



Here's How Much the 2025 Social Security Cost-of-Living Adjustment Could Boost Checks

We're about two weeks away from the much-anticipated announcement of the 2025 Social Security cost-of-living adjustment (COLA). The government will reveal it on Oct. 10, helping beneficiaries plan their budgets for next year.

We don't know what the COLA will be yet, but there are already predictions. Here's a closer look at how much the average check will likely increase in 2025.

The 2025 COLA is expected to be 2.5%

The latest projection from The Senior Citizens League puts the **COLA** estimate around 2.5%. This is below the 3.2% hike recipients got this year and reflects cooling inflation.

Since the COLA is a percentage, which the Social Security Administration applies to your existing benefits, you can get a good approximation of your 2025 benefit by applying the projected percentage to the current amount. For example, the average Social Security benefit for retired workers as of August was \$1,920 per month. If we add the 2.5% projection to this, we get an extra \$48, bringing the average check in 2025 to about \$1,968. That's an extra \$576 per year.

What to do if the COLA doesn't go as far as you had hoped

That probably would not be as much as many are hoping for.



They argue that the COLA computation doesn't actually help checks keep up with inflation. The Senior

Citizens League found that benefits have actually lost 20% of their buying power since 2010. So even with the COLA, you could wind up spending more of your own money to cover your expenses.

Planning ahead can help minimize this shock. If you have personal savings, you can fall back on these. Those without much of a nest egg might have to **try to diversify their retirement income**. This could involve taking a part-time job, renting out or selling extra property, or

considering strategies like a **reverse mortgage**. Anything that minimizes your reliance on Social Security can help.

You might also qualify for certain government benefits to help with your essential costs. Look into assistance programs for expenses like food, housing, utilities, and healthcare in your area to see what your options are and what criteria you must meet to claim them.

Once you know how far your checks will go and how much you'll get from Social Security, plan your budget for 2025. After a month or two, revisit it to make sure it's working for you and make adjustments as needed.

Will 2025 Social Security COLA increases be enough for retirees?

Social Security **cost-of-living adjustments (COLA)** were instated in 1975 to keep pace with inflation and help retirees maintain purchasing power. However, many people argue that the adjustments aren't enough to keep pace with the rising cost of necessities such as housing, groceries, and utilities. Annual COLAs are calculated using the Consumer Price Index (CPI) figures from the previous year to closely tie the adjustments to inflation. The September CPI — announced in October — is the last update factored into the calculations, making it a highly anticipated figure.

Bob Powell, CFP and editor of **Retirement Daily**, has a few predictions for the 2025 COLA, which will be announced shortly after the September 2024 CPI

release. He notes retirees are feeling the squeeze as consumer prices have remained high, and the recent Fed **interest rate cut** will likely impact investment yields. Inflation has become a growing concern for retirees Powell explains that the next CPI update will be a key indicator of the 2025 Social Security COLA. "The next CPI report comes out in October, and then shortly thereafter, the Social Security Administration will announce what the cost of living adjustment will be," he said. It will likely be low, I'm guessing maybe around maybe 3% or so." Although inflation is cooling, prices have not come down, adding an extra financial challenge for Americans of all ages.



"Whatever your social security benefit was the previous year, it will be adjusted upwards by that 3%," he explained. "Some folks are saying that 3% isn't enough to offset the cost of living — they'll still be behind the eight ball even with the adjustment. And I would say, by and large, that that might be true because you're probably spending more than you did in previous years." Lower interest rates are another issue for retirees Powell notes the stubborn inflation rates are becoming more of a challenge for retirees, as **there hasn't been an inflationary period of this magnitude in decades**.

"For many years, Social Security beneficiaries have benefited from the zero interest rate policy world — COLAs were low, but CPI was low as well," he continued.

"With the exception of the past few years, retirees haven't had to worry about inflation much. The adjustments were low, but so were consumer prices." "There's a Consumer Price Index that looks at the **cost of living for those 62 and older**, and that shows that it's roughly equal to the standard CPI," he added. Retirees are finding their expenses are outpacing their retirement savings, and **Social Security isn't as impactful as it once was**.

"To me, it's a double-edged sword. On one hand, when you have high inflation, you typically have high interest rates, which benefits the people investing in CDs and money market funds," he elaborated. "On the other hand, high inflation hurts people because their income may not rise as fast as their expenses."

ADD YOUR NAME

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

Breast Cancer Awareness Month can mean different things to different people. For some, it's a trigger — 31 days in the fall of pink-ribbon reminders of a disease that forever changed them. For others, it's a chance to show their support for the more than 2 million women around the world who are diagnosed with the disease each year.

Understanding the goals behind the global campaign and the emotions felt by the many different people living with the disease may help you decide if and how you want to commemorate the month.

This information is provided by [Breastcancer.org](https://www.breastcancer.org). [Donate](#) to support free resources and programming for people affected by breast cancer.

What is Breast Cancer Awareness Month? Breast Cancer Awareness Month is an international health campaign that's held every October. The month aims to promote screening and prevention of the disease, which affects 2.3 million women worldwide. Known best for its pink theme color, the month features a number of campaigns and programs — conducted by

groups ranging from breast cancer advocacy organizations to local community organizations to major retailers — aimed at: supporting people diagnosed with breast cancer, including those with metastatic breast cancer educating people about breast cancer risk factors encouraging women to go for regular breast cancer screening starting at age 40 or earlier, depending on personal breast cancer risk fundraising for breast cancer research Within the month of October, there are also specific dates designed to raise awareness of specific groups within the breast cancer community.

Metastatic Breast Cancer Awareness Day (October 13)

This information is provided by [Breastcancer.org](https://www.breastcancer.org). [Donate](#) to support free resources and programming for people affected by breast cancer.

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October 13 is nationally recognized in the U.S. as



Metastatic Breast Cancer Awareness Day. About 168,000 women in the U.S. are estimated to have metastatic breast cancer (cancer that spreads beyond the breast to other parts of the body). Researchers estimate that about 30% of early-stage breast cancers eventually metastasize. The day, which began in 2009, is meant to educate the public about the need for more money to go to the study of metastatic breast cancer and the development of new metastatic cancer treatments.

Men's Breast Cancer Awareness Week (October 17–23)

Although breast cancer is much more common in women, breast cancer affects men, too. In 2021, President Joe Biden designated October 17 to October 23 Men's Breast Cancer Awareness Week. According to the American Cancer Society, 2,790 men in the U.S. will be diagnosed with breast cancer in 2024, and about 530 are expected to die from the disease. But lack of awareness and stigma can be barriers to detection and care in men, trans men, and non-binary people.

This information is provided by [Breastcancer.org](https://www.breastcancer.org). [Donate](#) to support free resources and programming for people affected by breast cancer.

The history of Breast Cancer Awareness Month

The event began in 1985 as a week-long awareness campaign by the American Cancer Society, in partnership with Imperial Chemical Industries, a British company that made tamoxifen. The campaign eventually grew into a month-long event.

