



Social Security: More Than Half of Retirees Say 8.7% COLA Not Enough — What To Do If It Won't Cover Your Expenses

Social Security recipients will be getting much bigger payments next year thanks to an 8.7% cost-of-living adjustment for 2023 that will boost the average monthly check by \$146. But it still might not be enough to help many seniors pay their bills in a period of historically high inflation. More than half of retired Americans (55%) say the Social Security 2023 COLA isn't enough, according to a new **Motley Fool survey** of 750 U.S. retirees. Less than 40% say the adjustment is about right.

The vast majority of respondents (85%) say inflation is stretching their budgets, and nearly three-quarters say they rely heavily on Social Security benefits to pay their bills. More than one quarter (27%) describe their financial situations as a “daily struggle.”

Although healthcare costs typically take up a big chunk of seniors' budgets, those costs have been rising at a slower rate than other expense categories, said Matthew Frankel, a certified financial planner and contributing analyst at The Motley Fool. That's not the case with housing costs, which have **been rising in**

double-digit rates for most of 2022, as GOBankingRates recently reported.

“Housing costs have increased dramatically,” Frankel noted in an email to GOBankingRates. “Seniors who rent their homes are getting hit especially hard, as rent prices have increased sharply compared with pre-pandemic times.”

Retirees who believe they'll have a hard time making ends meet even with the 8.7% COLA do have options for getting help. In terms of housing costs, the U.S. Department of Housing and Urban Development offers a **Housing Choice Voucher Program** that helps very-low-income seniors and others afford housing in the private market. Another HUD program, **Supportive Housing for the Elderly Program**, subsidizes independent living apartments for seniors.

Food assistance is available through the U.S. Department of Agriculture's Supplemental Nutrition Assistance Program, which helps low-income seniors and others purchase food every month. Another USDA program,



the Commodity Supplemental Food Program, works to improve the health of low-income persons at least 60 years old by supplementing their diets with healthy foods.

Beyond that, seniors can save money in myriad other ways to help make ends meet if the 2023 COLA isn't enough. Here are a few ideas:

- ◆ Move to an area with comparatively low costs of living, such as Reno, Nevada or Tucson, Arizona.
- ◆ Relocate to a tax-friendly state like Alaska or New Hampshire, which have no sales or income taxes; or Florida, Nevada, South Dakota, Tennessee, Texas, Washington and Wyoming, which don't impose state income taxes or taxes on pension income.
- ◆ Research local restaurants and retailers that offer senior discounts that might save you up to 25% on meals and up to 10% on merchandise.
- ◆ Lower your prescription drug costs by buying generic whenever possible and enrolling in senior discount

programs at pharmacy chains.

If you need immediate cash to cover unexpected expenses, one option is a reverse mortgage. This is similar to a home-equity line of credit except that you'll never have to repay the money you receive for as long as you remain in your home, Frankel said. However, he warned that reverse mortgages “aren't right for everyone,” so be sure to research the pros and cons before using this option.

Finally, you can boost your income by getting a side hustle. As GOBankingRates previously reported, choices for the **best side hustles for seniors** include becoming a notary signing agent, personal chef, management consultant, delivery driver or bookkeeper. These jobs typically pay anywhere from about \$17 to \$60 an hour.

As Frankel noted, side gigs aren't ideal or even practical for every retiree. But, he added, “the reality is that there is an abundance of open part-time jobs right now. Plus, there has never been more opportunity to pick up side gigs that you can do on your own time, as much or as little as you want.”



To All The Rhode Island Alliance for Retired Americans Member Organizations Their Members and Families Happy Thanksgiving

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Report Examines Complaints about Medicare Advantage Marketing

A new **report** from the US Senate Finance Committee examines the **increase** in complaints about misleading Medicare Advantage (MA) marketing practices.

The Committee launched its inquiry after receiving information from the Centers for Medicare & Medicaid Services (CMS) that beneficiary reports of inappropriate MA marketing more than doubled from 2020 to 2021. The resulting analysis, based on information from 14 states and other stakeholders, including Medicare Rights, documents this troubling trend. It presents the alarming methods insurance companies, brokers, and third-party marketers sometimes engage in to boost enrollment—and profits—including “deceptive mail advertisements, misleading claims about increasing Social Security benefits, aggressive in-person marketing tactics, and enrolling beneficiaries, particularly those dually eligible for Medicare and Medicaid, in a new plan without their consent.”

Unfortunately, these findings align with our own experience. In recent years, we have seen an increase in calls to our national helpline about problematic marketing. Beneficiaries often report being misled about coverage, costs, and access to providers. Others have questions about predatory outreach, confusing advertising, and

involuntary enrollments. In both direct solicitations and general advertisements, we typically find plans and their agents paint overly rosy pictures of MA, like listing an array of “extra” benefits they may not offer or for which the individual may not qualify. This can cause consumers to mistakenly conclude the benefits are more available and more generous than they are. An October **Commonwealth Fund** issue brief **indicates** this is having an impact: nearly 25% of MA enrollees were drawn in by these promises; people with lower incomes, in particular, were more likely to find the extra benefits appealing.

Plan marketers also often fail to disclose the very real tradeoffs with MA, such as networks that may not include chosen providers, delays or denials of medically necessary care through utilization management, and potentially higher costs than might be available through Original Medicare and a Medigap.

Other common techniques include conveying a false sense of urgency, with the intent of spurring beneficiaries to action even if they are satisfied with their current coverage, and designing materials with visual cues to suggest Medicare, and not a plan, is behind the ad. It is not uncommon for our helpline



callers to report responding to such outreach only to be enrolled in a plan unknowingly and without their consent.

- ◆ The Committee recommends five ways for CMS to curb these and other tactics:
 - ◆ Reinstate **recently weakened** consumer protections.
 - ◆ Monitor disenrollment patterns and use CMS’s enforcement authority to hold bad actors accountable.
 - ◆ Require agents and brokers to adhere to best practices.
 - ◆ Implement robust rules around MA marketing materials and close regulatory loopholes that allow cold calling.
 - ◆ Support unbiased sources of information for beneficiaries, including State Health Insurance Assistance Programs and the Senior Medicare Patrol.
 - ◆ We support these proposals and appreciate CMS increasing oversight of MA marketing during this year’s Fall Open Enrollment, as outlined in an **October 19 memo**. The agency’s decision to review television ads is also very welcome.
- To more fully protect people with Medicare, we urge CMS to set and enforce standards for the marketing of supplemental

benefits. People with Medicare need unbiased, fully accurate information about these benefits and their limitations. Clear rules would also allow CMS to better oversee marketing materials and verify that plans are not merely using supplemental benefits as a marketing tool but are providing them adequately, equitably, and with reasonable promptness.

