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RI ARA

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

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Message from the Alliance *for* Retired Americans Leaders

Alliance to Host Retirement Security Seminar in November

Robert Roach, Jr
President, ARA

Join the Alliance virtually at our event, Retiree Security Symposium: A Seminar with AFL-CIO President Liz Shuler. It will be held on Tuesday, November 15, 2022 from 9:00 - 4:00 EST. The event will be livestreamed courtesy of the International Association of Machinists and Aerospace Workers (IAMAW). The nation continues to face a national retirement security emergency and protecting earned pension benefits must be part of the solution. This educational seminar is for union leaders and staff, legislative representatives, pension advocates, academics, lawyers and young workers. The current agenda is available **here.**

President Shuler will discuss the Butch Lewis Act and labor's role in the passage of the American Rescue Plan, and we will be engaging with young workers and students. Rep. John Larson (CT) will speak about protecting and enhancing earned Social Security benefits.

"The Butch Lewis Act was a gigantic first step to securing our pensions," said Robert Roach, Jr., President of the Alliance. "Now it is time to do more so that all Americans can enjoy a dignified retirement after a lifetime of hard work."

Register **here** to join.

New Study Offers Advice for Recovering from Elder Financial Exploitation

Rich Fiesta,
Executive
Director, ARA

Elder financial exploitation (EFE) robs millions of older adults of their money and property. It can happen to any older adult, and it can happen regardless of whether the person stealing the money is a stranger or a close contact. The Consumer Financial Protection Bureau (CFPB) has released new findings of a study that describes how older adults recover from elder financial exploitation. It details how older adults trying to recover their losses face a complicated multi-step process. The report, **Recovery from elder financial exploitation: a framework for policy and research**, outlines the stages of recovery from elder financial exploitation and addresses why some older adults are more likely to get their money back than others. The report also identifies areas of work in policy, research, and practices that can help seniors better understand how to improve the likelihood of recovery, including:

- Greater consumer protections on common payment methods used to defraud older adults;
- How to empower older adults and caregivers to recognize EFE and to know their rights for pursuing recovery of fraud losses; and
- More public awareness of successful prosecutions of EFE resulting in financial recovery.

"Read the report to learn more about fraud prevention and resources that you can use yourself or share with others in your community," said Richard Fiesta, Executive Director of the Alliance.

Early Voting Has Already Begun in Several States

Joseph Peters, Jr.
Secretary
Treasurer ARA

Michigan and some Illinois residents **started casting ballots** on September 29 for the midterm election, as both states opened early, in-person voting. Voting is also underway in some form in Minnesota, New Jersey, South Dakota, Vermont, Virginia and Wyoming.

"It is especially important to vote with candidates all across the nation continuing to threaten our earned Social Security and Medicare benefits," said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. "Thirty-six governorships, 35 U.S. Senate seats and control of Congress are at stake." "You can go to **vote.org** to see which option in your state best suits your needs, including early voting and vote by mail. You can also double-check voting deadlines and rules such as voter ID requirements at that site," added Peters.

Statement by Retiree Leader Richard Fiesta on the 8.7% COLA Increase for Social Security Beneficiaries

Rich Fiesta,
Executive
Director, ARA

The following statement was issued by Richard Fiesta, Executive Director of the Alliance for Retired Americans, regarding the announcement that there will be an **8.7% cost-of-living (COLA) benefit increase** for millions of Social Security beneficiaries, disabled veterans and federal retirees next year:

"Seventy million Americans who rely on their earned Social Security benefits will greatly benefit from this significant cost-of-living increase.This historically high COLA is needed to help ensure older Americans can make ends meet.

"The increase amounts to an additional $146 per month for the average retired worker. Yet as welcome as this news is, too many older Americans will continue to struggle to pay for basic needs.

"It is high time to strengthen and expand Social Security. If we make the wealthiest Americans pay their fair share into the system we can strengthen Social Security for future generations and increase benefits across the board.

"Instead Republicans in the House and Senate and on the campaign trail are tripping over each other to put forward their own extreme and risky schemes to cut or end Social Security as we know it.

"Retirees must be vigilant and make sure they are voting for candidates who will protect the benefits they earn, not put them on the chopping block."

ADD YOUR NAME

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

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riarajap@hotmail.com • http://www.facebook.com/groups/354516807278/

Where is Social Security Fairness now?

There are opponents to Fairness in high places!

In August, **H.R. 82** reached the magic number of 290 co-sponsors required to demand a floor vote, but still had to wait 25 legislative days before that could be done.

On Sept.16, the 24th legislative day, the Chairperson of the House Ways and Means Committee brought the bill up for review by his committee. That action broke the 25-day rule and prevented the mandatory vote.

The Ways and Means hearing presented little of substance, and the bill was sent back to the floor without any guarantee of a vote.

With only one day left before the House recessed for "work in districts" to prepare for the election, Rodney Davis presented a "discharge petition" which, upon reaching 218 signatures, would mandate a floor vote. The trick with the discharge petition is that the House Member must sign the petition on the House Floor during a session of Congress. **Since Congress will not be back in session until November 14, nothing can happen on the discharge petition during this time**. We can remind our own House Members to sign it when they get back after the election. We will have only from November 14 to the 30th to get the needed 218 signatures on the discharge petition.

Social Security Fairness — The Committee to Repeal the Government Pension Offset & the Windfall Elimination Provision

WHAT WE CAN DO NOW:

- **Show up at campaign stops** and demand that any candidate understand how urgent it is to fix these outrageous penalties on seniors who have worked for their communities as police, fire fighters, teachers, clerks, mail carriers, bus drivers and other public servants.
- **Talk to the House staff members,** both in district offices and in D.C. who are still on the job, since they are not allowed to work for campaigns. They need to fully understand our situation in order to take our calls and emails seriously. Explain the urgency of their member signing the discharge petition.
- **Make sure your Senator is among the 40 co-signers** of the **Senate bill S.1302** by Senator Brown. (Use the link on our homepage to see if both your Senators are already co-signers.) The Senate is also in recess for the election, so, although only a third of members are running at this time, they are involved in campaigns. Call their offices and make friends with their staff members and explain the issue while they are gone!

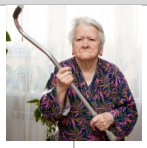
Do you use Twitter? Join the conversation @RepealWEP_GPO

Active Facebook pages with lots of information are: Social Security Fairness – Repeal the GPO/WEP and the National WEP & GPO Repeal Movement

Our persistence has made a difference. Thank you for Hanging in There!

Senate Republicans introduce bill to undo Democrats' prescription drug cost-cutting legislation

Congressional Democrats' **Inflation Reduction Act** (IRA) will lower health care costs for people with Medicare, capping their out-of-pocket drug costs and allowing Medicare to negotiate prices for some of the highest cost brand-name drugs, among other things. Oliver Willis reports for the **American Independent** that Senate Republicans have introduced a bill to undo the drug price negotiation provision in the IRA, apparently valuing Pharma's financial interests over the health and well-being of their constituents.



