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# RI ARA

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



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## December 8, 2019 E-Newsletter


The Alliance for Retired Americans, together with leaders of 17 labor unions, **released a strong statement** today in opposition to Senate Republicans' proposal for shoring up multiemployer pension plans.

The bill, sponsored by Senators **Chuck Grassley** (IA) and **Lamar Alexander** (TN), purports to address the multiemployer pension crisis but will in fact make it worse. It provides no federal financial assistance and imposes burdensome new costs that will most likely prompt the collapse of all multiemployer pensions.

"Contrast this to the over $700 billion that the government provided to the banks and Wall Street in 2008, or to the 2017 massive tax giveaway for corporations and multi-millionaires," said union leaders signed on to the statement. "Here, under the guise of a federal solution, Grassley and Alexander have crafted a tax increase that hits hardest those who do not bear responsibility for the financial challenges faced by troubled multiemployer pension plans—including retirees, pension plan participants, unions and employers."

There are other proposals that aren't so flawed and will be much more effective at tackling the multiemployer pension crisis. One of them, the Butch Lewis Act, has passed the U.S. House and now needs Senate approval.

1.3 million Americans' earned pension benefits are at risk. **Please click here to urge your Senators to pass the Butch Lewis Act.**

Robert Roach, Jr
ARA President

Congress bailed out Wall Street in 2008 and gave billions of dollars in tax breaks to corporations in 2017. It's time for them to help working and retired Americans in their time of need.

**Click here to send a message to your Senators.**

Sincerely,
Robert Roach, Jr. , President
Alliance for Retired Americans

## Alliance Mourns the Death of George J. Kourpias

### *"Founding President Set the Course for Activism and Growth"*

George J. Kourpias

**Washington, DC** - Members of the Alliance for Retired Americans are joined together in mourning the passing of George J. Kourpias, the beloved founding President of the Alliance. He died on Monday, December 2 at age 87.

"Our condolences go out to his wonderful family who meant so much to him, and to all of the retirees and union members who benefited from his lifetime of work on their behalf," said Robert Roach, Jr., current Alliance president. "George was a great friend and mentor to me personally for decades. He showed me what it meant to successfully represent union members."

"Countless retirees and union members are leading better lives today because of the life and work of George Kourpias," said Richard Fiesta, Executive Director of the Alliance. "His dedication to retirees came straight from the heart. He was an inspirational leader driven by his warmth and passion to make America a place where everyone regardless of background had the opportunity to work and retire with dignity."

Under Kourpias's leadership from 2001 to 2009, the Alliance for Retired Americans became a national grassroots organization dedicated to improving the quality of life for its members and all older Americans. From organizing bus trips to Canada to demonstrate outrageous U.S. drug prices to fighting greedy Social Security and Medicare privatization schemes to electing pro-retiree candidates, he never wavered in his belief that the American people have the power to create a more just society.

Prior to becoming Alliance president in 2001, he served as president of the National Council of Senior Citizens. A member of the International Association of Machinists and Aerospace Workers for 67 years, Mr. Kourpias served eight years as its international president from 1989 to 1997.

# No Itch to Switch: Few Medicare Beneficiaries Switch Plans

Each year, Medicare beneficiaries in private Medicare Advantage plans and Part D stand-alone prescription drug plans (PDPs) have the opportunity to change plans during the annual open enrollment period (October 15 to December 7). Medicare's private plans vary significantly from each other and can change from one year to the next, which can have a significant impact on enrollees' coverage and costs. The Centers for Medicaid & Medicare Services (CMS) encourages beneficiaries to shop for Medicare Advantage and prescription drug plans to potentially save money on prescriptions or get new benefits.

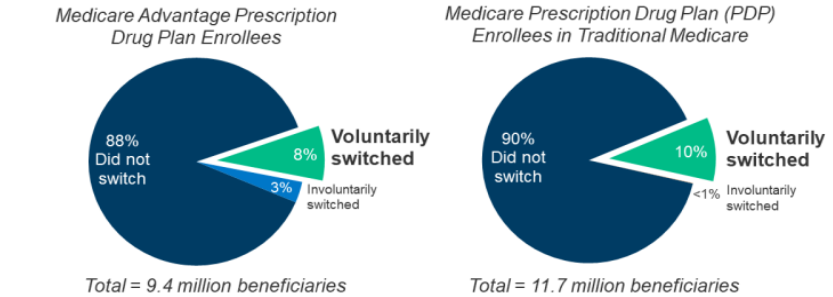
Understanding how Medicare private plan markets are working is increasingly important for both beneficiaries and the Medicare program overall. Many presidential candidates and policymakers have proposed establishing a public program, modeled on Medicare, to expand coverage, while others want to expand the role of private plans within Medicare itself. To inform these discussions, this analysis examines the share of people enrolled in Medicare Advantage prescription drug plans (MA-PDs) and PDPs who switched plans for the following year during the open enrollment periods between 2007 and 2016, the most current year available for analysis of Medicare private plan switching rates. This analysis excludes enrollees with low-income subsidies; more detailed methods are described below.

Overall, a small share of MA-PD and PDP enrollees without low-income subsidies (8% and 10%, respectively) voluntarily switched to another plan during the 2016 annual open enrollment period for the 2017 plan year (Figure 1)…

Among 9.4 million MA-PD enrollees without low-income subsidies, 7.6 percent (710,000 beneficiaries) voluntarily switched to another MA-PD during the 2016 open enrollment period for 2017, and another 0.9 percent (90,000 beneficiaries) switched from an MA-PD to traditional Medicare (with a PDP). Among 11.7 million PDP enrollees without low-income subsidies, 8.3 percent (980,000 beneficiaries) switched to another PDP and another 1.7 percent (200,000 beneficiaries) switched to an MA-PD during the 2016 open enrollment period for 2017. (A very small share of Part D enrollees switch to MA-only plans or traditional Medicare without Part D coverage; they are excluded from this analysis.).**Read More**

Figure 1

Only a Small Share of Medicare Advantage and Part D Prescription Drug Plan Enrollees Voluntarily Switched Plans Between 2016 and 2017




NOTE: Excludes beneficiaries in cost plans and employer group waiver plans; those originally or currently entitled to Medicare coverage due to ESRD; those with LIS eligibility; those who died in the year of open enrollment; those for whom it is not known whether they would have changed their coverage voluntarily or involuntarily; and those not enrolled in both Parts A and B during November and December of the year of open enrollment. Numbers may not sum due to rounding.

