Following Merck, U.S. Chamber of Commerce, Bristol Myers Squibb and PhRMA sue administration over drug price negotiation

The U.S. Chamber of Commerce, Bristol Myers Squibb and PhRMA, the drug industry’s trade association, have filed three separate lawsuits against the Biden administration to block Medicare’s authority to negotiate lower drug prices. They joined Merck, which sued over the policy on June 6.

PhRMA CEO Steve Ubl said the provisions of the Inflation Reduction Act that will allow Medicare to start negotiating prices for certain drugs amount to “a government mandate disguised as negotiation.” The lawsuits are the next step in an epic battle over the federal government’s efforts to bring skyrocketing drug prices under control. More lawsuits give the industry more opportunities for success, and PhRMA’s suit, filed in a Texas court, means the case could eventually be heard by the staunchly conservative 5th Circuit Court of Appeals.

Legal experts say the pharmaceutical industry will likely file many more lawsuits this fall, as drug corporations ultimately aim to take their battle to the U.S. Supreme Court to strike down the law.

The Alliance, health advocates, and consumer organizations note that negotiating a fair price for drugs is nothing new and is a hallmark of a free market economy — governments and insurance companies around the world negotiate drug prices on behalf of their citizens every day. In the United States, the Departments of Defense and Veterans Affairs and the Medicaid program already negotiate prices. Further, federal, state, and local governments routinely negotiate the cost of other goods they purchase from private sector companies. “The drug industry needs to quit making insincere arguments and start negotiating a fair deal,” said Robert Roach, Jr., President of the Alliance. “By giving Medicare the ability to negotiate prices, President Biden’s Inflation Reduction Act, once implemented, will save taxpayers and patients $25 billion. We should be building on this law to make sure people can afford the drugs they need to be healthy.”

Millions of Insured Older Americans Face Unpaid Medical Bills

Medical debt for older Americans with health insurance is on the rise: new research published by the Consumer Financial Protection Bureau Office for Older Americans found that while nearly 99% of people over the age of 65 have health insurance through enrollment in programs like Medicare, many are still swamped with unpaid bills for medical care.

Nearly four million older adults could not pay their medical bills in full in 2020, the latest year that data is available, per the report. Over two-thirds of those with unpaid bills had coverage from more than one source, such as Medicare, Veteran’s Affairs, Tricare, and employer-based coverage, or Tricare, the overall military health plan.

The average amount in unpaid medical bills reported by older adults in that period was $13,800, up 20% from $11,700 in 2019. That translates to an increase in unpaid medical bills among older adults from $44.8 billion in 2019 to $53.8 billion in 2020.

The most common causes are out-of-network charges, deductibles and other cost-sharing fees, services that are not covered by Medicare, in addition to frequent and complex medical care, and limited income, according to the researchers. However, the biggest reason for falling behind is medical billing errors.

“Older adults are more likely to have complicated health needs, which require a great deal of documentation,” said Richard Fiesta, Executive Director of the Alliance. “This can lead to delays in payment, errors in who is billed, and providers seeking inappropriate reimbursement. Whenever possible, patient advocates advise working with your health care providers to make sure a procedure is covered before you receive the care.”

Celebrating 20 years of the Rhode Island Alliance for Retired Americans
Weekly E-Newsletter.
Thank You To Everyone That Has Supported It!!

It is a day of pride for every American.…. This day belongs to us to keep our country safe and progressing…. Wishing a very Happy 4th of July.

Get The Message Out: SIGN THE GPO/WEP PETITION!!!!!
The Inflation Reduction Act (IRA), which became law in August 2022, appears to be working to rein in the ever-escalating price of some prescription drugs. Jonathan Cohn writes for the Huffington Post about 43 prescription drugs with price increases greater than the rate of inflation. The Biden administration has signaled them out for Medicare savings, imposing penalties on the drug companies that manufacture them.

Humira, a very popular drug that treats inflammatory conditions, and Leukine, a drug that protects people on chemotherapy from infections, are two drugs with big price hikes that the Biden administration has identified. As a result of the IRA, our federal government will impose monetary penalties on drug companies manufacturing the 43 drugs with excessive price increases. And, people with Medicare who take any of these drugs will pay lower coinsurance for them, saving $1 to $449 per prescription.

None of the drugs on this initial list are prescription drugs covered under Medicare Part D. Rather they are all administered by a doctor and are covered under Medicare Part B, under which people pay 20 percent coinsurance if they do not have supplemental coverage to pick up that cost. People with supplemental coverage should also benefit from the IRA because the government penalties should help keep their supplemental insurance premiums down.

Over time, the list will grow to the extent pharmaceutical companies raise prices at rates higher than the rate of inflation. And, the list will include drugs covered under Medicare Part D. The IRA also caps insulin costs for people with Medicare to $35 a month. And, beginning in 2025, the IRA caps out-of-pocket spending under Medicare Part D at $2,000 a year.

All these advances to curb prescription drug costs for the Medicare program and the older adults and people with disabilities who count on Medicare are meaningful. For some people, they will make it much easier to afford their drugs. But, the IRA still leaves people with Medicare paying far more than people in other wealthy countries for their drugs. And, even with the IRA, pharmaceutical companies can still gouge Americans when it comes to drug prices.

How Does Your State Rank for Health Care?

Folks living in Massachusetts, Hawaii and New Hampshire may be among the nation's healthiest, according to a new scorecard that ranks how well the health care system in each U.S. state is working.

By contrast, people in Mississippi, West Virginia and Oklahoma fare the worst when it comes to access to quality care and overall health and well-being.

Released each year by the Commonwealth Fund, a nonprofit group focused on health policy reform, the report card grades all 50 states and Washington, D.C., on 58 measures. They include access to health care, quality of care, cost, health outcomes and disparities in care.

This year's report drew on 2021 data, and it also looked at the state-by-state landscape for women's health, including reproductive health, for the first time.

The report noted there was an unprecedented spike in preventable deaths across the country from 2019 to 2021, largely due to the COVID-19 pandemic.

"We saw a large increase in death early in life from preventable and treatable causes due to COVID-19 including drug overdose and alcohol-induced deaths, suicide, firearm deaths [and death from] chronic illnesses that were worsened by COVID-19 health care disruptions," said senior scientist David Radley.

Rates of preventable disease due to COVID were highest in Louisiana, Mississippi, Texas and New Mexico, surging more than 35%. Arizona's rate rose by 45%, the largest increase in preventable deaths during this period.

Black and American Indian/Alaska Native people experienced some of the highest rates of avoidable death in many states, the new report card found.

