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Retirees Cautiously Optimistic About Drug Reimportation Plan

Retirees Cautiously Optimistic About Forthcoming Drug Reimportation Plan

The following statement was issued by Richard Fiesta, Executive Director of the Alliance for Retired Americans, regarding Health and Human Services Secretary Azar's comments this morning that the administration "will set up a system" allowing Americans to legally access lower-cost prescription drugs from Canada:

"This morning Secretary Alex Azar said that the Trump Administration will set up a system allowing legal access to lower-cost prescription drugs from Canada. The Alliance for Retired Americans has been working for this change since 2002 when our members began going to Canada on our Rx Express campaign for their needed prescriptions. We welcome this announcement. It's about time.

"Americans pay the highest prices in the world for prescription drugs, while pharmaceutical corporations are making record profits. Nearly 1 in 4 Americans report that they are skipping doses or not filling prescriptions their doctors have prescribed. Allowing Americans access to less expensive drugs from Canada could provide some patients immediate relief.

"Even more patients would be helped if Medicare were allowed to negotiate better prices for beneficiaries and taxpayers. Both Medicaid and the Veterans Administration negotiate prices with the pharmaceutical corporations and pay less than Medicare for some of the same drugs.

"The Administration should also get behind the Affordable and Safe Drug Importation Act (S. 97 and H.R. 447). That bill allows drug importation from Canada, OECD partners or other countries with comparable safety standards.

Rich Fiesta, Executive Director, ARA

"The members of the Alliance for Retired Americans will be watching closely to ensure that the plan Mr. Azar says is coming actually materializes. Our members cannot wait. "

Retirees to Celebrate Social Security's 84th, Medicare & Medicaid's 54th Birthday

Rhode Island --- To mark the 84th anniversary of Social Security and the 54th anniversary of Medicare & Medicaid, area retirees with the Rhode Island Alliance for Retired Americans along with RI Senator Sheldon Whitehouse and Alliance for Retired Americans Executive Director, Richard Fiesta and leaders of the Alliance for Retired Americans Northeastern Regional Chapters will celebrate these important birthdays at the RI AFSCME Council 94 lower hall, 1079 Charles Street, North Providence, RI on August 7, 2019 at 11:00 am.

"Retirees in our area are struggling to get by, but they know how much worse things would be without Social Security. Thanks to the Social Security Act signed into law on August 14, 1935 by President Roosevelt, with benefits that we have earned, not an entitlement, seniors are able to pay bills, buy groceries, and stay out of poverty.

The Medicare & Medicaid programs, signed into law on July 30, 1965 by President Johnson providing hospital and medical insurance for Americans age 65 or older, was signed into law as an amendment to the Social Security Act of 1935.

Some 19 million people enrolled in Medicare when it went into effect in 1966. In 1972, eligibility for the program was extended to Americans under 65 with certain disabilities and people of all ages with permanent kidney disease requiring dialysis or transplant.

And Medicaid, a state and federally funded program that offers health coverage to certain low-income people.

John A. Pernorio President, RI ARA

Particularly important to focus on the ever-increasing cost of prescription drugs. Americans pay the highest prescription drug prices in the world and seniors endure the most of those costs.

All of these very important programs need to be **PROTECTED and INCREASED**." said John A. Pernorio, President RI ARA.

Prescription Drug Rebates, Explained

This animation explains how rebates for prescription drugs work and why they matter in the debate about lowering drug costs. The video breaks down how prescription drug rebates are determined, who benefits from them, how they affect spending by insurers and consumers and the role of pharmacy benefit managers in the process.

The Trump Administration had proposed banning such rebates in Medicare Part D, but dropped the proposal amid concerns that it would lead to higher costs for insurers, consumers and the Medicare program. It is still possible that policymakers could make changes to the rebate system. They are also talking about many other ways to lower drug costs.

The animation is part of a broad collection of KFF analysis and data on **prescription drugs**.

Watch The Video On How Prescription Rebates Work.

New Legislation Looks to Address High and Rising Drug Prices

Last week, the Senate Finance Committee unveiled long-awaited drug pricing legislation, the Prescription Drug Pricing Reduction Act **(PDPRA)** of 2019. The bill outlines a number of changes to address the problem of high and rising drug prices within the Medicare program, including a redesign of the Part D benefit and the imposition of inflationary rebates.

The new Part D structure would cap beneficiary out-of-pocket spending at $3,100 and shift reinsurance liabilities in the catastrophic phase to plans and manufacturers. Beneficiary spending in the catastrophic phase would be eliminated.

The inflationary rebates would apply to certain drugs in Medicare Parts B and D. Under the policy, manufacturers would be required to provide a rebate to Medicare if the prices of their products increased faster than inflation.

According to the **Congressional Budget Office**, these two changes would save Medicare $85 billion over 10 years and reduce beneficiary out-of-pocket costs by $27 billion and premiums by $5 billion over the same time period. The legislation also includes reforms to Medicaid drug pricing policy that are projected to save taxpayers $15 billion over the next decade.

The committee approved its draft in a **hearing** on Thursday, and more changes are expected before the bill is considered by the full Senate. The House is working on a parallel track and is expected to release its drug pricing legislation in September.

Medicare Rights appreciates the Senate Finance Committee's bipartisan leadership, and we welcome the bill's provisions that would improve beneficiary access to affordable prescription drugs. In particular, and as outlined in a **recent letter** to the committee, we support efforts to cap out-of-pocket costs for beneficiaries and to require meaningful, proportional liability for drug manufacturers and plans throughout the Part D benefit, as well as policies to increase drug pricing transparency and to make the Limited Income Newly Eligible Transition (LI NET) Program permanent.