In 1992, the pink ribbon came into play after Alexandra Penney, SELF magazine's Editor-in-Chief, partnered with Evelyn Lauder, Estée Lauder's Senior Corporate Vice President and a breast cancer survivor, to distribute pink ribbons after the magazine's second annual Breast Cancer Awareness Month issue.

Other variations of the pink ribbon have emerged in recent years to raise awareness that all people with breast cancer are not the same. These include ribbons for raising awareness about metastatic breast cancer, men with breast cancer, inflammatory breast cancer, and more...[Read More](#)

Social Security: 3 Ways Your Marital Status Could Affect Your Benefits

There are many factors that influence the amount you'll receive from Social Security, including your age, earnings history, and the length of your career. But your marital status can also affect your benefit amount. Depending on your situation, you could potentially earn hundreds of dollars more per month in spousal, divorce, or survivors benefits -- even if you've never worked.

There are a few requirements you'll need to meet for each benefit type, however. Here's everything you need to know about how your marital status impacts your Social Security.

1. If you're married...

If you're currently married to someone who's eligible for Social Security retirement or disability benefits, you could qualify for spousal benefits. You don't need to have worked in the past to receive spousal Social Security; you could still collect this type of benefit even if you're

eligible for payments based on your own earnings.

The maximum you can receive in spousal benefits is 50% of your partner's benefit at their full retirement age (FRA). You'll also need to wait until your own FRA to collect this amount. If you file early, you'll receive a reduced payment each month.

If you're also entitled to retirement benefits based on your work history, you'll only receive the higher of the two amounts -- not both. So, for instance, if your spouse will collect \$2,000 per month at FRA, your maximum spousal benefit would be \$1,000 per month. If you're eligible for, say, \$800 per month, based on your own earnings, your total benefit amount would still be \$1,000 per month -- not \$1,800 per month.

2. If you're divorced...

Divorce benefits are similar to spousal benefits except they're



available to those who are divorced. To qualify, you can't currently be married (but if your spouse has remarried, it won't affect your ability to take divorce benefits). Your previous marriage also must have lasted for at least 10 years.

Like with spousal benefits, your maximum benefit amount is 50% of what your ex-spouse will receive at their FRA. If you're also entitled to Social Security based on your own work history, you'll collect the higher of the two amounts.

Claiming divorce benefits will not impact your ex-spouse's benefit in any way. Also, if they've remarried, it won't affect their current partner's ability to claim spousal benefits based on their work record.

3. If you're widowed...

Survivors benefits are a little different from spousal and divorce benefits. Available primarily to widow(er)s, many

people can collect their spouse's entire benefit amount in survivors benefits after their loved one has passed.

While this type of benefit is most often available to spouses, other family members are sometimes eligible -- including parents, children, and divorced spouses. Your benefit amount will vary based on your relation to the deceased, as well as other factors, like your age and the deceased-person's work record.

The average survivors benefit amount among nondisabled widow(er)s is around \$1,717 per month, as of October 2023, and the average spousal/divorce benefit is roughly \$887 per month.

If you qualify for any of these types of Social Security, it pays to make the most of them. When you know what you're entitled to, based on your marital status, you can ensure you're squeezing every penny out of your benefits.

Medicare 2025: Big Changes Are on the Way

Medicare in 2025 is set to get several meaningful changes that could impact part D enrollees. We're still awaiting additional information on Part A, B and C plans, but the Centers for Medicare and Medicaid Services is expected to share details in the coming weeks. 2025 will see additional rules from the 2022 Inflation Reduction Act go into effect, which could substantially change how much participants pay for their medications.

The Social Security Administration determines the costs of what the Medicare will be and raise or lower plan premiums accordingly. We expect to hear more details in October, following the **2025 COLA increase** announcement. We'll continue to provide updates to Medicare plan changes as more details are released, but below is what we know to expect to see in 2025. For more, don't miss **how to apply for Social Security Disability Insurance and four ways you can lose your Social Security benefits.**

Changes to Medicare Part A
Part A helps pay for inpatient care you get in hospitals, critical access hospitals and skilled nursing facilities. Almost 99% of Medicare beneficiaries get Part A for free because they paid Medicare taxes while working,

according to the **Centers for Medicare & Medicaid Services**. Last year, the CMS announced the 2024 changes to Part A on Oct. 12, 2023.

Changes to Medicare Part B
Part B covers medical services like doctors' services and outpatient care. Part B is optional, and for 2024, Part B's premium is \$174.70 per month. The CMS announces annual adjustments to Part B in the fall, so we'll have to wait a bit before we can get the full details for 2025.

Changes to Medicare Part C
Medicare Advantage, or Medicare Part C, will also be receiving some updates. Part C plans come from private companies and can offer extra coverage, such as vision, hearing, dental and health and wellness programs.

Pricing for this alternative varies by the plan you choose. An upcoming change to Part C will remind enrollees what they could be potentially leaving on the table. For Medicare Advantage participants, starting in 2025, a mid-year notification will inform you of any unused benefits that are available that you can take advantage of.

This will both remind you to use your benefits and reassess whether you need the specific



plan they signed up for. When reenrollment time comes around, you will be able to make a more informed decision about whether you should stay with your current plan or switch to a new one.

Expect several Medicare Part D Changes in 2025

Part D can help cover costs of prescription drugs. So, what's new with Medicare Part D for 2025? The Inflation Reduction Act will bring a host of changes to Part D plans this year. We'll break it down.

Base premium increase expected

According to the CMS, the Part D base beneficiary premium will increase by \$2.08, or 6%, from \$34.70 to \$36.78. The IRA adds in a 6% cap to the base Part D plans, but actual premiums may vary. CMS said it will release preliminary Part D premium averages later this summer.

New \$2,000 out-of-pocket maximums for medications

A big 2025 change for Plan D enrollees will be the \$2,000 out-of-pocket maximum per year for medications. This change could have some major benefits for enrollees that have expensive medications they need to take on a monthly basis.

Note that medications covered

under Medicare Part B will not count toward this maximum, as these are typically provided by a doctor or practitioner at a facility.

The Coverage Gap (doughnut hole) is gone in 2025

In 2024, there were four stages of coverage. Deductible, Initial, Coverage Gap (known as the donut hole) and Catastrophic. The Coverage Gap is a temporary limit on what the drug plan will cover for drug costs. In 2025, Medicare will eliminate the donut hole coverage gap, further simplifying coverages. Now, with the new out-of-pocket max of \$2,000, Plan D participants will need to pay they're deductible (up to \$590), then make copayments until they reach the new maximum, getting them to the next level of coverage faster than previous years.

New medication payment plan options

A new payment plan option will enable people to pay for their medications over the course of the year in the form of a payment plan instead of up front. The new plan allows someone to opt-in to this payment plan and spread the payments out for the remainder of the months in the year, and payments may not exceed a certain amount. The payment plan is opt-in only.

Dear Marci: Does Medicare cover COVID vaccines?

Dear Marci,

I want to get the updated COVID vaccine this fall. Will Medicare cover that?

