-pocket every year," Noel-Miller told Yahoo Finance. "Consequently, some people with traditional Medicare can face high expenses, especially if they become ill and need more medical services."

That's backed up by the report.

One in 10 traditional Medicare beneficiaries spent 52% of their income on medical outlays. The same share with traditional Medicare spent at least $11,767 in 2019, and the top quarter of spenders paid an average of $15,449.

Many Medicare beneficiaries purchase Medigap or enroll in Medicare Advantage plans to help offset these costs. They also enroll in Part D prescription drug plans. But the combination of premiums for supplement coverage and out-of-pocket expenses can put a significant financial stress on Medicare beneficiaries.

The report "reflects something that's been true about Medicare since the beginning, which is that the program provides broad coverage of needed medical services, but the benefits aren't free and out-of-pocket costs aren't capped in traditional Medicare," Juliette Cubanski, deputy director of the program on Medicare policy at the nonprofit Kaiser Family Foundation (KFF), told Yahoo Finance.

"As health care costs, premiums, and Medicare cost-sharing requirements have increased over time, people in traditional Medicare have become more reliant on supplemental coverage to help cover the cost sharing that Medicare requires," Cubanski said. "And a growing share are signing up for Medicare Advantage plans that are required to have an out-of-pocket cap."

Last year, nearly half (48%) of eligible Medicare beneficiaries were enrolled in Medicare Advantage plans.

One in five Medicare beneficiaries enrolled in a Medicare Advantage plan pointed to a limit on out-of-pocket spending as the main reason for their choice, according to The Commonwealth Fund's 2022 Biennial Health Insurance **Survey** of 1,605 adults enrolled in Medicare.

Noel-Miller's report does not provide a cost comparison for seniors enrolled in Medicare Advantage plans — which have their own set of **hassles** — but the savings targets are typically lower, according to a 2023 report by EBRI.

How Medicare costs break down

People with traditional Medicare generally pay a monthly premium for physician coverage, Part B, and for prescription drug coverage, Part D. Those premiums vary by plan. Some people pay a monthly premium for inpatient hospital coverage, Part A.

Each year the Medicare Part B premium, deductible, and coinsurance rates are reset. For 2023, the standard monthly premium for Medicare Part B — which covers physician services, outpatient hospital services, certain home health services, durable medical equipment, among other services not covered by Medicare Part A — is $164.90, according to the **Centers for Medicare & Medicaid Services.** Part B premiums typically are deducted from monthly Social Security benefits.

The annual deductible for all Medicare Part B beneficiaries is $226 in 2023….**Read More**

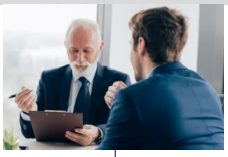
How Many Hours Can You Work and Still Collect Social Security?

As the name would imply, **Social Security retirement benefits** were meant to be paid out to beneficiaries after they stop working.

You can continue to work as long as you want, and you can still collect Social Security benefits. However, you should be aware that continuing to work after claiming Social Security benefits could reduce the amount that you receive, particularly if you have not yet reached full retirement age.

Working Before Full Retirement Age

From the perspective of the Social Security Administration, full retirement age for those born in 1960 or later is 67. If you continue to draw income before you reach full retirement age, the SSA considers you a worker rather than a retiree. As such, some of your benefits may be held back.



Specifically, for every $2 you earn above a certain limit, the SSA will withhold $1 of your earnings. For 2023, the earnings limit is $21,240.

As to how many hours you can work and still collect Social Security, this will obviously depend on your hourly wage. For example, if you earn $20 per hour, you can work 978 hours per year before your Social Security benefits are reduced, assuming you haven't yet reached full retirement age. At 40 hours per work week, that means you can work just over 24 weeks before hitting the earnings limit. If your salary is higher, that number obviously will be adjusted downward.

Working the Year You Reach Full Retirement Age

Things change the year you reach full retirement age. At this point, the amount you can earn before any benefits get withheld is $56,520, as of 2023. Further, benefits are reduced by just $1 for every $3 you earn above the earnings limit.

Working After Full Retirement Age

For some people, working after full retirement age is not the definition of "retirement." But for others, working after age 67 can be a joy — or a requirement.

