Federal Judge Finds Florida Voting Law Unconstitutional in Case Brought by the Florida Alliance and Others

A federal judge struck down Florida’s restrictive voting law, S.B. 90, on Thursday, finding the bill that passed in 2021 to be racially discriminatory.

“Older Floridians take voting seriously and we are grateful that the Court today struck down S.B. 90,” said Bill Sauer, President of the Florida Alliance. “The Court agreed that this law not only made it more difficult for millions of Florida citizens to exercise their constitutional right to vote but that it was intended to prevent millions of Floridians’ voices from being heard at the polls.”

The Florida Alliance filed a lawsuit on the day the bill was signed into law specifically challenging provisions that would make it harder for older and minority Floridians to vote, including:

◆ Imposing restrictions on drop boxes voters use to return mail ballots;
◆ Effectively banning organizations and volunteers from helping voters return their mail ballots;
◆ Requiring voters to request mail ballots more frequently; and
◆ Banning any non-poll worker from giving food or drink, including water, to voters waiting in line to vote. “The Alliance is fighting to make sure every one of our 4.4 million members nationwide, and all older Americans, can exercise their fundamental constitutional right to vote,” said Richard Fiesta, Executive Director of the Alliance. “Today’s decision shows that voter suppression will not go unchecked.”

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Alliance Praises House Passage of Legislation to Reduce the Price of Insulin

The United States House of Representatives passed the Affordable Insulin Now Act, H.R. 232-193 yesterday, capping the cost of insulin at $35 per month for all Medicare beneficiaries and many other Americans of all ages who need the drug to manage their diabetes.

“We applaud the House of Representatives for passing this important legislation, which will provide real relief for millions of patients whose health depends on insulin, if the Senate acts,” said Robert Roach, Jr., President of the Alliance.

“Americans pay the highest prices in the world for prescription drugs, and this is especially true with insulin. Insulin costs seven times more here than it does in other countries,” he continued. According to the American Diabetes Association, nearly 1 in 3 people over the age of 65 have Type 1 or Type 2 diabetes.

“Retirees welcome all proposals that bring relief to people facing skyrocketing prescription drug costs but capping insulin prices is not enough,” added Executive Director Fiesta. “We still need to allow Medicare to require drug corporations to negotiate lower prices and provide relief to seniors at the pharmacy counter. The 4.4 million members of the Alliance urge the members of the United States Senate to follow suit and pass similar legislation.”

Proposals to lower what people pay out-of-pocket for drugs tops the public’s list of health care priorities for Congress, a new KFF Health Tracking Poll finds. A majority of the public (61%) say limiting how much drug companies can increase the price of prescription drugs each year to not surpass the rate of inflation should be a “top priority” for Congress.

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President Biden’s 2023 Budget Offers Benefits, Protections for Older Americans

President Joe Biden unveiled his proposed budget for the 2023 fiscal year this week, calling for $5.8 trillion dollars in spending on a number of federal programs. Along with funding for national defense and action to combat climate change, the budget proposal also bolsters several programs that directly support older Americans.

The Social Security Administration (SSA) would receive a 14% increase in spending from 2021 under the proposal, to a total of $14.8 billion overall. Much of that spending would go to improve services by increasing staffing levels for SSA field offices. The agency administers retirement, disability and survivor benefits to nearly 70 million Americans, but had to cease in-person operations at the height of the pandemic.

The President’s budget also requests a 9.6% increase in spending for the National Institutes of Health (NIH), which is responsible for conducting biomedical and public health research. Much of that increase is slated for the NIH’s Advanced Research Projects Agency for Health, which executes high-risk, cutting edge research.

The country’s election infrastructure was tagged for a massive boost in spending as well. The President requested $10 billion to support state and local election officials, expand the Postal Service’s ability to administer vote-by-mail and protect marginalized communities from voter suppression. New restrictive voting legislation has already hampered older Americans’ ability to vote. In Texas, older Black voters have seen their mail-in ballots rejected at an alarming rate.

“We’re pleased to see that the President’s budget takes the needs of older Americans into account,” said President Roach. “Now it’s up to Congress to make these changes a reality.”
WEP/GPO REPEAL TASK FORCE
RALLY & DAY OF ACTION IN WASHINGTON, DC

May 18, 2022. 8 AM - 5 PM.
Rally from 11:30 AM - 1 PM

A zoom meeting for registered participants will be held prior to our meeting in D.C. We will send talking points, detailed schedule when we receive your registration.

APPOINTMENTS WITH LEGISLATORS: The focus of this event is a rally on May 18, 2022. Meeting with your elected legislators and/or other targeted legislators to tell your story and those of your friends, colleagues and family is another action we'd appreciate. Please make your appointments prior to coming to D.C.

Instructions for making appointments with legislators will be sent to registrants.

COVID SAFETY INSTRUCTIONS
Individuals are asked to be "up-to-date" on their COVID-19 vaccinations (which means fully vaccinated and having received any boosters for which they are eligible).

It is suggested that you take a Covid at-home swab test prior to traveling, and again once you are in your hotel room.

MASKS WILL BE REQUIRED during in-door meetings and when meeting with legislators.

REGISTRANTS WILL BE RESPONSIBLE for travel, housing, meals on their own.