-Lucia (Miami, FL)

Dear Lucia,

Yes! Medicare does cover COVID vaccines, including the updated vaccine. If you have Original Medicare, you will owe

no cost-sharing (deductibles, copayments, or coinsurance) if you see a provider who accepts Medicare. If you have a Medicare Advantage Plan, you should also not owe any cost-sharing if you see an in-network provider.

Learn more about **staying up-**



Dear Marci

to-date with COVID-19 vaccines from the

Centers for Disease Control and Prevention (CDC), and speak with your doctor if you have any questions.

Be aware of fraud schemes related to the vaccine. Do not share your Medicare number with anyone except for trusted

health care providers. Be wary of people who ask for your financial information. You cannot pay to get earlier access to the vaccine, and the vaccine should not cost you anything. Contact your **Senior Medicare Patrol (SMP)** if you suspect you have experienced Medicare fraud.

-Marci

Which states rely the most on federal aid?

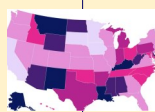
Which states received the most money from the federal government?

Federal funding comes through several overlapping programs targeting state and local governments. The proportion of state revenues attributable to federal aid is determined by combining the funding received

by both state and local institutions.

The five states that received the most federal aid were:

- California (\$162.9 billion)
- ◆ New York (\$110.2 billion)
- ◆ Texas (\$105.8 billion)
- ◆ Florida (\$58.8 billion)



◆ Pennsylvania (\$57.1 billion)

These figures largely correlate with population.

To interpret state reliance on the federal government more accurately, we can look at total aid as a percentage of annual state revenues.

In 2021, Montana led the states with the highest proportion of federal funding to the overall budget at 31.8%, followed by New Mexico (30.7%), Kentucky (30.1%), Louisiana (29.8%), and Alaska (29.0%). ...**Read More**

Why people on Medicare should look out for a letter from their insurers this year

Medicare beneficiaries with plans through private insurers should be on high alert for a letter from their insurance company about changes ahead of the open enrollment period that begins next month.

Every September, Medicare enrollees with prescription drug coverage through a standalone Part D plan or a Medicare Advantage plan, receive an annual notice of change alerting them of adjustments to their health care plans, intended to help people with Medicare prepare for the open enrollment window from Oct. 15 to Dec. 7.

Experts say this year's notice could be particularly important.

Medicare Part D or Medicare Advantage, which collectively have nearly 790,000 beneficiaries in Oregon, will see changes in 2025. Notably, the changes include a limit on how much patients will have to pay out of pocket for covered prescriptions.

And some private insurers who offer plans under Medicare Advantage, the private-sector alternative to traditional Medicare, have signaled plans to make sweeping changes that could affect enrollee's access to benefits.

Part D
Reforms to Medicare Part D,



supplemental prescription drug coverage, are a key element of 2022's Inflation Reduction Act and are designed to contain drug prices and make prescription plans more affordable.

Starting in 2025, Medicare Part D plans must cap out-of-pocket costs to \$2,000 per person, per year. Patients can also choose to enroll in a new payment plan that would spread out their medication costs over the course of the year, according to Jen Teague, director for health coverage and benefits at the National Council on Aging.

"People get the choice if they want to pay all their drug costs up front, or if they want to spread it

out over the cost of the year," Teague said.

It's unclear how insurance companies sponsoring Part D plans — or Medicare Advantage plans with drug coverage — will respond to the new cap on out-of-pocket drug expenses, which may put insurers on the hook for more costs, according to Teague. Some, she said, could decide to drop coverage for certain medications.

"We don't know yet ... what coverage plans are going to keep, what medication and which ones they are not going to cover for the following year," she said.

Medicare Advantage Pulling in Billions in Dubious Quality Bonuses

The Medicare Rights Center's policy series, **Medicare Advantage 101**, covers the history of and issues within Medicare Advantage (MA), **including overpayments** to the program that burden Medicare beneficiaries, and taxpayers.

One driver of these overpayments is a controversial system called the Quality Bonus Program (QBP). **As we have outlined before**, the QBP requires the Centers for Medicare & Medicaid Services (CMS) to rate plans in every county on a **five-star system**. Plans that score at least 4 stars get a bonus payment. In some counties, plans can get their bonuses doubled.

The QBP was created to reward high-quality plans and help people make informed decisions. But plan scores keep creeping up

across the board, leaving shoppers with little to compare and fewer clues about which plans are the best fit for them.

And, due to issues with the underlying metrics, it is unclear if the plans with higher scores genuinely have better quality. For example, Medicare Rights and others have observed that the QBP star ratings contain too many measures, diluting their relevance, and are not a useful tool for enrollees anyway because they are contract, rather than plan, specific. As the Medicare Payment Advisory Commission (MedPAC) **said in 2023**: "The current state of quality reporting is such that the Commission's yearly updates can no longer provide an accurate description of

Figure 1
Total Spending on Medicare Advantage
2024 After Years of Steady Increases



Figure 2
Bonuses Will Decline to \$11.8 Billion in 2024



the quality of care across MA plans." Yet plan ratings, and bonus payments, continue to rise.

A new report from KFF shows these trends remain entrenched. As illustrated in the KFF graphic below, payments have varied a bit in the past few years due to erratic effects from the COVID-19 public health emergency but have shown a general upward trend. In 2022, they were around \$10 billion, leaping to \$12.8 billion in 2023. In 2024, **the QBP is expected to pay out at least \$11.8 billion**. However, it is unclear if the surge in highly rated, highly paid plans is due to meaningful quality improvements or a ratings system that is inaccurate, ineffective, and easily manipulated.

Although the QBP's relationship to plan quality is questionable, its effect on Medicare costs is not. Since 2015, the program has paid out around \$74 billion in bonuses. And unlike other quality programs, the QBP is **not required to be budget neutral**. That allows payments to simply keep growing and gives plans carte blanche to game a broken system and collect ever-larger sums of unwarranted Medicare dollars.

Absent significant reforms, these problems will only escalate. At Medicare Rights, we think it is past time to revise or replace the QBP, curtail MA overspending more generally, and increase oversight and enforcement for MA plans.

84% of Older Americans Are Worried About Social Security Cuts. Should They Be?

Millions of older Americans today collect a monthly benefit from Social Security. And in the absence of that income, many would no doubt struggle financially.

But **Social Security** is facing some financial challenges in the coming years. And if lawmakers don't find a way to resolve them, benefit cuts could be on the table.

Such is the fear of 84% of Americans aged 60 to 65 recently **surveyed by Nationwide**. While inflation is the No. 1 concern among people

that age, Social Security ranks closely behind.

But are older Americans' Social Security concerns overblown? Or are benefit cuts a reality retirees should be bracing for?

It's too soon to know Social Security's primary source of revenue is the money it collects in payroll taxes. Since the country has and plans to have an active labor force, Social Security is not in danger of going away entirely. However, as baby



boomers continue to retire and fewer workers come in to replace them, the program's primary revenue source is apt to shrink.