Senator James Lankford, Oklahoma, Marco Rubio, Florida, Mike Lee, Utah, and Cynthia Lummis, Wyoming want to stop Medicare from negotiating prescription drug prices. The **Protecting Drug Innovation Act** argues against "price controls." Its sponsors seemingly fail to appreciate that the Inflation Reduction Act requires drug price negotiation; moreover, people with Medicare today currently are subject to price controls because the pharmaceutical industry effectively holds monopoly pricing power. The Republican Senators also curiously argue that they don't want to shorten lives, even though drug price negotiation is designed to make drugs affordable in order to enrich and extend lives. Every other wealthy country negotiates drug prices on behalf of their residents, and all of them have populations with longer life expectancies than the US.

The three Republican sponsors of the bill are all up for reelection next month. Given that voters have as a top policy priority reining in health care costs, these Senators' opposition to lower drug costs should lose them votes. Four in five voters support Medicare drug price negotiation, and nearly seven in ten Republicans support it. By **one estimate**, it will save a couple with Medicare more than $2,400 a year.

Republican policymakers also do not support **strengthening and expanding Social Security benefits**, another policy the vast majority of Americans support.

Medicare Advantage plans are an "Insatiable Cash Monster"

In a no holds barred expose, Reed Abelson and Margot Sanger-Katz report for the New York Times on the fraudulent activities of the largest health insurers offering Medicare Advantage plans. **"The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions"** takes a deep dive into how Medicare Advantage plans add diagnosis codes to patients' medical records in order to drive up profits. The overpayments the Medicare Advantage plans collect increase Medicare spending to the tune of tens of billions of dollars each year and do nothing to ensure that people in Medicare Advantage plans get the care they need.

The story explains how Medicare Advantage insurers reward physicians with champagne, money and other goodies for adding diagnosis codes to patient records. Each diagnosis code means more money for the Medicare Advantage plans, which receive a fixed amount for each enrollee, adjusted up for enrollees with multiple diagnoses.

Abelson and Sanger-Katz explain how "major health insurers exploited the [Medicare Advantage] program to inflate their profits by billions of dollars. Of the five large Medicare Advantage participants, UnitedHealth, Humana, Elevance (formerly Anthem) and Kaiser Permanente have been charged with fraud for adding inappropriate diagnosis codes to patient files. The Justice Department is currently investigating CVS Health for related conduct.

Instead of saving money, Medicare Advantage costs taxpayers a lot more than traditional Medicare. One former government official projects that overpayments in 2020 alone totaled $25 billion and that overpayments will **total $600 billion** over the next nine years. Not surprisingly, the Kaiser Family Foundation **reported** that the companies offering Medicare Advantage plans generate twice as much gross profit from Medicare as from their commercial health insurance business….**Read More**

The Social Security Administration announces the minimum requirement to collect retirement benefits

Many U.S. citizens want to know what the fundamental requirement for receiving a Social Security retirement benefit is

In the United States, the **Social Security Administration** is the agency in charge of retirement benefits. This Administration has very clear and strict rules regarding the requirements for collecting the monthly check. This means that in order to start receiving your retirement benefits you will need to meet all the requirements they propose. Otherwise, you will not be able to receive your monthly benefit.

While all of this is true, there are also exceptions. That is why it is so important to ask the **Social Security Administration** directly, either online or by phone, about your specific case. There are exceptions, such as disability, that make these requirements non-mandatory. And that is why it is better to consult our specific case to see if we are really entitled to any economic benefit.

As for the minimum requirement we are talking about, it is related to the years worked. So you cannot collect a **Social Security retirement benefit** if you have not worked previously. In spite of this, working the minimum number of years required grants a very low benefit. However, depending on one's situation, this may be sufficient. How many years of work as a minimum are mandatory before retirement?

The Social Security pension requirement

To start collecting a **Social Security** retirement benefit, you need 10 years of work. After working these years, you will be able to start collecting the retirement benefit. Watch out, this will happen if you have reached **the minimum age**. This second requirement is not exactly a requirement as such, since we are talking about something that is understood as natural. Even so, it is an indispensable requirement, since you will not be able to start your retirement benefit until you reach the age of 62. On the other hand, there are also exceptions in this sector. These exceptions are related to **people with disabilities**. Contact your **local office** if you have any type of disability, as both the retirement age and the requirements for years worked may change in your particular case.

However, to get the maximum benefit, which is $4,194, working for 10 years is not enough. You must work at least 35 years, have a good salary and, in addition, apply for retirement at age 70. This is the only way an American can get the maximum **Social Security** to collect a big check every month.

Receiving your pension immediately

Many **Social Security** users do not know that they can **receive their pension** immediately. To do so, all you need to do is activate **Direct Deposit**. With this method, the money will be available to you the same day it is sent by the SSA.

You don't need a bank account to have Direct Deposit, so it's all advantages. Check with your local office if you want to know more about this useful and fast method of getting your pension on the same day of payment.

The 3 Biggest Social Security Changes Likely on the Way

Social Security has been around since 1935. Like most 87-year-olds, it has changed in some ways throughout the years.

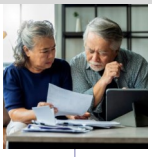
You can pretty much bank on the federal program transforming even more in the not-too-distant future. Here are the three biggest Social Security changes that are likely on the way.

1. Increased payroll tax cap

Social Security is projected to become insolvent by 2034 if nothing is done to bolster the program financially. That's the bad news. The good news is that there's a change that would go a long way toward preserving full Social Security benefits.

Currently, the maximum income subject to payroll taxes that fund Social Security is $147,000. President Joe Biden also wants to tax all income above $400,000. This change would create a "doughnut hole" with income between $147,000 and $400,000 not being taxed. However, that hole would likely disappear over time as the lower payroll-tax threshold is raised.

Increasing the payroll-tax cap is the **Social Security change that Biden wants that's most likely to happen**. It would offset around 61% of the projected shortfall for the program, according to the University of Maryland's Program for Public Consultation (PPC).



Importantly, this idea enjoys broad bipartisan support among Americans. PPC conducted a survey in June that found that 79% of Republicans and 88% of Democrats favor increasing the payroll tax cap to $400,000.

2. Changing the way COLAs are calculated

Biden also proposed during his presidential campaign in 2020 a change to the way Social Security cost-of-living adjustments (**COLAs**) are calculated. In particular, he'd like to replace the inflation metric used to determine Social Security increases.

Since automatic annual COLAs were introduced in 1975, the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) has been used to calculate the benefits adjustment. Biden wants to swap out the CPI-W with the Consumer Price Index for the Elderly (CPI-E).