We also urge improvements to simplify enrollment, such as **BENES 2.0**, and greater attention to inaccurate provider directories and mid-year network changes that may leave enrollees without access to their providers of choice.

MA plans are businesses, and their marketing efforts are, therefore, designed to attract new enrollees and maximize profits. From the beneficiary perspective, this can result in an overwhelming number of ads, calls, mailers, and other solicitations that make it hard to know who to trust. The evolution of digital marketing, search engine optimization, and algorithms is making it even more difficult for beneficiaries to find unbiased information about their Medicare choices. Reforms are long overdue.

The Committee’s report can be found **here**. An appendix for the report with additional examples of problematic marketing materials can be found **here**.

It’s Medicare Open Enrollment: To save money and avoid big risks, check out your options

The Medicare **Annual Open Enrollment Period** is underway through December 7. You could save a lot of money and headache if you check out your options. Most people don’t tend to switch Medicare drug plans or Medicare Advantage plans and many don’t even look to see how their benefits are changing next year, according to the latest research. To avoid big risks and beware of bad actors, check out **this post**. Here are a few additional tips:

If you have Medicare directly from the government and supplemental coverage that fills gaps, little is changing except your Medicare prescription drug plan options. Even if you have a

Medicare prescription drug plan that’s meeting your needs, keep in mind that everything about it can change in 2023.

If you have a Medicare Advantage plan from a health insurance company, check to see how your provider network, out-of-pocket costs and additional benefits are changing and compare your options. You might want to switch to a different Medicare Advantage plan to save money. Some might have lower out-of-pocket maximums, and some might offer you better prescription drug coverage than others. You also might want to switch to traditional Medicare.



With traditional Medicare, you will need to pay for prescription drug coverage and supplemental coverage separately, but the total cost of that coverage could be far less than your out-of-pocket costs in a Medicare Advantage plan, and you will have coverage from most doctors and hospitals throughout the US.

As important as it is to look at all your options each open enrollment season, one recent survey found that most people with Medicare don’t switch plans from one year to the next. In fact, 45 percent don’t look at their options during the Open Enrollment Period. Four in ten people in Medicare Advantage

plans don’t know how their benefits will change in 2023.

To be clear, there is a lot you can’t know about your future health care needs as well as differences among Medicare Advantage options, including your out-of-pocket costs if you are diagnosed with a serious health condition, the specialists your Medicare Advantage plan will cover and **your plan’s denial rates**. Traditional Medicare offers more predictable coverage and easier access to care from the physicians and hospitals you want to use.

Not Knowing These Social Security Rules Could Shrink Your Benefits for Life

The monthly benefit you collect from Social Security could be just the thing that helps you manage well financially during retirement. Granted, you'll need additional income on top of your Social Security checks to maintain a nice standard of living. But those monthly payments will no doubt be important, so it's essential that you squeeze as much money as you can out of Social Security. But if you're not well-versed in these three rules, you'll risk locking in a lower benefit for your retirement.

1. How benefits are calculated

The monthly benefit you're entitled to from **Social Security** is calculated based on your personal earnings record. To be more specific, your 35 highest -paid years of earnings will be accounted for.

What this means is that if you don't work a full 35 years, you'll have a \$0 factored in for each year you're missing an income. Similarly, if you have many years

of very low earnings, that, too, will be accounted for.

Once you learn how Social Security benefits are calculated, you can take steps to boost yours. Working a few extra years if you don't have a full 35 under your belt is one option. Similarly, if your earnings are higher at the end of your career, working a few extra years could make it so you're able to replace some lower earnings with higher ones in your personal benefits formula.

2. When you're eligible for your full monthly benefit

You're entitled to your full monthly Social Security benefit based on your wage history once full retirement age (FRA) arrives. That age, however, depends on your year of birth, and you can look at this table to see where it falls: **(see chart on right)**

Now you should know that you're allowed to claim Social Security before FRA arrives. But for each month you sign up early, your monthly benefit gets reduced.



The earliest age to claim Social Security is 62. But if you file for benefits at that point, you'll shrink them by 25% to 30%, depending on your exact FRA. If you don't want to face a reduction in benefits, you'll need to know your FRA.

3. That you're allowed a do-over

Some people claim Social Security at **age 62**, or at an age that's younger than their FRA, and regret it later. However, many are also quick to assume that they're stuck with a lower benefit for life.

That's not necessarily the case, though, because Social Security allows all filers one do-over in their lifetime. So, let's say you sign up for benefits at age 62 but realize that was a poor choice. You can undo your filing by withdrawing your

benefits application within a year and repaying all of the benefits you received, and then sign up for Social Security again at a later age.

Many people unfortunately don't know that this rule exists. But it's an option worth exploring for those who file for Social Security ahead of FRA and realize they couldn't really afford to do so.

The more you know about Social Security, the better positioned you'll be to make the most of it. Keep these rules in mind so you end up happier with the monthly benefit you lock in for your retirement.

Year of Birth	Full Retirement Age
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 or later	67

Social Security Beneficiaries May Not Receive a "Raise" In 2024

In September, the more than 48 million retired workers currently receiving a **Social Security benefit** brought home about \$1,674 for the month. This may not sound like a lot, but based on a survey conducted by national pollster Gallup earlier this year, it's a necessary source of income for nearly 90% of seniors receiving Social Security.

For the many people who have come to lean on Social Security income to help pay their expenses during retirement, the annual cost-of-living adjustment (COLA) is pretty much the **most anticipated announcement of the year**

Social Security's cost-of-living adjustment helps beneficiaries keep pace with inflation

COLA represents the payout increase recipients get most years to account for inflation. If prices go up for the items Social Security beneficiaries buy, their benefits should climb to match this increase (at least in an ideal world).

For the past 47 years, the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) has been the

program's COLA determinant. **As I've previously detailed,** the CPI-W has eight large spending categories and a multitude of subcategories, all of which have their own respective percentage weightings. These are important because it allows the CPI-W to be expressed as a single number, which can then be easily compared to the prior-year period to determine if prices are rising or falling for a large basket of goods and services.

Although some aspects of Social Security can be intimidating or hard to understand, calculating the program's COLA is **actually very simple**. If the average CPI-W reading from the current third quarter -- that's July through September -- is higher than the comparable period from the previous year, inflation has occurred and Social Security recipients get a "raise" in the upcoming year. Just keep in mind, this is a "raise" designed to match inflation and not outpace it, which is why I have "raise" in quotation marks.



The year-over-year percentage difference in average third-quarter CPI-W readings, rounded to the nearest tenth of a percent, determines how large the COLA is for the following year.