For more information and register by May 9th, CLICK HERE
Bill to Lower Insulin Cost Passes House

Last week the U.S. House of Representatives passed a bill that would cap the monthly cost of insulin at $35 for insured patients. Experts say the legislation would provide significant relief for privately insured patients with skimpier plans and for Medicare enrollees facing rising out-of-pocket costs for their insulin. Some could save hundreds of dollars annually, and all insured patients would get the benefit of predictable monthly costs for insulin. The bill would not help the uninsured. The bill now moves to the Senate but its fate there is very uncertain. For the legislation to pass, 10 Republican senators would have to vote in favor. Democrats acknowledge they do not have an answer for how that is going to happen. The idea of a $35 monthly cost cap for insulin has a bipartisan pedigree. The Trump administration had created a voluntary option for Medicare enrollees to get insulin for $35, and the Biden administration continued it. The good news is that Senators Susan Collins, Republican of Maine, and Democrat Jeanne Shaheen of New Hampshire are working on a bipartisan insulin bill. In addition, Georgia Democratic Sen. Raphael Warnock has introduced legislation similar to the House bill, with the support of Sen. Majority Leader Chuck Schumer of New York. However, some Republicans complain that the insulin bill is only a small piece of a larger package around government price controls for prescription drugs and that the bill would raise premiums and fail to target pharmaceutical middlemen seen as contributing to high list prices for insulin. About 37 million Americans have diabetes, and an estimated 6 million to 7 million use insulin to keep their blood sugars under control. It is an old drug, refined and improved over the years, which has seen relentless price increases. TSCL supports any legislation that lowers Insulin prices, and we urge you to contact your Senators, especially if they are Republicans, and urge them to support legislation to lower insulin prices. ♦ ♦ ♦

New Covid information Site Announced

Last week the Biden Administration launched a new covid information website that is meant to be a one-stop shop for everything from free high-quality masks to antiviral pills. The website, COVID.gov, follows through on a promise President Biden made in his State of the Union address. In that speech he announced a test-to-treat program "so people can get tested at a pharmacy, and if they're positive, receive antiviral pills on the spot at no cost." The antiviral pills he referred to are highly effective at preventing hospitalization and death among people who are at high risk of severe disease from COVID infection. But they have to be taken within the first five days of the onset of symptoms. Up to now, there has been a disconnect between people getting diagnosed and actually getting these life-saving medications. The site also offers:

- A vaccine/booster locator
- A form to order free at-home COVID tests (currently 8 maximum per household)
- A CDC community risk level lookup
- A testing locator
- Information about where to get free high-quality masks
- Information on COVID symptoms, treatment, testing and travel

Much of the information offered has been available in various other places but this site brings them all together in one place. Having the information and supplies now is less about concerns today than about what happens six months from now if there is another COVID surge, like is happening now in Asia and Western Europe. The COVID.gov website was designed to be as accessible and easy to use as possible. It is available in English, Spanish and a simplified Chinese, and the writing is purposely simple so the largest possible audience can understand and use the site. There is also a phone number for people who are not comfortable with the web. If you would like to see the website but do not use or have access to a computer or the internet, we encourage you to ask a family member or friend if they can help you. Also, public libraries usually have computers available for public use and you can ask a librarian for help in accessing the site.

Why Nurses Are Raging and Quitting After the RaDonda Vaught Verdict

Emma Moore felt cornered. At a community health clinic in Portland, Oregon, the 29-year-old nurse practitioner said she felt overwhelmed and undertrained. Coronavirus patients flooded the clinic for two years, and Moore struggled to keep up. Then the stakes became clear. On March 25, about 2,400 miles away in a Tennessee courtroom, former nurse RaDonda Vaught was convicted of two felonies and facing eight years in prison for a fatal medication mistake.

Like many nurses, Moore wondered if that could be her. She’d made medication errors before, although none so grievous. But what about the next one? In the pressure cooker of pandemic-era health care, another mistake felt inevitable.

Four days after Vaught’s verdict, Moore quit. She said Vaught’s verdict contributed to her decision.

“It’s not worth the possibility or the likelihood that this will happen,” Moore said, “if I’m in a situation where I’m set up to fail.”

In the wake of Vaught’s trial — an extremely rare case of a health care worker being criminally prosecuted for a medical error — nurses and nursing organizations have condemned the verdict through tens of thousands of social media posts, shares, comments, and videos. They warn that the fallout will ripple through their profession, demoralizing and depleting the ranks of nurses already stretched thin by the pandemic. Ultimately, they say, it will worsen health care for all.

Statements from the American Nurses Association, the American Association of Critical-Care Nurses, and the National Medical Association each said Vaught’s conviction set a “dangerous precedent.”

Linda Aiken, a nursing and sociology professor at the University of Pennsylvania, said that although Vaught’s case is an “outlier,” it will make nurses less forthcoming about mistakes. “One thing that everybody agrees on is it’s going to have a dampening effect on the reporting of errors or near misses, which then has a detrimental effect on safety,” Aiken said. “The only way you can really learn about errors in these complicated systems is to have people say, ‘Oh, I almost gave the wrong drug because . . .’”

“‘Well, nobody is going to say that now.’”

Fear and outrage about Vaught’s case have swirled among nurses on Facebook, Twitter, and Reddit. On TikTok, a video platform increasingly popular among medical professionals, videos with the “#RaDondaVaught” hashtag totaled more than 47 million views.

Vaught’s supporters catapulted a plea for her clemency to the top of Change.org, a petition website. And thousands also joined a Facebook group planning to gather in protest outside Vaught’s sentencing hearing in May. . . .

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Merrill Goozner writes for Goozner about the disadvantage of Medicare Advantage, which is administered through corporate insurers. MedPAC, the agency that oversees Medicare, has warned that, if the government continues to overpay Medicare Advantage plans, Medicare’s financing is in serious jeopardy. MedPAC wants the Medicare Advantage payment system overhauled so health plans can’t simply take the government’s money and run.

Enrollment in Medicare Advantage is growing. People with lower incomes are more likely to enroll in Medicare Advantage to avoid having to buy Medicare supplemental insurance. Unlike traditional Medicare, Medicare Advantage has an annual out-of-pocket cap, albeit one that forces people to pay as much as $7,550 for their care.