"The pandemic cut deep," Radley said during a media briefing. "The effect on the health care workforce and the ability of hospitals and health care providers to meet demand are real impacts that extend beyond daily awareness of the virus and will be felt for a long time."

Access to women's and reproductive health care was a mixed bag across states. The report card graded states on 12 measures, including access to prenatal and postpartum care and reproductive cancer screenings and other preventive services, as well as women's overall health outcomes.

Overall, women of childbearing age died at increasing rates from preventable causes, including pregnancy and childbirth as well as COVID and substance use during the pandemic.

Massachusetts, Rhode Island and New Hampshire ranked best for reproductive and women's health. ...Read More

We earned Social Security benefits like everyone else!

Current situation: Our House repeal bill, H.R. 82, has 284 co-signers. We are almost at our goal of 300! The Senate bill, S.597, has only 44 of the 60 co-signers needed. The Senate is our biggest challenge!

Check our website, ssfairness.org, for easy links to petitions, progress, and information on this year’s campaigns.

Thank your Congress Members if they have signed on and keep after those who haven’t. Even if they have already signed on, send them this explanation. Many of our supporters don’t really understand how cruelly the WEP and GPO work to undermine this country’s retired public servants.

The Senate is obviously a bigger challenge. Keep repeating: We paid into FICA just like everyone else. We earned these benefits! And tell them your personal story in a couple of sentences. Repeat!

The GPO hurts a public employee as well as their Social Security earning spouse who paid for spousal and survivor benefits through their contributions:

- Most retirees (70%) who are affected by the GPO lose ALL the benefits that were fully paid for by their spouse. Social Security benefits are usually calculated based on both years of work and the contribution amount, but the GPO ignores any years of true dependency, and counts only the amount of their public pension. This means that stay-at-home moms who go into the workforce later in life and only earn half a pension can lose all the Social Security dependent benefits their spouse paid for during their marriage. 83% of those affected by the GPO are women.

- More than 700,000 retirees and also their Social Security-earning spouses who paid for their benefits are punished by the GPO. Loss of the GPO survivor penalties can cost a retired teacher or police officer more than $20,000 every year.

The Windfall Elimination Provision punishes people who have had a non-FICA earning government job as well as a job where they paid into FICA:...Read More

If you haven’t signed the Petition, do so here NOW!
The Medicare Advantage program, Medicare Part C, which allows corporate health insurers to contract with the government to offer Medicare benefits, was born with the belief that it could save Medicare money. Instead, a new report out of the mainstream USC Schaeffer Center for Health Policy and Economics estimates that Medicare Advantage plans are costing taxpayers and people with Medicare an additional $75 billion in overpayments this year alone. The report only confirms findings by University of California at San Diego professor, Richard Kronick, of massive government overpayments to Medicare Advantage, but Congress sits on its hands.

Republicans in Congress don’t seem to care about eliminating all the waste in Medicare Advantage. It’s the health insurers offering Medicare Advantage plans that will help fund their 2024 reelection campaigns. And, that’s not something they want to jeopardize. Many Democrats in Congress also appear to live in fear of the corporate health insurers and are doing little to address the massive overpayments, as they should.

**How do these Medicare Advantage overpayments happen?** They happen for a variety of reasons but the largest reason is that the people enrolled in Medicare Advantage are considerably healthier than people in traditional Medicare. But, because of a defective payment system, the government pays Medicare Advantage plans as if their enrollees are sicker than people in traditional Medicare. The high proportion of people who are healthy in Medicare Advantage cost these plans on average less than $1,000 a year as compared to the more than $12,000 a year they typically receive to care for them.

MedPac, the agency overseeing these government payments has calculated the overpayments at $27 billion this year because the Medicare Advantage plans assign multiple diagnosis codes to their enrollees in order to boost their earning and often get quality bonus payments as well. But, MedPac has not factored into its calculations the $50 billion or so a year in Medicare Advantage overpayments resulting from the Medicare Advantage population being so much healthier than the traditional Medicare population. The researchers at USC appreciate that the Medicare payment system for Medicare Advantage plans is defective and needs an overhaul. Paying the insurers offering Medicare Advantage plans as the government currently does leads to massive overpayments. The researchers, however, do not speak to the fact that the defective payment system—upfront payments unrelated to the cost of services delivered—also leads to massive inappropriate delays and denials of care to people. People with cancer, heart disease, stroke and other costly and complex conditions are most at risk—and that’s most of us, if not now, down the road.

The USC researchers like the idea of competitive bidding among MA plans, which I hear is a nonstarter from the MA plans’ perspective. That shouldn’t matter, but it does. Regardless, competitive bidding doesn’t address the need to ensure that the payment system does not create a disincentive for the Medicare Advantage plans to withhold care from the people who most need it—the 10 percent of people with Medicare with the costliest conditions, which is what it does today.

The government’s payment system will be right only if and when the Medicare Advantage plans are promoting their high value care for people with cancer, heart disease and stroke. Until then, consider enrolling in traditional Medicare if you can. If you enroll in Medicare Advantage, beware the Medicare Advantage plans engaged in widespread delays and denials of care. The administration is not naming them for the most part. And sometimes, it is giving them four and five-star ratings.

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**Medicare Advantage ads will continue to mislead despite new rules**

No matter whether you are Medicare eligible, you have likely seen countless TV and print ads by health insurance companies offering you what sounds like a free lunch if you sign up for a Medicare Advantage plan. The ads are often profoundly misleading and don’t begin to help people understand the tradeoffs they are making, at times gambling away their health security, because many Medicare Advantage plans engage in widespread inappropriate delays and denials of care.

New government advertising rules are designed to eliminate some of the misleading elements in Medicare Advantage ads, but not nearly enough of them.

**Joe Namath and other superstars** will continue to be able to promote Medicare Advantage plans without warning you of the risks you could be taking if you sign up for some of these plans. But, as of September 30 of this year, the Medicare Advantage plans will not be able to use Medicare’s logo in their ads in ways that suggest that they are Medicare or the federal government.

The Medicare Advantage plans are the corporate health insurance alternative to traditional Medicare, which is offered directly through the federal government. While traditional Medicare provides coverage to people for care from almost all doctors and hospitals and defers to the opinions of treating physicians when determining whether care is reasonable and necessary, Medicare Advantage plans restrict access to most physicians and hospitals and often come between their enrollees and their treating physicians, second-guessing people’s care needs and denying care inappropriately to maximize their profits.

Because the government pays Medicare Advantage plans upfront, regardless of the cost of the care they deliver, the less care they cover, the more profits they earn. Prior authorization requirements, which they all impose, allow the Medicare Advantage to delay costly care, also helping to maximize their profits.