Next year's COLA is historic in a variety of ways. In 2023, retirees, disabled workers, and survivor beneficiaries are going to enjoy a **historic monthly payout increase**. As reported by the Social Security Administration during the second week of October, next year's cost-of-living adjustment came in at 8.7%. On a percentage basis, it's the **largest increase in monthly checks since 1982**. Meanwhile, on a nominal-dollar basis, it'll represent the largest year-over-year jump on record.

What does this mean on a dollar basis? For the aforementioned 48 million-plus retired workers, an **average monthly payout increase of \$146** is on the way in 2023.

The reason for this mammoth bump in Social Security payouts has to do with a more than four-

decade high for the prevailing inflation rate. In June, the yearly change in the U.S. inflation rate hit a jaw-dropping 9.1%. Though the year-over-year change fell ever so slightly from this 9.1% rate between July and September (the months used for the COLA calculation), it remains far above historic norms -- thus the multidecade high for 2023's cost-of-living adjustment.

To be a bit more specific, energy, food, and shelter expenses have been primarily responsible for driving the inflation rate higher. According to data released by the U.S. Bureau of Labor Statistics for September 2022, the year-over-year change in energy prices, which includes all types of fuel, utility service, and electricity, was close to 20%, based on the CPI for All Urban Consumers (CPI-U). The CPI-U is a similar inflationary measure to the CPI-W. Meanwhile, food and shelter costs respectively rose by 11.2% and 6.6% from the prior -year period.

Medicare Rights Supports Efforts to Improve Medicaid and MSP Enrollment and Retention

This week, the Medicare Rights Center **submitted comments** in response to a **proposed rule** that would **ease enrollment** into and retention of Medicaid, **Medicare Savings Programs** (MSPs), and related programs like the Children's Health Insurance Program (CHIP). If finalized, the rule would bring state and federal processes more in line and would reduce churn—enrollees losing eligibility because of procedures that create obstacles to staying enrolled. These changes are particularly needed in light of the looming end of the COVID-19 public health emergency (PHE), which will impact Medicaid eligibility for many.

Currently, some enrollees of Medicaid programs, often the 12 million people who are dually eligible for Medicaid and

Medicare, must complete paperwork as often as once per quarter to retain their coverage.

Such paperwork can often be difficult to fill out, requiring details, especially on assets, that some enrollees may find hard to provide. As a result, these redeterminations cause the unnecessary loss of Medicaid coverage.

The proposed rule would **reduce churn** by limiting redeterminations of Medicaid eligibility to once a year. In addition, it would curtail the amount of information applicants and enrollees would have to provide by leveraging other sources of information, such as data from Social Security. Administrative barriers like too frequent redeterminations and burdensome paperwork often



affect people enrolled in MSPs, which help cover Medicare costs for low-income beneficiaries.

The MSP enrollment process is **notoriously complex**. This likely contributes to **widespread under-enrollment**; an **estimated** 40% of those who are eligible—2.5 million people—are not enrolled.

The end of the PHE will **create coverage risks** for millions of Medicaid, CHIP, and MSP enrollees. Currently, people who were enrolled in Medicaid at the beginning of the pandemic are **likely still enrolled**. In 2020, Congress put **limits on states curtailing coverage** for those individuals. These limits only last while the PHE remains in place. The PHE is likely to expire next year, at which point states will begin the process of

redetermination for all Medicaid enrollees.

At Medicare Rights, we welcome the proposals that would be particularly important for dually eligible individuals. We will also continue to urge states to join New York and others in increasing income and asset thresholds for MSP and Medicaid eligibility to help older adults and people with disabilities gain and maintain coverage, protect their health and finances, and thrive.

[Read our comments on the proposed rule.](#)

[Read a fact sheet on the proposed rule.](#)

[Read more about the implications of ending the PHE.](#)

Senator Manchin Says Deal is Needed to “Shore Up” Medicare, Medicaid, and Social Security

West Virginia Senator Joe Manchin said last week that Congress needs to deal with the nation's “crippling debt” by making changes to shore up Social Security, Medicare, Medicaid, and other programs he said are “going bankrupt.”

Speaking at a conference, Manchin said he would like to see bipartisan legislation over the next two years to deal with entitlement programs, which he said are facing “tremendous

problems.” Some of the trust funds that help support the programs could run out of money in the next 12 years, which would trigger cuts to benefits.

Manchin made his remarks a few days before midterm elections that will decide control of Congress for the next two years. Republicans, who are forecast to take control of the House and are challenging for



control of the Senate, are running on promises to rein in government spending.

Some are proposing cutting outlays for Social Security and Medicare, popular but expensive programs that benefit the elderly or disabled and using next year's deadline to raise the US debt limit to extract concessions from Democrats.

President Joe Biden has vowed to protect the two programs and warned that a standoff over the

debt ceiling would unleash economic “chaos.”

Senator Bernie Sanders (I-Vt.) said in a *New York Times* interview published last Thursday that Democrats should raise the debt limit before the new Congress convenes in January if Republicans win the House or the Senate to protect Social Security, Medicare and Medicaid from cuts. That almost certainly would require Manchin's backing.

Doctors explain why pending 'ominous' cuts to Medicare would limit healthcare for seniors in the new year

- ◆ Reimbursements for doctors who see Medicare patients are set to be cut by up to 8.5% starting next year.
 - ◆ Doctors warn cuts will prevent seniors from getting vital health services.
 - ◆ A bipartisan group of congresspeople wrote a letter to congressional leadership asking them to intervene.
- New changes are set to come to Medicare next year. They will likely make expenses tighter for doctors, and put vital healthcare out of reach for some older patients.

The Centers for Medicare and Medicaid Services, a federal

agency within the Department of Health and Human Services, announced several policy changes in early November that will come into effect at the beginning of next year.

Among them are Medicare cuts to doctors through the Physician Fee Schedule, which is used to determine which services doctors are reimbursed for, and how much they get. Medicare reimbursement will decrease by about 4.5%, and surgical care will face a nearly 8.5% cut.

"It's affecting how doctors can run their businesses," Christian



Shalgain, Director of Advocacy and Health Policy at the American College of Surgeons, told Insider. "I've talked to doctors who are saying, 'I have to decide whether to hire a new person or buy a new piece of equipment.' That's a significant problem from a patient's perspective."

If healthcare providers get less money through Medicare, they won't be able to hire as many nurses, doctors, and other staff, as well as fund necessary equipment for services. It affects the quality of care patients are able to get, and can even impact

how many Medicare patients a healthcare provider can take on, Shalgain said.

In years past, Congress has been able to **postpone** these preplanned cuts until the next year, varyingly achieving full scraps of the plan, or reduced cuts. Doctors' groups lobby annually for Congress to intervene, because they say that it stretches their budgets thin, which is especially a problem given that hospitals are **already strained** from COVID and **healthcare costs** are skyrocketing... **[Read More](#)**

HCA hospital system is charged with overtreating patients to maximize its profit

Written by **Diane Archer**

Last week, I wrote about a **hospital that incorrectly charged a patient** for a costly service it did not render and only corrected the charge a year later, as a result of intensive efforts on the part of the patient's wife.