While the package addresses many of Medicare Rights' priorities, it does not include the Streamlining Part D Appeals Process Act's (**S. 1861/H.R. 3924**) critical updates to the Medicare Part D appeals process. This bipartisan, bicameral bill would bring much-needed efficiencies to the program by allowing a refusal at the pharmacy counter to function as the plan's initial coverage determination. This change would significantly simplify the current system, making it less burdensome for all involved. We thank Senators Ben Cardin (D-MD) and John Cornyn (R-TX) for their leadership of the Senate bill, and Congressmen Tom Suozzi (D-NY) and Tom Reed (R-NY) for **introducing** a House companion this week.

Looking ahead, we will continue to advocate for the inclusion of these and other reforms—such as vital improvements to Medicare's low-income programs—in any prescription drug legislation. Such solutions must be incorporated in order to meaningfully respond to the access and affordability challenges facing many people with Medicare.

Read Medicare Rights' fact sheet on S.1861 and H.R. 3924.

For more on why the bill is needed and who it would help, see Medicare Rights' Case Study.

Genetic-Testing Scam Targets Seniors And Rips Off Medicare

The 86-year-old woman in rural Utah doesn't usually answer solicitations from strangers, she said, but the young couple who knocked on her front door seemed so nice. Before long, she had handed over her Medicare and Social Security numbers — and allowed them to swab her cheek to collect her DNA.

She is among scores of older Americans who have been targeted in a scam that uses DNA tests to defraud Medicare or steal personal information. Fraudsters find their victims across the country through cold calls, door knocking, email, Facebook ads and Craigslist. They also troll low-income housing complexes, senior centers, health fairs and antique shops. Sometimes they offer ice cream, pizza or $100 gift cards. Some callers claim to work for Medicare, according to **a fraud alert** issued July 19 by the Federal Trade Commission.

The woman in Utah said she didn't know the purpose of the DNA test she submitted to this month — "I'm too old to remember" — but the visit troubled her for several nights, she said.

"I'd lie awake thinking about it, saying, 'You fool, you shouldn't have done that.'" (She spoke on the condition of anonymity for fear of being targeted by other scams.)

In interviews with Kaiser Health News, seniors around the country reported feeling betrayed, exposed and confused.

Capitalizing on the growing popularity of genetic testing — and fears of terminal illness — scammers are persuading seniors to take two types of genetic screenings that are covered by Medicare Part B, according to experts familiar with the schemes. The tests aim to detect their risk for cancer or medication side effects.

The scammers bill Medicare for the tests. The patients, who might never receive any results, typically pay nothing. But they risk compromising personal information and family medical history. And taxpayers foot the bill for tests that may be unnecessary or inappropriate.

Scammers can really cash in: Medicare pays an average of $6,000 to $9,000 for these tests, and sometimes as much as $25,000, according to the Office of Inspector General at the Department of Health and Human Services.

DNA test scams appear to be ramping up: Complaints to the inspector general fraud hotline have poured in at rates as high as 50 per week, according to Sheila Davis, an OIG spokeswoman. That's compared with one or two complaints a week at the same time last year, she said.

The inspector general issued **a fraud alert** in June, urging seniors to refuse unsolicited requests for their Medicare numbers and take DNA tests only with the approval of a doctor they know and trust. By Medicare rules, DNA tests must be medically necessary and approved by a physician who is treating the patient.…**Read More**

States' Failure to Expand Medicaid Resulted in Over 15,000 Deaths, According to New Study

A new **study** reveals that Medicaid expansion has reduced deaths in states where it has been adopted. By contrast, in states that have refused to expand their Medicaid coverage, approximately 15,600 people have died as a result. This study is the first large-scale assessment of the effect of Medicaid expansion on mortality.

Created by the Affordable Care Act (ACA), Medicaid expansion offers states the option to establish a pathway for Medicaid coverage for low-income adults aged 19-64. Prior to the ACA, these individuals were not generally eligible for Medicaid. In the first year of the expansion's availability, 29 states plus the District of Columbia leapt at this opportunity, and seven other states have since chosen to extend coverage.

The study, which focused on individuals who were between 55 and 64, found a large reduction in deaths in states that expanded Medicaid. Before Medicaid expansion was available, members of this group had similar mortality trends no matter where they lived. After the expansion, however, those in non-expansion states began dying at a higher rate. This trend started in the first year of the expansion and has increased every year that a state continues to offer the coverage. The authors calculate that approximately 15,600 deaths could have been averted if all states had adopted the Medicaid expansion. They also note that because of the nature of these health gains, the difference between expansion and non-expansion states is likely to continue to increase.

The study used large-scale federal survey data linked to administrative death records to investigate the relationship between Medicaid enrollment and mortality. Our analysis compares changes in mortality for near-elderly adults in states with and without Affordable Care Act Medicaid expansions. We identify adults most likely to benefit using survey information on socioeconomic and citizenship status, and public program participation. We find a 0.13 percentage point decline in annual mortality, a 9.3 percent reduction over the sample mean, associated with Medicaid expansion for this population. The effect is driven by a reduction in disease-related deaths and grows over time. We find no evidence of differential pre-treatment trends in outcomes and no effects among placebo groups.

Medicare Rights supports Medicaid expansion both because of its positive effects on the individuals who are eligible for coverage and for the benefits to the Medicare program of having people receive regular health care before they reach Medicare eligibility. This study should spur non-expansion states to take another look at the benefits of expanding coverage and the devastating costs a failure to expand may be inflicting on vulnerable residents.

NARFE Pushes For Social Security Fairness, Supports New Legislation to Reform Windfall Elimination Provision

Alexandria, VA – In response to Rep. Kevin Brady, R-TX, introducing the Equal Treatment of Public Servants Act, legislation that would provide much-needed relief to civil servants financially punished by the Windfall Elimination Provision (WEP), NARFE National President Ken Thomas issued the following statement: "By depriving dedicated public servants of full Social Security benefits that they rightfully earned through contributions to the Social Security system, the Windfall Elimination Provision is simply unfair. With low-earning households disproportionally affected by larger benefit reductions, the federal community experiences significant financial loss due to the WEP.