Regardless of the reasons you might have, the good news is that once you reach full retirement age, you'll no longer suffer any penalties for working. You'll be entitled to your full monthly Social Security benefit regardless of how many hours you work. Even if you decide to work full time or run a business, you'll get to keep your earnings and all of your Social Security payments.

You'll Always Be Made Whole….**Read More**

Dear Marci: *What mental health care does Medicare cover?*

Dear Marci,

What mental health care does Medicare cover? I have anxiety and depression, and my primary care provider recommended I see a therapist or psychiatrist.

-Josefina (Cleveland, OH)

Dear Josefina,

Medicare covers both inpatient and outpatient mental health care. And Medicare prescription drug plans cover medications used to treat mental health conditions, but be sure to check the formulary to ensure the brands and dosages you take are included.

Medicare Part B covers outpatient mental health care, including the following services:

- Individual and group therapy
- **Substance use disorder treatment**
- Tests to make sure you are getting the right care
- Occupational therapy
- Activity therapies, such as art, dance, or music therapy
- Training and education (such as training on how to inject a needed medication or education about your condition)
- Family counseling to help with your treatment
- Laboratory tests
- Prescription drugs that you cannot administer yourself, such as injections that a doctor must give you
- An annual **depression screening**

Be sure to ask any provider you see if they take your Medicare insurance before you begin receiving services. If they don't, you will likely be responsible for the full cost of the care. Psychiatrists are more likely than any other type of physician to opt out of Medicare, meaning Medicare will not cover any of the cost of the care from those doctors. Additionally, not all non-medical providers (like psychologists or clinical social workers) are Medicare-certified. If you need a list of providers near you who accept Medicare, you can go to **www.medicare.gov/care-compare**.

Medicare Part A covers inpatient mental health care that you receive in either a psychiatric hospital (a hospital that only treats mental health patients) or a general hospital. Your provider should determine which hospital setting you need.

If you receive care in a psychiatric hospital, Medicare covers up to 190 days of inpatient care in your lifetime. If you have used your lifetime days but need additional mental health care, Medicare may cover your care at a general hospital.

Medicare Part D covers most prescription drugs used to treat mental health conditions. You may have Part D coverage through a Medicare Advantage Plan or through a stand-alone Part D plan. All Part D plans must cover at least two drugs from most drug categories and must cover all drugs available in certain categories, including antidepressants and antipsychotic medications.

I hope this helps!

-Marci

STAY HEALTHY AND INDEPENDENT WITH THE SENIOR NUTRITION PROGRAM

By Cheryl Tudino
Social Security Public Affairs Specialist

Are you eligible for Social Security retirement benefits or already receiving them? Did you know that you can also receive healthy meals and other nutrition services through the National Senior Nutrition Program? Local meal programs in communities across the country are waiting to serve you.

As we age, we have different needs, different ways we take care of our health, and different nutrients we need to get from our food. But we don't always have enough healthy food or the desire to prepare or eat a meal. Whether you need more food, healthier food, someone to share a meal with, or just want to learn about good eating habits, a meal program can help.

Every day, senior nutrition programs serve almost one million meals to people age 60 and older. With home-delivered and group meal options, you can get the food you need in a way that works best for you. It can help you avoid missed meals – and save you time and money with less shopping and cooking.

Local programs serve up more than food — they offer opportunities to connect and socialize. We know this improves both your mental and physical health.

The programs can also teach you how to create a healthy eating plan. You can learn about healthy food recommendations based on your age, unique needs, and preferences.

A senior nutrition program can also connect you with other resources like transportation or homemaker services. This helps you stay connected and engaged in your community.

It's no surprise that 9 out of 10 participants say they would recommend a senior nutrition program to a friend. We know these services help create healthy, strong communities where everyone can thrive at any age.

Find a senior nutrition program in your area and help us spread the word about this program by sharing it with your loved ones, neighbors, and community. Visit **eldercare.acl.gov/Public/Index.aspx** for more information.

The Senior Nutrition Program is administered by the Administration for Community Living, part of the U.S. Department of Health and Human Services.

How to Stay Connected to Your Loved One in a Nursing Home

Virtual or traditional, these methods can help nursing home residents feel less isolated.