Now, **Kaiser Health News** reports on HCA, a for-profit hospital system that is charged with overtreating and overcharging patients and insurers. The government needs to hold hospitals accountable for inappropriate bills and other bad acts.

Kaiser Health News reports on a patient with Covid-19 who went to a hospital emergency room to get checked out at her PCP's direction. Instead of

sending her home after seeing her, the hospital admitted her as an inpatient for three days and charged her \$40,000. Of that amount, her insurer charged her \$6,000. In this case, the hospital was HCA, the largest hospital system in the country.

In this case, the patient's PCP did not believe his patient should have been admitted to the hospital. But, hospitals control these decisions. To maximize their profits, some hospitals might provide incentives for their doctors to refer ER patients for an inpatient stay, even when not medically necessary, according to some experts.

Congressman Bill Pascrell of New Jersey is hoping for the



government to investigate HCA to determine whether it is engaged in Medicare fraud. The claim is

that **HCA requires its doctors to meet hospital admission targets** and admit patients even when patients don't need to be admitted. The result is both financial harm and potential health risks for patients.

The Service Employees International Union (SEIU) released a **report** earlier this year documenting the issues particular to HCA. SEIU argues that overcharges to Medicare over the last ten years amount to nearly \$2 billion. But, HCA is not the only culpable hospital according to SEIU. SEIU has made similar claims against Community

Health Systems and Health Management Associations. Both hospitals systems settled, for \$98 million and \$262 million respectively.

It's not easy to prove that a patient was overtreated and did not receive appropriate care. You need the doctor to speak out, as one doctor did against an HCA hospital in Miami. This doctor claims that HCA told him that he would lose his job if he did not move more ER patients into the inpatient unit of the hospital. The government refused to investigate and to speak to a reporter about why it refused.

HCA profits were nearly \$7 billion in 2021.

There's an Easy Way to Grow Your Social Security Benefits -- but Should You?

The money you get from Social Security might be the one thing that really gets you through retirement. Many people wrap up their careers without having a lot of money in an IRA, 401(k), or other savings plan. So they become heavily reliant on Social Security once retirement rolls around.

You may have heard that the monthly **Social Security** benefit you lock in at the time of your filing will be the benefit you collect for life. And that's largely true.

Social Security benefits are entitled yearly to **cost-of-living adjustments**. But other than those adjustments, the monthly benefit you start out receiving is the same benefit you can expect throughout your retirement. As such, it's important to file at the right age to get the most out of Social Security.

Meanwhile, you're entitled to

your full monthly Social Security benefit based on your earnings history once you reach full retirement age, or FRA. That age is either 66, 67, or 68 and a specific number of months, depending on the year in which you were born.

You can also file for Social Security before or after FRA. Filing early will reduce your benefit, while delaying your filing will boost it for life.

If your goal is to get the highest monthly payday out of Social Security, then you don't need to develop a stealth strategy to make that happen. All you need to do is put off your filing until the age of 70, which is when delayed retirement credits stop accruing. While that's an easy way to grow your monthly benefit, you may want to go a different route.

Look at the big picture



Filing for Social Security at age 70 will result in a higher monthly benefit. It won't, however, guarantee you a higher *lifetime* benefit. And if you wind up passing away at a relatively young age, then you could end up losing out financially by postponing your filing that long.

Let's say you're entitled to \$2,000 a month from Social Security if your FRA is age 67. Hold off on claiming benefits until age 70, and you'll be looking at \$2,480 a month, instead. That's a nice bump, but it doesn't guarantee a higher lifetime payout.

If you pass away at age 76, filing at age 70 rather than FRA will mean collecting \$37,400 *less* in Social Security in your lifetime. So you shouldn't assume that a delayed filing is automatically your best bet.

Of course, the tricky thing in this regard is predicting your own life span. That's something nobody can do with certainty.

If you have health issues going into retirement, and your parents and grandparents passed away in their early or mid-70s, then you may want to file for Social Security at FRA or even earlier to score what could end up being a higher lifetime payout. On the other hand, if your health is great as retirement gets close and your parents and grandparents all lived well into their 90s, then filing at 70 could be a smart way to go.

Ultimately, delaying your Social Security claim until age 70 is an easy, guaranteed way to lock in a higher monthly benefit. Just make sure this route really makes sense before committing to it.

New Medicare enrollment rules that eliminate coverage gaps take effect in 2023. Here's what you need to know

For some individuals, signing up for Medicare hasn't translated into coverage starting right away.

That's poised to change: Beginning next year, current months-long delays in certain **Medicare enrollment** situations will be eliminated. Additionally, would-be beneficiaries who missed signing up when they were supposed to due to "exceptional

circumstances" may qualify for a special enrollment period.

Such delays can mean facing a gap in health insurance — which in turn may translate into either being unable to get needed care due to financial constraints or paying out of pocket for care, whether planned or an emergency.

"It's really about having access to pretty essential health



services," said Casey Schwarz, senior counsel for education and federal policy at the Medicare Rights Center.

Signup rules for Medicare can be confusing

Medicare's enrollment rules can be confusing at best and costly at worst, experts say.

For people who tap **Social Security** before age 65, enrollment in Medicare (Part A

hospital coverage and Part B outpatient care coverage) is automatic when they reach that eligibility age.

Otherwise, you are required to sign up during your "initial enrollment period" when you hit age 65 unless you meet an exception, such as having qualifying health insurance through a large employer (20 or more workers)...**Read More**

Sick Profit: Investigating Private Equity's Stealthy Takeover of Health Care Across Cities and Specialties

Two-year-old Zion Gastelum died just days after dentists performed root canals and put crowns on six baby teeth at a clinic affiliated with a private equity firm.

His parents sued the Kool Smiles dental clinic in Yuma, Arizona, and its private equity investor, FFL Partners. They argued the procedures were done needlessly, in keeping with a corporate strategy to maximize profits by overtreating kids from lower-income families enrolled in Medicaid. Zion died after being diagnosed with "brain damage caused by a lack of oxygen," according to the lawsuit.

Kool Smiles "overtreats, underperforms and overbills," the family alleged in the suit, which was settled last year under confidential terms. FFL Partners and Kool Smiles had no comment but denied liability in court filings.

Private equity is rapidly moving to reshape health care in America, coming off a banner year in 2021, when the deep-pocketed firms plowed \$206 billion into more than 1,400 health care acquisitions, according to industry tracker PitchBook.