But, a combination of relentless marketing by the Medicare Advantage plans and the additional costs in traditional Medicare for supplemental coverage and prescription drug coverage lead many people to opt for a Medicare Advantage plan. In fairness, it’s hard to understand the risks of Medicare Advantage and how it is so fundamentally different from traditional Medicare when it comes to having your care needs met. And, as long you’re healthy, you can save money. Of course, health insurance should be there for the unforeseeable likelihood that you will need costly care at some point.

The new government rule does not allow for “overly general ads about the Medicare Advantage program that often tend to confuse and mislead individuals,” according to Xavier Becerra, the Secretary of the Department of Health and Human Services. The rule appears to forbid ads that do not name one specific Medicare Advantage plan.

Health insurers also can only use the name Medicare in limited instances and cannot feature a Medicare card.

When ads contain a toll-free number, some people think they are calling the federal government and not an insurance company or its agents. Now, companies allegedly won’t be able to have ads that promote benefits unless they are available where the ads are being aired.
Americans are finding it increasingly difficult to meet their and their loved ones’ long-term care needs. Congress continues to sit on its hands, while some states are taking action. Mark Miller writes for the New York Times about the need for Congress to step in on behalf of all Americans who could need long-term care and, in the meantime, what some states are doing to help their residents.

The vast majority of Americans will need some kind of long-term care as they age, be it help with bathing, dressing and toileting or full-time home care or nursing home care. Only about one in five Americans will not. For now, there’s no hope of Congressional action as ensuring people’s long-term care needs are met costs money, and Republicans have taken raising taxes to cover additional healthcare costs off the table.

The average cost for one year of nursing home care was nearly $110,000 two years ago. Yet, nearly seven in ten Americans have done little if any planning and saving to cover the costs of their long-term care needs. Not even one in six Americans believe they are prepared financially, if they need long-term care. Those who are unprepared will likely have to count on family and friends to volunteer their time, if they do not qualify for Medicaid.

**Medicaid does cover long-term care.** It is an invaluable benefit. But, in order to get Medicaid, your income and assets need to be extremely low. Thankfully, in many states, if your income and assets are above the eligibility level, your health care expenses can bring your income and assets down to the Medicaid eligibility level so you can qualify for Medicaid.

Most people do not realize that Medicare does not cover long-term care. At best, people might qualify for 100 days of nursing home care, but that’s only if they’ve been hospitalized for at least three days prior to admission in a nursing home. And, people in Medicare Advantage plans rarely get coverage for more than a very short nursing home stay. People also might qualify for very limited Medicare-covered home care, and that’s only if they’re homebound and need either intermittent skilled nursing or therapy services.

Washington State is the first state to launch its own publicly-administered long-term care program, the WA Cares Fund, States such as California and Minnesota might do the same in time. But, it’s not only expensive, but tricky to implement.

In Washington State, long-term care benefits will be available to everyone beginning in 2026, and everyone will pay in for those benefits during their working lives through a 0.58 percent payroll contribution. But, the maximum benefit will only be $36,500, a fraction of the total cost for most people. Even that relatively small benefit should help with a year of home care costs.

The state might save on Medicaid expenses through this program. That’s what the state is hoping. Because of the program, some people will not need to spend down all their assets to qualify for Medicaid. But, nothing is clear at this point.

Some questions still need to be answered. For example, what if people also have private long-term care insurance? And, will people who contribute to the program lose their right to benefits if they move out of Washington state?

Keep in mind that private long-term care insurance has always been a gamble, with “level” premiums able to double out of nowhere and the benefit often more limited than people realize.

### The 1 Simple Mistake That Could Cost 70% of Social Security Beneficiaries an Average of $12,000 Every Year

For the vast majority of retirees, Social Security is an indispensable source of income. Over more than two decades, pollster Gallup has surveyed retired workers to gauge their reliance on America’s most successful retirement program. Every year, between 80% and 90% of respondents have claimed that their Social Security income is, in some capacity, necessary to cover their expenses.

Given how important Social Security income is to today’s retirees, it’s only logical that future beneficiaries would want to do everything possible to maximize what they’ll receive. Yet one common misconception about the program could have up to 70% of retirees leaving as much as $12,000 in Social Security benefits on the table every year.

A majority of workers are worried about Social Security’s solvency.

It’s no secret that Social Security is facing its fair share of challenges. Since 1940 -- the year the first retired worker check was mailed out -- the Social Security Board of Trustees has released an annual report that examines the short-term (10-year) and long-term (75-year) financial outlook for the program. It’s effectively an under-the-hood look at Social Security’s balance sheet, which allows anyone to see how the program generates income and where each of those dollars ends up.

The 2023 Social Security Board of Trustees Report outlined a projected $22.4 trillion funding obligation shortfall through 2097, and opined that the asset reserves of the Old-Age and Survivors Insurance Trust Fund (OASI) would be depleted by 2033, assuming no changes to the program. In other words, it signifies problems with the existing payout schedule given a number of ongoing demographic shifts.

### Drugmakers Are Abandoning Cheap Generics, and Now US Cancer Patients Can’t Get Meds

On Nov. 22, three FDA inspectors arrived at the sprawling Intas Pharmaceuticals plant south of Ahmedabad, India, and found hundreds of trash bags full of shredded documents tossed into a garbage truck. Over the next 10 days, the inspectors assessed what looked like a systematic effort to conceal quality problems at the plant, which provided more than half of the U.S. supply of generic cisplatin and carboplatin, two cheap drugs used to treat as many as 500,000 new cancer cases every year.

Seven months later, doctors and their patients are facing the unimaginable: In California, Virginia, and everywhere in between, they are being forced into grim contemplation of untested rationing plans for breast, cervical, bladder, ovarian, lung, testicular, and other cancers. Their decisions are likely to result in preventable deaths.

Cisplatin and carboplatin are among scores of drugs in shortage, including 12 other cancer drugs, attention-deficit/hyperactivity disorder pills, blood thinners, and antibiotics. Covid-hangover supply chain issues and limited FDA oversight are part of the problem, but the main cause, experts agree, is the underlying weakness of the generic drug industry. Made mostly overseas, these old but crucial drugs are often sold at a loss or for little profit. Domestic manufacturers have little interest in making them, setting their sights instead on high-priced drugs with plump profit margins.

The problem isn’t new, and that’s particularly infuriating to many clinicians. President Joe Biden, whose son Beau died of an aggressive brain cancer, has focused his Cancer Moonshot on discovering cures — undoubtedly expensive ones. Indeed, existing brand-name cancer drugs often cost tens of thousands of dollars a year.