We all need to feel connected to the outside world. For people living in **nursing homes**, staying in touch has always been more of a challenge, particularly with family members at a distance. And for many months now, the fluctuating COVID-19 pandemic has made essential connections that much more difficult, even when loved ones live nearby. The good news is that with **vaccination** and better control over COVID-19, visiting restrictions in long-term care facilities are easing. And a pandemic silver lining is the workarounds it inspired to link residents to family members, friends and fellow residents, even during the worst **isolation** periods. From virtual technology to in-person visits, from creative activities to traditional letters, cards and phone calls, it's almost always possible to somehow connect. Here's what you can do: Creative Connections Technology, delivery and comfort options that helped make the pandemic more endurable and activities more doable in the outside world, can do the same for nursing home residents:

- **Tablets**. These devices offer countless ways to keep residents entertained, engaged and connected. Family Zoom meetings, favorite YouTube videos, **subscriptions for music** and movie streaming are among possibilities.
- **Email.** Residents who don't care for texting may still enjoy connecting online through email. That allows them to read and respond to messages at their leisure.
- **Delivered edibles**. With DoorDash or other meal delivery services, residents can enjoy local takeout food. Or you can give the gift of sending favorite gourmet treats from across the country, providing "edible moments of joy," says Dr. Scott Schabel, senior medical director for long-term care at Rochester Regional Health in New York.….**Read More**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

FDA Approves First RSV Vaccine

The first vaccine for respiratory syncytial virus (RSV) has been approved by the U.S. Food and Drug Administration for use in seniors aged 60 and older.

Arexvy, manufactured by GlaxoSmithKline (GSK), is expected to help prevent lower respiratory tract infections caused by RSV, the agency said Wednesday.

"Older adults, in particular those with underlying health conditions, such as heart or lung disease or weakened immune systems, are at high risk for severe disease caused by RSV," **Dr. Peter Marks**, director of the FDA's Center for Biologics Evaluation and Research, said in an **FDA news release**.

"Today's approval of the first RSV vaccine is an important public health achievement to prevent a disease which can be life-threatening and reflects the FDA's continued commitment to facilitating the development of safe and effective vaccines for use in the United States," Marks added.

Now that the vaccine is approved, the U.S. Centers for Disease Control and Prevention will weigh later this summer whether all seniors should get the shot or just those considered at high risk for severe infection.

The FDA is also evaluating a competing RSV vaccine from Pfizer, and is expected to next consider the vaccines for use in pregnant women to protect newborns from RSV in the weeks following delivery. "This is a great first step ... to protect older persons from serious RSV disease," **Dr. William Schaffner**, medical director of the National Foundation for Infectious Diseases, told the *Associated Press*. Next, "we're going to be working our way down the age ladder" for what's expected to be a string of new protections.

RSV is a highly contagious virus that spreads widely during the cold and flu season, with cases typically starting in the fall and peaking in the winter, the FDA said. RSV hit Americans particularly hard during the last cold and flu season, as pandemic restrictions were finally lifted. The virus tore through populations of young children who had never been exposed to it.

In older adults, RSV can cause life-threatening pneumonia and bronchiolitis — swelling of the small airway passages in the lungs. Each year in the United States, RSV leads to approximately 60,000 to 120,000 hospitalizations and 6,000 to 10,000 deaths among adults 65 and older, according to the CDC.

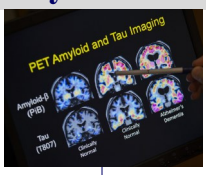
The FDA gave its approval based on a clinical trial in which approximately 12,500 participants from around the world randomly got an Arexvy vaccine, while 12,500 others received a placebo shot….**Read More**

'It's not a miracle drug': Eli Lilly's antibody slows Alzheimer's disease but safety issues linger

Clinical trial results released today by Eli Lilly and Co. indicate its antibody donanemab **clearly, if perhaps modestly, slows the progression of Alzheimer's disease.** Following on the heels of comparable results for a similar antibody, lecanemab, the data bolster the long-held but contested hypothesis that preventing the accumulation of a protein called beta amyloid in the brain could help the many millions of people who develop the fatal neurodegenerative disorder.