"While NARFE's ultimate goal is for Congress to fully repeal the WEP, reform efforts such as the Equal Treatment of Public Servants Act are a good first step toward correcting this discriminatory provision. We commend Rep. Brady for tackling this important issue and seeking to right a longtime wrong for millions of Social Security beneficiaries." Individuals currently affected by WEP could lose up to $463 per month in earned benefits. The Equal Treatment of Public Servants Act seeks to replace the WEP with a formula that equalizes benefits for certain individuals with non-covered employment. The bill would provide WEP-affected individuals age 60 and older with a monthly rebate of $100 ($50 for surviving spouses). For WEP-affected individuals currently under age 20, the bill would change how the WEP is calculated. For those between age 21 and 59, the individual's WEP penalty would be calculated either using the current formula or the new one created by the bill, whichever is more beneficial.

Who is affected by WEP?

WEP reduces the Social Security benefits of local, state and federal retirees who worked in Social Security-covered employment (e.g., private-sector jobs) and who also receive a government annuity from their non-Social Security covered government employment. According to the Congressional Research Service, as of December 2017, the WEP affects 1,804,095 beneficiaries, including 1,687,542 retired workers; 13,981 workers with disabilities; and 102,572 spouses and children.

Why are they affected?

Due to an arbitrary decades-old compromise, federal retirees who began their federal employment prior to 1983 and are covered by the Civil Service Retirement System (CSRS) pay a 7 percent payroll contribution toward their CSRS retirement annuities. They do not pay a 6.2 percent payroll tax toward Social Security, and, therefore, do not earn any Social Security benefits based on their federal work.

How are they affected?

Normally, Social Security benefits are calculated using a formula in which an individual's average indexed monthly earnings (AIME) are multiplied by three progressive factors – 90 percent, 32 percent and 15 percent – at different levels of AIME, resulting in a primary insurance amount (PIA) that becomes the basic monthly benefit.

Under the WEP, the 90 percent factor is reduced to as low as 40 percent. For 2019, this results in a monthly benefit that is $463 lower than the regular benefit formula.

On the Eve of ADA Anniversary, Langevin Introduces Legislation

Congressman Jim Langevin

On the Eve of ADA Anniversary, Langevin Introduces Legislation to Help More Small Businesses Become Accessible

Bill would make it easier for small businesses to comply with ADA

WASHINGTON – U.S. Representatives Jim Langevin (D-RI), co-chair of the Bipartisan Disabilities Caucus, and Donald McEachin (D-VA) introduced legislation today to make it easier for small businesses to become accessible for people with disabilities and help those businesses comply with the landmark Americans with Disabilities Act (ADA). The Disabled Access Credit Expansion Act bolsters the existing Disabled Access Credit (DAC), which helps businesses pay for renovations, by doubling the maximum tax credit and allowing more small businesses to receive it. The legislation also invests in programs that mediate ADA-related disputes to avoid additional litigation and help individuals and businesses understand the ADA. U.S. Senator Tammy Duckworth (D-IL) led the introduction of companion legislation in the Senate.

"The Americans with Disabilities Act is a groundbreaking civil rights law that has had profound impacts on me and millions of my fellow citizens," said Langevin, co-chair of the Bipartisan Disabilities Caucus. "However, twenty-nine years after it was signed into law, we're still fighting to break down barriers to access and inclusion. The Disabled Access Credit Expansion Act will help more small businesses comply with the ADA and ensure our communities are open to all. I'm proud to spearhead this effort with Congressman McEachin in the House, and I look forward to working with Senator Duckworth to get this bill signed into law."

"We are reintroducing the DACE Act because it is imperative that we improve access for Americans with disabilities," said McEachin. "By expanding the tax credit that allows small business owners to proactively accommodate and include those with disabilities, the DACE Act renews our commitment to fairness and equal access. On the eve of the 29th anniversary of the ADA, I am humbled to reintroduce this bill with Congressman Langevin and Senator Duckworth to support both Americans with disabilities and our small business community."

"I'm proud to work with my colleagues on this important legislation to strengthen the ADA and give Americans with disabilities increased opportunity to fully participate in our society," said Duckworth. "This bill will help more businesses across the country comply with a nearly 30-year-old law that protects the rights of people with disabilities. It is a common-sense alternative to misguided efforts that would roll back hard-earned protections for people with disabilities by rewarding businesses who refuse to comply with the ADA instead of encouraging them to become accessible."

The Disabled Access Credit Expansion Act would:

- **Expand the Disabled Access** Credit (DAC): Increase eligible expenses businesses can write off in order to make their facilities ADA-compliant to $20,500, double the maximum credit from $5,000 to $10,125, and expand the definition of small businesses to companies with gross receipts of $2.5 million or less from $1 million or less.
- **Increase Funding** for the ADA Mediation Program: Make the Department of Justice's (DOJ) ADA Mediation Program eligible to receive funding to train contracted mediators and increase personnel to help individuals with disabilities and businesses reach a resolution without increased litigation. The legislation would appropriate $1 million for the 2021 fiscal year to support these efforts.
- **Collect ADA Information** Line Data: Require DOJ to provide a report to Congress on the specific types of calls the ADA Information Line receives in order to improve the ways individuals with disabilities and businesses learn about their rights and how facilities can become ADA-compliant.

Since Langevin was elected as the first quadriplegic to serve in Congress, he has been a leading voice for the disability community and has fought to protect and strengthen the ADA. Earlier this year, Langevin co-led a letter to the Administration requesting information regarding its reported failure to hire and retain employees with targeted disabilities. He has also led efforts to improve protections for airline passengers with disabilities, establish a more inclusive process to address the needs of people with disabilities in disaster planning, and expand caregiver services for disabled veterans. Yesterday, the House passed Langevin's bill to strengthen coordinated respite services for family members who care for loved ones with disabilities and other chronic health conditions.