...Read More
During most of the COVID-19 pandemic, states were allowed to keep people continuously enrolled in Medicaid in exchange for enhanced federal funding. This flexibility ended on March 31. States are on different operational timelines, though all have or will soon begin redetermining Medicaid eligibility for current enrollees. Significant Medicaid losses are expected during this transition, as states disenroll not only those who no longer qualify, but also those who do not complete the renewal process for administrative reasons. Some who are newly ineligible may seamlessly transition to other insurance, but many may not. Even small gaps in coverage can have serious consequences. Studies consistently show people without health coverage are more likely to delay or skip care due to cost, to have difficulty paying medical bills, and to lack a usual source of care, all factors that can worsen outcomes and well-being. The nearly seven million people projected to lose Medicaid due to procedural barriers will also be at risk as they attempt to navigate complicated re-enrollment rules and timelines. KFF reporting suggests such periods of non-coverage are likely. In recent years, nearly 65% of people were uninsured after they were disenrolled from Medicaid. Relatively few (26%) retained other coverage for the full year post-disenrollment, and 41% re-enrolled in Medicaid—including 33% who did so after being uninsured, suggesting they were still eligible when they lost Medicaid.

An analysis of the early unwinding data, also from KFF, suggests many may already be uninsured. Nearly 1.4 million people across 22 states have lost Medicaid as of June 20. Alarming, 71% had their coverage terminated for procedural reasons, such as incomplete paperwork and outdated contact information. In an effort to minimize avoidable coverage losses, the U.S. Department of Health and Human Services (HHS) recently announced new opportunities for states to meet people where they are. The new strategies include: 

- Allowing states to delay an administrative termination for one month while the state conducts additional targeted outreach. This will give people more time to be reminded to fill out and return their renewal forms.
- Allowing pharmacies and community-based organizations to facilitate reinstatement of coverage for those who were recently disenrolled for procedural reasons based on presumptive eligibility criteria.
- Allowing managed care plans to assist people with Medicaid with completing their renewal forms, including completing certain parts of the renewal forms on their behalf. …Read More

**Pharmaceutical lobbyists challenge Biden's drug law in friendly territory**

The top lobbying organization for the pharmaceutical industry yesterday filed the fourth lawsuit challenging Democrats' law that gives Medicare the power to negotiate the prices of certain drugs, this time in a Texas district court. 

**Why it matters:** More lawsuits give the industry more opportunities for success. And filing in this particular court means the case would run through the staunchly conservative 5th Circuit Court of Appeals. 

**Driving the news:** The lawsuit, filed by the Pharmaceutical Research and Manufacturers of America, the National Infusion Center Association, and the Global Colon Cancer Association, argues the law is unconstitutional on several grounds, Axios' Peter Sullivan reported yesterday. 

- The plaintiffs argue it violates: the separation of powers by delegating too much authority to the Department of Health and Human Services; due process by denying drug companies input into the process of pricing drugs; and the Eighth Amendment's ban on "excessive" fines, given the heavy excise tax companies have to pay if they refuse to negotiate. 

- "This is not negotiation," PhRMA CEO Steve Ubl told reporters, saying the provisions are so burdensome they are actually just "price-setting." 

- State of play: PhRMA's lawsuit was preceded by ones filed earlier this month by Merck, the U.S. Chamber of Commerce and Bristol Myers Squibb. 

- All four were filed in courts that run through different circuit courts. Having multiple cases in front of multiple judges increases the odds that the implementation of the law gets delayed.

- "In general, of course, if you're able to get that kind of relief, you only need one, so the best strategy if you're trying to get that nationwide injunction is to file in as many places as you can," said Nicholas Bagley, a University of Michigan Law School professor. …Read More

**Expert Says ‘Stealth Tax’ on Social Security Hurts More Retirees Each Year — How It Works**

Social Security payments are largely determined by how much you paid into the program through payroll taxes during your working career. You could owe personal income taxes on them if they and other income reach a certain level in retirement. And thanks to annual cost-of-living adjustments (COLAs), a growing number of Social Security recipients now owe these "stealth" taxes on their benefits, financial experts say. 

Although Social Security benefits are adjusted for inflation every year through COLAs, income tax thresholds for recipients have not changed since benefits were first taxed in 1984. This means that whenever benefits are increased, more seniors are exposed to income taxes on Social Security. That’s a particular problem in 2023 thanks to the 8.7% COLA — the biggest in more than 40 years. 

Each year, a greater proportion of seniors have hit the income thresholds and therefore must pay taxes on their benefits, USA Today reported. "This is a stealth tax," Jordan Gilberti, senior lead planner and certified financial planner at Facet, told USA Today. "Everyone knows Social Security gets taxed, but rarely do they see how it’s taxed. People’s jaws would fall to the ground."

He’s not the only one who feels that way. David Freitag, a financial planning consultant and Social Security expert at MassMutual, also referred to it as a “stealth tax” in an April interview with CNBC.

As previously reported by GOBankingRates, individuals with provisional income above $25,000 and joint filers above $32,000 have up to 50% of their Social Security income taxed. For individuals with provisional income above $34,000 and joint filers above $44,000, up to 85% of Social Security is taxed. Because of historically high COLAs the past couple of years, more seniors are now subject to the 85% tax. But if the thresholds had been adjusted for inflation over the years, the original $25,000 threshold would now be around $73,000, according to The Senior Citizens League, a nonpartisan advocacy group. The $32,000 threshold for couples would be $93,200. …Read More

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Late last month, the U.S. Department of Health and Human Services Office of Inspector General (OIG) released a report finding Medicare often overpaid for physician services when beneficiaries were admitted to a skilled nursing facility (SNF) or hospital. Through audits, OIG found that these overpayments cost the program more than $44 million over 2 years while beneficiaries may have been overcharged by at least $11 million.

Practitioners providing physician services to beneficiaries who are inpatients in a facility like a SNF or hospital are paid at a lower rate than when they provide the same services to those who are not classified as inpatients, such as in an office-based setting. This difference in rates is meant to account for amounts Medicare has already paid to a facility. Medicare compensates facilities, like SNFs, for expenses such as staff, supplies, or equipment outside of what it pays practitioners. Non-facility rates for practitioners also include those same expenses to cover overhead. This means that paying the practitioner at the non-facility rate for performing in-facility services would be paying for those expenses twice.

There are two wrinkles in these calculations: 1) Even if the practitioners actually saw the beneficiaries outside of the facilities, services for these inpatients are paid at the facility rate; and 2) If the inpatients are not covered by Medicare Part A, the services are paid at the non-facility rate.