The CPI-E focuses on price changes impacting Americans ages 62 and older. It gives a heavier weighting to healthcare costs than the CPI-W does. As a result, replacing the CPI-W with the CPI-E could result in higher COLAs for Social Security recipients. There's a downside to this idea, though. The PPC estimates that using the CPI-E to calculate COLAs could increase the projected funding shortfall for Social Security by 12%.

3. Raising the retirement age

Raising the **full retirement age** for Social Security wasn't included in Biden's 2020 plan. However, the change seems likely to happen for several key reasons.

First, a gradual increase in the full retirement age from 67 to 68 would eliminate 14% of the projected Social Security shortfall, based on PPC's analysis. Combined with an increase to the payroll tax cap, this proposal would make a big impact on preserving Social Security benefits.

Second, the change is relatively popular. The PPC's June survey found that 75% of Americans endorsed gradually raising the retirement age to 68. This support is also bipartisan, with 75% of Republicans and 76% of Democrats favoring the proposal.

Third, this isn't a new idea. Social Security's full retirement age initially was 65. This age was raised as part of legislation passed in 1983 to bolster the program.

After 2023

When might these three Social Security changes happen? It will definitely be after 2023, at the earliest.

Some legislation has been introduced to Congress that includes increasing the Social Security payroll-tax cap and replacing the CPI-W with the CPI-E. However, the chances of these bills passing at this point appear to be low. Even if these Social Security reforms were enacted, they wouldn't go into effect until 2023 or later.

President Biden hasn't pushed for the Social Security plan that was part of his campaign yet. It's possible, though, that he could do so in the second half of his term.

The aforementioned changes might not even happen during Biden's presidency. However, with the clock ticking until Social Security reaches insolvency, the pressure will increase for something to be done. It's reasonable to expect some sweeteners (such as the COLA calculation change) to be included in any deal to firm up Social Security financially.

2022: Health care costs threaten the well-being of many Americans

Fewer Americans are uninsured than ever–almost half the number before the Affordable Care Act took effect. But, rates of underinsurance are high, with millions of people having gaps in their coverage, millions skipping care and millions falling into medical debt because they cannot pay their health care bills. **The Commonwealth Fund** surveyed Americans and found that, too often, health care costs threaten their well-being.

- The big takeaways: More than four in ten adults under 65 (43 percent) did not have adequate health insurance. People without insurance, people with gaps in insurance coverage during the year and people who could not afford their care are included in this group.
- Nearly three in ten people with employer coverage (29 percent) and more than four in ten people with coverage they bought (44 percent) were underinsured.
- Close to half of all people (46 percent) said that they had not gotten care or delayed getting care because of the cost. More than four in ten (42 percent) struggled to pay medical bills or were in medical debt.
- Half of people surveyed (49 percent) said they could not afford to pay an unexpected medical bill of $1, 000 within 30 days, primarily people with low incomes (68 percent), Black adults (69 percent) and Latin/Hispanic adults (63 percent).

Large numbers believe health care costs should be a top priority for the Biden administration and Congress. Democrats (68 percent), Independents (55 percent), and Republicans (46 percent).

The authors defined "underinsured" as those with out-of-pocket health care costs over 12 months, excluding premiums, at least 10 percent of household income for people living above twice the federal poverty level and at least 5 percent of household income for people living under twice the federal poverty level. ($27,180 for an individual and $55,500 for a family of four in 2022). Or, people whose health care deductible represented at least five percent of household income. People who lacked health insurance for at least a year tended to be young, poor, with one or more chronic conditions, living in the South, Latin/Hispanic. Undocumented individuals are not able to get affordable coverage.

Because the US lacks a national health insurance program or even a national health insurance enrollment program, a lot of people who might be eligible for coverage based on their age, income and needs, go without coverage. More than half the people surveyed (56 percent) who had employer coverage but had been uninsured at some point during the year did not know that they were eligible to enroll in their state health insurance exchange plans because they lost their coverage.

Americans likely would pay a lot less for their health care if the government set rates for all health care providers, as it does for people with Medicare. Because the US does not set provider rates–as all other wealthy countries do–these high rates drive high cost-sharing. Physician and hospital prices in the US are higher than anywhere else in the world.

Close to one in four people with chronic conditions, such as diabetes, are not filling their prescriptions regularly because of the out-of-pocket cost.

Of note, nearly one in four people with bills in collection said the bills stemmed from a mistake in billing. More than half of people with medical debt (56 percent) owed at least $2,000. To pay off their

Medical bills from out-of-network doctors at in-network hospitals represented almost half of all issues. These surprise bills are no longer permissible under the No Surprises Act, which took effect January 2022. But, the survey included a timeframe before then.

When the public health emergency is declared over, likely in 2023, states will lose their improved federal matching funds. Inevitably, with less money, they will reconsider Medicaid eligibility and restrict coverage.

Medicare Advantage: Beware of inappropriate nursing home stay denials

Susan Jaffe writes for **Kaiser Health News** about the risk that your Medicare Advantage plan will inappropriately deny you the nursing home care you need. Because the government pays Medicare Advantage plans a flat upfront fee, they have a powerful financial incentive to keep you from getting the costly care you need. They profit more the less they spend on your care.

No one is monitoring in real time when and how Medicare Advantage plans delay and deny nursing home care, or any other care for that matter. Medicare Advantage plans are paid to cover the same amount of medically necessary care as traditional Medicare covers. And, though the **Medicare nursing home benefit is limited,** it covers as much as 100 days in a nursing home for people who have been hospitalized as an inpatient for at least three days in the 30 days prior to nursing home admission and who need daily skilled nursing or therapy services.

The Office of the Inspector General (OIG) reports that Medicare Advantage plans can and do **stint on costly care**, even when your treating physician says it is medically necessary. And, the agency charged with overseeing Medicare, the Centers for Medicare and Medicaid Services (CMS) does not publicly identify the bad Medicare Advantage actors, let alone cancel contracts with those that engage in widespread inappropriate delays and denials of coverage.

In her story, Jaffe reports on a 97-year old woman in a nursing home whose Medicare Advantage plan told her it was ending nursing home coverage after only an 11-day stay. Her medical team disagreed with the decision, saying that she was not in good enough health. after taking a bad fall. to leave. Experts report that it has become increasingly common for Medicare Advantage plans to overrule the treatment preferences of patients and their doctors and deny care, without even seeing the patient.

The American Health Care Association has "significant concerns" about the behavior of Medicare Advantage plans. No question that people are better off in their homes when they are healthy and able to take care of themselves, as the Medicare Advantage plans argue. But, it's unsafe to push vulnerable older adults out of a nursing home before they are in good enough shape to manage at home.