SOURCE: KFF analysis of Centers for Medicare & Medicaid Services Chronic Conditions Data Warehouse, 5% sample (2016) and 20% sample (2017).

KFF HENRY J. KAISER FAMILY FOUNDATION

# Proposed Rule Would Drastically Affect Access to Food Stamp Benefits

This week, the Medicare Rights Center provided comment to the Food and Nutrition Service (FNS) in response to a proposed rule that would dramatically affect access to benefits by cutting billions of dollars of funding from the Supplemental Nutrition Assistance Program (SNAP), also referred to as food stamps.

Changes to SNAP benefits directly impact the individuals Medicare Rights serves. Many older adults and people with disabilities who are Medicare enrollees are also SNAP recipients, and this access to affordable, nutritious food is essential to helping them build and maintain their health and well-being. Cuts to SNAP, therefore, would exacerbate existing health and financial challenges for people with Medicare and put more people at risk of serious harm.

MEDICARE RIGHTS CENTER Getting Medicare right Blog

Our comments to this proposed rule, like many of our comments, focus on the stories and experiences we hear on our national helpline. Calls from individuals who are struggling to make ends meet and are choosing between paying their health care, housing, heating, and food bills reflect the need for improvements to, not cuts from, benefits and programs that provide a safety net. Over 5 million older adults were food insecure in 2017 and disability is a risk factor for food insecurity even in moderate income households.

Cuts to SNAP undermine Medicare's efficacy – the links between SNAP and improved nutrition and between improved nutrition and health are well established. The specific proposed cuts–which would disallow states from making state-specific adjustments to SNAP budgets in response to state-specific utility costs–would predominately impact northern states with higher heating costs, including some of the states with the highest percentages of older adults, including Pennsylvania, North and South Dakota, Iowa, Rhode Island, Maine, and Connecticut.

This proposal is particularly alarming when considered alongside the Trump administration's other efforts to cut SNAP. Just yesterday the administration **finalized a rule** that would weaken the program by imposing work requirements on SNAP recipients, a move that is without merit and expected to cause hundreds of thousands of people to lose access to the program. Meanwhile, another proposed rule would change how the federal poverty level is determined and potentially cut eligibility for SNAP, as well as other programs on which older adults and people with disabilities rely, including Medicare's low income assistance programs and Medicaid.

Accordingly, we urge FNS to withdraw this proposed rule in its entirety. Rather than seeking to cut benefits, the administration must do more to ensure that all Americans have access to the services and supports they need to live with health, dignity, and choice.

**Read our comments.**

# Major problem with the on-line Medicare Cost Finder, Continuing Resolution

An urgent story came out on Monday which reported that there is a major problem with the on-line Medicare Cost Finder that millions of seniors on Medicare use to make their choice of which Medicare supplement to use. According to the on-line news source Pro-Publica, the Medicare Cost Finder was redesigned for seniors to compare complex health insurance options. "But consumer advocates have identified instances when the tool has malfunctioned and given inaccurate plan and price data."

The report gives as an example a Medicare consultant in Wisconsin who said she used the tool to research three prescription drug plans for a client. The comparison page, which summarizes total costs, showed all but one of her client's medications would be covered. However, when she clicked on "plan details" to find out which medicine was left out, the plan finder then said all of them were covered.

So she started checking the plans' websites, and it turns out there are two versions of the same high blood pressure medication. One is covered. The other is not. The difference in price: $2,700 a month.

In another instance, EnvisionRxPlus, a prescription drug plan, sent an email to independent insurance brokers nationwide recommending they not use the Medicare Plan Finder because of incorrect estimates on drug prices and patient deductibles.

Because of these errors TSCL, other senior advocates and Medicare advisers are concerned that the problems caused by the tools' inaccuracies will not show up until the 2020 coverage year begins and as seniors head to pharmacies to fill prescriptions or show up for medical appointments.

As of Wednesday of this week there is no advisory on the government's official Medicare website that there may be significant problems with the cost finder. The end of the Medicare enrollment period is December 7 and unfortunately there seems to be no way to deal with this problem. **States do offer help through the federally supported Senior Health Insurance Program (SHIP), which offers free, one-on-one, counseling to those eligible for Medicare, their families and caregivers.** We suggest that you contact someone from that program in your state and ask for help in enrolling for next year.

# Website Errors Raise Calls For Medicare To Be Flexible With Seniors' Enrollment

Saturday is the deadline for most people with Medicare coverage to sign up for private drug and medical plans for next year. But members of Congress, health care advocates and insurance agents worry that enrollment decisions based on bad information from the government's revamped, error-prone Plan Finder website will bring unwelcome surprises.

Beneficiaries could be stuck in plans that cost too much and don't meet their medical needs — with no way out until 2021.

On Wednesday, the Centers for Medicare & Medicaid Services told Kaiser Health News that beneficiaries would be able to change plans next year because of Plan Finder misinformation, although officials provided few details. And the **Medicare.gov** website and representatives at Medicare's call center had no information about that option.

The overhauled **Plan Finder** debuted at the end of August, and 2020 plan information was added in October. Over the past three months, Plan Finder problems reported to CMS by the **National Association of Insurance Commissioners,** the National Association of Health Underwriters, and state and national consumer advocates included inaccurate details about prices, covered drugs and dosages, and difficulty sorting and saving search results, among other things.