"We are extremely pleased that donanemab yielded positive clinical results with compelling statistical significance," Daniel Skovronsky, Eli Lilly's chief scientific and medical officer, and president of Lilly Research Laboratories, said in a press release that noted the antibody had slowed the cognitive and functional decline of Alzheimer's patients by 35% compared with a placebo.

"This is monumental and aligns very closely to lecanemab as far as the amount of benefit," Donna Wilcock, an Alzheimer's disease scientist at the University of Kentucky College of Medicine, says. "In fact, it looks like donanemab may have greater benefit, although the trial designs do not allow direct comparison."



But Eli Lilly's preliminary donanemab results also reveal a sobering risk of brain swelling and hemorrhaging, side effects that the company disclosed may be linked to two—perhaps three—deaths in the clinical trial and that **echo hazards seen with lecanemab**, which is being marketed by Eisai and Biogen. With the U.S. Food and Drug Administration considering full approval for lecanemab next month and Eli Lilly vowing to quickly submit donanemab to the agency for review, many physicians, Alzheimer's patients, and their caregivers may soon face difficult conversations about whether to risk immediate harm to take these therapies, the first to be clinically proven to somewhat thwart a slow but inexorable destroyer of the brain.

Donanemab is "not a miracle drug," cautions Sorbonne University neurologist Nicolas Villain, who helped clinically test lecanemab and worries that Eli Lilly's antibody may carry even higher risks.

Both donanemab and lecanemab bind to various forms of beta amyloid in the brain and are intended to promote their clearance from the extracellular deposits knowns as plaques that many scientists suspect cause neurons to malfunction and die. Brain scans taken during Eli Lilly's phase 3 trial, which involved more than 1700 people with early signs of Alzheimer's disease, showed that donanemab cleared the protein effectively. More than half of participants receiving the antibody via monthly infusions had their amyloid plaque fall to a level that trial designers had designated in advance as a criterion for stopping treatment and switching to the placebo group—Eli Lilly designed this aspect of the trial to help see whether amyloid would then resume accruing or hold at the lower level.

But more important, the preliminary results from the trial found that treated individuals declined more slowly in two different assessments of cognitive and physical functions over 18 months than those given a placebo. That echoes the groundbreaking result for lecanemab reported more than a year ago.

Eli Lilly only presented topline numbers from the trial today, saying it plans to reveal more data at an Alzheimer's disease meeting in July and in a forthcoming publication. For now, the company says the drug slowed the disease's expected progression by 35% based on a scale it developed and by 36% on the more widely used Clinical Dementia Rating-Sum of Boxes, or CDR-SB, scale, which gathers clinical and caregiver assessment to rank dementia severity on an 18-point scale. Eli Lilly also reported that 47% of the treated trial participants had no worsening of disease severity based on the CDR-SB, compared with 29% among the placebo group. The treated individuals also, on average, maintained a greater ability to perform key daily activities such as using the toilet independently and dressing themselves, the company said.

The Eli Lilly trial also looked at another brain protein, tau, that has attracted the interest of many researchers. Unlike beta amyloid, which forms plaques outside brain cells, tau malfunctions inside neurons, becoming enmeshed in clumps known as tangles. ….**Read More**

Ultrasound Breaches Blood-Brain Barrier, Helping Drugs Fight Tumors

Brain cancers are notoriously difficult to treat because most chemotherapy drugs can't breach the blood-brain barrier, a microscopic layer of cells that protect the brain from toxins.

But researchers now say they can temporarily open that barrier and get more chemo to brain tumors, using an experimental ultrasound device.

The technology led to a four- to sixfold increase in chemo drug concentrations within the brains of patients. The researchers observed this increase with two different powerful chemotherapy drugs, paclitaxel and carboplatin. These drugs aren't typically used to treat brain tumors because they normally can't cross the blood-brain barrier.

For this study, doctors surgically removed patients' glioblastoma — the most common malignant brain tumor in adults — and then implanted a grid of nine ultrasound emitters in their skulls.

Within a few weeks of surgery, patients started chemo treatment to kill any residual cancer cells in their brains.

The experimental emitter grid, designed by French biotech company Carthera, opened the blood-brain barrier at large, critical regions of the brain. This allowed the intravenous chemo drug paclitaxel to seep into the brain.