The Disabled Access Credit Expansion Act has been endorsed by American Association of People with Disability (AAPD), The Arc of the United States, Association of University Centers on Disabilities (AUCD), Disability Rights Education and Defense Fund (DREDF), Equip for Equality, Paralyzed Veterans of America (PVA), American Network of Community Options & Resources (ANCOR), American Foundation for the Blind (AFB), Rhode Island Disability Law Center, Disability Rights North Carolina, Disability Rights California and Epilepsy Foundation.

WATCH LIVE: Opening statements from a historic full committee hearing on EXPANDING Social Security!

SOCIAL SECURITY WORKS.

https://www.facebook.com/socialsecurityworks/videos/2352958864956353/?fref=gs&dti=354516807278&hc_location=group

SCL Legislative Update for Week Ending July 26, 2019

This week was a busy one for Social Security and Medicare Advocates! There was considerable activity to combat the high cost of prescription drugs. The Ways and Means Committee had a hearing on the Social Security 2100 Act. And, work continues on repealing the Windfall Elimination Provision.

Lowering drug prices is a singular area where bipartisan legislation could make it into law this year. On Monday, Senator Jeanne Shaheen (D-NH) in introduced legislation that would cut the cost of insulin by 75% compared with the level expected in 2020. The proposal would create a new pricing model that limits the use of rebates for Medicare Part D and the private insurance market, Sens. Tom Carper (D-Del.), Susan Collins (R-Maine) and Kevin Cramer (R-N.D.) have already signed on as co-sponsors to the legislation.

Tuesday Senators Grassley (R-IA) and Wyden (D-OR) announced legislation, The Prescription Drug Pricing and Reduction Act of 2019. The bill if adopted would save taxpayers more than $100 Billion, lower Medicare Beneficiaries out-of-pocket costs by $27 Billion and premiums by $5 Billion, according to the Congressional Budget Office. A hearing on Thursday of a key panel of legislators advanced the legislation out of the Senate Finance Committee despite close-call votes on controversial provisions, priming the legislation to be considered by the full Senate in the fall.

Later in the week, the President doubled down on his promise to try and cut prices on branded prescription drugs. Word is out that the President is considering an executive order to combat the problems of high cost drugs sold to Medicare and other government programs.

On Thursday, the Ways and Means Committee held a long overdue hearing on the Social Security 2100 Act. The bill was introduced by Congressman John Larson (D-CT-1) in January of this year. A companion bill was introduced in the Senator by Senator Richard Blumenthal (D-CT). If adopted these bills would strengthen and reform Social Security by providing beneficiaries with a 2 percent benefit increase, would base the cost-of-living on the CPI-E, create a new minimum benefit set 125 percent of the poverty line and cut taxes for beneficiaries. Increase costs to the program would be paid for my applying the payroll tax to income over 400,000 and gradually increase the payroll tax rate to 7.4 percent.

Several times in the hearing, repeal of the Windfall Elimination (WEP) was mentioned as a priority issue. The Windfall Elimination Provision (WEP) is simply a recalculation of Social Security benefit for individuals who also have a pension from "non-covered" work (no Social Security taxes paid). The normal Social Security calculation formula is substituted with a new calculation that usually results in a lower benefit amount. H.R. 141 and S. 521 would repeal this provision.

The Senior Citizens League was pleased to see support continue to grow for several of its key bills this week, and we thank the new cosponsors for their support. In the months ahead, we will continue to advocate for the passage of *the Social Security Fairness Act*, *the Social Security 2100 Act*, *the Fair COLA for Seniors Act*, and get adoption of legislation that would lower the cost of prescription drugs.

Federal probe shines light on Medicare Advantage claims denials

This article was published n October 2018.

A growing number of seniors are choosing Medicare Advantage, the popular private insurance alternative to traditional coverage. But a new report by federal investigators finds that Advantage plans have a pattern of inappropriately denying patient claims.

The good news is that those denials are frequently overturned if people bother to appeal.

The report found "widespread and persistent problems related to denials of care and payment in Medicare Advantage" plans, which usually are managed-care HMO or PPO plans. The Advantage payment model reimburses plans a pre-set amount per patient, and this may be incentivizing plans "to deny preauthorization of services for beneficiaries, and payments to providers, in order to increase profits," concludes the report, which was conducted by the **Office of Inspector General** (OIG) at the U.S. Department of Health and Human Services.

The OIG report, which looked at appeals filed by patients and healthcare providers from 2014 through 2016, found that when denied claims were appealed, the Advantage plans themselves overturned those denials 75 percent of the time.

The findings are worrisome because very few claim denials are appealed – just 1 percent during the three-year period reviewed in the OIG report. That suggests that patients who do not appeal claims are going without the requested services, or may have paid out of pocket. It also means the provider may not have been paid.

Enrollment in Medicare Advantage is growing quickly. The annual fall Medicare enrollment period is under way now (reut.rs/2yj24dB), and Medicare projects Advantage enrollment next year will rise 11.5 percent to 22.6 million, accounting for 37 percent of beneficiaries.

The overturn rates uncovered by the OIG report are significantly higher than in the traditional fee-for-service Medicare program. In 2013, the OIG reviewed traditional Medicare appeals from 2008 to 2012. The review found that 24 percent of denied Medicare Part A (hospitalization) claims were overturned on appeal, and 51 percent of Part B (outpatient services) denials were overturned. A larger share of enrollees in traditional Medicare (2.6 percent) appealed claim denials – still a relatively small share. (The OIG notes that numbers from the two reports are not directly comparable due to the different time periods studied.)

Does Long-Term Care Insurance Cover Assisted Living?