CMS made almost daily corrections and fixes to the website, which is the only tool that can compare dozens of private drug and medical plans — each with different pharmacy networks, covered drugs and drug prices. The website provides information for more than 60 million people with Medicare and their families, as well as state Medicare counselors and the representatives who answer the 800-MEDICARE help line.

In an **unsigned blog article** published on a Medicare website last week, officials said they're "not done improving the Plan Finder." And they promised "in the coming months we'll be scoping out additional improvements that we can implement based on lessons we learn this year."

Although CMS has earned praise for responding to errors identified by Plan Finder users, some people may have signed up for plans before the mistakes were caught — mistakes they may not notice until their coverage kicks in next year.

"Seniors should be able to choose the plans that work best for them," said Sen. Susan Collins (R-Maine), chairwoman of the Senate Special Committee on Aging. "Issues with Medicare's new Plan Finder website, however, have reportedly created confusion among beneficiaries as well as those assisting them." She added that she was concerned "this problem even occurred."

Medicare's response, Collins said, "must be vigorous with extensive outreach to inform seniors of special enrollment periods."

Sen. Bob Casey of Pennsylvania, the senior Democrat on that committee, also said Medicare needs to reach out so people know they can request a "special enrollment period" if they discover next year they made a wrong choice due to inaccurate Plan Finder information.

"People with Medicare must be aware that this reprieve exists and should not have to jump through hoops to qualify," he said. The administration should "use all means necessary" to let beneficiaries know about their options for a special enrollment period.

In the statement to KHN Wednesday, CMS said it provides special enrollment periods for **a number of reasons**. It added that beneficiaries can get a special enrollment period related to Plan Finder issues anytime next year.

They can "call 1-800-MEDICARE and explain to our call center representatives that they have an issue with their plan choice. It is not CMS's expectation that beneficiaries will have documentation or screenshots," the statement said. The call center representatives "are trained and ready to help the beneficiary through the rest of the process."

CMS officials refused to be identified but would not give a reason….**Read More**

# Social Security Expands Public Hours at Offices Nationwide

**Wednesdays to Return to Full Public Service Hours; Agency to Hire 1,100 Direct Service Employees**

Starting on January 8, 2020, Social Security offices nationwide will be open to the public on Wednesday afternoons, Andrew Saul, Commissioner of Social Security, announced. This change restores Wednesday public service hours that were last in place in late 2012. "I don't want someone to come to our office at 2:30 on a Wednesday only to find our doors closed," Commissioner Saul said.

In another move to improve service to the public, Commissioner Saul announced in his Open Letter to the Public at **www.ssa.gov/agency/coss-message.html** that the agency is hiring 1,100 front line employees to provide service on the agency's National 800 Number and in its processing centers. The agency is currently bringing onboard 100 new processing center employees and approximately 500 new teleservice representatives for the 800 Number. An additional 500 hires for the 800 Number will occur later in 2020.

"Improving service is my top priority. Increasing full public service hours at our nationwide network of more than 1,200 field offices is the right thing to do and will provide additional access," Commissioner Saul said. "The hiring of a thousand new employees to provide service through our National 800 Number and an additional 100 hires to process people's Social Security benefits at our processing centers around the country are steps in the right direction in our mission to greatly improve the service we provide."

Currently, a field office is generally open to the public from 9:00 a.m. to Noon on Wednesdays. Beginning on January 8, 2020, offices will remain open until 4:00 p.m. on Wednesdays, with typical field office hours from 9:00 a.m. until 4:00 p.m., Monday through Friday.

While the agency continues to improve both the access to and the experience with its services, it is important to note that most Social Security services do not require the public to take time to visit an office. People may create a *my* Social Security account, a personalized online service, at **www.socialsecurity.gov/myaccount**.

Through their personal *my* Social Security account, people can check personal information and conduct business with Social Security. If they already receive Social Security benefits, they can start or change direct deposit online, and if they need proof of their benefits, they can print or download a current Benefit Verification Letter from their account.

People not yet receiving benefits can use their online account to get a personalized *Social Security Statement*, which provides earnings history information as well as estimates of future benefits. Currently, residents in 40 states and the District of Columbia may request a replacement Social Security card online if they meet certain requirements. The portal also includes a retirement calculator and links to information about other online services, such as applications for retirement, disability, and Medicare benefits.

Many Social Security services are also conveniently available by dialing toll-free, **1-800-772-1213**. People who are deaf or hard of hearing may call Social Security's TTY number, **1-800-325-0778**.

# 'An Arm And A Leg': How Much For Stitches In The ER? Hard To Gauge Upfront

Sarah Macsalka had heard the stories about **how expensive an emergency room visit can be**, even for a minor complaint.

So when her 7-year-old son, Cameron, tripped and gashed his knee in the backyard, the ER was not where her family headed first. In fact, Macsalka did just about everything she could to avoid paying a big, fat bill to get Cameron's knee stitched up.

Ultimately, she failed.

Her adventure raises a big question: In a system where consumers are encouraged to "shop" for the best deal in health care, why is it so hard to get simple information, like a price?

On this week's episode of "An Arm and a Leg," we get some answers.

Instead of taking her son to the local emergency room for stitches, Macsalka took him to an urgent care clinic, one that provides patients with prices ahead of the service. There, the staff said stitching up Cameron's knee would cost $150.

But there was a problem. The clinic didn't have the topical anesthetic the doctor would need to numb Cameron's skin first.

"And Cameron is like screaming and crying," Macsalka said. "He doesn't take pain well."

So, reluctantly, the family headed to the local emergency room.

Macsalka tried to be a smart shopper there, too. When a staff member came to take her insurance information, Macsalka grilled him about how much the visit would cost.

"He was like, 'I don't know. Just walking through the ER [door] costs $600,'" she said.

To Macsalka, that sounded like a "facility fee" — a cover charge of sorts, separate from any health care services. And it sounded pricey. But she was over a barrel.

"The kid is still screaming and crying," she said. "His knee's a mess." She wasn't about to drive him back to the urgent care place and start over again.

They got the stitches in the ER. And, as it happened, the anesthetic wasn't very effective.