When these practitioners bill Medicare, they are required to include a code that identifies where they furnished the services and whether the beneficiary was covered by Part A. According to the report, the OIG audits found that some practitioners included the wrong codes. In some cases, practitioners incorrectly identified the beneficiaries as not in a facility, leading to over $22 million in overpayment and as much as $5.7 million in additional cost sharing and coinsurance from beneficiaries. In other cases, practitioners incorrectly identified beneficiaries as not covered by Part A, leading to another $22 million in overpayment and as much as $5.6 million in additional cost sharing.

OIG noted that many practitioners stated that they had difficulty tracking whether beneficiaries were covered by Part A at a given time and that many of the codes may have been simple error. OIG recommended that the Centers for Medicare & Medicaid Services (CMS) seek recoupment of the overpayments and create systems and enhanced education for providers to catch or avoid future issues. CMS concurred with these recommendations. OIG also recommended that CMS should promulgate clarifying regulations to ensure that there are no legal loopholes in the coding requirements. CMS said it would consider new regulatory actions.

At Medicare Rights, we applaud this OIG report and also note that the issue of payments being determined partially based on the location of the services can often create this sort of confusing landscape for providers and beneficiaries alike. For example, practitioners may be paid more for providing services at a hospital than in an office, which can create incentives for hospitals to acquire practices, hire physicians to work as salaried employees, and shunt more services to more lucrative settings.

Better alignment of payments across settings—usually called site neutrality—can eliminate some of these incentives and reduce financial pressure on people with Medicare, taxpayers, and the program itself. Watchdogs identify lack of site neutrality as driving tens of billions in Medicare payments and beneficiary spending.

### Major Cuts to Social Security Are Back on the Table — What’s Being Proposed Now?

A group of Republican lawmakers aims to balance the federal budget and slash government spending by targeting programs like Social Security — and some seniors could see a major reduction in lifetime benefits if the plan makes it into law. The proposal was unveiled June 14 by U.S. House conservatives, Bloomberg reported. One of its main features is to raise the full retirement age (FRA) at which seniors are entitled to the full benefits they are due.

The 176-member House Republican Study Committee (RSC) approved a fiscal blueprint that would gradually increase the FRA to 69 years old for seniors who turn 62 in 2023. The current full retirement age is 66 or 67, depending on your birth year. For all Americans born in 1960 or later, the FRA is 67.

As Bloomberg noted, workers expecting an earlier retirement benefit will see lifetime payouts reduced if the full retirement age is raised. Those payouts could be drastically reduced for seniors who claim benefits at age 62.

When you are first eligible, lawmakers on both sides of the political aisle have been working to come up with a fix for Social Security, and while the program’s Old Age and Survivors Insurance (OASI) Trust Fund runs out of money, that could happen within the next decade or so. When it does, Social Security will be solely reliant on payroll taxes for funding — and those taxes only cover about 77% of current benefits.

While most Democrats want to boost Social Security through higher payroll taxes or reductions to benefits for wealthy Americans, the GOP has largely focused on phasing down or privatizing the program.

As previously reported by GOBankingRates, House Speaker Kevin McCarthy (R-Calif.) recently told Fox News that this month’s debt limit bill was only “the first step” in a broader Republican agenda that includes further cuts.

“This isn’t the end,” McCarthy said. “This doesn’t solve all the problems. We only got to look at 11% of the budget to find these cuts. We have to look at the entire budget… The majority driver of the budget is mandatory spending. It’s Medicare, Social Security, interest on the debt.”

As Bloomberg noted, Republicans argue that failing to change Social Security could lead to a 23% benefit cut once the trust fund is depleted. Raising the retirement age is a way to soften the immediate impact. The RSC said its proposal would balance the federal budget in seven years by cutting some $16 trillion in spending and $5 trillion in taxes.

“The RSC budget would implement common-sense policies to prevent the impending debt disaster, tame inflation, grow the economy, protect our national security, and defund [President Joe Biden’s] woke priorities,” U.S. Rep. Ben Cline (R-Va.), chairman of the group’s Budget and Spending Task Force, told Roll Call.

Democrats were quick to push back against the proposal. “Budget Committee Democrats will make sure every American family knows that House Republicans want to force Americans to work longer for less, raise families’ costs, weaken our nation, and shrink our economy — all while wasting billions of dollars on more favors to special interests and handouts to the ultra-wealthy,” U.S. Rep. Brendan Boyle, (D-Pa.), the Budget Committee’s top Democrat, said in a statement.

Meanwhile, White House Press Secretary Karine Jean-Pierre issued a statement saying the RSC budget “amounts to a devastating attack on Medicare, Social Security, and Americans’ access to health coverage and prescription drugs.”

Although the proposal might make it through the GOP-led House, it’s unlikely to become law — at least while Biden is still president. Even if a bill somehow got approved by the Democrat-controlled Senate, Biden would almost certainly veto it.
What Are Back Spasms, and Can They Be Treated?

Many factors can contribute to these sudden and often painful muscle contractions. Understanding the underlying triggers is essential in both preventing and addressing back spasms.

The Cleveland Clinic provides this list of common back spasm causes:

◆ Insufficient muscle usage — Prolonged periods of sitting, poor posture, lack of exercise and underutilizing back and abdominal muscles can result in weakness, making the muscles prone to spasms and discomfort.

◆ Overexertion and excessive use of muscles — Athletes and individuals involved in heavy lifting activities may experience spasms due to muscle strain, which involves small tears in the muscle fibers, causing inflammation.

◆ Dietary factors — Inadequate water, potassium and calcium intake can contribute to back spasms. These essential nutrients are vital for maintaining proper muscle function and preventing imbalances that can trigger spasms.

◆ Mental and emotional wellbeing — Anxiety and stress can lead to muscle tightness, potentially resulting in spasms and discomfort.

◆ Traumatic incidents such as falls or car accidents — The sudden impact or force applied to the back can strain the muscles, ligaments or even the spine itself, causing pain and spasms as a protective response.

Back spasm symptoms
Back spasm symptoms are like a distress signal from your body, alerting you to underlying issues. Recognizing these symptoms is crucial in addressing and managing back spasms effectively.

The Mayo Clinic lists these symptoms:

◆ Back pain ranging from a muscle aching to a shooting, burning or stabbing sensation.

◆ Pain can radiate down a leg.

◆ Bending, twisting, lifting, standing or walking can make it worse.

Generally, back pain will subside after rest and home care. However, you should consult your doctor or health care provider if the pain:

◆ Lasts longer than a few weeks.