This article is based on reporting that features expert sources including Kelly Short; Colleen Dennis; Rachel Reeves; Julie Westermann

Long-Term Care Insurance for Assisted Living

SUPPOSE YOUR ELDERLY mother is struggling with day-to-day activities like laundry, cleaning and cooking. But she's not truly ill and doesn't need a high level of daily health care. She's not ready to move into a nursing home, but you worry about her walking up and down stairs or carrying a bag of groceries. An assisted living facility may be the place for her.

What Is Assisted Living?

Assisted living is a type of housing that seniors move into when they are fairly healthy but need a bit of extra help, says Colleen Dennis, case management team manager with Genworth Insurance. "They typically provide room and board, meals and some level of nursing oversight. It is more advanced than independent living but less comprehensive than a nursing home," she says, which provides skilled nursing services 24 hours a day, seven days a week.

Assisted living is a great intermediate step on the continuum of elderly care. But, like all health care, it's expensive.

According to Genworth's 2018 Cost of Care Survey, the national median monthly cost of care in an assisted living facility is $4,000. Who pays? Usually, you do.

"Assisted living is primarily paid for by individuals' private or personal funds, such as long-term care insurance or personal assets. Medicare does not cover long-term supports and services," says Rachel Reeves, director of communications for the National Center for Assisted Living.

Medicaid may cover some costs, but the rules vary by state. "How the program is set up in each state determines how residents can use Medicaid to help pay for LTC in home- and community-based settings, such as assisted living communities," Reeves says. About 1 in 6 assisted living residents relies on Medicaid to cover their costs, many of whom must spend down their personal assets first to qualify for Medicaid coverage, she adds.

That's where long-term care insurance comes in. Most LTC insurance policies cover expenses at an accredited assisted living facility. "Everything is policy-dependent, but most assisted living facilities are private pay and can be reimbursed by LTC," Dennis says.

Check Your Policy Carefully

LTC insurance premiums vary widely depending on where you live and how much coverage you want; the average is about $2,700 a year, according to AARP. Whatever you decide to purchase, you need to check the details of your policy carefully. "In general, long-term care insurance is flexible along the continuum of care. monthly assisted living cost of about $4,000 varies depending on amenities and location. And there are often additional fees for related services, such as physical therapy, laundry help, meals, dog walking and more.

There's no federal definition for what constitutes assisted living – and laws and regulations vary significantly from state to state. "Generally, to be eligible for insurance benefits, a person needs to require help in at least two major activities of daily living such as bathing, dressing and eating," Short says.

Some states – but not all – require licensed assisted living centers to have registered nurses on staff 24/7. States also differ in the amount of education required of facility directors; "maybe the person needs a degree in health care administration, for example, or maybe nobody's asking," Short says. Regulations about training for other workers also vary, as do laws about facility cleanliness, meal preparation, organized social activities for residents and much more.

In addition, some states have different levels of licensure for assisted living facilities. One important advanced license to look for involves memory care or dementia care. "This sort of license lets an assisted living center keep caring for a resident even if he or she loses a good deal of independence," Short says. "Choosing an assisted living center with an advanced license can help a person avoid the stress and expense of relocating again. It can also help couples maintain residence together." The laws governing assisted living are numerous and they change often, she says, so it is wise to search online for state-specific information….**Read More**

Sign now to help stop pharma price gouging.

54 years ago, President Lyndon B. Johnson signed Medicare into law. Since then generations of seniors and people with disabilities have had access to health care.

To stay fiscally solvent, Medicare needs the power to lower the prices it's paying for prescription drugs. It isn't allowed to use its bargaining power to secure a better deal for beneficiaries or taxpayers.

This has to change.

Sign the petition to add your name to thousands of Americans who are demanding lower prices and want Medicare to negotiate a better deal.

To: U.S. Congress

From: [Your Name]

It's ridiculous that our government is prohibited from negotiating lower prescription drug prices for seniors under Medicare.

Alliance for Retired Americans®

Americans already pay the highest prices in the world for prescription drugs and pharmaceutical corporations continue to raise prices. Meanwhile, retirees and their families can't afford the medicines their doctors prescribe.

Action is overdue. There is no reason why Medicare should not be allowed to negotiate the same way that Veterans Administration and Medicare do now.

We urge you to celebrate Medicare's 54th birthday by passing legislation now to implement this common-sense policy.

Sign The Petition Here

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Heart disease: Millions taking daily aspirin without doctor's advice

New research suggests that many adults in the United States who take low dose aspirin daily to prevent heart disease could be at risk of harm.

The individuals potentially at risk include older adults and those who have or have had **peptic ulcers.**

Peptic ulcers are open sores that can occur in the stomach and small intestine. These painful lesions, which are prone to bleeding, affect about **10%** of people.

The recent study suggests that close to 6.6 million U.S. adults are taking aspirin every day to protect against heart disease without seeking medical advice.

Researchers at Beth Israel Deaconess Medical Center (BIDMC) and Harvard Medical School, both in Boston, MA, report these findings in a recent ***Annals of Internal Medicine*** paper.

The lead author is Dr. Colin W. O'Brien, who is a fellow at Harvard Medical School and also a senior resident in internal medicine at BIDMC.

He and his colleagues note that a key message of their findings is that people without a history of cardiovascular disease who are taking **aspirin** daily to prevent **heart attack** or **stroke** should talk to their doctor about whether it is wise for them to continue.

Revised guidelines

Aspirin works by reducing the stickiness of blood platelets and, therefore, decreasing their ability to clot. However, this same property also raises the risk of bleeding.

Until recently, the medical community supported the daily use of low dose aspirin for the prevention of cardiovascular events — such as heart attack and stroke — by those at higher risk.

The view was that, for those individuals, the benefits outweighed the risks.

However, the publication of three major studies in 2018 revealed that for many people, the dangers of internal bleeding offset the few benefits of aspirin use.

Those findings prompted the American Heart Association and the American College of Cardiology to **revise the guidelines** on aspirin use for the prevention of cardiovascular disease.