If your Medicare Advantage plan denies you skilled nursing facility or rehab care that your medical team says you need, **you have the right to appeal.** With a letter from the medical team explaining why care is medically reasonable and necessary and why you meet the eligibility requirements for skilled nursing facility or rehab benefits, there is a very high likelihood the Medicare Advantage plan will reverse its decision. And, if it does not do so, you can appeal to a higher level authority, where you are likely to succeed on appeal.

There is no cost to appealing, other than the emotional stress it causes, and it's easy. You will likely face bills from the nursing facility while your appeal is being decided. But, you can ignore the bills if you win your appeal. The Medicare Advantage plan will have to pay. Unfortunately, your Medicare Advantage plan faces no penalty for inappropriate denials. So, it can continue to deny care inappropriately without any likely consequence.

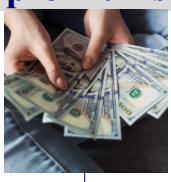
2023: Medicare premiums and other costs

The **Medicare Open Enrollment period** begins on October 15 and ends on December 7, so you will have several weeks to review your Medicare options for 2023. Particularly if you have Medicare **Part D drug coverage** or are enrolled in a Medicare Advantage private plan –a health plan offered by a corporate health insurance company–reviewing your options could save you a lot of money. Your Medicare Part B premium will be slightly lower in 2023, regardless of whether you are enrolled in traditional Medicare or a Medicare Advantage plan.

In 2023, the **standard monthly Medicare Part B premium,** which covers medical and outpatient care, is $164.90, a monthly decrease of $5.20 from $170.10, for people with annual incomes of $97,000 or less in 2021. In addition, you will get a **Social Security increase** of around nine percent. The exact increase will be announced shortly.

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

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



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

Medicare Part B annual deductible: $26, a decrease of $7 from the 2022 annual deductible of $233.

If your income is low, you may qualify for help paying your premium and sometimes also your deductibles and coinsurance through the Medicare Savings Programs: People with incomes up to 135 percent of the federal poverty level, **($1,549 in monthly income for an individual** and $2,080 for a couple in 2022; these amounts may increase in 2023) are eligible for **help paying their premiums through Medicaid or a Medicare Savings Program**.

For more than four decades, the Medicare Part B premium (medical insurance) was the same for everyone regardless of income, geography or health status, a quarter of the cost of Part B services. (Medicare Part A, hospital insurance, is premium-free if you have contributed into Social Security for at least 40 quarters.) In 2007, wealthier people with Medicare began paying higher premiums.

Here are 2023 Medicare Part A costs:

- There is no Medicare Part A premium if you or your spouse have at least 40 quarters of coverage.
- The Medicare Part A premium, if you or a spouse has at least 30 quarters of coverage, is $259 a month; if you don't have at least 30 quarters, the premium could be $471 a month.
- The Medicare Part A inpatient hospital deductible is $1,600, in 2023 an increase of $44 from 2022, and coinsurance for hospitalizations after day 60 is $400 a day in a benefit period; coinsurance for lifetime reserve days is $800 a day.
- The Medicare Part A daily coinsurance for skilled nursing facility stays after day 20 is $200.00, an increase of $5.50 from $194.50 in 2022.

If you have Medicare and are 36 months post kidney transplant, you are no longer eligible for full Medicare coverage. But, beginning in 2023, you can elect to continue Part B coverage of immunosuppressive drugs if you pay a premium. In 2023, the immunosuppressive drug premium is $97.10.

Medicare Part D premiums

Premiums for Part D prescription drug coverage vary by income and by Part D plan. The premium is generally deducted from your Social Security check. People with annual incomes at or under $97,000 do not pay an additional income-adjusted premium amount.

If your annual income is above $97,000, you will be charged between $12.20 and $76.40 a month extra. The extra amount is based on how much higher than $97,000 your income is, with a cap at $750,000.

Insulin

Beginning July 1, 2023, you will pay no more than $35 a month out of pocket for insulin. If you take insulin through a pump you get through Medicare, you will have no deductible.

Medicare might cover more dental services in a limited way

For years, Democrats in Congress have tried to add a dental benefit to Medicare without success. But, now, Susan Jaffe reports for **Kaiser Health News** that the Biden administration is proposing to change Medicare rules so that more people receive Medicare-covered dental services. However, Medicare is only planning to cover a limited suite of dental benefits for a small cohort of additional people.

Today, Medicare's coverage of dental benefits is limited to services that are necessary for treatment of another health condition. Those services include wiring teeth in connection with surgery to fix a broken jaw as well as removal of infected teeth in advance of a kidney transplant or radiation treatment for people with cancer in their neck or head.

The Biden administration is proposing to expand the number of conditions for which dental services would be needed. For example, it might cover medically necessary removal of infected teeth for people with breast cancer who receive chemotherapy and radiation. Or, Medicare might cover services to treat a dental infection for people needing organ transplants beyond kidney transplants.

It appears that the government's goal is to expand dental coverage for people being treated for health conditions in which dental services could substantially help their health outcomes. People getting hip and knee replacements, for example, might receive dental services if their teeth are infected. That said, Medicare would not cover medically necessary follow-up dental care.

Also, for unknown reasons, the Centers for Medicare and Medicaid Services (CMS) does not appear to be considering covering dental services for the large cohort of people with Medicare who have diabetes. Medicare covers insulin, diabetic supplies and a range of services for these 16 million people. Dental care to address periodontal disease could help lower their blood sugar levels. One recent report from the National Institutes of Health found that nearly 6o percent of people with Medicare have periodontal or gum disease.

If CMS expands dental benefits, coverage would begin in 2023. It is not clear how much CMS would pay for these dental services.

Dear Marci: *How do I compare Part D plans?*

Dear Marci

Dear Marci,
I have Original Medicare and a Part D plan. I'm considering changing my Part D plan this Medicare Open Enrollment Period. How can I compare Part D plans?
-Mina (Walla Walla, WA)

Dear Mina,

I'm glad to hear you're comparing your Medicare coverage options this fall! Research shows that many people with Part D could lower their costs by shopping among plans each year. There could be another Part D plan in your area that covers the drugs you take with fewer restrictions or with lower costs, so it's great that you are trying to compare plans.

I would recommend using **Plan Finder** to compare Part D plans. Medicare Plan Finder is an online tool at **www.medicare.gov** that can be used to compare stand-alone Part D plans or Medicare Advantage Plans. Plan Finder provides information about costs, which drugs are included on the plan's formulary (list of covered drugs), and the **star rating** of the plan.

To use Plan Finder, follow these steps:

- Go to **www.medicare.gov** and click on the button that says, "Find Plans Now."
- You can do a general search on the right side of the page, under the title "Continue without logging in" button. If you wish to save your drugs and pharmacy information, you can log into or create your Medicare account on the left side of the page.
- Next, put in your zip code and use the drop-down list to choose whether you are looking for a Medicare Advantage or Part D plan. Make sure you click "Apply" and then click on "Start" to begin your search.
- Then you can enter the drugs you take, choose the pharmacies you use, and indicate whether you are interested in a mail order option.