Macsalka said her son's screams were ear-piercing. "Yeah, Cameron's lungs did not give out," she said. "Those are very healthy lungs."

As it turned out, Macsalka's attempts to figure out what the final price would be weren't very effective either. A few weeks after the ER visit, she got a bill for the doctor's services and paid it: $214 after insurance.

Then there was another bill from the hospital. One line: $2,824.

Macsalka went back into smart-consumer mode. She called the hospital billing department and asked if there had been a mistake.

Macsalka said the person she spoke with on the phone told her that "just walking through the doors" of the emergency room cost $4,200. That amount matches a number on her insurance statement — an amount before the insurance company's negotiated discount.

After that discount, the bill was $2,824 — and because Macsalka's family had a high deductible, they were responsible for paying it all….**Read More**

# Congress: Pass the Strengthening Social Security Act Now

Nearly half of Americans rely on Social Security for 50% of their income, and a quarter of Americans over age 65 rely on Social Security for 90% or more of their income. The Strengthening Social Security Act would strengthen and expand this vital lifeline for retirees.

Sign the petition to help us urge Congress to take action to expand Social Security for current and future retirees!

**To: U.S. Congress**

Today's average monthly Social Security check is $1,461—barely above the federal poverty level of $1,041. Nearly 50% of Americans rely on Social Security for half their income and 25% of Americans over 65 rely on Social Security for 90% of their income.

The Strengthening Social Security Act (H.R. 2654) provides:

• an $800 annual benefit increase

• a lifetime guarantee of full benefits

I call on you as my elected representatives in the United States Congress to immediately pass this legislation and expand Social Security for all current and future beneficiaries.

Sincerely, Your Constituent

**Sign Petition Here**

# White House delays expansion of Agent Orange benefits, leaving 80K veterans to wait

The Trump administration should stop blocking Vietnam veterans with bladder cancer and three other diseases the government does not **recognize as tied to Agent Orange** from getting the benefits they deserve, two California congressmen said in a letter to the White House on Monday.

House **Veterans Affairs Committee Chairman Mark Takano,** D-Riverside, and Rep. Josh Harder, D-Turlock, sent a letter to **White House Acting Chief of Staff Mick Mulvaney** saying his decision to block bladder cancer, Parkinson's-like symptoms, hypothyroidsism and hypertension from being added to a list of conditions that are tied to Agent Orange was "despicable."

"My grandfather served in Vietnam, was exposed to Agent Orange, and died from cancer as a result of his service – but his story is not uncommon. I refuse to stand by and let other veterans die because they didn't get the health care they need," Harder said. "Some bureaucrat shouldn't be able to block health care for all these folks just to save a buck. It's rotten, and it's not who we are."

If the diseases were added, it would make it easier for veterans to get Department of Veterans Affairs benefits and covered health care.

Former VA secretary David Shulkin tried to get at least three of those diseases — possibly excluding hypertension — added in 2017 but the White House opposed the recommendation, saying more research was necessary.

Shulkin, contacted Tuesday by McClatchy, said that the administration's rationale — that additional research was needed, on top of what had been done by the National Academies of Sciences, Engineering and Medicine and other organizations — did not serve veterans who have waited for decades for the VA's help.

"There's not always perfect scientific evidence when you are looking at issues from 50 years ago," Shulkin said. Shulkin was removed as VA secretary in March 2018 and replaced with current secretary Robert Wilkie.

An estimated 83,000 veterans have one of the three conditions that would be added to the list of "presumptive conditions," ailments that are presumed to be connected to Agent Orange, a toxic herbicide the military used during the Vietnam War.

The White House did not respond to a request for comment on the record. The OMB did not respond to a request for comment.

VA spokeswoman Christina Mandreucci said officials are still awaiting the results of two studies, the **Vietnam Era Health Retrospective** Observational Study and the **Vietnam Era Mortality Study**, before they make further decisions on this issue.

"VA is committed to regular review of all emerging evidence of adverse impacts to Veterans from Agent Orange, but the department will not be announcing any new presumptive conditions until there is sufficient evidence to support an informed decision," Mandreucci said.

Vietnam Veterans of America executive director for policy and government affairs Rick Weidman said the two ongoing studies will be "of limited use."

"You've got the science, it's already done," said Weidman, who served as an Army medical corpsman in Vietnam. "Shulkin got it forward and OMB slapped it down."

Shulkin said that when the **OMB turned down the three additional conditions** last year, it was not clear if the agency's call for additional research meant that a decision was "just being kicked down the road, or if it was being definitely declared that the answer was 'no,'" he said.

"If it was 'no,' then legislation is probably the best way to go," he said.

This fall McClatchy in an exclusive investigation of all **cancer billings at the VA** from fiscal year 2000 to fiscal year 2018 found that the rate of urinary cancer treatments rose 61 percent in that timeframe.

Harder also plans to introduce a resolution – a companion to a Senate resolution by Sen. Sherrod Brown, D-Ohio – to encourage President Donald Trump to add Parkinson's-like symptoms, bladder cancer, hypertension and hypothyroidism to this list of presumptive coverage for Vietnam veterans. A resolution would not mandate such coverage.

It's the latest of multiple congressional efforts to push Mulvaney and OMB to expand benefits and care for veterans for a war they fought more than 50 years ago. On Jan 1, 2020, the VA will begin to process claims for **Navy and Coast Guard veterans who were also exposed to Agent Orange**, but were not included in the original covered care, which only covered land forces.

Harder cosponsored that legislation and has held workshops in his district to help area veterans apply for those newly available benefits.

**Five Democratic senators wrote a letter** similar to Harder and Takano's in October, asking OMB to "stop blocking" presumptive coverage for the three conditions. The lawmakers also include hypertension in the list of conditions they say VA must cover, as did Harder and Takano.

"We are frustrated that previous letters addressed directly to you have gone unanswered," wrote the five senators, led by the top Democrat on the Senate Veterans Affairs Committee Jon Tester, D-Montana. They called current scientific evidence "overwhelming."

# RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

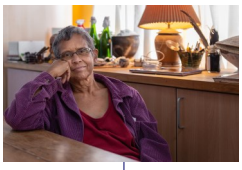
## Medical Device Failures Brought To Light Now Bolster Lawsuits And Research

Lorraine Bonner felt as though she was the only one. The surgical staples used to seal her colon after surgery had leaked, she has alleged in a lawsuit, spurring additional surgeries and a long, difficult recovery.

And then, just over a year after the ordeal, she read **a Kaiser Health News investigation** that described worse cases. KHN revealed that the Food and Drug Administration had allowed stapler maker Covidien to quietly file tens of thousands of reports of stapler malfunctions into a then-hidden database.

Alarmed that others had been harmed and reports had been hidden, Bonner, a retired Oakland, Calif., doctor, decided to go forward with a lawsuit against the stapler maker.

"If the information had been out there, then maybe Covidien would have changed the design of the staplers and made them safer," she said, "and that would have obviated the problem in the first place."



Bonner's lawsuit is one example of how a vast cache of records that were released this summer are taking on a life of their own.

For almost 20 years, malfunctions and injuries linked to 108 medical devices, including dental implants and pacemaker leads, were funneled into an FDA database that few patients, doctors or even FDA officials knew existed.

In 2016, for example, Covidien reported 84 injuries or malfunctions in the public database known as MAUDE, while nearly 10,000 incidents flowed into the hidden database, KHN reported in March. A few MAUDE reports mentioned the existence of an "alternative summary reporting" program, but until this summer, the FDA made that internal data available only through the Freedom of Information process, which can take up to two years.

KHN's investigation prompted then-FDA commissioner Scott Gottlieb to pledge in a tweet to open the hidden data to the public. The agency released all 5.7 million records in June.

Since then, researchers, lawyers and the FDA's own officials have taken a closer look at the data to learn more about which devices malfunctioned, and how often.

Libbe Englander, the founder and CEO of Pharm3r, a medical data consulting firm, discovered that the devices in the hidden database were much riskier than other devices tracked by the FDA.

Her firm **concluded that** the hidden reports were "more likely to be associated with life-threatening devices and to contain potentially serious problems."

For example, just 10% of the devices tracked in the MAUDE database are implanted in the body. But 44% of those in the hidden data are lodged in a patient's body, including pacemakers and heart valves.

The Pharm3r report also found that the devices in the hidden data were more likely to be subject to a Class 1 recall, initiated when a device problem could cause serious injury or death. The report also underscored how vast the now-open data is — accounting for about 40% of the total device-problem reports lodged with the FDA over the past two decades..

The once-hidden reports also figured into the ECRI Institute's annual list of health technology hazards, a list circulated to hospitals and health systems..

**...Read More**

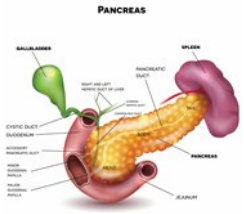
## Israeli scientists find way to treat deadly pancreatic cancer in 14 days

The tumor in one mouse that was injected with human cancer cells completely disappeared.

A new treatment developed by **Tel Aviv University** could induce the destruction of pancreatic cancer cells, eradicating the number of cancerous cells by up to 90% after two weeks of daily injections of a small molecule known as PJ34.

**Pancreatic cancer** is one of the hardest cancers to treat. Most people who are diagnosed with the disease do not even live five years after being diagnosed.

The study, led by Prof. Malka Cohen-Armon and her team at TAU's Sackler Faculty of Medicine, in collaboration with Dr. Talia Golan's team at the Cancer Research Center at Sheba Medical Center, was recently published in the journal *Oncotarget*.




Specifically, the study found that PJ34, when injected intravenously, causes the self-destruction of human cancer cells during mitosis, the scientific term for cell division.

The research was conducted with xenografts, transplantation of human pancreatic cancer into immunocompromised mice. A month after being injected with the molecule daily for 14 days, "there was a reduction of 90% of pancreatic cells in the tumor," Cohen-Armon told The Jerusalem Post. "In one mouse, the tumor completely disappeared."

"This molecule causes an anomaly during mitosis of human cancer cells, provoking rapid cell death," she said. "Thus, cell multiplication itself resulted in cell death in the treated cancer cells."

Moreover, she said, PJ34 appears to have no impact on healthy cells, thus "no adverse effects were observed." The mice, she said, continued to grow and gain weight as usual.

She added that she first published about the mechanism in 2017 when it was used to effectively treat triple-negative breast cancer implanted in xenografts. This type of breast cancer – which tests negative for estrogen receptors, progesterone receptors and excess HER2 protein – like pancreatic cancer, is very hard to treat and many women don't live more than five years after being diagnosed.

Though Cohen-Armon said the team did not specifically study whether or not the treatment could prolong the lifespan of a patient, one can assume such an effect could result if the cancerous cells are eliminated.

How long will it take to move from mice trials to human trials?

She estimates that would take "at least two years on the condition that we get enough funding."

First, she said, the group will test the treatment on pigs and then apply for permission from the FDA to administer humans with this molecule.

"I am optimistic," Cohen-Armon concluded.

# MRIs of Dense Breasts Find More Cancer but Also False Alarms

Giving women with very dense breasts an MRI scan in addition to a mammogram led to fewer missed cancers but also to a lot of false alarms and treatments that might not have been needed, a large study found.

The results give a clearer picture of the tradeoffs involved in such testing, but they can't answer the biggest question — whether it saves lives.

For women with dense breasts trying to decide on screening, "the dilemma remains," Dr. Dan Longo of the New England Journal of Medicine wrote in an editorial published with the study on Wednesday.

About half of women over 40 have dense breasts and about 10% have very dense ones. That raises their risk of developing cancer and makes it harder to spot on mammograms if they do. U.S. regulators are making rules to require that women get breast density information when they have mammograms, and many places provide it now. But what to do if you have dense breasts is unclear — it's not known if more or different types of screening such as MRIs or ultrasounds help.

