Research Provides Further Evidence that Pensions are Superior to 401(k) Plans

A new study by the Center for Retirement Research at Boston College has found that retirees are exhausting their 401(k) savings at an alarming rate, providing further proof that 401(k) accounts do not provide the same level of retirement security as pensions.

Since the transition towards the 401(k) over traditional pensions in the 1980s, workers are increasingly responsible for saving for their retirement themselves. However, retirees with 401(k)s are drawing from their savings at a much faster rate than those with pensions. By age 75, 401(k) savers had $86,000 less than those who had a pension.

Financial experts and senior advocates stress that 401(k) plans do not offer the guaranteed income that pensions do. In addition, 401(k) accounts do not offer the monthly payments and withdrawal calculations of pension plans, leaving retirees to make difficult financial decisions on their own.

Now that Americans are living longer than ever before, the risk of depleting retirement savings becomes ever more concerning. About half of retirees are living past the age of 85, but many are in danger of entirely exhausting their savings before then.

“This study shows why Alliance members fight for traditional pensions,” said Robert Roach, Jr., President of the Alliance. “Too few American workers are on track for secure retirements. Replacing defined benefit pension plans with 401(k)s fails workers and retirees.”

New Bipartisan Legislation Aims to Limit Insulin Prices for Patients

Sens. Jeanne Shaheen (D-NH) and Susan Collins (R-ME) announced a bipartisan bill on Wednesday that promises to curb the rising cost of insulin.

The result of months of negotiations, this compromise would cap insulin costs at $35 per month for all insured Americans while eliminating some authorization hurdles that previously complicated insurance coverage of the drug. Patients with private insurance as well as those enrolled in Medicare would not be charged more than $35. However, patients without insurance are not protected by this bill.

Although Sens. Shaheen and Collins claim bipartisan support for the bill, House Republicans argue that a price cap could harm research efforts. Top Senate Democratic leaders are pledging a vote on the bill, but its fate is uncertain with Democrats a narrow margin in the Senate. The House passed H.R. 6833, the Affordable Insulin Now Act, on March 31.

“Passage of this bill would be a step in the right direction. However, Congress must quickly build on it with additional legislation that lowers drug prices,” said Richard Fiesta, Executive Director of the Alliance. "It is not a substitute for more substantial reforms, such as allowing Medicare to negotiate prices for other drugs and limiting the overall out-of-pocket costs seniors pay for their medications.”

U.S. Supreme Court Upholds Rule Requiring Return of Medicare Overpayments

The U.S. Supreme Court declined to hear a challenge to a Medicare requirement by UnitedHealth Group on Tuesday, effectively upholding the government rule requiring Medicare Advantage insurers to promptly return any payment that was based on an unsupported diagnosis.

UnitedHealth took issue with applying 2014 law’s application to private Medicare Advantage plans. They unsuccessfully argued they were unfairly audited because Medicare Advantage plans were being treated differently from traditional Medicare. At stake were billions of dollars that Medicare Advantage insurers are now obligated to return to the federal government.

“This outcome prevents private insurers from padding their profits by pocketing money they were paid in error,” said Joseph Peters, Jr., Secretary-Treasurer of the Alliance. “This decision is a big win for retirees who paid into Medicare with every paycheck they earned.”
Medicare and Social Security are big and growing parts of the federal budget problem

In the last few months, many have developed a renewed appreciation for the costs and risks that large federal government budget deficits cause. In the recent past, when inflation and interest rates were quite low, a view arose that budget deficits did not matter much, unleashing the administration and Congress to spend substantially above the revenues collected. Now, with inflation seemingly out of control and interest rates rising, the realization is reawakening that large budget deficits can cause excess aggregate demand, and that the rapidly growing interest payment burden on the federal budget arising from massive outstanding debt combined with new deficits is not sustainable. In this context, it is worth examining more closely the historical and projected role that Medicare and Social Security are playing in this growing budget problem.