Seeking quick returns, these investors are buying into eye care clinics, dental management chains, physician practices, hospices, pet care providers, and thousands of other companies that render medical care nearly from cradle to grave. Private equity-backed groups have even set up special "obstetric emergency departments" at some hospitals, which can charge expectant mothers hundreds of dollars extra for routine perinatal care.

As private equity extends its reach into health care, evidence is



mounting that the penetration has led to higher prices and diminished quality of care, a KHN

investigation has found. KHN found that companies owned or managed by private equity firms have agreed to pay fines of more than \$500 million since 2014 to settle at least 34 lawsuits filed under the False Claims Act, a federal law that punishes false billing submissions to the federal government with fines. Most of the time, the private equity owners have avoided liability.

New research by the University of California-Berkeley has identified "hot spots" where private equity firms have quietly moved from having a small foothold to controlling more than two-thirds of the market for physician services such as anesthesiology and gastroenterology in 2021. And

KHN found that in San Antonio, more than two dozen gastroenterology offices are controlled by a private equity-backed group that **billed a patient \$1,100** for her share of a colonoscopy charge — about three times what she paid in another state.

It's not just prices that are drawing scrutiny.

Whistleblowers and injured patients are turning to the courts to press allegations of misconduct or other improper business dealings. The lawsuits allege that some private equity firms, or companies they invested in, have boosted the bottom line by violating federal false claims and anti-kickback laws or through other profit-boosting strategies that could harm patients.... **Read More**

American Medical Association Pushes for Permanent Use of Standard Time

While the U.S. Senate voted this year to establish a permanent daylight saving time, the American Medical Association's (AMA) House of Delegates is instead recommending a permanent change to standard time.

Standard time is healthier and more natural, according to the AMA and other experts, including the American Academy of Sleep Medicine.

"For far too long, we've changed our clocks in pursuit of daylight, while incurring public health and safety risks in the process. Committing to standard

time has health benefits and allows us to end the biannual tug of war between our biological and alarm clocks," AMA Trustee **Dr. Alexander Ding** said in an AMA news release.

The AMA delegates were holding their interim meeting Monday in Honolulu.

Twenty states have endorsed the bill establishing permanent daylight saving time, but the U.S. House of Representatives has not yet voted on it. To become law, both the Senate and House would have to approve and the president would have to sign it.



Daylight saving time shifts daylight hours earlier in the morning, best aligning with the human body clock, according to sleep experts. Daylight saving time shifts daylight hours to evening.

The sudden change to daylight saving time each March is associated with significant public health and safety risks, including increased risks for heart problems, mood disorders and motor vehicle crashes, according to the AMA. The statement notes that some studies have suggested the human body clock fails to adjust to daylight saving time

even after a few months.

"Eliminating the time changes in March and November would be a welcome change. But research shows permanent daylight saving time overlooks potential health risks that can be avoided by establishing permanent standard time instead," Ding said. "Sleep experts are alarmed. Issues other than patient health are driving this debate. It's time that we wake up to the health implications of clock setting."

Live alone? How to make sure you have the supports to get the medical care you need

Over the years, I've written about the importance of having a **health care buddy**, someone who you can talk to about your health, who can be another set of eyes and ears at the doctor's office, someone who can take you to a health care appointment. If you live alone, don't have a buddy, and need help getting to a medical appointment, Kerri Fivecoat Campbell writes for **Next Avenue** about what you can do.

If you're married, you might not have yet thought about the

complications that arise when you need someone with you after a hospital discharge or a colonoscopy visit. But, it's challenging. We generally don't have any systems in place to help. It can take a lot of effort.

Where to turn? An Uber or other hired driver won't help because you need someone to be with you for an extended period after discharge.

Who can you count on when you're living alone? Lots of people are in this situation. More



than one in four adults between 50 and 64 (28 percent) live alone. More than one in three over 65 (36 percent) live alone. Many of them cannot afford to pay someone and so are often forced to skip critical medical care.

While transportation issues always have posed challenges for single people, the situation appears to be worsening. Families are increasingly spread out across the country, and there are fewer social supports in most communities.

How to find help?

If you don't have family or friends who can serve as a health care buddy, look into the **PACE program**. There are hundreds across the country, although many have long waitlists. They are designed to help isolated older adults age in place, providing needed community supports. That said, **beware of for-profit PACE programs**. You can contact your **Area Agency on Aging** or you can visit the **Eldercare Locator**.

Medicare to Expand Access to Behavioral Health and Substance Abuse

Last week the Centers for Medicare and Medicaid Services (CMS) finalized policies aimed at expanding access to behavioral health and substance use disorder treatment services for Medicare beneficiaries in rural areas.

Starting Jan. 1 of next year, the annual Medicare physician payment rule and Medicare hospital outpatient and ambulatory surgical centers

rule will do the following:

- ◆ **Make it easier for addiction counselors, family therapists and others** to offer services, particularly in rural areas.
- ◆ **Make a pandemic-era flexibility permanent** that allows hospital outpatient departments to bill for in-home telebehavioral health services.
- ◆ **Extend Medicare coverage to**



- include opioid treatment programs** that initiate the prescribing of buprenorphine — a medication-assisted treatment — via telehealth. Medicare will also cover such services provided through mobile units.
- ◆ **Other provisions include** new monthly payments for comprehensive treatment and management services for patients with chronic pain, as

well as expanded access to certain cancer-screening coverage and dental care.

In addition, CMS will offer enhanced Medicare payments to incentivize hospitals to purchase N95 respirators manufactured in the United States, in an effort to sustain domestic production of the masks for future public health emergencies.

Dangerous Myths Keep Many Adults With Food Allergies From Getting an EpiPen

The EpiPen is a known lifesaver when someone with a serious food allergy eats something they can't tolerate.

Yet the auto-injection treatment is greatly underused in the United States, according to a new survey.

Just over half of at-risk adults said they had ever been prescribed the device, researchers found. And more than one-third of severe allergy sufferers mistakenly believe the EpiPen itself is a serious threat to their health.

"The results were eye-opening," said study co-author **Erin Malawer**, executive director of AllergyStrong based in McLean, Va.

Food allergy affects more than 32 million Americans. EpiPens contain epinephrine, the only medication able to stop life-threatening **anaphylaxis**, which can occur from a severe allergic

reaction.

Roughly 1,000 patients were surveyed online. Those without EpiPens on hand gave a wide range of reasons, among them insurance issues. Without health coverage, Malawer said the injectors cost hundreds of dollars for a two-pen set, which is standard protocol. Brand name EpiPens, marketed by Mylan pharmaceuticals, retail for about \$700, while generic versions are about \$350, according to healthshare101.com.

Survey respondents also cited a lack of access to doctors and/or pharmacies; out-of-stock pharmacies; and fear of needles.