The study involved more than 40,000 Dutch women ages 50 to 75 with very dense breasts who had normal results from a mammogram, a screening X-ray offered every two years in the Netherlands. About 8,000 of them also were offered an MRI scan, which uses powerful magnets to create detailed images, and 4,783 women agreed. Researchers then tracked how many breast cancers were detected in each group within two years. Finding more of these "interval cancers" implies that the initial screening may have missed them.

The rate of these cancers after two years was twice as high in the group that was only offered mammograms. This suggests that adding MRIs to initial screening did catch more cancers, but they also gave a lot of false alarms— about 80 per 1,000 scans. Three quarters of women who had a biopsy after a questionable MRI turned out not to have cancer.

MRIs also led to more side effects during the scan or later testing, such as fainting or problems from an IV. And they cost much more than mammograms.

The study only looked at the first two years of screening with MRIs and it's too soon to say whether the test will save lives.

Without such evidence, it's tough to say what value there is in finding more cancers, especially many very small, early stage ones, Longo wrote. Doctors already know that some of these will never cause symptoms or become life-threatening.

"Our dilemma is that, for most tumors, we cannot tell the difference between cancers that can kill you and those that cannot," he wrote.

# How Social Media Has Affected Our Health in the Last 10 Years

It's not as if social media was invented 10 years ago, but it did hit a kind of tipping point right around then. By 2011, **the population of Facebook** was equivalent to the third-largest country in the world. Twitter growth was exponential, and Instagram, Pinterest, and Snapchat had all joined the fray.

Around the same time, we discovered that teens had hit a wall — psychologically. They were more depressed, more suicidal, and more anxious, found Jean Twenge, author of the book ***iGen: Why Today's Super-Connected Kids Are Growing Up Less Rebellious, More Tolerant, Less Happy — and Completely Unprepared for Adulthood — and What That Means for the Rest of Us***. And all things pointed to those addictive social media sites and smartphone apps, swallowing up our time and attention, and replacing our IRL relationships.

**A decade later,** it's not all that different — we're social-media obsessed. Click through the slideshow above to learn what it's doing to us**….Read More**

# DISABILITIES INFORMATION

A disability is any limitation that makes it difficult for a person to carry out daily activities. Disabilities can be physical or mental in nature, and they can range greatly in severity. Disabilities are also quite common, with almost one in five Americans having some form of disability. Some disabilities are due to a problem that a person is born with, while others develop later in life as a result of an injury or illness.

**Types of Disabilities**

Many types of disabilities exist and are grouped into categories. Chronic medical disorders refer to diseases that cause disability, such as arthritis, diabetes, cerebral palsy or multiple sclerosis. Cognitive and intellectual disorders include brain injuries, stroke, Down syndrome and disabilities related to other mental problems. Some people become disabled because of drug or alcohol abuse. There are also sensory disabilities, such as being deaf or blind. And there are disabilities that become more common as a person ages, such as disabilities related to Alzheimer's disease, for example.

**Opportunities for People With Disabilities**

The treatment for a disability will differ based on the type and severity of the disability, but it's important that people with disabilities have the opportunity to be successful in life. The Americans with Disabilities Act protects these rights and ensures that people with disabilities have many of the same opportunities as Americans without disabilities. Some people with physical disabilities can get assistive devices, such as wheelchairs or braces, to help them with movement. And some intellectual disabilities can be treated. For those with sensory disabilities such as blindness or deafness, there are tools ranging from Braille for reading to closed captioning on television programming to help them in daily life.

**SOURCES:** U.S. Department of Health and Human Services.

# Parkinson's: Ultrasound technology may relieve symptoms

A new study shows that pulses of minimally invasive ultrasound waves improve the quality of life for people living with Parkinson's disease by immediately and significantly reducing tremors.

A new study shows that pulses of minimally invasive ultrasound waves improve the quality of life for people living with Parkinson's disease by immediately and significantly reducing tremors.

The study involved a minimally invasive procedure that offers significant benefits over some other treatments that carry higher risks.

Dr. Federico Bruno, a radiologist in the Department of Biotechnological and Applied Clinical Sciences at the University of L'Aquila in Italy, led the research.

The procedure uses a technology called magnetic resonance-guided focused **ultrasound** (MRgFUS) that works by focusing sound energy beams to eradicate a small part of the thalamus in the brain.

Although a procedure called deep brain stimulation has been successful in some people, it carries potential risks, such as bleeding and infections.

Deep brain stimulation requires a surgical procedure, which involves a surgeon implanting a small electrode into the brain. The implant connects with a pacemaker-like device in the chest.

The device works by relieving tremors on the opposite side of the body to the treatment point. For example, tremors on the right side of the body respond to the treatment on the left side of the brain, and vice versa.

Dr. Bruno and his team presented their findings at **the Radiological Society of North America 105th Scientific Assembly** in Chicago, IL.

**The study had excellent results**

The study involved 39 people with an average age of 64.5 years old. All the participants had experienced disabling tremors and had not responded to other treatments.

Of the 39, 21 had **Parkinson's disease**, and 18 had **essential tremor**. All of the participants had been experiencing symptoms for an average of over 10 years.

The results of the study were very promising — almost the entire group (37 out of 39) saw "substantial and immediate" improvement in their tremor activity.

The procedure had several advantages over deep brain stimulation, in terms of the risks involved and how fast the treatment worked.

"Another advantage is the immediate effect this treatment provides, unlike deep brain stimulation, which requires a break-in period for the electrostimulation," says Dr. Bruno.

"Additionally, treatment with MRgFUS requires shorter hospitalization and is a fairly well tolerated procedure even by more fragile patients."

Parkinson's is a serious brain disorder

While Parkinson's disease typically starts gradually, it tends to worsen over time. According to the National Institute on Aging, ...**Read More**

# If you have heart disease, drug therapy may be as good as bypass surgery or a stent

Carolyn Johnson reports for **The Washington Post** on a new large **federal study** which finds that people with heart disease may do as well with drug therapy and lifestyle changes as with a stent. As previous studies have found, doctors too often perform unnecessary bypass surgery.