Now, Social Security has cash reserves known as trust funds it can tap to keep up with benefit payments for a while. But once those trust funds run out of money, the program may have to cut benefits.

Recent projections call for cuts in the ballpark of 20%. And recent estimates also have Social

Security's trust funds running dry by 2034. So, all told, benefit cuts could be a mere 10 years away.

As such, it's understandable that older Americans would be concerned. But one thing to know is that this isn't the first time Social Security has faced the possibility of benefit cuts. And in the past, lawmakers have managed to avoid them. So, solutions may be introduced in the coming years that could once again stave off those cuts...**Read More**

Beware of medical devices that the FDA has recalled

David Hilzenrath reports for [KFFHealth News](#) on how defective medical devices end up remaining in use. Even when the FDA sends out notices about medical devices that can cause serious injuries or even death, physicians might be using them. Inexplicably, manufacturers and the FDA do not end their use or effectively recall them from use.

In most cases, when an agency recalls a product, be it food or an automobile or a crib, it asks that customers return the product to its place of purchase for repair or

to discard it. But, an FDA medical device recall does not mean that the product is actually recalled. Rather, a recall could mean something other than an end to a product's use. It can mean a fix of some sort, be it a repair or adjustment or inspection of a device.

In one case, Abbot, a medical device manufacturer, explained that instead of removing a defective implanted medical product from the market, it changed instructions on how to



use it and required physicians to get training before implanting it. Of 338 medical device recalls between 2019 and 2034, 164 were "corrections." Only 174 products were actually taken off the market. When it does not remove a medical device from the market, the FDA says it is because the frequency or severity of the bad consequences from the product is not great or that the fix is effective and the benefits to patients are greater than the loss of the product. To be sure, there

are risks from removing implanted devices from patients. **The takeaway:** Be sure to look into any medical device your doctor recommends before agreeing to it. I have reported several times, including [here](#) and [here](#) and [here](#), on dangerous medical devices that the FDA has failed to remove from the market, to the detriment of patients, allowing manufacturers the ability to "fix" the defects at some risk to patients.

U.S. Restarts Free COVID Test Program

Starting today, the U.S. government is offering another round of free COVID tests.

"U.S. households will be eligible to order 4 free COVID-19 tests at [COVIDTests.gov](#)," according to the Department of Health and Human Services. "The COVID-19 tests will detect current COVID-19 variants and can be used through the end of the year."

More than 900 million such tests have already been distributed to help folks get tested and treated earlier, and to perhaps keep them from

spreading COVID to others.

If you've never tested for COVID before, the nasal swab kits are easy to use.

"At-home COVID tests can be taken at home or in other locations and typically provide results within 30 minutes or less," according to the HHS. "COVID tests can be administered to both vaccinated and unvaccinated individuals."

Testing may come in handy as gatherings for Halloween, Thanksgiving and Christmas



push people into close proximity.

"The best plan going into this winter is for everyone to remain vigilant, to use the tools we have: vaccines, testing, treatment against the illnesses responsible for the majority of fall and winter deaths and hospitalizations," **Dr. Mandy Cohen**, director of the U.S. Centers for Disease Control and Prevention, said Friday, *CNN* reported.

And don't forget vaccines.

The latest, strain-specific formulation of COVID vaccine is

now available, in both the RNA form (Moderna and Pfizer) or Novavax' protein-based alternative.

The mRNA vaccines target the KP.2 'FLiRT' variant, which has been a dominant strain since late spring, while Novavax' shot targets JN.1, which is still around but perhaps less dominant than in months past.

All vaccines are available at pharmacies nationwide, and it's fine to get a COVID and flu shot simultaneously, experts say.

US health care system ranks dead last among 10 of the world's richest countries

The Commonwealth Fund this week released its biennial [ranking of the health systems of 10 of the world's richest countries](#), and once again the United States comes in dead last – as it has for the past 20 years – not just overall but on most performance measures, especially access and affordability.

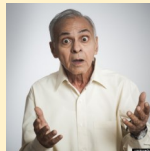
Throughout the report, it's clear that one of the reasons the U.S. always brings up the rear internationally is the fact that far too many Americans – including those of us with health insurance – can't afford to get the care we need. And tragically, so many of us who do seek care – with or without insurance – wind up deep in debt. As the Commonwealth Fund reports over the years have shown, that is a uniquely American tragedy.

As KFF News has reported, [more than 100 million Americans – 41% of adults –](#)

[are mired in medical debt](#), and the vast majority of those people have both jobs and health insurance. The problem is that their "coverage" is just not nearly sufficient because of the ever-increasing out-of-pocket demands big insurance conglomerates (and the employers that hire them to administer health care benefits) saddle us with to boost their profits. (We're the only country that allows for-profit insurance companies to run its health care system.)

As the Commonwealth Fund's report shows, we spend around twice as much for health care as the average of the other nine countries and almost twice as much as a percentage of GDP, yet we are the only one of the bunch that has not achieved universal coverage.

Despite the big gains in coverage we've made since the



enactment of the Affordable Care Act, more than 26 million of us remain uninsured. But just as unacceptable is the fact that far more than that –

one of every four working adults in this country – are *underinsured* because of the uniquely American high-deductible plans that our employers and insurers have forced us into. For many of us they are not just high, they are sky-high. Forbes magazine has called people in such plans [functionally uninsured](#).

The Commonwealth Fund's researchers [note](#) that unaffordable cost-sharing requirements – deductibles, copays and coinsurance obligations – "render many patients unable to visit a doctor when medical issues arise, causing them to skip medical tests, treatments, or follow-up visits, and avoid filling prescriptions or skip doses of

their medications." And when they do get the tests, treatments and medications they need, they all too often find themselves buried in debt.

It has become such a problem that the Biden-Harris administration has made alleviating medical debt a [priority](#). The White House is expected to lay out at least some of the steps the federal government can take to do that in the coming weeks.

One important thing the administration already has done is ask Congress to pass legislation that would cap out-of-pocket costs for prescription drugs at \$2,000 a year – and make sure that cap applies to all of us – not just Medicare beneficiaries. A \$2,000 cap for people enrolled in Medicare Part D (and the private replacement plans marketed as Medicare Advantage) will go into effect in January.

Researchers Argue that Government Data Fails to Capture Full Scope of Disability in the United States

Writing this week in [STAT](#), researchers from the Johns Hopkins Disability Health Research Center, Syracuse University, and the Institute for Health and Disability Policy Studies at the University of Kansas argue that the questions used by the US Census Bureau and other federal agencies are “missing millions” and severely undercounting both the number of people with disabilities and the types of disability experienced.

Currently, two question sets are frequently used to assess disability

in federal surveys—including Census Bureau surveys and in surveys used by the Centers for Disease Control and Prevention to monitor health and healthcare in the population. These question sets focus on asking respondents about their limitations on specific tasks and activities. For example, they ask if someone has difficulty seeing, even while wearing glasses.