"The biggest surprise was that a staggering 25.6% of our respondents replied that the reason they did not have an (EpiPen) was because their doctor did not indicate it was needed," Malawer added. "This needs to



change." Only 52% had been prescribed an allergy pen, and 36% endorsed the belief that EpiPens can cause life-threatening side effects, the investigators found.

The researchers "did not explore the genesis of this mistaken belief," said co-author **Jennaveve Yost**, an education and health research manager with Food Allergy Research & Education in Burke, Va. But she pointed out that the anti-vaccine movement "is not likely helping the narrative that epinephrine is a safe and effective medication."

Another possibility, she said, "is the misunderstood belief that Benadryl — a first generation antihistamine — is the appropriate first-line of action against an allergic reaction. In comparison to Benadryl — which

is affordable, and has been on pharmacy shelves and in medicine cabinets for decades — injectable epinephrine appears to be an extreme treatment."

Yost also said the high cost of epinephrine and the inconvenience of having to carry it around give people "just enough excuse to question whether it is needed in the first place."

The findings were presented last week at the annual meeting of the American College of Allergy, Asthma & Immunology, in Louisville, Ky. Research presented at meetings is usually considered preliminary until published in a peer-reviewed medical journal.

What can be done?

Epinephrine must become more accessible and affordable, Malawer said. ... **Read More**

Moderna's Booster Shot Prompts Strong Immune Response Against Omicron Subvariants

Moderna, Inc., announced Monday that its updated booster shot triggers strong antibody responses against three Omicron subvariants.

"We are pleased to see that both of our bivalent booster vaccine candidates offer superior protection against Omicron BA.4/BA.5 variants compared to our original booster, which is encouraging given COVID-19 remains a leading cause of hospitalization and death globally. In addition, the superior response against Omicron persisted for at least three months," Moderna CEO Stéphane Bancel said in a **news**

release.

"Our bivalent boosters also show... neutralizing activity against BQ.1.1, an increasingly dominant emerging variant, confirming that updated vaccines have the potential to offer protection as the virus continues to evolve rapidly to escape our immunity," Bancel added.

Taken together, about 45% of all new COVID-19 cases were one of these subvariants, **according** to the U.S. Centers for Disease Control and Prevention.

Moderna tested the blood of 511 adult volunteers who had



received the booster, comparing their results to others who had a booster of the original vaccine.

The investigators found antibodies that were about fivefold higher in those who had a booster and a previous COVID-19 infection and sixfold higher in those without a documented infection.

The company also assessed 40 volunteers for antibodies against the subvariant BQ.1.1. They found "robust neutralizing activity," though less so than against the other variants.

The results on BA.4 and BA.5 immunity have not been

published in a peer-reviewed journal, but they are similar to those **announced** earlier this month by Pfizer Inc. on its updated booster shot.

Whether these increased antibody levels will mean stronger protection against the virus is still unclear.

"Do these vaccines bring back durable protection against infection and onward transmission of SARS-CoV-2 [COVID], and if so, for how long?" said Dr. Isaac Bogoch, an infectious disease specialist at the University of Toronto, according to *NBC News*.

Raise Med Dosages in Weeks After Heart Failure Crisis for Better Outcome: Study

When people with heart failure wind up in the hospital, it tends to become a slippery slope: They are more likely to be readmitted or die within six months during this vulnerable period.

Now, new research shows that ramping up doses of three heart failure medications within two weeks of hospital discharge along with more frequent follow-up visits cuts the risk of both hospital readmission and death.

About 6.2 million U.S. adults have heart failure, according to the U.S. Centers for Disease Control and Prevention. With heart failure, the heart isn't pumping oxygen-rich blood as

well as it should, causing fatigue and shortness of breath.

Current guidelines call for the use of three or four drugs to help reduce the chances that a person returns to the hospital or dies from heart failure, but few doctors follow them. Optimal doses of these medications are given to just 1% of heart failure patients in the United States.

"When patients are hospitalized for heart failure all around the world, they leave the hospital with no special medications, and the problems come back after two to four weeks," said study author **Dr. Alexandre Mebazaa**.



He is a professor of anesthesia and critical care at the University of Paris and head of critical care at Assistance Publique Hôpitaux de Paris, a French public hospital.

"With this protocol, they are receiving full doses of therapy at two weeks and have markedly reduced rates of readmission and death from heart failure," Mebazaa said.

The best part? The three heart failure drugs used in this study -- beta-blockers, aldosterone inhibitors, and renin-angiotensin inhibitors/angiotensin receptor-neprilysin inhibitors -- are inexpensive and available as

generics. The three drugs work together to make it easier for the heart to pump blood out to the rest of the body.

"These findings should change practice," Mebazaa said.

For the study, researchers followed more than 1,000 people worldwide with heart failure after they checked out of the hospital between 2018 and 2022. Folks received usual care based on their doctor's preferences or high-intensity care, which called for ramping up doses of the three medications before they left the hospital. They were also seen for follow-up visits more often... **Read More**

Emergency rooms are clogged with people who are waiting for inpatient beds

Emergency rooms are clogged with people who are waiting for inpatient beds or other care and it's causing a crisis, according to the American College of Emergency Physicians (ACEP).

ACEP is one of more than 30 medical, patient advocacy and public health and safety groups who have sent **a letter** to the White House asking for a summit to work on immediate and long-term solutions.

The problem is urgent as U.S. emergency rooms deal with a "triple-demic" -- the respiratory disease threat of influenza,

COVID-19 and respiratory syncytial virus (RSV).

Dubbed "boarding," the problem means too many patients are waiting to be seen by ER doctors, for hospital admission, to return to their nursing home or to be transferred to psychiatric, skilled nursing or other specialized facilities.

"Boarding has been an unresolved, systemic challenge for decades, but it's currently at a level that we've never seen," said ACEP President **Dr. Christopher Kang**.

"Patients with nowhere else to



go are being held in emergency departments for days, weeks, or even months in some cases," he said in an ACEP news release. "Boarding is straining our system, accelerating emergency physician burnout, and putting patients' lives at risk."

ACEP collected more than 100 stories from emergency physicians throughout the United States to illustrate the severe consequences of boarding on emergency care teams and their patients.

Patients deteriorate and

sometimes die while waiting to be seen, according to ACEP.

The groups are seeking collective action to help emergency departments address the crisis.

"If the system is already this strained during our 'new normal,' how will emergency departments be able to cope with a sudden surge of patients from a natural disaster, school shooting, mass casualty traffic event or disease outbreak?" the letter to the White House asks.

Alzheimer's Experts Offer Tips for 'Dementia-Friendly' Homes

While most homes aren't designed to be dementia-friendly, they can easily be adapted, according to a national Alzheimer's disease group.