And, though people who join Medicare Advantage are giving up choice of doctors, coverage anywhere in the country, and the freedom to access care without referrals and prior authorizations, they often get partial coverage for dental or hearing care and an out-of-pocket cap; the government pays Medicare Advantage plans about four percent more per person than it spends on traditional Medicare.

Medicare Advantage companies bid to offer their plans at about 15 percent less per person than traditional Medicare. They can afford to and still make a big profit since they tend to spend around 25 percent less on medical care than traditional Medicare by restricting access. Moreover, the government pays Medicare Advantage plans a higher rate if they can show more diagnoses for their enrollees—upcoding—even if the Medicare Advantage plans don’t provide enrollees with additional services. In 2020, these overpayments cost between $12 billion and $20 billion.

The government pays Medicare Advantage plans even more money in the form of “quality bonuses,” stemming from self-reported data. MedPAC says this data is of such low quality that it is of no good value.

The government is hard-pressed to collect back overpayments to Medicare Advantage. It must go to court to do so at substantial expense.

Notwithstanding, 346 members of Congress, including progressives such as Ilhan Omar and Barbara Lee, seem to be ok with these overpayments, recently sending CMS a letter praising Medicare Advantage.

Medicare Advantage is incredibly profitable because of the high fixed capitated payments per member they receive regardless of whether they cover any care for the member. Private equity and venture-backed physician practices have entered that market, as well as the new direct contracting market in traditional Medicare, which also pays companies to cover people’s care on a capitated basis.... Read More

Gretchen Morgenson reports for NBC News.com on a medical director fired after exposing the risks of emergency treatment at his hospital in Kansas City. Inadequate staffing jeopardized patient safety. But, his private-equity employers, Kolberg Kravis (KKR) and, before that, Clayton, Dubilier & Rice, like other for-profit owners of medical groups, were focused on maximizing profits.

Ray Brevont, the medical director and independent contractor, complained about the fact that, at times, understaffing in the emergency department meant no physician was present when a patient’s life was at risk. Brevont was let go. How often does this happen? For sure, many other doctors in Brevont’s position fear speaking out against their employers and putting their jobs at risk.

Today, four in ten emergency departments are controlled by for-profit entities, which are responsible for the staffing. KKR, which owns Envision Healthcare, and Blackstone, another private equity group, which owns TeamHealth, are two big companies in this space.

Private equity firms are generally in the business of buying up companies, finding ways to increase their profits, often through cutting costs, and selling them off a few years later at a profit. Because emergency departments are big profit centers, private equity firms are buying up control of these departments and have been charged with interfering in the practice of medicine to the detriment of patients.

Private equity firms implement policies in hospital emergency departments that are often unavailable for public scrutiny. But, Brevont claimed that KKR’s “code blue” policy put patients’ lives in danger. Emergency room physicians were expected to care for patients outside the hospital’s emergency department. The consequence: No emergency room physician in the emergency department.... Read More

**Medicare Sequestration 2022: Does sequestration impact Medicare Advantage?**

When it comes to Medicare sequestration, it can all be a bit confusing, so it's worth taking the time to inform yourself to make sure you're doing the right thing and you know how it affects you.

Sequestration is the automatic reduction or cancellation of certain federal spending, generally by a uniform percentage. The sequester is a budget enforcement tool that was established by Congress in the Balanced Budget and Emergency Deficit Control Act of 1985.

You may be wondering what Medicare sequestration is, so let's go over the basics quickly.

**What is Medicare sequestration?**

- Medicare sequestration reduces government spending to meet budgetary goals.
- Sequestration means Medicare pays its providers two-percent less.
- Medicare beneficiaries are not responsible for the cost difference.

- It is designed to prevent increased debt, but does place a burden on providers.

- A sequestration is a reduction in federal spending by a set percentage. In the case of Medicare, it's two-percent and it is the service providers who receive a smaller payment.

**As a Medicare beneficiary, am I affected by sequestration?**

A key tenet of this policy is that beneficiaries of Medicare service do not bear the burden for the added cost to the provider. Although, sequestration is implemented in different ways in different areas, the benefit structure generally remains the same and beneficiaries shouldn't notice many changes. It is the providers who will notice the change in payments.

As a beneficiary, you should not be charged any extra as a result of sequestration. What you pay for your coverage will remain the same.
Want the Max $4,194 Social Security Benefit? Here's the Salary You Need

Each year, there's a maximum Social Security benefit. In 2022, the largest monthly check a retiree could receive from the Social Security Administration is $4,194. This is a substantial sum, especially considering the average senior on Social Security has a monthly benefit of $1,657.

While a Social Security check that gives you $50,328 per year to live on may sound really nice, it's probably not going to happen for you. That's because there's a certain minimum salary you'd have to earn to end up with so much retirement money -- and it's well above the amount most people make each year.

The salary needed to max out Social Security benefits is shockingly high

To be on pace to earn a $4,194 Social Security benefit, your earnings in 2022 would need to be at least $147,000. Considering the fact that the Bureau of Labor Statistics data shows average weekly earnings were $1,095.83 as of February 2022, the typical worker will be about $90,000 short.

Even those lucky enough to earn $147,000 or more this year will also need to have high earnings for many additional years as well. In fact, it's necessary to have at least a 35-year history of being among the country's highest earners in order to be on track to max out your monthly Social Security payments.

Why is the salary necessary to earn a $4,194 Social Security benefit so high?

To understand why you'd need to earn $147,000 or more in order to max out Social Security, it's helpful to have some background in how your retirement benefits are determined. Social Security benefits are calculated based on a formula that gives you retirement income equaling a percentage of the average wage you earned over 35 years (with each year's wages adjusted for inflation).