Plan Finder will display results for plans in your area. Note that a plan may not cover all of the drugs you take, but it may have alternatives on its formulary. Speak to your provider about whether these alternatives would be appropriate for you. Plan Finder also tells you if the plan has a deductible and how much the monthly premium is. Initially, the plans will be sorted by "lowest drug + premium costs." This is the closest estimate to what you may pay out of pocket for your Part D coverage for the year. You can select "Plan Details" to find out more specifics about coverage, including any **coverage restrictions** that might apply to your drugs.

Before enrolling, it is a good idea to call the plan directly to confirm any information you read on Plan Finder, as information may not be completely up to date. **Here is a list of questions you can ask when calling a company about their prescription drug coverage.** You can enroll in a plan online, by calling 1-800-MEDICARE, or by calling the plan directly.

Note that this year, there are some additional things that people who take insulin should consider when using the Plan Finder tool. Beginning in 2023, cost-sharing for insulin is capped at $35 per prescription. However, the Plan Finder tool does not reflect this price change. If you take insulin, do your Plan Finder search without your insulin included in your drug list. This will show you the lowest cost plans for your other medications.

Then separately check with a plan to see if your insulin is on the plan's formulary.

You can make as many changes as you want between October 15 and December 7, but only the last change you make will take effect on January 1. If you choose a plan and realize that it is the wrong plan after Fall Open Enrollment is over, in most cases you will not be able to **change your coverage** until the next Fall Open Enrollment Period. For this reason, it is important to carefully consider all of your options and take the time to research each plan in order to make a decision that fits your health care needs. Good luck choosing the best Part D plan for your needs!

-Marci

Medicare Annual Open Enrollment: Beware of Bad Actors

Medicare Annual Open Enrollment begins on October 15 and runs through December 7. You have many choices to make and you should take the time needed to make them, for both your physical and your financial health. A smart choice could save you money and steer you away from bad actors.

Five things to keep in mind:

Many insurers offering Medicare Advantage have **long histories of fraud,** which can **endanger enrollees' health and well-being**. They profit more if they cover less care.

- Choose a Medicare plan that covers care from high quality doctors and hospitals, including **cancer centers of excellence**.
- Referrals and prior authorizations pose **barriers to care** in Medicare Advantage.
- **Out-of-pocket costs** in Medicare Advantage pose barriers to care.
- If you opt for Medicare Advantage, you might lock yourself out of traditional Medicare because federal law does not guaranteed you the right to buy supplemental coverage.
- **Access to care: Health insurance is about your care needs today and unforeseeable needs.** Your Medicare plan should cover all medically necessary care if you're diagnosed with cancer, heart disease or stroke, fall and break a bone, or are in a serious accident.
- Traditional Medicare covers all the care you need from most physicians and hospitals across the US, without a referral or the need for prior approval.

Medicare Advantage plans often **limit access to a small network of physicians**. They may engage in **widespread inappropriate delays and denials of care, overriding** your physicians' opinions about the care you need. You often need **prior approval** for care.

Cost: Many older adults skip needed care because of high out-of-pocket costs.

- Traditional Medicare covers virtually all your out-of-pocket inpatient and outpatient costs, so long as you have supplemental coverage—Medicaid, retiree benefits or Medigap, which you buy in the individual market for about $2,500 a year.
- Medicare Advantage plans charge deductibles and copays that **average around $5,000 a year and can be as high as $7,550**. Each one charges different amounts for in-network care and most do not cover out-of-network care.
- **Fraud: Some providers and Medicare Advantage plans have histories of engaging in fraud.**
- Whether you're in Traditional Medicare or Medicare Advantage, remember that not all health care providers are equal. Make sure you can **trust your providers**.

Many health insurers offering Medicare Advantage plans have long histories of **fraud** against the government, including **consumer protection-related violations**. Before enrolling in a Medicare Advantage plan, protect yourself. Look up the insurance company on violationtracker.org. **You can't trust the Medicare star-ratings**.

Incentives: Beware of physicians and insurers that profit from denying or delaying your care.

- Traditional Medicare pays for each service you receive, so physicians have no incentive to withhold care you need or to keep you from seeing top specialists.
- Medicare Advantage plans are paid a flat upfront fee, so they have a **financial incentive to keep you from getting costly care**. The less care you get, the more they profit.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

CDC Warns of Possible Severe Flu Season Ahead

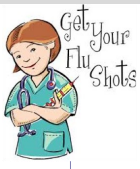
Australia is experiencing its worst **flu** season in five years, and that doesn't bode well for the United States, federal health officials warned Tuesday.

America's flu season often mirrors what unfolds in Australia, where winter spans April through October.

Making matters worse, only 49% of Americans plan to get a flu shot during the 2022-2023 flu season, according to a new **survey** of more than 1,000 people by the National Foundation for Infectious Diseases (NFID). In addition, one in five people at higher risk of developing serious flu-related complications aren't planning to get vaccinated this year, the survey showed.

"We don't know exactly what to expect this flu season, but we do know the best way to prevent flu is to get vaccinated each year, ideally before flu activity begins in your community," Dr. Rochelle Walensky, director of the U.S. Centers for Disease Control and Prevention, said during a media briefing on the upcoming flu season.

It's never too late to get your flu shot, and it's safe to get it at the same time as your COVID-19 booster, she stressed.



People who are 65 or older should get one of the ramped-up flu shots for better protection, Walensky added.

There are three types available: **Fluzone High-Dose** and Flublok, which contain higher doses of the main anti-flu ingredient; and **Fluad Adjuvanted**, which contains an ingredient to boost immune response.

If one of these flu shots isn't available, older Americans should get whatever flu shot is, Walensky noted.

Besides getting your annual flu shot and other vaccines, including those for COVID-19 and **pneumonia**, take precautions to stave off illness, officials said.

"Stay home if you are sick, avoid people who are sick, practice good hygiene, wash your hands often, and cover your mouth when you cough and sneeze," Walensky said. If you do get the flu, **antiviral drugs** can shorten its duration and lessen its severity.

There have been worrisome drops in flu vaccine coverage during the past two flu seasons, Walensky said, with the main reasons being that some people don't think it works or are concerned about side effects.

Each year, scientists track flu patterns and make an educated guess about which strains will circulate. Sometimes they get it right, and sometimes they don't. But getting a shot still helps.

"Even if the flu vaccine is not a perfect match, it provides some protection against severe disease and complications of influenza," said NFID director Dr. William Schaffner.