"Virtually every aspect of a home can affect the person's quality of life," said **Charles Fuschillo Jr.**, president and CEO of the Alzheimer's Foundation of America (AFA).

"From purchasing higher-tech appliances all the way down to labeling dresser drawers and putting up old family photos, there are a variety of adaptations family care partners can use to make their loved one's home more dementia-friendly," he said in a foundation news release.

The AFA offers tips for creating a space that will be soothing for a loved one with a dementia-related illness.

Color can help set the mood, so

blue can be a calming choice in a bedroom, bathroom or area where someone might relax.

Red, orange and purple are energetic and stimulating, and may not be ideal choices for helping someone stay calm.

Keep color contrast in mind for helping aid in vision, depth perception and spatial orientation, the AFA suggests. For example, dishware that contrasts with the tablecloth color can make it easier for someone with dementia to see the food on the plate.

The AFA has a **full-scale model** of a dementia-friendly residence on its website.

Visual clues can simplify life for someone with dementia, according to the foundation. This can include putting labels on dresser drawers with a small



picture and the name of the contents, such as shirts or socks.

Décor can also be soothing and help with mood and memory recall. Family photos, pictures of places someone enjoys and vintage magazines that help remember a time in the past can all be helpful.

Proper lighting can help your loved one with dementia see better but can also affect the body and behavior. For example, blue light rays stimulate the brain, increasing alertness and elevating energy levels.

Lighting that mimics natural patterns of high blue light during the day and low blue light at night can improve sleep and reduce agitation. Lights that produce glare may make it harder for someone to see, and

flickering lights can increase agitation.

Technology can fill needs for care partners who don't live with the individual who has dementia. These can include app-controlled thermostats to program, change and maintain the temperature remotely.

Smart alarms for smoke and carbon monoxide can be programmed with friendly human voices and monitored with an app.

Interactive virtual assistant technology can be used to schedule reminders and events that will be audibly played for a loved one. This might include phrases at the right times of day, such as "it's lunchtime now" or "time to take your medication."

The Worst and Best Hours of the Day for Hayfever Sufferers

When it comes to pollen allergies, there are not only bad days and bad seasons, experts with the right technology can now break down pollen counts by the hour.

Specifically, pollen counts are lower between 4 a.m. and noon, a **new study** done in Georgia found. They're higher between 2 p.m. and 9 p.m.

While experts have been monitoring pollen levels for many years to better understand them and advise patients, they typically measure counts for a 24-hour period, said lead author **Dr. Stanley Fineman**, an allergist with Atlanta Allergy and Asthma.

For the new study, his team and researchers at Emory University in Atlanta used imaging technology to measure pollen in real time.

The investigators found that higher counts seemed to align with rising temperatures.

"Now we've got some real-time data and can tell patients if they're allergic and they want to do outdoor activities, they should really do it early in the morning," Fineman said.

The research team monitored hourly pollen levels in three areas of Atlanta for a week in March 2021. They averaged pollen concentrations during the week to

reduce day-to-day fluctuations caused by weather changes.

Warming trends in the United States due to climate change have caused pollen counts to rise earlier in the year than they used to. Plants tend to release more pollen when the temperature is warmer.

Fineman said specific advice will still vary by patient, but someone with a severe springtime pollen allergy should do any outdoor activity early in the morning.

The research affirms what allergists knew about pollen counts varying during the day, said **Dr. Payel Gupta**, medical director for LifeMD in New York City. She was not involved with the study but reviewed the findings.

It's also true that weather variations, in addition to warming, can spread pollen in different ways, Gupta said. For example, windy days disperse more pollen, while heavy rain can lift grass pollen from the ground.

"I'm sure they saw a lot of variation depending on the day," she said. "I would like to see even more data on all the little factors that might have played a role."

Knowing when pollen counts are highest may be helpful for



allergy sufferers who want to leave their windows open at times or exercise outside, Gupta said.

"I always tell [patients], if they're going to be working out outdoors, check the pollen count," Gupta said. "This would be helpful for people to say, 'OK, I'm going to try to work out during these hours as opposed to these hours.'"

During pollen season, it's a must for those with allergies who spend time outdoors to clean up when they get inside, washing their face and hands, removing their shoes to avoid tracking pollen inside and changing their clothes, Gupta advised. She also suggests shampooing hair before bedtime.

Gupta could see the advantage to transferring this technology to something that is user-friendly.

"If you could transfer that information to an app, then it's really nice because then you have real-time information for people that are suffering from allergies," she said.

For those who need something more, over-the-counter medication can be helpful, but it's beneficial to get advice from a pro on how to use it best, Gupta added.

"A lot of the counseling that we do as an allergist is just tweaking the way that someone's using the medications that they already have in their home," she said.

When someone has tried everything and has had no relief, immunotherapy can help. That might mean shots for an array of environmental allergens. For some, it can be U.S. Food and Drug Administration-approved tablets, which are available for both dust mite and grass allergies.

"The allergy shots and the allergy tablets really do help patients," Gupta said. "With tablets, you can do it from your home as opposed to having to go to the allergist's office, so it makes it feel less cumbersome. I don't think all patients know that option exists."

To treat symptoms they do have, patients should first visit an allergist and be tested to determine what is affecting them, Fineman advised.

"Then they can come up with a treatment plan," he said.

The research was recently published in the *Annals of Allergy, Asthma & Immunology* and is being presented this week at a meeting of the American College of Allergy, Asthma and Immunology in Louisville, Ky.

Medicare Plan Finder Likely Won't Note New \$35 Cap on Out-of-Pocket Insulin Costs

A big cut in prescription drug prices for some Medicare beneficiaries kicks in next year, but finding those savings isn't easy.

Congress approved in August a \$35 cap on what seniors will pay for insulin as part of the **Inflation Reduction Act**, along with free vaccines and other Medicare improvements. But the change came too late to add to the **Medicare plan finder**, the online tool that helps beneficiaries sort through dozens of drug and medical plans for the best bargain.

Officials say the problem affects only 2023 plans.

To fix anticipated enrollment mistakes, Medicare officials will give beneficiaries who use insulin a chance to switch plans next year. They can make one change after Dec. 8 and throughout 2023

through a special enrollment period for "exceptional circumstances." Typically, people are locked in for an entire year.

The Centers for Medicare & Medicaid Services provided initial details of the opportunity in a **document distributed to the State Health Insurance Assistance Program**, or SHIP, which assists Medicare enrollees in every state. Although Medicare did not publicize the document, beneficiaries can get more information by contacting their local SHIP office. CMS officials would not answer questions about whether the ability to change plans will be granted automatically.

"We are pleased that CMS is offering the special enrollment period that will allow insulin



users to change plans in 2023," said Chris Reeg, director of the Ohio Senior Health Insurance Information Program.