There may be an impression that, with their trust funds, Medicare and Social Security are walled off from the general federal budget, with dedicated revenue sources and large reserves. However, this has never been true for Medicare. While the Hospital Insurance (HI) segment is funded by payroll taxes and taxes on Social Security benefits, the other, larger, segment — Supplemental Medical Insurance (SMI), which covers physicians’ and other provider fees and prescription drugs — is less than quarter-funded by premiums. Nearly all the rest of SMI is funded by a general revenue transfer from the federal budget. But even HI is now a drain on the federal budget, as both interest on the HI Trust Fund and the drawdown on the HI Trust Fund assets as it approaches exhaustion (projected in 2028) are funded by general revenues. Similarly for Social Security (OASDI), after 2010, cash flow into the OASDI Security Trust Fund turned negative. That is, interest on the OASDI Trust Fund has been a draw on the federal budget, and, since 2021, OASDI Trust Fund assets are being redeemed and funded from the federal budget, until the projected exhaustion date of 2035.

The draw grew rapidly in the leading up to the Great Recession, as the prescription drug benefit was introduced and health care costs increased rapidly, to around $400 billion. It then stayed at that level until increasing to around a $500 billion draw more recently. This chart shows these same statistics as a percent of GDP and places them next to the overall federal budget deficit also shown as a share of GDP. The Medicare-Social Security draw on the budget is now above 2% of GDP, which was the level of the entire federal budget deficit as recently as 2015. Recessions increase the deficit as a matter of counter-cyclical fiscal policy, but the most recent pandemic years were truly spending blowouts.

As bad as recent experience has been, the draw from Medicare and Social Security is projected to get much larger in the next decade as the baby boom generation continues to retire and grow old and health care costs rise. This chart shows the trustees’ projections, including the assumption that the HI and OASDI Trust Fund deficits will be filled by general revenue transfers past their projected exhaustion dates. The draw on the federal budget nearly doubles from 2.16% of GDP in 2022 to 4.04% of GDP in 2035, and to 4.37% in 2040. Stated another way, the federal budget responsibility for Medicare and Social Security alone from general revenues will be as large as a relatively bad government deficit year, with no consideration for other government programs, new or old.

There has been no budget planning for this eventuality. Clearly both Medicare and Social Security will require reforms, along with other areas of the federal budget. And the sooner this happens the better, to reduce risks and costs.

Seniors Struggle with Health Care

Bloomberg Business News has reported that “Older Americans are sacrificing basic necessities to afford costly health services, according to a (Gallup) survey that shows how many elderly people cut personal expenses to take care of medical needs. “Out-of-pocket health costs for elders in the US rose 41% from 2009 to 2019…”

“Around 9% of Americans 65 and older spent less on food, 6% cut spending on utilities and 19% trimmed clothing expenditures to help cover health costs…”

Unfortunately, that information is not news to many TSCL supporters who have contacted us and let us know of their desperate situations. As we also know, many seniors have avoided getting medical treatment for health issues they have and many don’t pick up the prescription medicines they are supposed to take, both because of the cost.

In addition, according to that same survey, nearly half of Americans ages 50 through 64 who aren’t eligible for Medicare also share the same concerns as those who are on Medicare.

That is why TSCL has launched a nation-wide petition effort and has been lobbying Congress for months to provide a $1,400 emergency stimulus check in order to help seniors survive during this unprecedented time of inflation.

Watch this POWERFUL “Rally Trailer” Repeal WEP & GPO NOW!

Dear Folks:
I have been on the sidelines watching as this effort has been increasing momentum.

With this wonderful "Rally Trailer", it should become one of the quickest yet powerful ways to get Congressional support. After all, we are all for getting rid of the obstacles that millions of Workers face in not receiving what's financially due them.