The new guidelines now advise that adults aged 70 years and older should not use daily low dose aspirin for the primary prevention of cardiovascular disease. They define a daily low dose as 75–100 milligrams.

In addition, the guidelines explicitly recommend against daily low dose aspirin for the primary prevention of cardiovascular disease in people of any age who have a raised risk of bleeding.

The recommendations do not apply to individuals who have already experienced a heart attack or stroke or to those who have undergone procedures such as stent insertion or bypass surgery to prevent cardiovascular events.

In a message accompanying the revised guidelines, the American Heart Association **advise** that unless a doctor prescribes it, people should avoid taking aspirin every day….**Read More**

Calorie restriction may benefit healthy adults under 50

Calorie restriction is a type of diet that reduces calories without impacting nutrition. It can be achieved by eating less overall. Previous research has shown possible health benefits from long-term calorie restriction. Animal studies suggest that calorie restriction can delay progression of a number of age-related diseases.

Dr. William E. Kraus of Duke University led a team of researchers to investigate the health effects of calorie restriction in young and middle-aged adults who were not obese. The 2-year trial was supported by NIH's National Institute on Aging (NIA) and National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

The investigators randomly assigned 218 adults to either calorie restriction or their usual eating pattern. At the beginning of the study, the men and women were healthy and either normal weight or slightly overweight. Those in the calorie restriction group were given coaching over the course of the trial to help them try to achieve and sustain a 25 percent reduction in their daily caloric intake.

The researchers tracked energy intake and expenditure. On average, the 143 adults in the calorie restriction group maintained nearly 12 percent calorie restriction over the entire 2-year period. This group also achieved an average reduction of 10 percent in body weight, mostly body fat. The 75 adults in the control group had stable calorie intake and weight during the study.

The team published a **report in 2015** on the primary outcomes of the study, which were chosen to test whether calorie restriction would affect metabolism. They found that calorie restriction didn't affect body temperature. It lowered the resting metabolic rate for a time, but the difference wasn't significant at the end of 2 years.

In their new report, the researchers detailed outcomes related to risk factors for heart disease and diabetes. The findings were published on July 11, 2019, in *Lancet Diabetes and Endocrinology*.

Compared to the control group, calorie restriction substantially reduced waist measurements and blood pressure. Lab tests showed reduced LDL cholesterol and triglycerides. In addition, measures of inflammation, insulin resistance, glucose control, and metabolic syndrome greatly improved.

The findings suggest that modest calorie restriction may reduce the risk of heart disease and diabetes even in healthy adults who are not obese. "People can do this fairly easily by simply watching their little indiscretions here and there, or maybe reducing the amount of them, like not snacking after dinner," Kraus says.

More research is needed to understand how calorie restriction results in these benefits. The long-term impact of calorie restriction in healthy adults of normal weight also needs further study.

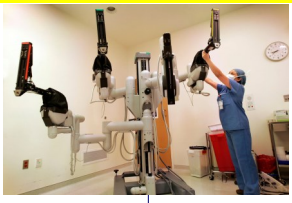
Robotic Surgical Tool, Not Medical Evidence, Drives Free Hernia Screenings

Some hospitals are trying a curious new tactic to attract patients: free hernia screenings.

One Illinois hospital **raffled off tickets for a smart speaker** to entice people to get their abdomens checked by a surgeon, while an Indiana hospital offered a chance to win dinner at a chophouse.

Announcements for screening events in **Colorado** and **Maryland** warned about "life-threatening" complications that could arise if hernias are left untreated. And hospitals in **Georgia** and **California** included a chance to "test-drive" a surgical robot.

Hospitals say such screenings provide valuable education about treatment options for the common medical condition, in which part of the intestine protrudes through a weak spot in the abdominal wall.



But no research has been done on hernia screenings, and some experts worry that these outreach efforts — some of which showcase da Vinci robotic surgery devices made by **Intuitive Surgical** based in Sunnyvale, Calif. — could lead people to get potentially harmful operations they don't need.

"My question is: Why are we doing this?" said University of Michigan Medical School associate professor Dr. **Dana Telem**, the director of Michigan Medicine's Comprehensive Hernia Program. "Even with the best intent, it makes me worry about the unintended consequences down the line."

A Common Condition

An estimated 1.6 million groin hernias are diagnosed and 500,000 are surgically repaired annually in the U.S., according to the Centers for Disease Control and Prevention. Some 27% of men and 3% of women are expected to have a groin hernia — the most common type — during their lifetimes.

Hernias can cause pain and abnormal bulges, and many patients eventually opt to get them fixed with surgery. Surgery can also prevent a rare but serious condition called strangulation, in which a hernia can entrap the intestine and cut off blood flow, requiring emergency surgery.

However, complications from hernia surgery are common. While any surgery carries risks, such as infection, groin hernia repairs leave as many as 12% of patients with chronic pain that can be debilitating, according to a 2016 study.

There's also good evidence that people who have few symptoms can safely opt for **watchful waiting** rather than go under the knife, according to a 2018 article in JAMA. But such cautionary information is often missing in hospital screening announcements.

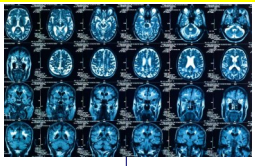
In fact, experts, including the American College of Surgeons, say there's no data to back the use of such hernia screenings.

"A screening for hernia? That makes no sense to me," said Dr. **Michael Rosen**, director of the Cleveland Clinic's Hernia Center and medical director of the Americas Hernia Society Quality Collaborative, a consortium that tracks treatment outcomes. "Obviously, it's just there to drive people to the operating room." ….**Read More**

Artificial intelligence is taking an increased role in diagnosing and treating cancer

Doctors hope the future of cancer treatment is personal: Using genetics, they'll be able to match patients with precisely the drug or treatment option that will fight their tumors. However, information on tumor genetics often isn't linked with data on how well patients with those tumors did on particular treatments. This makes it difficult for researchers to tailor treatments to individual patients. "Sometimes all that's known is how long patients lived who had a particular pathology, if that's even known," says Kenneth Kehl, a medical oncologist at the Dana-Farber Cancer Institute in Boston. "Asking questions like which mutations predict benefit from a particular treatment has been more challenging than one might expect."