The researchers argue that the question sets define disability only in terms of functional limitations,



causing the questions to miss large groups of disabled people, including “between **23% and 59%** of people with mental health or psychiatric disabilities, between 13% and 33% of people with intellectual and developmental disabilities, and between 32% and 53% of people with chronic health conditions, such as [long Covid](#).” They highlight the impact that these data limitations have had on their research – without accurate prevalence estimates, it is “challenging to understand and

address the barriers this population faces across all sectors of life, including education, employment, health and healthcare, housing, transportation and food access. Without improved measures of disability and the collection of this data as a core demographic, we can’t answer simple questions: How many teachers have disabilities? What percentage of public transit riders are disabled? What is the fall rate of patients with disabilities in nursing homes or hospitals?”...[Read More](#)

Raising the full retirement age to 69 would cut Social Security benefits — and it wouldn’t save the program

Raising Social Security’s **full retirement age** by two years to age 69 would decrease individuals’ lifetime benefits and overall spending by the program, but would not stave off Social Security’s expected insolvency in 2034.

Gradually raising the full retirement age to 69 years old, up from the current rule of 67 for those born in 1960 or later, would mean that individuals would get less money over their lifetime, the [Congressional Budget Office](#) said in a response to queries by Democratic Rep. Brendan Boyle released

Wednesday.

Under the “specified policy” calculated by the CBO, the earliest age at which a person can claim Social Security would remain 62, but the age at which a person could get the maximum Social Security payout would increase to 72, up from 70 currently.

The analysis comes as Social Security faces insolvency in less than a decade and countries such as China have raised their retirement age.

In a letter to Boyle, who represents Pennsylvania’s 2nd District and is the ranking



member of the House committee on the budget, the CBO said that for workers born in 1965, the full retirement age

would be 67 years and three months, and would increase by an additional three months per birth year until it reached age 69 for workers born in 1972 or later.

The CBO gave these examples of how the higher full retirement age would affect workers’ payouts. For workers born in 1972, claiming Social Security at the earliest possible age of 62 would reduce their benefits by 40%. Under the current law,

claiming early reduces benefits by 30%.

Meanwhile, for people born in the 1970s — the first 10-year birth cohort in which all beneficiaries would be affected by the increase in the full retirement age — the average retirement benefits for workers who claimed benefits at age 65 would be 13% less than under current law. The decline in benefits for those born in the 1980s would be similar to that for the 1970s cohort, the CBO said....[Read More](#)

Medicare Advantage Denials Increased Before the Implementation of New Prior Authorization Rules

[KFF](#) recently analyzed [Medicare Advantage \(MA\)](#) data [on prior authorization](#), finding that the rates of requests, or submissions from providers and beneficiaries asking the plan to cover a service, remained steady while plan denials increased compared to the previous two years. Rates of appeal remained low, signaling that most enrollees facing a denial had to change treatment plans or go without provider-recommended care.

KFF’s most recent MA data analysis shows that MA organizations received 46 million prior authorization requests in 2022. While this is an increase of 5 million from 2019, this increase reflects the rise in enrollment for MA plans and is not an increase in the frequency of prior authorization requests per enrollee. Plans received an average of 1.7 requests per enrollee for prior authorization in

2019 and 2022.

While the rate of requests remained steady, plans denied 7.4% of them on average in 2022. This is an increase from 5.7% in 2019 and 5.8% in 2021.

When plans deny a request for prior authorization, they must explain their decision in writing. However, in our experience, these denial notices can be confusing, missing vital information, or never received by the beneficiary at all. Many people do not understand their appeal rights or may not feel they have the time or capacity to appeal. If they do not appeal, they must either go without the item or service or pay out of pocket.

Unsurprisingly, KFF found that the appeals rate remains low, with under 10% of denied requests being appealed. This echoes [previous estimates](#) that enrollees often do not appeal MA



denials.

When enrollees do appeal, however, they are often successful. KFF found that appeals were successful over 80% of the time. This could mean that only people with very strong cases file appeals. But it could also mean that plans are inappropriately denying care, either inadvertently due to misunderstanding or misapplying the rules or deliberately to reduce costs—hoping that the administrative burden of an appeal or lack of information will dissuade people from pursuing coverage.

New rules went into effect in 2023 and earlier this year. [These rules](#) are intended to [clarify and improve prior authorization processes](#) within plans. Because some plans may inadvertently deny care, these clarifications may help the plans and their network providers better

understand the coverage rules. If appeals processes are clearer and simpler, this could reduce the number of requests or denials or increase the number of appeals.

Because the KFF analysis uses data from 2022, it creates an important baseline for comparison once data about prior authorizations and appeals under the new rules are available.

At Medicare Rights, we see prior authorization as one of our callers’ most significant barriers to care. In 2022, the same year as the KFF data, [29% of all calls to our helpline were about denials and appeals](#), with a majority coming from MA enrollees experiencing care access issues. We will continue to work with policymakers to curtail inappropriate denials of care and increase transparency and clarity in MA processes.

U.S. Suicide Death Rate Is Rising Again

U.S. suicide rates are ticking back upward again after a dip during the pandemic, new statistics show.

Suicide deaths per 100,000 people had fallen from 14.2 recorded in the pre-pandemic year of 2018 to 13.5 in 2020.

However, by 2022, the latest year for which statistics are available, the rate had climbed once more to 14.2 deaths per every 100,000 Americans, report researchers from the U.S. Centers for Disease Control and Prevention.

This continues a tragic, longstanding trend, they noted. "From 2002 to 2018, the total rate [of suicide deaths] increased 30%,

from 10.9 deaths per 100,000 standard population to 14.2," wrote report co-authors **Matthew Garnett** and **Sally Curtin**, of the CDC's National Center for Health Statistics (NCHS).

Looking at final 2022 data from the National Vital Statistics System, the researchers found some variations in suicide death by age, gender and method used.

Among males, rates decreased somewhat among boys and young men ages 10 through 24 between 2020 and 2022, but it rose among men over the age of 24.

However, rates for **suicide death among males** overall did rise, and "the suicide rate for



males was three to four times the rate for females across the period," Garnett and Curtin reported.

In 2022, the suicide death rate among males was 23 fatalities per 100,000 people, compared to 5.9 among females.

Nevertheless, the number of girls and women who died by suicide is still higher than in decades past -- from 4.2 in 2002, to a peak of 6.2 in 2018, to a rate of 5.7 per 100,000 people in 2022. Women in middle age seemed to be at highest risk.

Overdoses were the leading method of suicide for females between 2002 and 2015, but by 2022 firearms had become the

most common method used, the CDC data showed.

That trend was even more pronounced among boys and men: "The firearm-related suicide rate among males increased from 10.3 [per 100,000 people] in 2006 to 13.5 in 2022," the report's authors said.

The findings were published Sept. 26 as an **NCHS Data Brief**.

If you or a loved one is in mental health crisis, free, anonymous counseling is at hand 24/7 at the **988 Suicide & Crisis Lifeline**.