The ultrasound procedure takes about four minutes and is performed with the patient awake, the researchers reported. Patients go home after a few hours.

The blood-brain barrier quickly reestablishes itself following the procedure, with most of its integrity restored within one hour, the study authors said.

The report was published May 2 in ***The Lancet Oncology*** journal.

"There is a critical time window after sonification when the brain is permeable to drugs circulating in the bloodstream," said lead researcher **Dr. Adam Sonabend**, an associate professor of neurological surgery at Northwestern University Feinberg School of Medicine, in Chicago.

The doctors escalated the dose of paclitaxel delivered every three weeks, using the ultrasound implant to make sure the chemo got to the brain.

The treatment was safe and well-tolerated, the researchers said. Some patients got up to six chemo treatment cycles for their brain tumors.

The findings of this study have formed the basis for a clinical trial in which patients will receive a combination of paclitaxel and carboplatin to their brains, to see if the treatment prolongs their survival.

Glioblastomas are the fastest-growing brain tumors, and they are nearly always advanced when detected. Five-year survival rates are 22% for people aged 20 to 44, 9% for adults 45 to 54, and 6% for those aged 55 to 64, according to the American Cancer Society.

The researchers said the ultrasound technique could be used to help deliver many different types of medication to the brain.

"While we have focused on brain cancer (for which there are approximately 30,000 gliomas in the U.S.), this opens the door to investigate novel drug-based treatments for millions of patients who suffer from various brain diseases," Sonabend said in a university news release.

Medical Marijuana Can Safely Control Cancer Patients' Pain: Study

Medical marijuana can safely reduce cancer pain, and is apparently so effective that patients wind up taking lower amounts of opioids and other pain meds, a new study reports.

Weed produced clinically significant reductions in cancer patients' worst pain, average pain and overall pain severity, said senior researcher **Dr. Antonio Vigano**, an associate professor of oncology and medicine at McGill University Health Center in Montreal.

"Medical cannabis can be safely introduced in the care of cancer patients and can really lead to a decrease in different parameters by which we measure cancer-related pain," Vigano said. "These reductions in those measures can be stable and can last up to one year of follow-up."

Adding cannabis to a patient's pain regimen also caused as much as a 32% decrease in the use of opioids and other pain medications, according to the study.

"As a consequence of using pot, we could also see a reduction in overall consumption of medication," Vigano said. These reductions included opioids, antidepressants, anti-convulsives and non-steroidal anti-inflammatory drugs (NSAIDs).

Up to now, medical cannabis has largely been seen as a way to treat nausea and vomiting caused by chemotherapy, researchers said in background notes. Two marijuana-derived drugs, dronabinol and nabilone, have been approved for that use.

For this study, Vigano and his colleagues tracked for up to one year 358 adults with cancer whose treatment data was submitted to the Quebec Cannabis Registry between May 2015 and October 2018.

The patients' average age was 57, and the most common cancer diagnoses were genital and urinary, breast and colon.

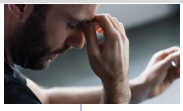
Pain was the most frequently reported symptom that prompted a prescription for medical cannabis, with 72% of cases citing it, researchers found.

Most patients took their medical cannabis by mouth (57%), through oils or capsules, Vigano said. About 13% smoked or inhaled their weed, and 25% combined one or more modes of administration.

Patients entered the study with their worst pain around 5.5 on a scale of 1 to 10, Vigano said.

At nine months, patients using weed had a 35% decrease in their worst levels of pain and a 43% decrease in the amount that cancer pain interfered with their daily lives.….**Read More**

How to Relieve a Stress Headache



You had a rough day at work and got stuck in traffic on the way home, and suddenly your head starts pounding.

Stress headaches can be debilitating in the moment, but you don't have to suffer indefinitely.

If you're struggling with stress, you're not alone. More than one-quarter of adults in the United States reported they're too stressed out to function, according to a recent survey from the **American Psychological Association**.