To help ease those challenges, Kehl worked on a team that developed a machine learning algorithm that could pull information from doctors' and radiologists' notes in electronic health records in order to identify how particular patients' cancer progressed. Their tool, **published this week** in the journal *JAMA Oncology,* might in the future help identify patients who could benefit from clinical trials or other specific interventions—and it's a piece of larger efforts to bring artificial intelligence into oncology.



Most of the information about the progression of tumors in cancer patients is contained in written notes from radiologists, who examine scans and track changes in the status of the cancer. Because it's raw text—not choices from a drop-down menu or data points in a spreadsheet—most analytic methods can't pull the relevant information. The tool created in this study leveraged improvements in machine learning for language to identify those details in electronic health records.

The machine learning system was able to identify cancer outcomes as well as human readers, and much more rapidly. Human readers could only get through three patient records an hour. The tool would be able to analyze an entire cohort of thousands of cancer patients in around 10 minutes.

Hypothetically, Kehl says, the tool could be leveraged to sweep the health records of every patient at an institution and identify those who are eligible for and would need clinical trials, and match them to the best possible treatments based on the characteristics of their disease. "It's possible to find patients at scale," Kehl says.

For this particular tool, the scans from cancer patients were initially read by human radiologists. But artificial intelligence and machine learning can read images, as well, and research shows that they can analyze scans of tumors as effectively as human radiologists. **In another study** published this month, radiologists and artificial intelligence experts partnered to develop an algorithm that could determine if lumps on a thyroid should be biopsied—and found that recommendations from the machine learning tool recommended biopsies similarly to expert radiologists using the American College of Radiology (ACR) system.…**Read More**

Stopping statins may increase cardiovascular risk

.A large new study following thousands of participants found that older people who stop taking statins have a significantly increased risk of hospital admission due to cardiovascular problems.

Statins are a class of drugs that people take to keep their blood **cholesterol** levels under control.

Aside from this, they also have another use — that of **protecting against heart disease** and other cardiovascular conditions and events.

However, statins' effectiveness in protecting the heart health of older individuals has remained a matter of debate.

Knowing this, Dr. Philippe Giral, from Pitié-Salpêtrière Hospital in Paris, France, and a team of specialists set out to investigate how giving up statins could affect the health of healthy individuals aged 75 years and over.

"A particularly relevant practical question is whether existing statin therapy can be stopped in older people with no history of cardiovascular disease," write Dr. Giral and colleagues in their study paper, which appeared today in the ***European Heart Journal***.

"This issue," the researchers add, "currently concerns a large proportion of the population over the age of 75 years, as well as large numbers of people under the age of 75 years, currently taking evidence-based treatment with statins and reaching ages for which only limited evidence of efficacy is available."

Warning for those taking statins preventively

In the current study, the team analyzed the health information of 120,173 participants living in France. All of these individuals reached the age of 75 years between 2012 and 2014, had no history of cardiovascular disease, and had been taking statins regularly in the 2 years prior to joining the study….**Read More**

Study: Getting the right medicine after a heart attack may depend on where you live

Where heart attack survivors live in the U.S. may affect their chances of getting the best medication to prevent a second attack, a new study suggests.

Researchers found that New Englanders were most likely to get the right therapy after a heart attack, while those in the central part of the country were least likely.

Women overall were less likely than men to receive the appropriate medication after a heart attack, according to the report in JAMA Cardiology.

"We know from clinical trials that individuals at high risk for a (heart attack or) who just had a (heart attack) ... do better with high-intensity statin therapy than with moderate-intensity statin therapy, and that moderate-intensity is better than no statin," said the study's lead author, Dr. Vera Bittner, section head of general cardiology, prevention and imaging at the University of Alabama, Birmingham.

High-intensity and moderate-intensity statin therapy are defined by how much they reduce levels of LDL-cholesterol in the blood, she explained. On average, high-intensity statins achieve about a 50% reduction and moderate-intensity statins achieve about a 30% reduction.

To take a closer look at whether geography plays a role in the prescribing of high-intensity statins to heart attack survivors, Bittner and her colleagues studied Medicare data on nearly 140,000 patients aged 66 and older who were hospitalized for a heart attack in 2014 or 2015.

When they analyzed the data by geographic region, they found that patients from New England were the most likely to receive a high-intensity statin (73%), while those from the West South Central U.S., which included states such as Arkansas, Oklahoma and Louisiana, were the least likely (41%).

Patients in larger hospitals (with 500 or more beds) were also more likely than those in the smallest hospitals (with fewer than 100 beds) to get high-intensity statins: 59% versus 39%. Women were less likely than men to get high-intensity statins: 49% versus 56%.

Bittner and her colleagues don't know why patients from certain areas of the country are less likely to receive high-intensity statins after a heart attack.

"The regional differences are evident even when we adjusted for patient and hospital characteristics," she said in an email. "It is also unlikely to be lack of access to information on the healthcare providers' part - guidelines are easily accessible on the internet, so are conference proceedings, papers, etc. It is also not access to prescriptions because our population only included individuals with Medicare Part D prescription coverage."

Bittner hopes the new findings will spur hospitals all around the country to scrutinize their own data.

"If they find underutilization," she said, "then they should develop treatment pathways designed to improve the treatment gap: something as simple as a checklist on discharge for patients with a (heart attack) that asks the clinician 'Is this patient going home on a high-intensity statin? Yes/No, if no provide reason,' may help."