Specifically, the benefits formula is targeted to give workers a check equaling about 40% of pre-retirement earnings. This money is supposed to be one of several sources of support, along with savings and employer-provided pensions. Based on how the benefits formula works, someone who earned the inflation-adjusted equivalent of $1 million per year would theoretically receive around $400,000 in annual benefits. But lawmakers who created Social Security decided they wanted to cap the amount someone could get so the wealthiest Americans didn't receive huge monthly payments. As a result, they set a "wage base limit." Every dollar up to the wage base limit is subject to Social Security tax, and is counted when determining the average wages benefits are based on. The wage base limit is adjusted according to inflation each year. As you can see, though, it's pretty high, at $147,000 in 2022.

For someone to get the max benefit, they'd need to earn at least that limit each year for 35 years -- so you'd need to earn the inflation-adjusted equivalent of $147,000 for more than three decades to be on track for the highest possible Social Security check.

If you'll fall far short, don't feel bad -- only around 6% of workers each year have an income equal to or exceeding this limit, so very few Americans get a $4,194 monthly check. Just be aware that your own payment is likely to be much lower, and plan to have savings to supplement it since you can't comfortably live on 40% of pre-retirement earnings alone.

What is the average Social Security check at age 65?

The retirement age when Americans can claim the full benefits earned over their years of laboring from the Social Security Administration is gradually getting higher. Currently, those who were born in 1960 and after will need to wait until they are 67 years old, and one month, to reach the full retirement age.

Beneficiaries can start earlier, but at the cost of reduced monthly payments in their golden years. Likewise, retirees can wait longer to start claiming benefits to receive even higher monthly entitlement. Retiring before full retirement age reduces benefits.

For many years until 1983, the full retirement age, also known as the "normal retirement age," was 65. However, as the US population’s health and life expectancy increased, as well as high inflation raising benefits, the viability of the Social Security Trust Funds was put at risk. To correct this, Congress passed a law to gradually raise when a beneficiary could claim their full benefit. Nowadays, collecting benefits starting at age 62 could see your monthly payments permanently cut by almost a third for those born in or after 1960. The full retirement age is gradually rising from 66 for those born in 1954 and before to 67 for those born in 1960 and later. Technically, you need to tack on another month to the full retirement age being that you need to be the set age throughout the first month of retirement.

Average Social Security retirement benefits in 2022

The amount that you can receive when you retire is determined by a few main factors. The Social Security Administration looks at your 35 highest-income years and calculates the average. Then that number is plugged into a formula, taking into consideration at what age you retire, that will determine your primary insurance amount (PIA). You can use the Social Security Administration's calculator to see what your benefits could be.

The maximum monthly payment amount in 2022 for those that have reached full retirement age when they file rose to $3,345, up $197 from the year before. Social Security payments are indexed to take into account inflation so that it doesn’t erode the purchasing power of monthly benefits. High inflation in the wake of the covid-19 crisis saw the largest cost-of-living adjustment in years, at 5.9 percent, for 2022...Read More

6 Types of Rooms in Assisted Living Communities

There’s a room or apartment for every budget and need in the world of assisted living.

Independent but supported living

As we age and our health concerns increase, we often need some help with formerly easy tasks like shopping or bathing. Many families turn to assisted living facilities to support and care for older relatives.

"An assisted living community is housing for seniors that provides long-term senior care, including daily support around personal care services like meals, medication management, bathing, dressing and transportation,” says Sue Johansen, executive vice president of the community network A Place for Mom, a senior referral service based in Seattle. These communities also offer a wide range of activities to help seniors live vibrant and enjoyable lives.

If you or a loved one is looking to move into an assisted living community, there are a lot of factors to consider in choosing the right one. Among these decisions is the type of room you’ll move into.

Here are six of the most common types of rooms in assisted living.

Rhode Island Alliance for Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381
rirajap@hotmail.com • http://www.facebook.com/groups/354516807278/
Despite Doctors’ Concerns, Pharmacists Get More Leeway to Offer Treatment With Testing

When Reyna or Justin Ansley or one of their three kids feels sick and needs to be tested for strep throat or flu, there’s a good chance they’ll head to their local pharmacy in Hemingford or Alliance, Nebraska. Dave Randolph, the proprietor of both locations of Dave’s Pharmacy, can do a rapid test, give them medicine if they need it, and send them on their way.

“I’m a cattle rancher,” said Reyna Ansley, whose family lives about 15 miles outside Hemingford. “You don’t necessarily have the time to drive to the doctor and sit in the waiting room. It’s really quicker through Dave.”

The Ansleys don’t have health insurance and using the pharmacy, where Randolph charges $50 to $60 to do the tests, is cheaper than paying up to $200 for an office visit with a local doctor, Ansley said. If the test is positive, the medications generally cost $20 to $30.

Randolph’s ability to provide treatments for flu and strep throat is somewhat unusual. He can do so in Nebraska because he has an annual collaborative practice agreement with a local doctor that is subject to state approval. He easy availability of pharmacists also helped propel them into a key role during the pandemic as they became a go-to resource for covid-19 testing and vaccines. Yet even before covid engulfed the country, many states were giving pharmacists a bigger role in consumers’ health.

According to the National Alliance of State Pharmacy Associations, more than a dozen states have expanded what pharmacists can do to include testing and treating people for illnesses such as strep throat, flu, and urinary tract infections and preventing HIV. Some states allow pharmacists to prescribe oral contraceptives or drugs to help people quit smoking. Typically, pharmacists have prescribing authority under agreements with doctors or rules called statewide protocols.

But a limited number of states have gone further, allowing pharmacists to prescribe medications on their own to treat a broad range of conditions for which there are rapid point-of-care tests, if it’s appropriate based on clinical guidelines.