It is common for doctors to do bypass surgery or to use stents to open up blocked coronary arteries in patients. Indeed, more than 30,000 heart disease patients have stents implanted each year. But, this invasive procedure does nothing more to decrease the risk of heart attacks or death than drug therapy in many cases.

Indeed, even patients with very blocked arteries did as well with drug therapy as with stents. Bypass surgery and stents were found to be beneficial only in some cases of patients with chronic chest pain or angina. For patients who are not experiencing chest pain, these invasive procedures are generally unwarranted.

According to Gina Kolata at **The New York Times**, the study looked at 5,179 patients over three and a half years, most of whom had experienced chest pain. It specifically did not assess the value of bypass surgery on patients who have heart attacks or blocked left main coronary arteries. In those two cases, using stents can save people's lives.

Some doctors still disagree with the findings. They argue that the study did not look at the benefits of stents for people with LDL cholesterol. They further argue that newer stents release drugs that reduce the likelihood that arteries will close after surgery. And, in this study, attention was paid to ensuring patients adhered to their drug treatment plan, which is not feasible in normal situations.

Of course, drug therapy only works if patients comply with the treatment plan. Usually, the treatment includes cholesterol-lowering drugs, such as statins, blood pressure medicines and aspirin. Still, even patients with stents must take strong drugs that prevent clotting for as long as 12 months. Moreover, one in three of them experience chest pain again within six months of getting a stent, requiring yet another stent.

Part of the reason that the stents may not have any better results than drugs is that artery blockages can present themselves in multiple places. Some plaque that narrows the artery may never lead to a heart attack and other plaque could. Yet, it is not possible to know which plaques are potentially lethal.

People who take prescription drugs instead of getting a stent or bypass surgery have the benefit of a treatment for all their coronary arteries, not simply an isolated area. If chest pain persists, then a stent or bypass may be warranted to ease the pain. Moreover, patients who take drugs instead of undergoing an invasive procedure take fewer drugs than patients who undergo invasive procedures.

There remains a strong difference of opinion among doctors about the value of stents relative to drug therapy. But, the evidence is strong that stents and bypass surgery are unnecessary and unhelpful in many cases. One takeaway from the study is that patients with blocked arteries who are not feeling chest pain do not put themselves at any risk if they opt for drug treatment. They can decide to undergo an invasive procedure if they later experience chest pain.

# RESPIRATORY AND ALLERGY INFORMATION

Respiratory problems most often affect the lungs and make it difficult to breathe, which can dramatically alter quality of life. Various factors can cause a respiratory problem, including a virus, bacteria, allergen or an environmental factor like cigarette smoke. In some instances, breathing problems are caused by a problem with the heart rather than the lungs.

**Causes of Respiratory Problems**

Many lung and breathing problems are due to an infection from a virus or bacteria. In most cases, these types of respiratory problems are short-lived and can be treated with medication. The flu, pneumonia and tuberculosis are a few of many respiratory problems that match this description. In some instances, these infections are dangerous, so it's best to have them treated by a doctor.

People can also develop breathing problems as a complication of allergies. This primarily is in the form of asthma, a disease in which the airways begin to narrow when exposed to an irritating allergen.

Some respiratory problems are chronic, lifelong disorders. For example, people may develop emphysema and chronic obstructive pulmonary disease (COPD) after many years of smoking cigarettes. Environmental exposures to dust and other irritants can also lead to these problems. Breathing problems can also result from heart disease, when the heart doesn't pump enough blood to supply the body with oxygen. And, stress and anxiety also cause breathing problems in some.

**Treatment of Respiratory Problems**

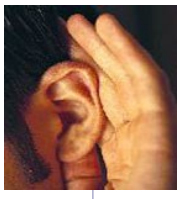
Treatment for respiratory problems depends on the cause. Some lung infections can be treated with antibiotics or other medication, or the person may need to rest until the virus goes away. Asthma can be managed with long-term control medications, and quick-relief rescue medications can stop an asthma attack when it occurs. For diseases such as emphysema and COPD, there is no cure. However, medications and self-care strategies can still help people live comfortably, even with their conditions.

# HEARING INFORMATION

The process of hearing sounds is fairly complex. And, because the ear also plays a role in the body's balance system, a problem with hearing can be associated with balance problems as well.

**How Hearing Occurs**

When a sound reaches the ears, it hits the outer ear first. This contains the ear canal and houses the ear drum. The sound causes the ear drum to vibrate. These vibrations are then picked up by three tiny bones, called ossicles, that are connected to the ear drum. The ossicles are located in the middle ear, and they, in turn, create movement in fluid that's located in the inner ear. As this fluid moves, it causes hair cells in the inner ear to send electrical signals to the body's auditory nerve. This nerve then passes the information along to the brain, where the sound is interpreted and understood.



**Hearing Problems**

When hearing loss occurs, it can happen in a number of ways and for a variety of reasons. Some children are born with hearing problems, whereas others acquire them over time because of a head injury, noise exposure or an infection. Some medications can also cause hearing loss.

The type of hearing loss a person experiences is typically categorized based on the part of the ear that is affected. For example, conductive hearing loss refers to a problem with the ear canal, ear drum or ossicles in the outer or middle ear. When the inner ear is affected, this is known as sensorineural hearing loss. There's also mixed hearing loss, which is a combination of problems in the different parts of the ear. Though conductive hearing loss can often be corrected medically or surgically, sensorineural and mixed hearing loss are typically more difficult to treat. Hearing problems are often treated by a health care professional known as an audiologist.

# HEALTH TECHNOLOGY INFORMATION

"Health technology" is a very broad term that refers to medical devices, medications, procedures and systems that improve people's health care and quality of life. It includes the devices used to diagnose diseases, the medications administered to treat diseases, the way health records are organized and accessed by both physicians and patients and much more.