In some cases, a special enrollment period can be avoided, said Janet Stellmon, director of the Montana State Health Insurance Assistance Program. If the plan charges more than a \$35 copayment for a member's insulin, a SHIP counselor can ask the plan to correct the mistake. "Plans usually try to make it right quickly," said Stellmon, who helped one beneficiary save \$565 a month on insulin.

Medicare patients spent \$1 billion in 2020 on insulin products — four times the amount in 2007, with some paying **as much as \$116 a month** out-of-pocket, KFF has found. Americans paid an average of **five to 10 times** as

much for insulin in 2018 than in other countries, according to a recent study. About 3.3 million people with Medicare rely on one or more insulin products to control blood sugar levels.

The \$35 copay for injectable insulin products takes effect Jan. 1, and July 1 for patients who use an insulin pump.

When beneficiaries who use insulin now check the plan finder, the price could show up as thousands of dollars a year instead of the maximum \$420 stipulated by law. An inaccurate price could also distort the costs of other drugs, which depend on what coverage phase patients reach. For example, once both the plan and the patient spend a total of \$4,660 for all drugs next year, the member pays no more than 25% of the cost for non-insulin drugs.... **Read More**

Damage to Health Mounts With Each New COVID Infection

Every time a person gets infected with COVID-19, their risk of dying or suffering serious long-term health problems increases dramatically, a new study has found.

People with repeated COVID-19 infections are twice as likely to die and three times as likely to be hospitalized compared to those only infected once, according to the report published online Nov. 10 in the journal [Nature Medicine](#).

Repeat COVID-19 patients are also three times more likely to develop lung and heart problems, and 60% more likely to develop a brain condition, the researchers found.

"Without ambiguity, our research showed that getting an infection a second, third or fourth time contributes to additional health risks in the acute phase, meaning the first 30 days after

infection, and in the months beyond, meaning the long COVID phase," said senior researcher [Dr. Ziyad Al-Aly](#). He is a clinical epidemiologist at Washington University School of Medicine in St. Louis.

The researchers also found that the risk rises with each additional infection.

"This means that even if you've had two COVID-19 infections, it's better to avoid a third," Al-Aly said in a university news release. "And if you've had three infections, it's best to avoid the fourth."

For the study, the investigators analyzed medical records of about 5.8 million patients treated by the U.S. Department of Veterans Affairs, the nation's largest integrated health care system.



The researchers compared nearly 41,000 people who had two or more documented COVID-19 infections with more than 443,000 people who had been infected once and 5.3 million others who were COVID-free between March 2020 and April 2022.

Most of the people who had been reinfected had gone through two or three bouts with COVID-19. A small number had four infections, and no one had five or more.

Statistical modeling assessed the health risks of repeat COVID-19 infections within the first month after contracting the virus, and then up to six months after.

The results pierce the "air of invincibility among people who have had COVID-19 or their vaccinations and boosters, and especially among people who

have had an infection and also received vaccines," Al-Aly said.

People who have had COVID-19 once should take every possible precaution to protect their health and prevent reinfection, he advised.

"Going into the winter season, people should be aware of the risks and practice vigilance to reduce their risk of infection or reinfection with SARS-CoV-2," Al-Aly said.

He urged people to wear a mask, get all of their eligible boosters and stay home when they're ill.

"Also, get a flu shot to prevent illness," Al-Aly added. "We really need to do our best to reduce the chance we will have a twin-demic of both COVID-19 and the flu this winter season."

Pharma pours money into telehealth

One of the upsides of the Covid-19 pandemic is that it has become much easier to see a doctor, if you're willing to go online. Medicare and many insurers will cover your care without an online visit. With telehealth, it's also much easier for Pharma to ensure you get the prescriptions they're marketing, regardless of whether you really need them.

Katie Palmer reports for [Stat News](#) on the benefit of telehealth for pharmaceutical companies. They can reach patients directly

online and offer access to health care providers who can prescribe their drugs. You don't need to see your PCP to fill a prescription.

The one-two punch of pharmaceutical company online ads and telehealth can boost sales for Pharma. So, Pharma is investing a lot in telehealth. In addition to more drug sales, they collect a lot of data on people. The question becomes are patients getting overprescribed, what are the risks and who's paying attention?



Currently, the federal government, through the FDA, determines what drugs are approved, what goes on their labels and how they can be

advertised. States in turn oversee the health care providers who prescribe the drugs and the pharmacies that distribute them. With telehealth, ads and distribution go together. It's not clear whether states or the federal government is in charge.

Many states do not allow "the corporate practice of medicine."

But, it's easy enough for pharmaceutical companies to invest in, or otherwise collaborate with, separate entities to do the prescribing and have patients click on a button to reach a virtual doctor on a separate web site. The pharmaceutical companies can then claim that these entities are acting independently when they prescribe their drugs....[Read More](#)

Should you brush your teeth before or after breakfast

Have you ever thought about whether you should brush your teeth before or after breakfast? Lots of us wake up and brush our teeth first thing and others feel that since they brushed their teeth after dinner, they should wait until they've eaten breakfast to brush again. Hannah Seo reports for the [New York Times](#) that it might not matter, both options have pros and cons.

There's not a lot of data to support pre-breakfast brushing or post-breakfast brushing. Experts disagree on the best time to brush your teeth in the morning. Here's the thinking:

The value of brushing when you wake up: It wipes out the

bacteria in your mouth. If you eat a bunch of sugar at breakfast and don't brush your teeth beforehand, the bacteria that has accumulated in your mouth while you were sleeping will feed on those carbohydrates. The bacteria will grow. And that bacteria contains acids that erode the enamel protecting your teeth, increasing the likelihood of your getting cavities.

Brushing also helps you to produce saliva, which protects and strengthens your teeth. While you're sleeping the bacteria building in your mouth tends to erode the minerals that saliva produces. The bicarbonates in



saliva also help reduce acidity in your mouth. In addition, brushing with fluorinated toothpaste helps protect your teeth from decaying, keeping acids at bay and strengthening tooth enamel.

But, you need to do a thorough brush or you will not kill all the bacteria in your mouth.

The value of brushing after breakfast: Unless you do a thorough brush first thing in the morning and kill all the bacteria that has grown in your mouth overnight, brushing after breakfast will kill all the bacteria in your mouth that comes from eating breakfast. Moreover, the

fluoride in your toothpaste is likely to perform better since it will remain on your teeth and not be disturbed from your eating breakfast.

That said, brushing after you drink juice or coffee could hurt the enamel on your teeth. So, if you are going to brush after breakfast, you are better off waiting a half hour or so. And, then, the question becomes will you remember to brush?

Bottom line: Brush every morning, whenever makes the most sense for you, and do a thorough brushing!