“We’re seeing more states looking at direct prescribing authority now as opposed to collaborative practice agreements,” said Allie Jo Shipman, director of state policy at the National Alliance of State Pharmacy Associations. The alliance offers point-of-care testing and point-of-care treating training programs for pharmacists and pharmacy students.

Heart Disease Is Women's #1 Killer. So Why So Little Female-Focused Research?

Heart disease is the leading cause of death for women in America, accounting for more than one in five deaths. Still, far too few women realize the danger.

In fact, "Awareness of heart disease as the leading cause of death among women actually declined from 2009 to 2019," Dr. Dipti Itchhaporia, president of the American College of Cardiology (ACC), said during a HealthDay Now interview. "We've done so many educational efforts over the past decade and still less than 50% of women recognize that heart disease is the number one killer."

It's also not widely known that women differ from men in the structure of their hearts, the types of heart problems they have, the risk factors for heart disease they carry, and even the symptoms they experience during a heart attack, experts say. "I had a patient with jaw pain," said HealthDay Now medical correspondent Dr. Robin Miller. "She went to the dentist twice before she came to see me, and she was in the midst of having a heart attack."

Much of the problem stems from the fact that cardiology has long been a male-dominated field, said Itchhaporia, who is an interventional cardiologist with Hoag Heart and Vascular Institute in Newport Beach, Calif.

"I think women may not even think of cardiology," Itchhaporia said of female doctors. "Women have different perceptions of cardiology than men, and they have different goals that could influence their choice."

Female cardiologists are more likely to report sex discrimination, but it goes beyond that, Itchhaporia said. Women in medicine tend to choose fields that allow for long-term patient relationships, as well as a more family-oriented lifestyle.

Unfortunately, that lack of female perspective in cardiology has caused research into heart disease to be largely focused on men, Itchhaporia noted.

A study to be presented at the ACC’s upcoming meeting found that clinical trials led by a female doctor tended to have more women participating in them — 45%, compared with 38% when a man is in charge of the study, Itchhaporia said.

Half of Americans Now Die With Dementia Diagnosis, Better Record-Keeping May Be Why

A record number of American adults are now dying with a dementia diagnosis, new research shows.

Yet, that increase of 36% from two decades ago may have more to do with better record-keeping than an actual rise in dementia cases, the study authors said.

About half of all older adults are diagnosed with dementia before their deaths, according to a study from Michigan Medicine – University of Michigan.

The study used data from 3.5 million people over the age of 67 who died between 2004 and 2017, including bills submitted to the Medicare system in the last two years of their lives.

About 35% of these end-of-life billing claims mentioned dementia in 2004. By 2017, that statistic was 47%. About 39% of people had at least two medical claims mentioning dementia in 2017, compared to 25% in 2004. This grew most substantially when Medicare allowed hospitals, hospices and doctors’ offices to list more diagnoses on their requests for payment, according to the study. During this time, the National Plan to Address Alzheimer’s Disease also increased public awareness and quality of care while offering more support for patients and their caregivers.

The research provides a starting point for individuals to talk to their families and health care providers about what type of care they would like to receive if they are diagnosed with Alzheimer’s disease or other cognitive decline, the researchers said.

End-of-life care for patients with dementia has also changed in these years, including a lower percentage who died in a hospital bed or intensive care unit, or who had a feeding tube in their last six months of life. Nearly 63% received hospice services, up from 36%. This coincided with a national increase in hospice care overall.

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The chances of passing election-year legislation to help people afford insulin — which weeks ago seemed mired in political fighting — are looking brighter as a bipartisan effort to tackle the issue takes root in the Senate.

That effort is still in the early stages, but it is moving forward with the support of Senate Majority Leader Chuck Schumer, who tapped Sens. Susan Collins (R-Maine) and Jeanne Shaheen (D-N.H.) to craft a compromise that members of both parties could accept. Adding pressure to the Senate’s efforts was a vote by the House on March 31 to pass a different bill that caps out-of-pocket insulin costs for many patients with insurance at $35 a month.

Collins said in an interview March 30 that the two senators had come up with an outline based on a bill they worked on three years ago that goes beyond capping what diabetes patients pay and aims to bring down the prices drugmakers charge.

“It tackles the broader issue of the high list price for insulin, and the conflicts of interests that occur in the chain from manufacturer to the consumer buying it at the pharmacy counter,” Collins said.

The idea of reducing patients’ out-of-pocket insulin costs is immensely popular, and more than half of the public sees it as a “top priority” for Congress, according to a KFF poll out last week.

It had been a key selling point of President Joe Biden’s Build Back Better plan, but when that legislation stalled, Biden and Schumer gave Sen. Raphael Warnock (D-Ga.) an open lane to promote a stand-alone measure identical to the House bill that caps insulin costs at $35 a month for people with private insurance and Medicare coverage.

The political climate, however, presented roadblocks. The odds that a bill sponsored by a Democrat facing a tough reelection in the fall could get enough Republicans in the Senate on board seemed slim, and even some Democrats were nervous about stripping the insulin provisions from a possible revised version of the Build Back Better bill. So Schumer embraced a different option from Collins and Shaheen that would include a cap on out-of-pocket costs and possibly draw more votes.

Insulin prices have spiked dramatically since the early 2000s, with Americans paying 10 times what people in other developed countries pay. 

Social Security's retirement age is moving to 67. Some experts say that could go even higher

While many people hope to retire at 62, Social Security doesn't pay full benefits until as late as age 67.

That normal retirement age could get pushed even higher based on how lawmakers choose to address the program’s solvency issues.

Here’s what those changes could mean for people in retirement or planning for it.

Many Americans eagerly look forward to a time when they can stop working and officially set their status to “retired.”

But when asked what age they anticipate that could be, there isn't a consensus.

The average age when people say they hope to retire is 62, according to one survey.