On a number of levels, health technology has played a large role in improving health care in recent decades. Advances in health technology, for example, have led to longer life expectancies, a reduction in hospital days and a drop in disability rates and mortality rates.

**Health Technology in Improving Patient Care**

Despite these advances, many improvements remain to be made, particularly on a global scale. One of the concerns of the World Health Organization is to increase the availability of cutting-edge health technology in developing nations. For example, devices that are commonly used for diagnosis in the United States, such as X-rays or computed tomography (CT scans), are often difficult to gain access to in low-income countries. Even access to basic medicine that is taken for granted in the United States is a real concern in developing nations.

**Health Technology in Improving Efficiency**

Beyond cutting-edge devices and medications, another category of health technology is health information technology. This branch of health technology is largely devoted to improving access to health information and patient records. The gradual adoption of electronic health records is designed to increase the efficiency and safety of health care.

**Some of the Technology Improvements**

**CAT Scans**
**Lasers / Laser Surgery**
**MRI Scans**
**DNA**
**Stem Cells**
**X-Rays**
**Hearing Aids**

# Even in Small Doses, Air Pollution Harms Older Americans

Even a little exposure to the fine particles of air pollution can translate into higher hospitalization rates for a number of common conditions among older Americans, a new study suggests.

"The study shows that the health dangers and economic impacts of air pollution are significantly larger than previously understood," said study author Yaguang Wei, a doctoral candidate at the Harvard T.H. Chan School of Public Health, in Boston.

For the study, researchers analyzed data on more than 95 million inpatient hospital claims for Medicare beneficiaries, aged 65 and older, from 2000 to 2012. They also assessed levels of fine particulate air pollution (PM2.5) in the patients' ZIP codes.

Sources of PM2.5 include motor vehicles, coal-fired power plants and wildfires.

Short-term exposure to PM2.5 was linked with hospitalizations for common conditions such as septicemia (serious bloodstream infection), fluid and electrolyte disorders, kidney failure, urinary tract infections, and skin and tissue infections.

The researchers also confirmed previously identified associations between short-term PM2.5 exposure and hospitalization for a number of other conditions, including heart and lung diseases, Parkinson's disease and diabetes.

Each 1 µg/m3 increase in short-term exposure to PM2.5 was associated with an annual increase of nearly 5,700 hospitalizations, over 32,000 days in the hospital, and 634 deaths. That resulted in $100 million in inpatient and post-acute care costs, and $6.5 billion in "value of statistical life," a measure of the economic value of lives lost.

All of the associations remained consistent even when daily PM2.5 levels were below the World Health Organization air quality guideline, according to the study published online Nov. 27 in the *BMJ*.

"These results raise awareness of the continued importance of assessing the impact of air pollution exposure," study principal investigator Francesca Dominici, a professor of biostatistics at the school, said in the news release.

**More information**

The U.S. Centers for Disease Control and Prevention has more on **particle pollution**.

# Ready to quit smoking? Medicare will help you

**It's never too late to quit smoking** and improve your health. If you smoke and are ready to try quitting, Medicare will cover smoking-cessation counseling sessions. Medicare covers up to four sessions twice a year. During these sessions, a counselor will work with you one on one. (Medicare also covers a host of other valuable **preventive care services**.)

Medicare's coverage depends upon whether you have a health condition related to or caused by smoking. If you have **Original Medicare** (also called traditional Medicare) and you do not have a smoking-related condition, Medicare will cover the full cost of your smoking cessation sessions so long as you visit a Medicare-certified provider. Smoking-cessation is one of many **preventive care services** that Medicare covers in full. If you have a corporate Medicare plan, sometimes called a **Medicare Advantage plan,** will cover the full cost from an in-network provider. If you have a smoking-related condition, Medicare will cover 80 percent of the cost of the sessions from a Medicare-certified provider. You will first need to meet your deductible. **Supplemental insurance**, such as a Medigap plan, retiree coverage or Medicaid, will generally fill these coverage gaps.

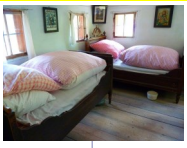
**Medicare will also cover prescription drugs to help you quit smoking through the Part D prescription drug benefit**. Medicare will not cover nicotine patches, gum or other over-the-counter treatments to quit smoking, It will also not cover hypnosis.

The folks at the tobacco companies are the only people who think you should keep smoking. This **John Oliver video shows you what lengths they will go to to promote smoking around the world.** It's horrifying and really worth watching.

# Beware: Some people have serious allergic reactions to feather bedding and jackets

Winter is fast upon us. And, thousands of us will buy a new feather blanket, pillow or jacket. Beware: Wudan Yan reports for **The New York Times** that, in a small number of cases, feather products could cause an infection in your lower respiratory tract.

After buying new feather bedding, one 43-year old man felt tired and out of breath all the time for three months without appreciating the cause. Fortunately, his doctor asked a lot of questions about his domestic situation. After ruling out allergies to dogs, cats and mold, the doctor asked whether the man had new feather bedding.



A chest X-ray and blood test revealed that the man had hypersensitivity pneumonitis or lung disease. It was caused by antibodies or allergies to bird feather dust, aerosolized bacteria and fungi. That dust was in the man's new bedding.

This type of lung disease is uncommon. But, if left undetected, it can cause respiratory failure or scarring in the lungs. Should you buy a duck or goose feather jacket or bedding? Allergic reactions that lead to lung disease are rare enough that you should buy goose or duck feather products if you are so inclined. However, if you become out of breath or start coughing soon after, try staying clear of the feathers. Allergies could be the cause. You should also talk to your doctor.

Steroids will help if you do have an allergic reaction to the feathers. Also, consider replacing your feathered items with hypoallergenic ones.

**Do You Have Winter Allergies?**

If you're allergic to pollen, you may get a break when the weather gets cold. But if you have indoor **allergies** such as **mold** and **dust mites**, you may notice your **allergy symptoms** more during winter, when you spend more time inside...**Read More**