Can stress cause headaches? Yes, in fact the most common type of primary headache is a tension headache, also referred to as a muscle tension headache or stress headache, according to **Harvard Health.** Tension headaches may be episodic, meaning that they occur less than 15 days a month; if they occur more than 15 days a month for more than three months in a row, they are called chronic tension headaches, according to the **Cleveland Clinic.**

Here, experts break down how to relieve a stress headache and how to help prevent one from happening in the first place.

How does stress cause headaches?

Stress triggers the "fight-or-flight" response that then stimulates physical changes that can contribute to headaches. These include the following:

- Neck, shoulder, scalp, face and jaw muscles tensing
- Teeth grinding
- Problems with sleeping
- Meal skipping that imbalances blood sugar levels...**Read More**

New 'E-Tattoo' Is Worn on Chest to Track Your Heart Health

Could an electronic chest "tattoo" -- wireless, lightweight and razor-thin -- upend heart monitoring and lower the odds of heart disease for folks who are at high-risk?

Just possibly.

The clear patch in question is not quite 4 by 5 inches in size, weighs less than an ounce, and is powered by a battery no bigger than a penny.

And just like a temporary tattoo sticker, it's designed to stretch over heart patient's chest. Once in place, it can provide round-the-clock monitoring of two key heart functions: electrical activity and mechanical capacity.

The bio-electronic tattoo, explained study author **Nanshu Lu**, is basically a "wear-and-forget device." It sits on the skin like medical dressing and can operate for upwards of 40 hours straight before a change of battery.

While current wearable patches only operate as an electrocardiogram (ECG), the new tattoo serves both as an ECG and a seismocardiogram (SCG), added Lu, a professor of aerospace engineering and engineering mechanics at the University of Texas at Austin.

An ECG enables tracking of a heart's electrical status. An SCG provides a running assessment of the heart's mechanical operation by tracking subtle vibrations of the body.

Both ECG and SCG results are streamed wirelessly in real-time via Bluetooth to an external host device that allows third-party monitoring for signs of trouble.

Lu said providing both electrical and mechanical assessments at the same time gives doctors a "more comprehensive understanding of cardiac function than just ECG alone," allowing them to detect and manage various heart conditions more effectively.

She said the tattoo is designed for "high-risk populations," including patients emerging from heart surgery, or those with coronary heart disease who struggle with reduced blood flow to the heart.

Lu's team has not yet tested the tattoo on heart disease patients.

Instead, researchers conducted a proof-of-concept investigational trial with five healthy men between the ages of 20 and 28. None had a prior history of heart disease.

Tattoo readings were then compared with measurements obtained using current gold-standard methods for assessing both ECG and SCG.

Researchers said the results confirmed that the data generated by the tattoo device was highly "accurate." Those outfitted with the tattoo said the device was exceptionally easy to wear throughout.

Lu and her colleagues plan to team up with the Cleveland Clinic to test the tattoo in a pool of congenital heart disease patients emerging from surgery.

Dr. Gregg Fonarow, director of the Ahmanson-UCLA Cardiomyopathy Center in Los Angeles, reviewed the findings.

"There has been significant interest in developing noninvasive, wireless, battery-powered, reliable, convenient and comfortable cardiac monitoring technology," to replace much larger conditional monitoring and imaging devices, he noted.

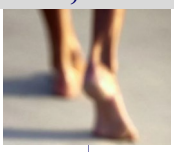
Theoretically, such devices offer advantages, given their "potential to provide long-term cardiac physiologic data in the home environment," Fonarow said.

But he added, this was just a "small pilot study."

"Further studies will be needed to further evaluate and validate these sensors, and ultimately test to determine if there can be clinical utility," Fonarow said.

The findings were recently published in the journal ***Advanced Electronic Materia***

Achilles Tendinitis: What Is It, and What Are the Treatments?



Chronic tendon issues are a frequent source of pain and can limit activity. They become more common with age, weight and certain activities, and early and appropriate diagnosis by a doctor is critical to get the best outcomes.

The Achilles tendon is the biggest tendon in the human body. It connects the calf to the foot, and it is responsible for push-off power. The tendon is critical for stability during standing, walking, running and other activities. During muscle contraction, the tendon functions as a rope. It has elasticity to generate the tension required to handle the force of six times a person's body weight.

What is Achilles tendinitis?