◆ Is severe and doesn't improve with rest.

◆ Spreads down one or both legs, especially if the pain goes below the knee.

◆ Causes weakness, numbness, or tingling in one or both legs.

◆ Is paired with unexplained weight loss… Read More

Is Alzheimer's Disease Genetic?

Alzheimer's disease is a devastating diagnosis, and if a close relative has had it you may worry whether you will be next.

According to the National Institutes of Health, it is estimated that over 6 million Americans over 65 suffer from Alzheimer's. Since this is primarily a disease that comes with age, those numbers are expected to grow as the population ages.

For those who have family members with this disease, there is the ultimate question, “Is Alzheimer's disease hereditary?” But there are others: How does Alzheimer's develop? Are there things I can do to lower my risk? Here, experts address these questions.

Is Alzheimer's genetic?

Since Alzheimer's disease is most common in those in their late 70s and 80s, age is the greatest risk factor for this disease.

However, researchers have discovered several genes that are associated either with an increased risk (risk genes: APOE-2, APOE-3 and APOE-4) of developing Alzheimer's, or those that directly cause the disease (deterministic genes: APP, PS1, PS2).

According to the Alzheimer's Association, 40% to 65% of people diagnosed with Alzheimer's have the APOE-4 gene, which is the risk gene most likely to be associated with Alzheimer's disease.

Deterministic genes only account for 1% of all cases and cause the inherited early-onset forms in which symptoms usually develop between the early 40s and mid-50s.

So, to answer the question, while 45% to 60% of Alzheimer's patients inherit a risk for the disease, only 1% actually inherit the gene which essentially guarantees an Alzheimer's disease diagnosis.

How does Alzheimer's disease develop?

According to the Alzheimer's Association, Alzheimer's disease develops when proteins build up in the brain to form structures called "plaques" and "tangles." This causes brain cells to die and damages functions controlled by the brain.

Your brain has billions of neurons that communicate with each other through electrical charges that run down axons from one neuron to another, where chemicals jump across the synapse between them allowing them to communicate and perform all of our body's functions. Inside the neurons there is tau, a protein that supports the microtubules that provide nutrients to the cells.

Researchers believe that with Alzheimer's, abnormal tau builds up in the neuron, causing the microtubules to tangle. This prevents nutrients and other essential supplies from moving through the cell and it dies. In addition, plaques form around the neurons when pieces of a protein called beta-amyloid clump together.

However, researchers believe that other forces could be at work in our bodies, which lead to Alzheimer's.

Your vascular system fails to provide enough blood and nutrients to the brain.
The brain lacks the glucose needed to provide enough energy for the brain's activities.

Chronic inflammation sets in as the debris is not cleared properly from around the neurons.

Eventually, the neurons can't communicate and they die, and the brain begins to shrink.

Is Alzheimer's disease preventable?

"Not yet," Dr. Jonathan Graff-Radford said in a recent Mayo Clinic article. "But there's strong evidence that healthy lifestyle habits — such as diet, exercise and not smoking — may play a role in reducing your risk of Alzheimer's disease and other types of dementia."... Read More
Taking daily low-dose aspirin increases the risk of anemia in the elderly, a new clinical trial suggests.

Not only does it raise anemia risk by more than 20% in people 70 or older, it is also associated with a decline in blood iron levels, researchers report.

"This finding about anemia and aspirin is noteworthy because, in many older people, anemia has other consequences such as fatigue and general decline in function," said lead researcher Dr. Zoe McQuilten, an associate professor of hematology with Monash University in Australia.

About half of seniors in the United States take aspirin to prevent heart attacks and strokes, the researchers noted.

However, major groups that once strongly recommended low-dose aspirin -- such as the American Heart Association and the U.S. Preventive Services Task Force -- have tightened their guidelines after newer studies found the therapy increases the risk of dangerous bleeding.

"We knew from large clinical trials that daily low-dose aspirin increased the risk of clinically significant bleeding [bleeding that requires a blood transfusion or other treatment for the bleeding]," McQuilten said.

But it wasn't clear whether aspirin also contributed to full-fledged anemia, or a lack of healthy red blood cells to carry oxygen to the body's organs, the researchers added.

Symptoms of anemia include fatigue, shortness of breath, dizziness, irregular heartbeat, headache, chest pain and pale or yellow skin, according to the Cleveland Clinic.

For this study, researchers reanalyzed a previous clinical trial in which more than 19,000 people 70 or older were randomly assigned to take either a placebo or 100 milligrams of aspirin daily.

Those assigned to take aspirin had a nearly 24% risk of developing anemia within five years compared to the placebo group, results showed.

Seniors taking aspirin also had a small but greater decrease in their levels of hemoglobin, the substance in red blood cells that enables them to transport oxygen, researchers found. Further, the aspirin group also had lower levels of iron in their blood. The body uses iron to make hemoglobin.

The findings were published June 20 in the Annals of Internal Medicine.

It's natural that this would occur due to aspirin's effect on platelets, said Dr. Margaret Ragni, medical director of the Hemophilia Center of Western Pennsylvania in Pittsburgh.

Aspirin interferes with platelets' ability to form clots, which is why it can be effective in preventing heart attacks and strokes, said Ragni, a spokeswoman for the American Society of Hematology. She was not involved in the new study.

"That's not shocking. This is not life-shattering news," Ragni said of the new findings.

"However, it really should help people make better decisions as they go forward."

Ragni added that it's normal for all seniors to develop anemia, but that aspirin appears to worsen that aspect of aging.

"It should be noted that people who are over 70 are going to have more anemia than people who are much younger," Ragni said. "In this clinical trial, both groups had some anemia. It was just more profound in the group that took aspirin."...Read More

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### What Is Early-Onset Alzheimer's?

There's understandable uncertainty and fear following an Alzheimer's diagnosis, but when that diagnosis comes before the age of 65, it can be even more terrifying.

Known as early-onset Alzheimer's, the condition is rare and strikes its victims in their 40s and 50s, even their 30s. Here, experts will dig into the causes, symptoms and treatment for this particularly devastating diagnosis.

**What is early-onset Alzheimer's?**

Alzheimer's is a progressive brain disorder that impacts memory, thoughts and behaviors. It's considered a disease of aging because it usually affects individuals over 65.

But early-onset Alzheimer's, also referred to as young-onset Alzheimer's, is different because it affects people before the age of 65. It's considered rare, with only about 5% of all Alzheimer's patients having the early-onset type.

There are some distinct differences between early-onset and late-onset Alzheimer's, according to the BrightFocus Foundation.