Just 58% of kids aged 6 months to 17 years got the flu shot during the 2021-2022 flu season, which is about 6% less than it was in 2019-2020, according to **CDC statistics**.

Meanwhile, only half of pregnant women, who are at high risk for severe flu-related complications, got the shot during the 2021-2022 flu season, compared to nearly 55% in the previous season.

The flu vaccine is safe during pregnancy and can also help protect the baby, said Dr. Tamika Auguste, chair of women's and infants' services at MedStar Washington Hospital Center in Washington, D.C.

"Women can receive the flu shot during any trimester, postpartum and even while breastfeeding," Auguste said.

Patricia Stinchfield, president of NFID, stressed that "the flu is not just a bad cold. It can cause life-threatening complications including hospitalization and death, and healthy individuals at any age can get severe influenza."

The message is clear: "Anyone 6 months of age or older needs a flu vaccine, and this is particularly important for those at high risk for influenza complications including young children, pregnant women, people with compromised immune systems, people aged 65 or older, people with chronic conditions, and certain racial and ethnic minorities," Stinchfield noted.

New Test of Pancreatic Cysts Might Boost Cancer Detection

Pancreatic cancer is often fatal, but a molecular test that can accurately distinguish benign cysts from those that could become cancerous may be a key to saving lives.

Researchers tested the technology — called PancreaSeq — to see if it could work in a clinical setting and found success.

"Based on the results of this study, molecular testing of pancreatic cysts is poised to enter international consensus guidelines for the diagnosis of pancreatic cysts and early detection of **pancreatic cancer**," said co-senior author Dr. Aatur Singhi. He is an associate professor of pathology at the University of Pittsburgh School of Medicine and UPMC Hillman Cancer Center.

"Our hope is that PancreaSeq will not only improve early detection of pancreatic cancer but also avoid overtreatment and unnecessary surgery of non-cancerous cysts," Singhi said in a university news release.

The study, which included more than 1,800 patients at 31 institutions, was funded by the U.S. National Cancer Institute, the Pancreatic Cancer Action Network and the U.S. Department of Defense, among others.

For the study, the researchers analyzed molecular markers in pancreatic cyst fluid collected from patients and followed them for two years.

The test identified 88% of **mucinous cysts** that had advanced to cancer, with a specificity of 98%. A high specificity means there are few false positive results.

When researchers then examined cells under a microscope to look for cancer-associated changes, accuracy rose to 93%. Specificity remained high at 95%.

"There is a very low likelihood of mucinous cysts giving rise to cancer, but accurately identifying this type of cyst is important because it gives us a window of opportunity to monitor patients and prevent pancreatic cancer from developing," Singhi explained.

While mucinous pancreatic cysts can become cancerous, another type of cyst known as non-mucinous is benign.

The investigators found that based on mutations in genes called KRAS and GNAS, PancreaSeq diagnosed mucinous cysts accurately in 90% of cases, with no false positives.

PancreaSeq also was able to detect non-mucinous cysts and pancreatic neuroendocrine tumors, called PanNETS. These tumors are typically benign but can be fatal if they spread from the **pancreas** to other parts of the body.

"This study lays the foundation for developing prognostic biosignatures for PanNETs so that we can identify which tumors will metastasize [spread] and which won't," Singhi said.

The study found that PancreaSeq can accurately sequence 22 genes associated with pancreatic cysts. Up to 15% of people in the United States develop a pancreatic cyst, though most are benign….**Read More**

COVID Boosters Could Save 90,000 Lives This Winter. Will Americans Get Them?

How many Americans will die of COVID-19 this winter could depend on how many get their booster shots, a new report shows.

Up to 90,000 U.S. COVID deaths could be prevented through the fall and winter, but that is less likely if vaccine uptake continues at the current slow pace, the Commonwealth Fund **study** released Wednesday predicted. Death rates could peak at more than 1,000 per day during the winter if nothing changes.

"When you look at the data of the deaths and severe disease among unvaccinated versus vaccinated and boosted, versus vaccinated and doubly boosted, the data are crystal clear of the difference in severity and death among people who are not vaccinated," said Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases.

Fauci was speaking at a **webinar** hosted by the University of Southern California's Center for Health Journalism on Tuesday.

"In this rich country of ours, we have 68% of the population is vaccinated and only one half of those have received one booster," Fauci said. "We rank very poorly in our acceptance of vaccines. Somehow we've got to get down to the root cause of that, and I know it's going to be very complicated because a lot of it is because of political divisiveness."

About 7.6 million Americans have received an updated booster dose so far, according to the **latest data** from the U.S. Centers for Disease Control and Prevention.

The updated shots, made by both Moderna and Pfizer, were **authorized** in late August by the U.S. Food and Drug Administration.

The researchers determined that if COVID booster vaccinations happened at a rate similar to flu vaccinations in 2020-21, there would be 75,000 fewer deaths, 745,000 fewer hospitalizations and $44 billion less spent in medical costs from Oct. 1 to the end of March 2023, compared with a scenario in which daily vaccination rates were unchanged.

In another scenario, analysts determined that if 80% of people received their updated booster doses, it would prevent not only 90,000 deaths but more than 936,000 hospitalizations and save $56 billion in six months.

At the current pace of booster shot uptake, if there is a winter virus surge, that could bring a peak of 16,000 hospitalizations and 1,200 deaths per day by March.

Right now, there is an average of more than 400 COVID deaths daily in the United States, *CNN* reported.

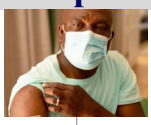
Only about two-thirds of the U.S. population is fully vaccinated with an initial series. About half of those, or 33.3% have received a booster dose, according to the CDC. Americans may need to get an updated COVID vaccination each year.

Extremely Low Incidence of COVID Hospitalization After Vaccine, Boosters: Study

Getting vaccinated and boosted greatly reduces the odds for hospitalization if you get infected with COVID-19, according to a large new study conducted at U.S. Veterans Health Administration facilities.

"This is remarkable, good news about the power and effectiveness of receiving COVID-19 boosting for all groups," said co-author Dr. Dawn Bravata, a research scientist at the Regenstrief Institute and the Roudebush VA Medical Center, both in Indianapolis.

The study looked at records of 1.6 million patients at VA facilities nationwide. Bravata's team found what they described as a surprisingly low rate of hospitalization for COVID, especially among those under age 65 with no high-risk conditions.



Those vaccinated folks who wound up in the hospital were almost all at high risk, a category that includes older people and adults of all ages who are immunocompromised or have certain health issues.

The rate of new hospitalizations for **COVID pneumonia** or death was 8.9 for every 10,000 people who had been vaccinated and boosted. The rate for those with certain health issues was 10 times higher, but researchers said that was still considered low.

To avoid misclassifying death or serious outcomes, researchers looked for cases of breakthrough COVID, COVID pneumonia and death instead of only including patients who had a positive COVID-19 lab test.