Over time, the tendon can become strained, injured or inflamed. On a day-to-day basis, people put stress on their Achilles tendon. A healthy tendon will handle this stress, repair any "microtears," and a patient will have no symptoms. But over time, for various reasons, the Achilles tendon will develop inflammation and microtearing that will outpace the body's ability to repair and heal the damage, and the patient will develop symptoms including pain, discomfort, soreness and swelling. This is Achilles tendinitis, and I often treat such cases here at **Yale Medicine Orthopaedics & Rehabilitation.**

In reality, Achilles tendinitis is not just inflammation of the tendon, as the name implies. Achilles tendinitis is the accumulation of degenerative changes in the tendon, especially in chronic cases, caused by disorganized repair of areas of tendon damage that have accumulated gradually over time. The tendon will become thickened and lose its normal elasticity in many cases.

Causes, risk factors

Too much exercise is a major cause. Sports with repetitive stopping and starting, like tennis, running, basketball and dance can increase the risk of Achilles tendinitis. Swimmers rarely develop Achilles tendinitis, because there is less tension on the Achilles tendon.

Another major cause is weight. Overweight patients are more likely to develop Achilles tendinitis than someone of normal weight. Increasing body weight by just one pound increases the force on the Achilles tendon by six pounds.

Tightness and weakness of the calf muscle is another major risk factor. A calf muscle that is tighter leads to more tension and stress on the Achilles tendon. Over time, this tension can lead to the microdamage that is tendinitis. Having a weaker muscle also increases this damage. Think of the Achilles tendon and calf muscle as one unit. The stronger the muscle is, the more it protects the tendon. The weaker it is, the more work the muscle puts on the tendon.

Achilles tendinitis symptoms

There are two main forms of Achilles tendinitis — insertional and non-insertional.

Insertional Achilles tendinitis is pain and inflammation (swelling, redness) at the back of the heel, where the Achilles tendon attaches to the heel bone. This results in pain, swelling, and soreness at the back of the heel. This can also create a bump and lead to pain with shoes rubbing against the heel.

Non-insertional Achilles tendinitis is also known as fusiform tendinitis. The pain is higher up, more in the mid portion of the tendon. Swelling is a bit less common, and more often the tendon achieves a thickened appearance. The main symptom here is pain with activity, and some sensitivity of the tendon.

Achilles tendonitis treatment

Initial treatment usually involves rest. That means if the tendon is really hurting after tennis five times a week, stopping tennis for a bit and resting completely is usually a good idea. Occasionally, one can remain active, but avoid the higher impact sports — for example, do more biking or swimming and less tennis.

In severe situations, immobilization in a cast or boot is a first-line treatment….**Read More**

Key to Post-Stroke Recovery: Exercise

Physical activity after a stroke may be crucial to a more successful recovery, according to a study by Swedish researchers.

They found that patients who increased and sustained their exercise in the six months after their stroke were functioning better than those who didn't.

"People who have experienced a stroke can gain functional benefits by increasing physical activity, regardless of stroke severity," said lead researcher **Dr. Dongni Buvarp** of the Institute of Neuroscience and Physiology at the University of Gothenburg.

Men and patients with normal mental abilities were more likely to maintain a steady exercise regimen, regardless of the severity of their stroke, the study found.

These findings may spur ways to target people whose physical activity drops in the wake of a stroke, Buvarp said.

"This would allow an improvement of functional outcome after stroke," she said.

At least four hours a week of light exercise is the ideal to shoot for after a stroke, Buvarp said. Activities can include riding a bike or walking, gardening, fishing, table tennis or bowling, she suggested.

"Engaging in physical activity can enhance both brain and body capacity to aid in stroke recovery," Buvarp said. "Physical activity promotes brain plasticity and also improves recovery at the cellular level."

She noted that an active lifestyle can boost stroke patients' mobility and reduce their risk of falls, depression and heart disease.

"Maintaining physical activity, even at a light intensity, can contribute to better stroke recovery, regardless of stroke severity," Buvarp added.

For the study, her team collected data on nearly 1,400 men and women (average age 72) who suffered a stroke and were part of a Swedish drug trial between October 2014 and June 2019.

Among them, 53% increased their physical activity and 47% decreased it. Those who boosted their activity over six months had better recovery of physical function, compared with those who slacked off, the findings showed.