- Memory loss shows up later in the progression of the disease and is less notable in early-onset Alzheimer's.
- Individuals with early-onset disease might demonstrate difficulty finding words when communicating.
- Visual complaints, including difficulty reading, are not uncommon in early-onset Alzheimer's.
- The inability to perform limb movements on command is a unique difference in disease presentation.
- Some early-onset patients become apathetic, which is not linked to depression. Research and data on early-onset Alzheimer's life expectancy aren't readily available. In fact, an Indiana University School of Medicine article concludes this is "due to the rarity of this form of Alzheimer's and the fact that very few research studies have been done to date."

To their genetic makeup, Dr. Andrew Budson said in a recent Harvard Health article, "More than half of people with Down syndrome develop Alzheimer's disease, typically in their 40s and 50s."

**Early-onset Alzheimer's symptoms**

According to leading experts at Johns Hopkins Medicine, symptoms are similar to other types of Alzheimer's disease and affect memory, thoughts and behavior....Read More

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### Why Your Family History Is So Important to Your Doctor

Your family medical history may reveal some important details about your health, making it vital information to share with your medical provider.

It's helpful to gather what you can before your next visit with your primary care physician.

"Knowing your family history can be helpful in identifying if you're at higher risk for certain chronic diseases, mental health conditions or cancers," said Dr. Saundra Nguyen, an assistant professor at Baylor College of Medicine in Houston.

"For example, someone with a strong family history of colon cancer may be recommended for a colonoscopy earlier than the general population, or we may screen for diabetes in someone with a family history of diabetes," Nguyen said in a college news release. "We can also identify early warning signs of disease and work on preventive lifestyle measures."

It's recommended that you gather information on family history of chronic diseases, such as heart disease, high blood pressure, high cholesterol and diabetes. Also important are details about family members with cancer, mental health conditions, dementia and genetic disorders. Try to find out the age of diagnosis, when possible.

"If a lot of family members are developing a cancer at age 40, this could be an indication of an inheritable risk factor versus if people develop cancer in their 70s and 80s, when cancer is more common due to age," Nguyen said...Read More

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The phrase "pain in the neck" is a tongue-in-cheek way to describe annoying situations or people that test our patience, but for those who experience genuine neck pain, it's no laughing matter.

Neck pain can be a debilitating condition that affects daily life and leaves sufferers longing for relief. This article will explore some practical strategies to alleviate neck pain and provide self-care tips, neck pain exercises and other helpful treatments to try.

**Neck pain causes**

Neck pain, also called cervicalgia, is the discomfort experienced in or around the spinal area beneath the head. The Cleveland Clinic says neck pain is common, affecting 10% to 20% of adults.

And it should come as no surprise that your neck, medically known as the cervical spine, plays a crucial role in supporting the weight of your head and facilitating its movements. But various injuries and medical conditions can give rise to neck pain. Left untreated, neck pain can become a persistent hindrance, interfering with your daily activities and diminishing your overall quality of life.

In an article, Dr. Zacharia Issae, medical director of the Comprehensive Spine Care Center at Brigham and Women's Hospital in Boston and director of interventional physical medicine and rehabilitation at Harvard Medical School, writes that neck pain usually builds over time.

"Neck pain rarely starts overnight," he writes in a school web page. "It usually evolves over time. And it may be spurred by arthritis or degenerative disc disease, and accentuated by poor posture, declining muscle strength, stress, and even a lack of sleep." Fortunately, most neck pain causes are not severe and can be effectively addressed through conservative treatments.

The Mayo Clinic provides this list of common neck pain causes:

- **Muscle strain** -- Activities like prolonged computer or smartphone use and seemingly minor actions such as reading in bed can strain the neck muscles due to overuse.
- **Worn joints** -- Like other joints, the neck joints can experience wear and tear over time. This can lead to the development of bone spurs, affecting joint motion and triggering pain.
- **Nerve compression** -- Chronic neck pain can be attributed to the compression of nerves caused by bone spurs or herniated disks within the vertebrae of the neck. As these structures exert pressure on the nerves branching out from the spinal cord, it can lead to persistent discomfort.

- **Injuries** -- Rear-end auto collisions often cause whiplash injuries, where the head is forcefully jerked backward and forward, straining the neck's soft tissues.
- **Diseases** -- Certain medical conditions, such as meningitis, rheumatoid arthritis or cancer, can potentially have neck pain as a symptom.

Johns Hopkins Medicine notes that pain that may come on quickly or slowly and that lingers for weeks, three months or more is considered chronic. Chronic neck pain is less common than acute pain... Read More

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**Sciatica: What Is It, and How Can You Ease the Pain?**

If you have had a sharp pain shooting down one leg, you may be experiencing a condition called sciatica.

Here is what you need to know about sciatica, including what it is, its causes, symptoms and treatments. Plus, learn about medications, self-care and stretches that may provide relief.

**What is sciatica?**

**Sciatica refers to pain that travels along the path of the sciatic nerve.** The sciatic nerve travels from the lower back through the hips and buttocks and down each leg. The pain may be severe but usually clears up in a few weeks.

Sciatica nerve pain causes and risk factors

Causes of sciatic nerve pain include anything that affects the sciatic nerve, according to Penn Medicine:

- Slipped or herniated disk
- Spinal stenosis
- Piriformis syndrome
- Pelvic injury or fracture
- Tumors
- Spondylolisthesis

The Cleveland Clinic notes that risk factors include:

- A current or previous injury
- Normal wear and tear
- Excess weight or obesity
- Insufficient core strength
- Your job
- Type 2 diabetes
- Physical inactivity
- Improper form when lifting
- Tobacco use

Sciatica symptoms

Penn Medicine further reports sciatica pain can vary from mild tingling to a dull ache or a burning sensation. Typically, the pain affects one side of the body. It may worsen:

- After standing or sitting
- At night
- When sneezing, coughing or laughing
- When bending backwards or walking a few yards
- When straining or holding your breath

Sciatica treatment

Sciatic nerve pain will typically improve on its own, although the following treatments may provide relief:... Read More

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**Hot Flashes & What to Do About Them**

Hot flashes are a common -- and uncomfortable -- symptom of menopause.

More than 80% of menopausal women experience sudden, often debilitating bursts of heat that last several minutes, according to the U.S. Food and Drug Administration. They are the most common symptom of menopause that women note.

This article will examine what hot flashes are, why they happen, how they differ during and after menopause, and available treatment options.

**What are hot flashes?**

A **hot flash** is just what it sounds like -- a brief sensation of heat that flashes through your body. It can cause sweating, flushing and when it is over, leave you chilled. How intense, frequent and long-lasting hot flashes are varies from person to person.