Medicare's unprecedented delay in premium announcements sparks concern

Medicare is a cornerstone of healthcare for Americans, providing essential insurance options for residents across the country. The program's structure includes various parts, from **Part A**, which covers basic hospital insurance, to **Part D**, which includes prescription drug coverage. Traditionally, the **Centers for Medicare & Medicaid Services (CMS)** have announced the projected

premiums for the following year, a practice that has been in place since 2006. However, this year marks a significant deviation from that norm.

For the first time in nearly two decades, CMS has not released the projected premiums for the upcoming year. This delay has caused a ripple of uncertainty among beneficiaries and insurers. The absence of this critical



information leaves many wondering about the future costs and coverage of their **Medicare** plans. The delay is particularly concerning given the upcoming changes to Medicare Part D, which will see a cap on prescription drug costs at \$2,000 annually starting next year.

In addition to the cap on prescription drug costs, there are expectations of increased

deductibles and copayments for insurers. This could lead to a reduction in coverage for certain medications, further complicating the landscape for Medicare beneficiaries. According to CMS, the basic premium for Medicare Part D in 2025 will be \$36.78, an increase of \$2.08 or a maximum of 6% from 2024....**Read More**

Is It Better to Collect Social Security at 62, 65, or 70? A Thorough Study Offers a Concise Answer.

For most Americans, Social Security represents more than a check. It's a financial foundation that many retirees would struggle to live without.

An analysis conducted by the Center on Budget and Policy Priorities found that **Social Security** lifted 22.7 million people above the federal poverty line in 2022, 16.5 million of whom were adults aged 65 and above. The simple fact that Social Security exists and provides a guaranteed monthly benefit to eligible retirees has reduced the poverty rate among seniors aged 65 and above from an estimated 38.7% without the program to 10.2% with it.

For most future retirees, maximizing what they'll receive from Social Security is imperative. But in order to do so, they'll first need to understand the nuts and bolts of how their monthly benefit is calculated, as well as **gain perspective on the**

importance of claiming age. Collecting benefits early (age 62), at a middle-ground age (65), or at the tail end of the traditional claiming age range (age 70), can have a myriad of advantages and drawbacks.

Four variables are used to calculate your monthly Social Security check

Although not every aspect of Social Security is straightforward -- e.g., you might be surprised to learn that a portion of your benefits can be taxed at the federal level, as well as in nine states -- the four variables the Social Security Administration (SSA) uses to calculate your monthly check are easy to understand:

- ◆ Earnings history
- ◆ Work history
- ◆ **Full retirement age**
- ◆ Claiming age



Neither of the first two variables can exist without the other. When determining how much you'll receive each month, the SSA accounts for your 35 highest-earning, inflation-adjusted years. Keep in mind this means wages and salary and excludes investment income

The quirk to this calculation is that the SSA will penalize beneficiaries who don't have 35 years of qualifying work history. For every year less than 35 worked, \$0 is averaged into your calculation. In other words, if you want to maximize what you'll receive from America's leading retirement program, working 35 years, if not longer, is a necessity.

The third factor of importance is your full retirement age, which is the **age you become eligible to receive 100% of your retired-worker benefit**. Since your full retirement age is determined by the year you're born, it represents

the only variable you have no control over.

he third factor of importance is your full retirement age, which is the **age you become eligible to receive 100% of your retired-worker benefit**. Since your full retirement age is determined by the year you're born, it represents the only variable you have no control over.

The fourth and final factor, and the one most responsible for variances in monthly and lifetime benefit collection, is your claiming age. Though retired-worker beneficiaries have the option of taking their payout as early as age 62, **there's a financial incentive to be patient**. For every year a worker waits to claim their Social Security benefit, beginning at age 62 and continuing through age 69, their monthly check can grow by as much as 8%. You can see how this dynamic plays out in the table below....**Read More**



New report finds alcohol is likely responsible for rise in cancer rates

Roni Caryn Rabin reports for [The New York Times](#) on the increase in rates of colorectal and breast cancer and a new report from the American Association for Cancer Research that finds a possible link between these cancers and alcohol consumption. Drinking alcohol increases your likelihood of getting cancer.

Cancer rates are falling. But, more people are getting certain types of cancer for reasons yet unknown. Of note, 40 percent of

cancer cases are linked to behaviors that can be changed.

The report urges people to drink less alcohol, stop smoking, eat a healthy diet, exercise, avoid ultraviolet radiation and stay away from pollutants. It recommends adding warning labels to alcohol products. Drinking alcohol affects the bacteria in your gut, which in turn can lead to cancer growing and spreading.



New data is showing that people who drink small amounts or in moderation do not reduce their risk of heart disease relative to people who drink occasionally. In fact moderate and light drinkers are more likely to die from cancer than occasional drinkers.

Put differently, it's a myth that drinking red wine will help your heart. Whatever benefits you get from drinking red wine are outweighed by your risk of

getting cancer.

More than one in 20 cancer (5.4 percent) diagnoses today are attributed to drinking alcohol. What types of cancer are you most likely to get from drinking alcohol? Esophageal squamous cell carcinoma as well as some types of head, neck, breast, colorectal, liver and stomach cancers.

Live longer, eat less protein?

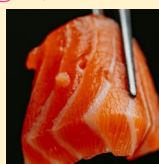
Protein is critical to our well-being. It's a macronutrient promoting growth, tissue repair and strength, among other good things. As we get older, protein is all the more important. Emily Laurence reports for [The Huffington Post](#) that we should not reduce our consumption of food high in protein because it helps maintain muscle, but we also should not eat too much animal-based protein.

Howard LeWine MD at [Harvard Health](#) explains that too much protein can cause kidney stones. Also, protein from red meat can cause heart disease and colon cancer. We should discriminate among the protein-

rich foods we eat.

Some foods rich in proteins are better for you than others. There are animal-based proteins and plant-based proteins. Too much red meat can keep you from living a long healthy life. You are better off eating vegetables, beans and fish rich in protein. Yogurt also provides good protein.

If you eat too much protein from meat, it could actually speed up the aging process and hurt the health of your cells. Animal proteins contain a lot of advanced glycation end products (AGEs) and trimethylamine-N-oxide (TMAO). AGEs can be bad



for your health in combination with sugar in your bloodstream. They can build up in tissue and cause inflammation, which leads to cellular aging.

They can cause diabetes and heart disease.

TMAO fosters a buildup of cholesterol in your arteries. It hurts your heart and, like AGEs, causes inflammation.

Foods with healthy proteins: Beans, soy, nuts, chickpeas, seeds and lentils. They have lots of antioxidants. They promote heart health and lower inflammation. Americans should also eat a lot more fish.

One recent study found that

eating a lot of fish lowers your odds of dying prematurely. Fish rich in protein has been found to promote brain health, fight inflammation, and foster a hormone balance.

Keep in mind that, on average, depending upon your weight, you need around 50 grams a day of protein. Protein should represent about 10 percent of your caloric intake each day.

The takeaway: Stick to a balanced diet with a variety of healthy foods, including vegetables, fruits, fish and fiber; and, avoid red meat. Check out the [Mediterranean diet](#) or the [DASH diet](#).