The new findings make sense in light of earlier research showing that the same areas of the country with lower prescription rates for high-intensity statins are also the ones with the highest heart disease death rates, said Dr. Suzanne Steinbaum, director of Women's Cardiovascular Prevention, Health and Wellness at The Mount Sinai Hospital in New York City.

If physicians are part of the problem, "then we really need to take a look at this study and make sure we are part of the solution," Steinbaum said. While the researchers found an overall increase in the use of high-intensity statins, from 23% in 2011 to 56% in 2015, "an almost two-fold improvement, quite frankly, is not impressive," she added.

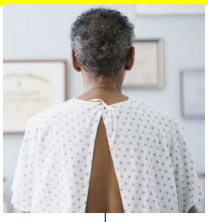
Steinbaum was also concerned that women still aren't getting the same treatment after a heart attack as men. "Sadly, it's not surprising," she said. "But it's never not upsetting. The guidelines are very clear. We need to be treating everyone equally."

Why Are Older Men Bailing Out on Testosterone Therapy?

If you're an older man thinking about testosterone therapy to improve your mood, energy and sex drive, there's an important distinction to be made: Do you actually have low testosterone levels, confirmed by blood tests? Or do you have normal or low-normal testosterone levels but want to try treatment anyway?

Among men who have genuinely low testosterone – officially called hypogonadism but also known as "low T" – and are experiencing certain symptoms, testosterone replacementmay help. Fatigue, increased body fat, reduced sex drive and erections, difficulty concentrating and other symptoms could be signs of low testosterone.

However, older men with normal testosterone levels won't find a burst of youth from testosterone treatments. Prescription testosterone isn't really helpful in these cases, research suggests, and may expose men to unnecessary health risks.



Testosterone is a male hormone, or androgen, largely produced in the testicles. With effects on bone density, muscle size and strength, body fat distribution, facial and body hair, sperm production, sex drive and red blood cell production, testosterone plays multiple roles in maintaining men's health.

Testosterone levels shift throughout males' lives. In puberty, which generally occurs in boys between 10 and 14, testosterone production increases. From its peak levels in adolescence and early adulthood, testosterone gradually declines about 1 percent a year after a man reaches roughly 30 to 40 years old.

According to the Endocrine Society, the normal total testosterone range is about 265 to 915 nanograms per deciliter for younger men ages 19 to 39. Guidelines discourage doctors from prescribing testosterone unless blood levels are clearly low. In the absence of symptoms in men ages 65 and older, low testosterone levels alone shouldn't routinely lead to prescribing testosterone therapy, according to the society's recommendations.

Tide Turning

Following an earlier surge in testosterone treatment spurred by heavy marketing, doctors today are writing fewer testosterone prescriptions.

In 2013, a study encompassing insurance prescription data on more than 10 million men ages 40 and older from 2001 to 2011 was published in JAMA Internal Medicine. Over that decade, androgen replacement therapy – testosterone prescribed in the form of topical gels, skin patches, pills and injections – more than tripled.

Then the trend reversed. Testosterone prescriptions for U.S. men ages 30 and older decreased by 48 percent overall from 2013 to 2016, according to findings published July 10, 2018, in JAMA after researchers revisited the database.

In the five-year period between studies, findings on possible **heart attack** and **stroke risksfrom** testosterone treatment appeared in several high-impact medical journals. In October 2016, the **Food and Drug Administration** approved changes to testosterone labeling to highlight the potential for heart-related side effects and mental health/abuse risks of testosterone products….**Read More**

AHA News: Here's How Many Years You Could Gain by Keeping Heart Disease at Bay

Heart disease is the nation's No. 1 cause of death, killing about 650,000 people every year. Life expectancy is cut short by the disease and the health problems that stem from it. But by how much – and what can people do to take those years back?

For heart attacks alone, more than 16 years of life are lost on average, according to American Heart Association statistics. Researchers estimate people with heart failure lose nearly 10 years of life compared to those without heart failure.

"In the past few years, there have been tremendous gains in reducing cardiovascular disease and increasing life expectancy, but we've hit a plateau," said Paul Muntner, an epidemiologist at the University of Alabama at Birmingham.

Some people are at greater risk than others.

African Americans, for example, are more likely to have high blood pressure, obesity and diabetes, and they live 3.4 years less than their white counterparts. Among the six largest Asian American subgroups, research shows Asian Indian, Filipino and Vietnamese populations lose the most years of life to heart disease – up to 18 years for some – compared with white people.

The risk of early death also is high for people with a history of diabetes, stroke and heart attack. Reporting in the *Journal of the American Medical Association* in 2015, researchers found people with all three conditions had their life expectancy cut by 15 years compared to those without any of the health problems. Even having just two of the conditions reduced life expectancy by 12 years.

But there is hope. A 2012 study found non-smokers without diabetes who had optimal cholesterol and blood pressure lived an average of 14 years longer than people with two or more of those risk factors.

"Applying a healthy lifestyle, even taking a small step, like a brisk 30-minute walk five times a week, can add up to a longer life," said Yanping Li, a senior research scientist at the Harvard T.H. Chan School of Public Health.

Li led a recent study showing women who adapted a healthy lifestyle could expect to live 14 years longer than those who didn't, while men would have 12 additional years of life.

"The healthier lifestyle, the longer life expectancy," Li said.

"Even modest changes have been shown to reduce cardiovascular risk by 20% to 30%," Muntner said. "If we can just shift the curve a little bit, there will be incredible gains in terms of life expectancy as well as reducing cardiovascular risk."

Great strides have been made in the past 50 years, Muntner said. Far fewer people develop hypertension and high cholesterol, and many who do are being treated. Rates of obesity and diabetes, on the other hand, are skyrocketing.

"We have a long way to go, but I think we can do it just based on what we've seen in the past," Muntner said. "It's not just about living longer. Preventing heart disease and strokes will also lead to a higher quality of life."