**Hot flashes during menopause:** Hot flashes can occur during perimenopause, the period before menopause when you start noticing changes, however, it is most common during menopause. Menopause can occur anytime in your 40s or 50s, but the average age in the United States is 51.

While it isn't clear how hormonal changes set off hot flashes, the Mayo Clinic notes that most research suggests that hot flashes occur when decreased estrogen levels cause your internal thermostat (hypothalamus) to become more sensitive to slight changes in body temperature. When the hypothalamus considers your body too hot, it instigates a chain of events -- a hot flash -- to cool you down.

- Hot flashes after menopause: For many women, hot flashes continue after menopause, in some cases lasting the rest of their lives. According to the Women's Health Research Center at Michigan State University, new research indicates that hot flashes continue, on average, for five years after menopause, and more than a third of women may experience hot flashes for up to 10 or more years after menopause... Read More

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An advisory panel of the U.S. Centers for Disease Control and Prevention voted on Wednesday to recommend the first RSV vaccines for seniors. The U.S. Food and Drug Administration has already approved the vaccines, one made by GSK called Arexvy and a version from Pfizer Inc. called Abrxvy.

During the meeting, the panel called for "shared clinical decision-making" between doctors and patients to discuss benefits and risks, but stopped short of recommending that all seniors get the shots. Younger seniors, those in their early 60s, will have fewer risks of severe disease from the virus, CBS News reported. The vaccine trials did have a small number of very rare, but severe, "inflammatory neurologic events."

"Lives, hospitalizations, we could have a significant impact this year. So that's why we wouldn't want to delay further," panel chair Dr. Camille Kotton said during the meeting. CBS News reported. CDC officials plan to closely follow data from vaccine safety systems as seniors begin getting the RSV vaccines.

"I want to remind everyone that we have one of the best vaccine safety systems in the world. We have the ability to rapidly acquire information, rapidly assess it and act on it. We saw that during the COVID pandemic, that system is viable and is in place," the CDC's Dr. José Romero, director of the National Center for Immunization and Respiratory Diseases, told the panel, CBS News reported.

Prices have not been finalized, but GSK has said its vaccine could carry a price tag of $200 to $295 per dose. Pfizer has said its shot will be between $180 and $270, CBS News reported.

Infants may also soon have an RSV vaccine. The FDA is expected to consider those vaccines later this year.

"This field will undoubtedly change within the next five to 10 years. We'll learn a lot more. So we're trying to make a decision as best we can with the data we have now, at this time," Kotton said.

CDC Panel Backs RSV Shots for Seniors

Social Lives Can Thrive in Walk-Friendly Neighborhoods

Living in a walkable neighborhood fosters socialization and helps create a strong sense of community, new research shows.

Among the active behaviors these walkable neighborhoods promote are walking for leisure or as transportation to school, work shopping or home.

"Our built environments create or deny long-lasting opportunities for socialization, physical activity, contact with nature and other experiences that affect public health," said senior study author James Sallis, a professor at the Herbert Wertheim School of Public Health at the University of California, San Diego.

"Transportation and land use policies across the U.S. have strongly prioritized car travel and suburban development, so millions of Americans live in neighborhoods where they must drive everywhere, usually alone, and have little or no chance to interact with their neighbors," Sallis added in a university news release.

Data came from the Neighborhood Quality of Life Study, which included 1,745 adults ages 20 to 66 living in 32 neighborhoods located in and around Seattle, Baltimore and Washington, D.C.

In walkable neighborhoods, people can wave hello to a neighbor, ask for help or socialize in their homes, said study first author Jacob Carson, a student in the UC San Diego – San Diego State University Joint Doctoral Program in Public Health.

Neighborhoods where driving is necessary may have the opposite effect, preventing neighbors from socializing.

"Promoting social interaction is an important public health goal. Understanding the role of neighborhood design bolsters our ability to advocate for the health of our communities and the individuals who reside in them," Carson said in the release.

"Fewer traffic incidents, increases in physical activity and better neighborhood social health outcomes are just a few of the results of designing walkable neighborhoods that can enrich our lives."

These walkable neighborhoods support one of the U.S. Surgeon General's six foundational pillars in the national strategy to address a public health crisis caused by loneliness, isolation and lack of connection in this country.

The advisory issued in May by U.S. Surgeon General Vivek Murthy says that loneliness and isolation can lead to a 29% increased risk of heart disease, a 32% increased risk of stroke and a 50% increased risk of developing dementia among older adults. It also increases the risk of premature death by more than 60%.

The study findings were published online in the July issue of Health & Place. The research was funded in part by the U.S. National Institutes of Health.

1.3 Billion People Worldwide Could Have Diabetes by 2050

Diabetes is skyrocketing, with more than 500 million people of all ages living with the disease today and the number of cases worldwide projected to hit 1.3 billion in the next 30 years.

"The rapid rate at which diabetes is growing is not only alarming but also challenging for every health system in the world, especially given how the disease also increases the risk for ischemic heart disease and stroke," said lead researcher Kanyin Liane Ong, of the Institute for Health Metrics and Evaluation at the University of Washington School of Medicine, in Seattle.

"While the general public might believe that type 2 diabetes is simply associated with obesity, lack of exercise and a poor diet, preventing and controlling diabetes is quite complex due to a number of factors. That includes someone’s genetics, as well as logistical, social and financial barriers within a country’s structural system, especially in low- and middle-income countries," Ong said in an institute news release.

Worldwide, 6% of people have diabetes, making it one of the top 10 leading causes of death and disability, the new study found. The highest rate is in North Africa and the Middle East, 9%, which is projected to reach 17% by 2050. The rate in Latin America and the Caribbean is projected to increase to 11%.

In every country, the disease is commonly seen in people 65 and older with a prevalence rate of more than 20%. The highest rate was 24% for 75- to 79-year-olds. The highest rate for people in that age group is in North Africa and the Middle East (39%) and the lowest is in Central Europe, Eastern Europe and Central Asia (20%).

In all, 96% of diabetes cases are type 2 diabetes. Obesity was the primary risk, accounting for 52% of disability and premature death, followed by poor diet, environmental and occupational risks, smoking, inactivity and alcohol use, the researchers found.

"Some people might be quick to focus on one or a few risk factors, but that approach doesn't take into account the conditions in which people are born and live that create disparities worldwide," said co-author Lauryn Stafford, a post-bachelor fellow at the institute.

"Those inequities ultimately impact people's access to screening and treatment, and the availability of health services. That's precisely why we need a more complete picture of how diabetes has been impacting populations at a granular level."

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