Falling Linked to Raised Risk of Dementia in Older People

More than 14 million seniors a year take a tumble, and those falls can be life-changing.

"The relationship between falls and dementia appears to be a two-way street," said [Molly Jarman](#), senior author of a new study showing that cognitive decline may increase an older person's risk for a fall and the trauma that follows a fall may also speed up progress of dementia.

The study by Jarman, deputy director of the Center for Surgery and Public Health at Brigham and Women's Hospital in Boston, and her colleagues notes that falls are among the most common reason for trauma center admissions and the No. 1 cause of injury in older adults.

"Thus, falls may be able to act as precursor events that can help us identify people who need further cognitive screening," Jarman said in a hospital news release.

Her team looked at Medicare claims data for more than 2.4 million seniors who suffered a traumatic injury and how they were doing a year later.

Half of the patients were injured in a fall. Of those, 10.6% were later diagnosed with dementia, the study found. Falls increased the risk of a future dementia diagnosis by 21%.

As such, the researchers recommend that older adults who go to the hospital for care after a fall undergo cognitive screening



either in the ER or in the hospital. Such screening could enable seniors who need treatment for mental declines to get it sooner, they said.

Nationwide, 1 in 4 older adults report a fall each year, leading to more than \$50 billion in health care costs, according to the U.S. Centers for Disease Control and Prevention.

Study's first author [Dr. Alexander Ordoobadi](#), a surgical resident at Brigham and Women's, often sees patients who are admitted after a fall.

"We treat the injuries, provide rehabilitation, but often overlook the underlying risk factors that contribute to falls, despite a growing body of evidence

suggesting a link between falls and cognitive decline," he said.

Ideally, he said, older adults who fall should receive follow-up with a primary care doctor or geriatrician, a specialist in elder care, who can monitor their thinking skills and long-term recovery. But many seniors don't have a primary care doctor and lack access to a geriatrician, he pointed.

"Our study highlights the opportunity to intervene early and the need for more clinicians who can provide comprehensive care for older adults," Ordoobadi said.

The findings were published Sept. 30 in the journal [JAMA Network Open](#).

Gum Disease Germs Could Help Trigger Cancer

Bacteria that causes gum disease can also raise a person's risk of head and neck cancers, a new study says.

More than a dozen bacterial species have been linked to a collective 50% increased risk of head and neck cancer, researchers found.

"Our results offer yet another reason to keep up **good oral hygiene habits**," said co-senior author **Dr. Richard Hayes**, a professor of population health at NYU School of Medicine in New York City. "Brushing your teeth and flossing may not only help prevent periodontal disease, but also may protect against head and neck cancer."

Some of these microbes have been shown to contribute to serious gum infections that can eat away at the jawbone and the soft tissues that surround teeth, researchers noted.

For the study, researchers analyzed data from three ongoing research projects tracking nearly 160,000 Americans from across the country, all looking into potential risk factors for cancer.

As part of the research, participants all provided saliva samples that showed the number and types of bacteria living in their mouths.

In this study, researchers tracked the people for 10 to 15



years, to record the development of any cancers. During that time, 236 patients were diagnosed with head and neck cancer.

The research team compared the mouth microbes of head and neck cancer patients to those of another 458 people who hadn't developed cancer.

Overall, 13 bacterial species were shown to either raise or lower risk of head and neck cancer, creating a combined overall increased risk of 30%, results show.

When combined with five other bacterial species often seen in gum disease, the overall risk

increased by 50%, the researchers added.

The new study was published Sept. 26 in the journal **JAMA Oncology**.

"Our findings offer new insight into the relationship between the oral microbiome and head and neck cancers," said lead researcher **Soyoung Kwak**, a postdoctoral fellow with the NYU School of Medicine's Department of Population Health. "These bacteria may serve as biomarkers for experts to flag those at high risk."

The study found no increased risk of cancer from naturally occurring fungi in the mouth, researchers noted.

Synthetic THC May Calm Agitation in Alzheimer's Patients

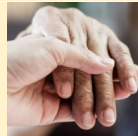
A synthetic form of the active ingredient in cannabis helps reduce agitation in people with **Alzheimer's**, new research shows.

Synthetic THC (dronabinol) also gave patients' caregivers a boost, according to findings presented Thursday at a meeting of the International Psychogeriatrics Association in Buenos Aires.

The findings may provide

encouragement for the families of the 7 million Americans who have Alzheimer's or another form of dementia. Nine out of 10 develop behavior problems, and agitation is the most common, affecting 4 in 10.

Agitated patients with Alzheimer's often pace, wander, yell, scream and get verbally abusive. Their behavior may also leave their caregivers burned out



and depressed. "It is the agitation, not the memory loss, that often drives individuals with dementia to the emergency

department and long-term care facilities," said study co-author **Dr. Brent Forester**, director of behavioral health for Tufts Medicine in Boston.

"Dronabinol has the potential to both reduce health care costs and make an important, positive

impact on caregivers' mental and physical health."

The new study included 75 outpatients with Alzheimer's dementia. For three weeks, they took either 5 milligrams (mg) of dronabinol twice a day or a dummy pill.

Symptoms of agitation were significantly improved in the patients who took dronabinol, and researchers said the drug was well-tolerated....**Read More**

Blood Cancers: What You Need to Know

Blood cancer is not a diagnosis anyone wants to receive, but understanding the different types of this disease and how best to catch them early is essential, one expert says.

First, blood cancers are far more common than you might think: One person in the United States is diagnosed with a **blood cancer**, including leukemia, lymphoma or myeloma, every three minutes.

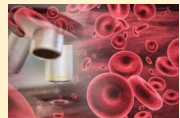
"Highlighting blood cancer is crucial, as awareness and education are our best tools in combating these diseases and supporting patients in their recovery journey," said **Dr. Claire Yun Kyoung Ryu Tiger**, a medical oncologist in the Leukemia/Lymphoma/Hematologic Malignancies Program at Rutgers Cancer Institute. "Knowing the distinctions of each type of blood cancer is vital for accurate diagnosis and effective

treatment."

So, what are three main types of blood cancers? Here's a list:

◆ **Leukemias** are cancers of the white blood cells in the bone marrow and blood and, rarely, the lymphatic system. The abnormal production of white blood cells can interfere with the body's ability to fight infections. There are several types of leukemia, including acute lymphoblastic leukemia (ALL), acute myeloid leukemia (AML), chronic lymphocytic leukemia (CLL) and chronic myeloid leukemia (CML).

◆ **Lymphomas** are cancers of immune cells called lymphocytes. The two main types of lymphoma are Hodgkin lymphoma and non-Hodgkin lymphoma. These cancers can be slow-growing or fast-



growing, and can be found in various parts of the body, including the lymph nodes, spleen and bone marrow.

◆ **Myeloma**, also known as multiple myeloma, is a cancer of the plasma cells, immune cells that are found in the bone marrow. When myeloma cells multiply, this can lead to bone damage, anemia, kidney problems, high blood calcium levels and a weakened immune system.