That is also the age at which people can first claim Social Security retirement benefits, so long as they are eligible based on their work records.

However, people receive reduced benefits for claiming early. If they wait until full retirement age to claim — generally 66 or 67, depending on when they were born — they receive the full benefits which they have earned. If they wait until age 70, they stand to get an 8% per year benefit increase over their full retirement age.

But when asked what age they anticipate that could be, there isn't a consensus.

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Meanwhile, the House of Representatives last week approved a retirement bill that would push out the age for required minimum distributions on certain savings accounts to 75, up from the current age of 72. That change, if it passes the Senate, would be gradually phased in by 2032.

The proposal reflects a reality that many people today are generally healthier than generations past and therefore are living and working longer, said Mark J. Warshawsky, a senior fellow at the American Enterprise Institute and former deputy commissioner for retirement and disability policy at the Social Security Administration.

"It should cascade to other official ages throughout the tax code and the government’s programs, Social Security included," Warshawsky said. "To be sure, no imminent changes to the Social Security program are in the works. "It has and will continue to be the third rail of politics because of the public sensitivity around the issue," said Shai Akabas, director of economic policy at the Bipartisan Policy Center.

Got A-Fib? Shed Pounds Before Treatment to Stop Its Return

If you're one of the millions of people with a common heart rhythm disorder called atrial fibrillation (a-fib), losing weight before treatment may increase the odds that your a-fib doesn't come back.

In a new study, patients with a-fib who were overweight or obese when they underwent ablation to correct their abnormal heart rhythm were more likely to experience a return of a-fib than folks who were not.

A-fib occurs when the upper chambers of the heart quiver chaotically, causing a fast and irregular heartbeat. Left undiagnosed or untreated, it dramatically raises risk for stroke and heart failure. Ablation involves burning or freezing a small portion of the heart to create a scar and prevent the spread of abnormal electrical impulses. "Overweight patients have a higher risk of recurrent a-fib after ablation compared to normal-weight patients, and the risk of recurrent a-fib increases incrementally by increasing body mass index," said study author Dr. Jacob Tønnesen, a cardiologist at Herlev-Gentofte University Hospital in Hellerup, Denmark.

"Aggressive weight management, pre-ablation, in overweight patients could potentially provide substantial benefits and improve short- and long-term outcomes after ablation," he said.

Exactly how much weight a person with a-fib should lose before ablation therapy isn't known yet.

"One study found that a weight loss of 10% leads to a significantly lowered burden of atrial fibrillation, but further studies on this are warranted," Tønnesen said. 

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Researchers are working on a pill that might safely help people with early Alzheimer's disease improve their thinking and memory skills and possibly even live independently longer. The new study was only designed to gather data on the experimental drug's safety, but when 26 patients with mild to moderate Alzheimer's disease took SAGE-718 daily for two weeks, they showed marked improvements in tests measuring thinking function as quickly as one week. Not only that, these improvements lasted for at least a month. "We are seeing an improvement in symptoms that will be meaningful to patients, and being able to see improvements so early on is a really exciting thing," said study author Dr. Aaron Koenig, vice president of early clinical development at Sage Therapeutics in Cambridge, Mass. Sage is the drug's maker and study sponsor.

SAGE-718 is a positive allosteric modulator of N-methyl-D-aspartate (NMDA) receptors. "Over the course of the disease, there is a deficit in the NMDA receptor, and the new drug helps the receptor function normally," explained Koenig.

The drug is also in clinical trials for the treatment of thinking impairments due to Parkinson's disease and Huntington's disease.

For the study, participants took SAGE-718 daily for two weeks and were followed for another two weeks. When the study began, they had an average score of 20.7 points on a standard cognitive test, which suggests mild cognitive impairment or mild dementia. After one month, scores on the cognitive test had gone up by an average of 2.3 points. Some people also showed improvement in performing complicated activities such as using a computer, performing household chores, driving, cooking and managing their medications. These gains dovetailed with improvements seen on multiple tests of executive functioning. "These are meaningful things for patients," Koenig noted.

The drug is also extremely safe, he said: No patient stopped early due to adverse events, while five people had mild or moderate side effects such as headache or constipation. The company plans to begin conducting larger randomized, controlled studies to see if these findings hold up.

There are other medications that can help ease some symptoms of Alzheimer's disease such as memory loss for a limited time, but they are largely approved for later stages of the disease, Koenig said. These drugs include cholinesterase inhibitors that increase levels of acetylcholine, a brain chemical that sends signals from one brain cell to another.

"Available drugs don't slow the progress or affect higher-order cognitive deficits," Koenig said. "We know that Alzheimer's disease is a progressive disease and that there are stages that increase in severity and character, and that treating early in the disease probably has the highest chance of success."

The study will be presented at the American Academy of Neurology's annual meeting, held in Seattle April 2-7. Findings presented at medical meetings should be considered preliminary until published in a peer-reviewed journal.

Dr. Howard Fillit is founding executive director and chief science officer at the Alzheimer's Drug Discovery Foundation in New York City. "This is a really potentially interesting drug directed toward the NMDA receptor," he commented…. Read More

Walking Your Way to Better Health? Remember the Acronym FIT

So you put on extra pounds during the pandemic. Your cholesterol's too high. Maybe you need to do a better job managing blood pressure. It can feel like a lot to tackle.

But taking that first step toward better health can be as easy as … taking a first step. Literally. Just putting one foot in front of the other – as often as you can.

Franklin, director of preventive cardiology and cardiac rehabilitation at Beaumont Hospital in Royal Oak, Michigan. "It lowers your risk factors for cardiovascular disease, decreases body weight and fat stores, decreases blood sugar levels, modestly improves your lipid profile and reduces chronic stress."