"Early in the pandemic, many researchers, including our own group, published studies about COVID-19 hospitalizations," Bravata said in a Regenstrief news release. "But we're in a different era now when patients who are admitted to the hospital with a non-COVID illness are screened; some of whom will test positive. Evaluating outcomes such as COVID-19 pneumonia or [death rates] -- as opposed to simply considering all hospitalization -- makes more sense."

Grants from the VA and the U.S. National Institute of Allergy and Infectious Diseases supported the study.

"These results, from a period of **Delta and Omicron** predominance, should encourage people to get vaccinated and boosted," said Bravata, who is also a professor of medicine at Indiana University School of Medicine.

Americans Are Prioritizing Mental Health. With New 988 Hotline There to Help

As the 988 crisis line debuts across the United States, a new Harris Poll shows that Americans are ready to make mental health and **suicide prevention** a top priority.

Over eight in 10 adults now believe it's more important than ever to consider suicide prevention a national public health crisis, according to the poll sponsored by the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center.

Unfortunately, the poll also revealed some major misconceptions about how the 988 line actually works, as well as potential barriers that could keep people from reaching out for the help they need.

The good news? Nearly everyone who responded to the poll (94%) sees suicide as a preventable public health issue.

"More people during the pandemic talked about mental health. In the early days of the pandemic, we frequently saw mental health as the headline in newspapers," said Colleen Carr, director of the National Action Alliance for Suicide Prevention (NAASP). "Ten years ago, I don't think we would have seen mental health front and center at the beginning of a global pandemic, and we really did see that this time."

The successful launch this summer of the **988 crisis line** reflects this new emphasis on mental health.

Nearly three in five Americans are familiar with 988, even though it's only been in place for two and a half months, the poll found.

"I thought it was very interesting that even though 988 only came out in July, already more than half of people have heard of it," said Jill Harkavy-Friedman, senior vice president of research for the American Foundation for Suicide Prevention. "The effort to get that information out has been successful. I'm hopeful that people will know the number is there and will use it if they need it, whether for themselves or somebody else."...**Read More**

New Alzheimer's drug shows promise at slowing cognitive decline

Damien Garde and Adam Feuerstein report for **Stat News** on likely FDA approval of a new drug to treat Alzheimer's disease. In a clinical trial, the drug was shown to slow cognitive decline by 27 percent. Biogen and Eisai developed the drug, which they call lecanemab.

Earlier this year, Biogen tried unsuccessfully to get FDA approval of Aduhelm to treat Alzheimer's disease. But, Aduhelm showed limited at best clinical benefits and **serious side effects**.

The clinical trial for lecanemab involved 1,800 patients with early -stage Alzheimer's disease. It showed that patients fared better in terms of memory loss than patients who did not receive the drug. It also showed toxic plaque (amyloid) reduction in the brain and other benefits in terms of preserving memory and brain function.

One in five patients who received lecanemab had brain swelling or bleeding. But fewer than three in one hundred showed symptoms.

The FDA has said it will decide whether to conditionally approve lecanemab by Jan. 6. With new data, it could give full approval to lecanemab by the summer.

The trial showed that patients who received lecanemab performed .45 points better on memory, problem-solving and personal care than patients who received the placebo, out of a total score of 18. The .45 point improvement is considered statistically significant, but this improvement may not be noticeable in a patient. Some experts believe the data available shows minimally significant positive results and want more data.

Patients receive lecanemab twice a month through infusion.

How sweet is your diet?

Our brains are programmed to love sugar. And, sugar is in all foods with carbohydrates, including fruits, vegetables, grains, and dairy. Eating these whole foods is fine because your body digests them slowly and they provide energy to your cells. But, foods with added sugars are another story and are best to avoid. How sweet is your diet?

If your diet is like the typical American's, you're eating way too much sugar every day. The food industry adds sugar to practically every processed food we eat, including ketchup, hot dogs and salad dressing. That helps explain why we eat so much sugar.

Try to avoid eating and drinking foods with added sugar. You can get your carbohydrates elsewhere. We get most of our unhealthy sugar from sugary beverages, including sports drinks. Four grams of sugar is a teaspoon. One can of cola has 39 grams of sugar, 10 teaspoons!

Even fruit juice has a lot of natural sugar and some fruit juice has added sugar. Fruit juice also contains vitamins and other nutrients, but those benefits are offset by all the sugar. Breakfast cereal and yogurt (except plain yogurt) also generally contain a lot of sugar.

Our bodies need sugar to survive. But our body can get all the sugar it needs from glucose. Our bodies make glucose by breaking down carbohydrates, proteins and fats we eat. We do not need to eat foods with added sugar to feed our brains. Those foods can cause **heart disease**, fatty liver disease, **diabetes**; they can also raise your blood pressure.

How much added sugar is ok to eat each day? The **Harvard School of Public Health** says that you can have about 50 grams or 12 teaspoons of sugar a day or 200 calories from sugar, ten percent of a typical adult's recommended calorie intake. The American Heart Association recommends even less: Women should have no more than six teaspoons of sugar a day and men nine teaspoons to reduce risk of heart disease and obesity.

There are many types of sugars: Sucrose (table sugar), corn sweetener, high-fructose corn syrup, fruit-juice concentrates, nectars, raw sugar, malt syrup, maple syrup, fructose sweeteners, liquid fructose, honey, molasses, anhydrous dextrose are all types of sugar. In fact, you can pretty much assume that any word ending in "*-ose,"* the chemical suffix for sugars, describes a type of sugar. If any sugar is listed on a food label, you should assume that the product has a lot of sugar. You can look at the nutrition facts label of most foods for the amount of "total carbohydrate."

With Days Getting Shorter, Are You at Risk for Seasonal Depression?

When summer turns to fall, the shorter days can cause some people to feel the "winter blues." Now one expert offers information on how to cope with seasonal depression, which comes during the cold, dark months of the year.

Also known as **seasonal affective disorder** (SAD), the condition can reflect a change in serotonin levels and be linked to **depression**.

"According to the Mental Health America National Organization, symptoms of seasonal depression can be similar to those that occur with depression," said Jeannie Larson, a professor at the University of Minnesota. "It can sometimes be difficult to discern SAD from other types of depression."

A diagnosis of seasonal depression can only be made after two consecutive occurrences of depression that begin and end at the same time every year, along with no symptoms during other times of the year, Larson said.

While about 5% of the U.S. population experiences SAD, the numbers are as high as 10% in the northern latitudes, a 2013 study showed.

Women have higher rates of SAD, which tends to start when person is between 20 and 30 years old.