So, what are the symptoms to watch for with blood cancers?

While there are no routine screening tests for leukemia or lymphoma, knowing the warning signs can help doctors diagnose and treat these cancers successfully, Tiger said. Common symptoms include:

- ◆ Fever
- ◆ Drenching night sweats
- ◆ Persistent fatigue

- ◆ Weakness
- ◆ Bone/joint pain
- ◆ Unexplained weight loss
- ◆ Swollen lymph nodes, liver or spleen

Anemia
"Many patients with blood cancers initially experience vague symptoms that can be attributed to less serious conditions. It's crucial to pay attention to persistent or unusual changes in your health and seek medical advice promptly," Tiger said in a Rutgers news release.

"Advances in blood cancer treatment have given us more effective ways to treat these diseases," Tiger added. "With ongoing research and new therapies, patients have more options with more effective and less toxic treatments. We're in a new era of treatment for many types of blood cancer, and have never been more hopeful."

Treatment Could Be New Option for People Battling Ulcerative Colitis

An experimental monoclonal antibody treatment appears to ease the digestive disorder ulcerative colitis in patients who've failed other medications, a new trial shows.

The treatment, **tulisokibart**, spurred remission of symptoms in more than a quarter of patients, compared to only 1.5% of those taking a placebo, an international group of researchers reported Sept. 26 in the *New England Journal of Medicine*.

Ulcerative colitis affects over 900,000 Americans and is a form of inflammatory bowel disease (IBD). The exact causes of the illness remain unknown, but ulcerative colitis can be disabling, causing stomach cramps, diarrhea, weight loss and rectal bleeding.

The new trial was funded by Prometheus Biosciences, which is developing **tulisokibart**.

Researchers are hoping the drug might offer patients a valuable new treatment option.

"Findings from this study are poised to have a remarkable impact on treatment for ulcerative colitis and IBD overall," said study senior author **Dr. Stephan Targan**. He's a professor of medicine at Cedars-Sinai in Los Angeles and director of Cedar Sinai's Inflammatory Bowel Disease (IBD) Center.

As the researchers explained, a protein called **TL1A** appears to exacerbate ulcerative colitis, and **tulisokibart** is thought to work by mimicking the effect of natural antibodies that target **TL1A**.

The monoclonal antibody thereby reduces inflammation and fibrosis (a stiffening of tissues) that lies behind many ulcerative colitis symptoms.



"Managing ulcerative colitis often requires a personalized approach and ongoing adjustments based on the patient's

response to therapy, especially for patients with more severe cases," noted lead investigator **Dr. Bruce Sands**, a professor of medicine at the Icahn School of Medicine at Mount Sinai in New York City.

"**Tulisokibart** offers a new potential treatment option and addresses a critical gap in treatments for ulcerative colitis," he said in a Mount Sinai news release.

The 12-week trial involved two cohorts, all people with ulcerative colitis who'd been taking steroids long-term or had failed other conventional and/or advanced therapies.

In the first cohort, 135 patients were randomly selected to either

intravenous **tulisokibart** (1,000 milligrams (mg) on day 1 and 500 mg at weeks 2, 6, and 10) or a "dummy" placebo.

More than a quarter (26.5%) of folks who got the new therapy went into remission by week 12, the researchers reported, compared to just 1.5% of those on placebo.

In a second cohort, **Sands** and colleagues first had 43 patients undergo a specially designed diagnostic test to assess their suitability for **tulisokibart**. Another 32 patients had been selected using the test in the first group of patients, as well.

Among the 75 patients who got the new "Dx-positive" diagnostic assessment, 31.6% achieved remission of their disease by week 12, compared with 10.8% of those who got the placebo....[Read More](#)

Your Pillow Is Destroying Your Neck. Here's the Solution

Sleep THIS way to leave one crucial muscle tight and fatigued — it won't relax even during deep sleep

This is crazy that 83% of people don't know this.

If you have a regular pillow... It's ruining your health every night.

It doesn't follow the natural bend of your neck, so it doesn't stay properly aligned.

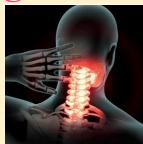
As a result, the trapezius muscle, which goes along your

neck and shoulders, stays active instead of relaxing during sleep.

That's why some people keep suffering from neck pain, headaches, and inability to have a good night's sleep. No matter how much money they spend on specialist visits!

Over time, if the muscle is continuously strained during the night...

this can lead to chronic stiffness and soreness, not just



in the neck...

but in the surrounding areas, such as the shoulders and upper back too.

This constant tightness can trouble the blood flow to the muscles, making them more tired and sore.

Without the right support, this never-ending stress on the neck muscle all night makes you feel pain during the daytime.¹

The worst part... Sleeping

THIS way also drastically increases your chances of developing a migraine.

That gives you headaches during the day that sometimes lead to dizziness, blurred vision, or even vomiting.

A poor sleeping position puts stress on the trapezius muscle, causing persistent tension.

This tightness blocks blood flow and nerve signals in that area, leading to headaches with a dull ache....[Read More](#)

Shorter Course of Breast Cancer Radiation Won't Affect Breast Reconstruction

A shorter course of post-mastectomy radiation doesn't jeopardize a patient's chances of successful breast reconstruction, a new study finds.

About 40 percent of people with **breast cancer** have mastectomies, followed by five to six weeks of radiation therapy to kill any cancer cells that may remain in the chest wall or lymph nodes. Most opt for breast reconstruction.

"Over the past 10 years, we've tried to move all patients who need breast radiation to a shorter, more convenient schedule," said lead researcher **Dr. Matthew Poppe**, a professor of radiation oncology at the University of Utah. "But patients after

mastectomy who were planning breast reconstruction were the one group where we didn't have sufficient data to support shorter courses."

The large Phase 3 trial shows that treatment time can be reduced to three weeks without compromising patients' reconstruction surgery, he said.

The findings were to be presented Sunday at the American Society for Radiation Oncology annual meeting in Washington, D.C.

Researchers described the study as the first international effort to show that a shorter course of post-mastectomy radiation is safe and effective.



They said cutting treatment time nearly in half -- from 25 to 16 sessions -- could make post-mastectomy radiation a more accessible option for patients.

Other research has shown that a shorter course of treatment is not only as effective in preventing cancer's return, it also improves a patient's quality of life. But those studies typically excluded patients seeking breast reconstruction, due to concerns that higher daily doses of radiation might affect the reconstructive process and increase side effects.

The new study investigated whether that would be the case. It included 898 patients at 209

cancer centers in the United States and Canada. Some had smaller tumors, some larger with spread to nearby lymph nodes. Their median age: 46, meaning half were younger, half older.

Half had five weeks of conventional radiation, half had a higher dose over three weeks. In all, 51% received chemotherapy before their mastectomies and 37%, afterward.

The 650 patients who had breast reconstruction during the study period were followed for a median of five years. Researchers documented complications such as problems with wound healing, reconstruction failure or formation of scar tissue affecting the new breast....[Read More](#)