But how much walking does it take to make a difference? Dr. Felipe Lobelo, director of Emory University's Exercise is Medicine Global Research and Collaboration Center in Atlanta, uses the acronym FIT to help people remember the important components of a good walking program…. Read More

Heart Groups Endorse New Class of Meds for Some Heart Failure Patients

People who live heart failure with reduced ejection fraction can now turn to a diabetes drug to help them feel better, stay out of the hospital and potentially live longer.

Three leading heart organizations -- the American College of Cardiology, American Heart Association and the Heart Failure Society of America -- released new guidelines on Friday that added sodium-glucose cotransporter-2 (SGLT2) inhibitors to the list of heart failure treatments. These medications cause the kidneys to remove sugar from the body through urine. They have also been found to lower the risk of death in heart failure patients. "When I discuss it with my patients, I explain that the evidence behind these recommendations is very solid. If you took 100 clinicians who were experienced and they looked at the evidence base, pretty much all 100 should come to the same conclusion that these are really recommended therapy," Dr. Mark Drazner, president of the Heart Failure Society of America and clinical chief of cardiology at UT Southwestern, told CNN.

The other classes of medications for this condition are ACE inhibitors, angiotensin receptor blockers (ARBs) and ARN inhibitors, beta blockers and antimineralocorticoids. Will your doctor be talking over the new drug option at your next appointment? Maybe not, Drazner said, because there are often delays in real-world implementation of new treatment recommendations. "There's a gap between the guideline recommendations and what the people in the country are actually getting treated with," Drazner said. "Unfortunately, many patients don't get on the highest level recommended therapy."

In heart failure, the heart's weakened muscles cannot pump blood as well as they should. Ejection fraction measures the ability of the left ventricular compartment of the heart to squeeze. With normal functioning, that ejection fraction is higher than 50%. Anything below 40% is considered reduced…. Read More
Major heart complications soon after a stroke can put survivors at higher risk for a heart attack, death or another stroke within five years, new research shows.

Heart problems after a stroke are common and are referred to as stroke-heart syndrome. These heart problems were known to increase stroke survivors’ short-term risk of disability and death, but the long-term impacts had been unclear. "I was particularly surprised by how common stroke-heart syndrome was and the high rate of recurrent stroke in all subgroups of adults with stroke-heart syndrome," said study lead author Benjamin Buckley, a postdoctoral research fellow at the University of Liverpool in England. "This means that this is a high-risk population where we should focus more secondary prevention efforts."

He and his colleagues analyzed the medical records of more than 365,000 adult survivors of ischemic stroke treated at more than 50 health care sites -- most of them in the United States -- between 2002 and 2021. Ischemic strokes are caused by blocked blood flow in the brain.

The study compared patients diagnosed with stroke-heart complications within four weeks of a stroke and an equal number of stroke survivors without heart complications (control group). About 1 in 10 stroke survivors (11.1%) developed acute coronary syndrome; 8.8% developed the heart rhythm disorder atrial fibrillation (a-fib), and 6.4% developed heart failure. In all, 1.2% had severe rhythm disorders called ventricular arrhythmias and 0.1% developed so-called "broken heart" (Takotsubo) syndrome, the study found.

Compared to those in the control group, the risk of death within five years was significantly higher among those diagnosed with new heart complications within four weeks of their stroke.

The risk of death was 49% higher if they had acute coronary syndrome; 45% higher if they had a-fib/flutter; 83% higher if they had heart failure, and twice as high if they had severe ventricular arrhythmias.

The risk of hospitalization and heart attack within five years was also significantly higher among those who developed heart problems within four weeks of their stroke, according to findings published March 31 in the journal Stroke.

It also found within five years after their stroke, stroke survivors with Takotsubo syndrome were 89% more likely to have a major heart event; those with a-fib were 10% more likely to have a second stroke, and those with newly diagnosed heart complications were 50% more likely to have a recurrent stroke.

Buckley said the study shows the need for treatments to improve outcomes for people with stroke-heart syndrome.

"For example, comprehensive exercise-based rehabilitation may be helpful after a stroke, so for people with stroke and newly developed heart complications, it should also be beneficial, maybe even more so," he said in a journal news release. "I think this is an interesting area for future research."

The affected harvest locations were distributed in 13 states, but others may also have received them through further distribution within the United States, the FDA said.

States confirmed to have received the tainted oysters are California, Colorado, Florida, Hawaii, Illinois, Massachusetts, Minnesota, New Jersey, New York, Nevada, Oregon, Texas and Washington.

The FDA and the states conducted what is known as a "trace forward investigation" to determine where the raw oysters were distributed and remove them from the food supply.

While food contaminated with norovirus may look, smell and taste normal, it can cause diarrhea, vomiting, nausea, stomach pain, fever, headache and body ache within 12 to 48 hours after being eaten.

Most people get better within one to three days. Children under age 5, older adults, and people with weakened immune systems are more likely to have severe infections. The symptoms can lead to dehydration, especially in children, older adults and people with other illnesses.

The FDA said it's important to call your health care provider if you or your child become dehydrated. Symptoms of dehydration include a decrease in urination, dry mouth and throat, and dizziness when standing up. Children who are dehydrated may have few or no tears and be unusually sleepy or fussy. The affected harvest locations in Baynes Sound include #1407063, #1411206, #278737 in BC 14-8, and #1400036, in BC 14-15. "Baynes Sound" will show on product tags as "14-8" and/or "DEEP BAY," or "14-15."

The FDA said:

Restaurants and retailers should throw out or return to the distributor any products included in the recall. Those who have processed and packaged any potentially tainted products should be aware of cross-contamination of food processing equipment. Work surfaces should be thoroughly cleaned and sanitized, and hands should be washed with warm water.