Symptoms include those of depression, **anxiety**, mood changes, sleep problems, changes in eating habits, **lethargy** and sexual problems. The condition may present as feelings of misery, guilt, hopelessness, diminished interest in activities and loss of self-esteem. A person may feel tension or be unable to tolerate stress. Sometimes a person with SAD has mood extremes, with periods of mania in spring and summer. Other symptoms can include increased appetite, loss of libido, desire to avoid social contact and disturbed sleep.

A person with SAD may feel symptoms worsen as the winter begins and feel more isolated or anxious than in the past because of ongoing stressors from the pandemic.

"The beginning symptoms of SAD may exacerbate the preexisting stressors from COVID, making one less capable of dealing with issues then one might have been able to before," Larson said in a university news release.

Larson manages the Nature-Based Therapeutic Services at the Minnesota Landscape Arboretum of the University of Minnesota, and her areas of expertise include therapeutic horticulture, **animal-assisted interactions** and therapeutic landscapes.

She is working with an interdisciplinary team of scientists to look at the effects of walking in green and suburban environments on a patient's mood and other outcomes.

Late-Night Meals Especially Bad for Weight Gain: Study

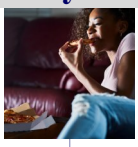
Your fondness for midnight snacks has caused you to pack on the pounds over the years, and now researchers have a better understanding of why.

While late-night eating has long been linked with an increased risk for obesity, researchers weren't sure exactly how it caused weight gain until now.

"When meals are delayed by four hours and everything else stays the same, you burn fewer calories, have an increased drive for food, and experience changes in fat tissue that would promote weight gain," said study author Frank Scheer. He's the director of the Medical Chronobiology Program at Brigham and Women's Hospital in Boston and a professor at Harvard Medical School.

The solution? Eat earlier in the day, he said.

"The new data suggest, together with the literature, eating earlier in the waking day results in changes in physiology that would promote weight loss and limit weight gain," Scheer said.



For **the study**, 16 people who were overweight or obese stuck to a strict early and late meal schedule for one day each in a lab. In the weeks before each experiment, folks maintained fixed sleep schedules. They also ate identical diets and stuck to the same meal times at home.

The participants reported on their hunger and appetite, provided blood samples throughout the day, and had their body temperature and calorie use measured. Researchers also collected samples of fat tissue.

In addition to feeling hungrier, burning fewer calories, and showing changes in fat tissue, eating later also affected the hunger and appetite-regulating hormones, leptin and ghrelin. Ghrelin is the "go" hormone that tells you when to eat, and leptin is the hormone that tells you to stop. Leptin dropped by 16% when folks ate four hours later, the study showed.

Due to the study's design, researchers were able to tightly control for exercise, sleep and light exposure, which could affect how many calories participants burned. More research is needed to see if these findings hold in real life, Scheer said.

"In the real world, when people change meal times, they may also change other behaviors such as timing or quality or time of sleep or how much they exercise, which could affect weight," he said.

The study was published Oct. 4 in the journal ***Cell Metabolism.***

Dr. Louis Aronne, director of the Comprehensive Weight Control Center at Weill Cornell Medicine and New York-Presbyterian in New York City, reviewed the findings. When you eat matters to weight control, he said.

"Eating all calories early in the day has been shown to reduce weight," Aronne said. "This study … demonstrates that eating the same number of calories late rather than early can trigger mechanisms that lead to weight gain."

Many people who eat late have little or nothing for breakfast, he noted. "You may not be hungry in the morning because you eat so much at bedtime," Aronne said.

His advice? "Try to shift your eating to early in the day by [eating] a bigger breakfast and lunch to reduce appetite at night."

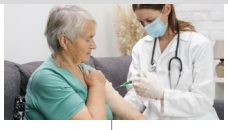
Marion Nestle, a retired professor of nutrition, food studies and public health at New York University, said eating earlier is not necessarily a panacea for **weight loss**, but it could be helpful for some people.

"This study suggests that eating late at night changes the **metabolism** of people who are overweight in ways that make it more difficult for them to lose weight," said Nestle, who also reviewed the study findings.

"Most research on the question of meal timing says it doesn't really matter, [but] what does matter is the total amount eaten in relation to caloric expenditure," she said. "People who are trying to lose weight need to figure out how to do that in ways that work for them, [and] not eating late at night is worth a try."

Government Study Shows Corona Virus Vaccinations Saved Hundreds of Thousands of Lives Last Year

A new study from the Department of Health and Human Services (HHS), not yet published in a peer-reviewed journal, estimated that coronavirus vaccines were linked to roughly 670,000 to 680,000 fewer hospitalizations as well as 330,000 to 370,000 fewer related deaths from September 2020 to December 2021.



According to HHS, these estimates represented between 39 and 47 percent fewer deaths than in a possible scenario in which vaccines were not available. The research did not include potential cases that were averted, with HHS citing the rise in at-home testing that isn't reported to officials.

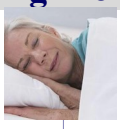
On top of these potentially averted deaths and hospitalizations, the HHS study estimated more than $16 billion in direct hospitalization costs were saved due to immunization….**Read More**

Retirement Means Sleeping More, Exercising Less: Study

Retirees, it's time to get up out of your easy chair and get moving.

That's the message from a **Finnish study** that used a wrist-based device to determine just how much retired adults were moving every day.

"Based on our research, people who are retiring should aim to increase the amount of physical activity, particularly moderate-to-vigorous activity," said lead author Kristin Suorsa, a postdoctoral researcher at the University of Turku. "At the same time, long periods of sedentary time should be avoided and sitting should be divided into shorter periods with frequent walking breaks."



Participants — part of the **Finnish Retirement and Aging Study (FIREA)** — wore accelerometers for a week before they retired and again, at the same time of year, for a week after their retirements.

Not surprisingly, they were sleeping more and, as a result, their physical activity dropped. Before retiring, the 551 participants worked in the municipal sector.

The researchers were able to study how 24-hour movement behaviors — including sleep, being sedentary, light activity and moderate-to-vigorous physical activity — changed after a person retired.

Increasing the time spent on one of those behaviors will inevitably lead to a decrease in at least one other, the study authors pointed out in a university news release.

In participants who were retiring from manual labor or the service industry, sleep and sedentary behavior increased in relation to physical activity. This change was stronger in women than in men.

For those retiring from non-manual work, sleep increased in relation to both physical activity and sedentary time. Their moderate-to-vigorous physical activity fell off more than their light physical activity, the findings showed.

"The decrease in the amount of physical activity is probably explained by the absence of activity related to work duties and commute to and from work when a person retires," Suorsa said. "These are replaced to some extent by sleep and, in the case of manual workers, also sedentary time."

The researchers noted that replacing moderate-to-vigorous physical activity with any other type of movement increases the risk of heart disease and type 2 diabetes.

FIREA began in 2013 with an aim of studying changes in living habits, health and functional capacity of retirees.