Exercise is vital to the best recovery after a stroke, said **Dr. Rohan Arora**, a neurologist at LIJ-Forest Hills Hospital in New York City, who reviewed the findings.

Basically, you are reprograming the brain, he said.

"When you're exercising you're sending messages to the normal parts of the brain that are taking over for the stroke-damaged part of the brain," Arora said. "When you do physical activity, you are trying to change the configuration of the brain."...**Read More**

Pills, Exercise, Dieting: What Works Best to Lose Weight?

Hundreds of thousands of people are jumping on the Ozempic bandwagon and taking prescription medications to slim down, while others swear by intermittent fasting and other diet fads, but new research shows that they're all likely barking up the wrong trees.

There isn't any shortcut or magic bullet to losing weight, keeping it off, and improving your health, a **new study** of more than 20,000 people affirms.

"Most adults slowly gain weight over decades of their life but turn to drastic, often dangerous, means to decrease body weight," said study author **Colleen Spees**, an associate professor of medical dietetics at Ohio State University in Columbus. "Indeed, non-evidence-based diet practices are on the rise in large part due to social media influencers and popular actors."

Take the craze surrounding the injectable type 2 diabetes drug Ozempic, she said.

"Although it is not U.S. Food and Drug Administration-approved for weight loss, individuals without diabetes are now taking Ozempic in hopes of rapid weight loss," Spees said.

Does it work? Yes, at least in the short term, she said.

"Once individuals discontinue the use of this medication, their appetite returns along with the weight they lost while using it," Spees added.

For the study, researchers compared behaviors of more than 20,300 U.S. adults who were part of a national health and nutrition survey from 2007 to 2016. They compared participants who lost 5% of their body weight to those who didn't.

Participants reported on their exercise habits, tobacco use, sleep, weight history, weight loss strategy and what they had eaten in the previous 24 hours. Researchers also measured their blood pressure, "bad" cholesterol, blood sugar and their body mass index (BMI). BMI is an estimate of body fat based on height and weight.

This information was used to gauge compliance with the U.S. Dietary Guidelines for Americans and a list of heart health factors touted by the American Heart Association dubbed Life's Essential 8.

Overall, nearly 17,500 had lost less than 5% of their body weight, maintained their weight, or gained weight in the past year. In contrast, 2,840 folks reported an intentional weight loss of at least 5% of their body weight during the past year….**Read More**

Do All Heart Attack Survivors Need Long-Term Beta Blocker Meds?

It's standard for heart attack survivors to take beta blocker medications for years afterward, but a new study suggests that may be unnecessary for people who've had a milder heart attack.

Researchers found that among heart attack survivors whose hearts still had normal pumping ability, there was no added benefit from using beta blockers for more than one year. They were no less likely to die or suffer a repeat heart attack than patients who were not on beta blockers long term.

Experts said the findings, published May 2 in the medical journal ***Heart***, are not enough to change treatment guidelines.

But it's also "reasonable" for patients on beta blockers to ask their doctor why they're using the medication, and whether continuing is necessary, said **Dr. Ajay Kirtane**.

Kirtane, who was not involved in the study, is a member of the American College of Cardiology's Interventional Council and a professor at Columbia University Irving Medical Center, in New York City.

"It's difficult for patients to be on a lot of medications," Kirtane said. So if there's a way to "streamline" a post-heart-attack drug regimen, he added, that's important.

Beta blockers are among the most widely prescribed medications, and include drugs like atenolol, carvedilol and metoprolol. They help protect the heart by blocking the effects of "stress" hormones, slowing down heart rate and making it easier for the heart muscle to contract.

Studies have shown that beta blockers improve the outlook for heart attack survivors who have heart failure — a progressive weakening in the heart's pumping ability.

But it hasn't been clear whether long-term use helps people who've had a milder heart attack that left the heart muscle's pumping capacity intact.

The practice of keeping those patients on beta blockers is based on older trials — predating some of the other treatments available now, explained study author **Dr. Gorav Batra**, a cardiologist at Uppsala University, in Sweden.

Those treatments include procedures to clear clogged heart arteries and medications to help prevent future blood clots….**Read More**