The United States and Canada are investigating a multistate outbreak of norovirus illnesses linked to raw oysters from Canada.

Restaurants and retailers should not serve or sell these potentially contaminated raw oysters, which were harvested in the south and central parts of Baynes Sound, British Columbia, Canada, the U.S. Food and Drug Administration said.

The oysters were distributed in 13 states, but others may also have received them through further distribution within the United States, the FDA said.

States confirmed to have received the tainted oysters are Rhode Island Alliance for Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381 riarajap@hotmail.com • http://www.facebook.com/groups/354516807278/
Could an annual eye exam save your sight if you have diabetes? Most definitely, one vision expert says. "Diabetes is known to alter the health of the blood vessels in the retina and these vascular changes do not cause symptoms in the early stages," explained Dr. Jeffrey Sundstrom, an ophthalmologist and retina specialist at Penn State Health Eye Center in Hershey, Pa. "It's extremely important to detect any changes early so we can take steps to prevent vision loss -- and the way to do that is with an annual dilated eye exam," he said in a Penn State news release.

With diabetes, the blood vessels in the retina often become leaky, and this can trigger a swelling of the macula -- the part of the retina at the back of the eye that is responsible for central vision.

"Severe vision loss from diabetes can occur when abnormal blood vessels grow in the retina and into the vitreous -- the gel portion of the eye," Sundstrom said. "These abnormal blood vessels can lead to bleeding in the back of the eye and even cause a type of retinal detachment. If any of these conditions are left untreated, they can lead to progressive visual loss and blindness." More than half of people with diabetes will develop diabetic retinopathy, one of the leading causes of blindness in the United States, yet fewer than half of diabetes patients get annual vision checks.

Pregnant women with gestational diabetes are also at risk for diabetic retinopathy and should be seen multiple times throughout their pregnancy, according to Sundstrom.

There are several treatments if eye problems are discovered, including laser treatments and drugs.

As well as getting an annual dilated eye exam, diabetes patients should follow the ABCs to manage diabetes and lower their risk for vision loss and other potential complications such as heart attack and stroke, Sundstrom said.

♦ A stands for the hemoglobin A1C test, which tracks whether blood sugar levels are under control. For those with diabetes, the target is below 6.5%.
♦ B stands for blood pressure.
♦ C stands for cholesterol, which should be below 200 mg/dL.

"Patients should work with their primary care doctor to optimize all three of the ABCs, and see their eye care provider for annual diabetic retinopathy screening exams," Sundstrom recommended. "The key to maintaining good vision is a good relationship with both your primary care provider and your eye doctor."

By managing their ABCs and getting an annual eye exam, most patients with diabetes can retain good vision, he said.

Almost no one in the world is breathing good air, according to a new World Health Organization report, which issued a call for reducing the use of fossil fuels.

Air quality is the worst in WHO's Eastern Mediterranean and Southeast Asia regions, but 99% of the global population breathes air that exceeds air quality limits and contains disease-causing particles. Air quality is also especially poor in Africa.

"After surviving a pandemic, it is unacceptable to still have 7 million preventable deaths and countless preventable lost years of good health due to air pollution," said Dr. Maria Neira, head of WHO's Department of Environment, Climate Change and Health.

"Yet too many investments are still being sunk into a polluted environment, rather than in clean, healthy air," Neira said in a news release from the United Nations health agency. Dangerous particles in the air can penetrate deep into the lungs and enter the veins and arteries, causing disease. These particulates come from transportation, power plants, agriculture, waste burning, industry and natural sources such as desert dust.

The WHO database included PM2.5, PM10 (particle matter 2.5 and 10 micrometers small) and now ground measurements of nitrogen dioxide, the latter of which is generated through burning of fuel and is common in urban areas. WHO found the highest concentrations in the eastern Mediterranean region. Nitrogen dioxide exposure can contribute to asthma and cause symptoms including coughing, difficulty breathing and wheezing.

"Particulate matter, especially PM2.5, is capable of penetrating deep into the lungs and entering the bloodstream, causing cardiovascular, cerebrovascular [stroke] and respiratory impacts," WHO said. "There is emerging evidence that particulate matter impacts other organs and causes other diseases as well."

When Diabetes Strikes, Eye Exams Can Save Your Sight

Health care workers battling the pandemic may be suffering moral traumas at a rate similar to soldiers in a war zone, a new study suggests.

The pandemic has brought a stream of stories about overtaxed health care workers, facing repeated COVID surges, resource shortages and public resistance to the vaccines that can keep people out of the hospital. Workers' distress is often called burnout.

But the new study looked at a different concept called "moral injury." It refers to the damage done when people cause, witness or fail to prevent acts that violate their moral beliefs.

Moral injury was first defined a little over a decade ago, in military veterans who were scarred by their combat experience -- but in a way that was distinct from the anxiety, nightmares and flashbacks that mark post-traumatic stress.

"It's different from PTSD," said lead author Jason Nieuwsma, an associate professor of psychiatry and behavioral sciences at Duke University in Durham, N.C. "It's more about guilt, shame, losing your sense of identity, or feeling betrayed by authority figures when you're in a high-risk situation."

The bulk of research into moral injury has focused on military members. But in the past few years, there has been a growing recognition that moral injury also affects doctors, nurses and other health care workers.

"This didn't start with the pandemic," said Dr. Wendy Dean, co-founder of the nonprofit Moral Injury of Healthcare. But, she added, the pandemic has shined a light on the situation to the point that "we can't look away."

The nonprofit is working to reframe as moral injury what has long been described as burnout, and to identify its causes. What is clear is that medical professionals are not just overworked and fatigued.

"They all go into this knowing it's going to be hard. They know it's going to be exhausting," said Dean, who wasn't part of the study. "What they didn't anticipate was how hard it can be to get your patients the care that they need."