I realize the timing of getting this Legislation passed by both Houses NOW is everyone's focus. Because of the short time frame, my only suggestion is that we try to get a few more powerful Congressional Representatives to go on camera to give a quick but hearty endorsement of getting rid of the offsets. These few additions to the Trailer need to be representatives whose endorsement would sway the votes of another faction of Congress that could help put us over the top in getting critical votes for the Legislation's success. By doing so, this "Rally Trailer" would be a quick yet very effective means of making our case for the Legislation needed.

Finally, if my suggestion works for the Group, I would be glad to serve on a Special Committee to work on its Nationwide adoption in helping us get the needed Congressional support.

Congrats for the producers of this video. If utilized effectively, it could be our ticket to success we all are seeking... and deserve.

Respectfully submitted.
Sheldon Lehner
2015 Federal Retiree after 36 years of Federal Service ... to start with!
A new study published in the *Annals of Internal Medicine* shows that the Medicare Part D insurers would have saved Medicare several billion dollars on generic drugs in 2020 if they paid Mark Cuban’s Cost Plus pharmacy prices. But, then these insurers would have lost billions in profits. Why is the administration continuing to promote a failed corporate health insurance model, over public health insurance, to the detriment of taxpayers and people with Medicare?

The whole idea behind having private health insurers “compete” to offer drug coverage is that competition will bring down drug prices down. But, this new study by Harvard researchers completely ignores that the problem is that the Part D health insurers are not in business to bring down drug prices. They are unwilling to do what Mark Cuban is doing to bring costs down or even to offer their enrollees’ coverage of their generic drugs through Cuban’s Cost Plus Pharmacy.

Ed Silverman reports for *Stat News* that the study finds $3.6 billion in savings to Medicare in one year alone. Of course, that would mean savings to people with Medicare who use these drugs, as well. When the study was done, Cuban’s company produced 100 generic drugs. Now, it produces 700 drugs, suggesting savings would be far greater now.

The study’s authors say that “The lower prices from [Cuban’s] direct-to-consumer model highlight inefficiencies in the existing generic pharmaceutical distribution and reimbursement system.” What’s more shocking is that it highlights that the Part D private health insurance model for providing drug coverage to people with Medicare will never put taxpayer interests or the interests of people with Medicare first. (Recently, *Kaiser Health News* exposed that people can’t even count on a given published price of a drug on the Medicare Part D web site. Drug prices can change at any time at the insurers’ whim.)

The authors say that 64 cents of every dollar spent on generic drugs goes to the producers and distributors, including pharmacy dispensing and shipping. How much of the price goes to the health insurers?

Meanwhile, many older adults and people with disabilities are cutting their pills in half, delaying filling their prescriptions or dropping their medications altogether because they can’t afford the cost. For thousands each year, an additional $10.40 in copays means stopping filling prescriptions and premature death, according to a recent *NBER study.*

For the most part, Cuban’s Cost Plus pharmacy offers lower costs than competitors like Walmart and GoodRx. But, not always.

For this study, the researchers looked at 77 generic drugs and found that if the insurers had paid Mark Cuban’s Cost Plus prices, they would have cut 37 percent of Medicare’s $9.6 billion in generic drug costs. An additional 12 generic drugs cost the same with Cuban’s pharmacy as Medicare paid.

Some of the price differences between what the insurers are paying and what Cuban charges are inexplicably huge. Esomeprazole, which is used to treat acid reflux (a generic for Nexium,) cost Medicare about $1.77 a pill. Cuban charges about one tenth the price—$0.19 a pill.

### Medical debt plagues 100 million Americans

Noam Levey reports for *Kaiser Health News* that medical debt plagues 100 million Americans. Levey’s reporting is based in part on a *Kaiser Family Foundation poll* revealing that 41 percent of adults in the US have medical debt. The extent of this debt—which is likely over $200 billion total—has gone unrecognized because a lot of it is hidden in the form of credit card debt, loans from family members, and payment plans to physicians and hospitals.

With income relatively flat relative to soaring costs, Americans are struggling more and more to save. Half of Americans do not have $500 in the bank, according to a Kaiser Family Foundation poll. About a third of people owe their providers less than $1,000 and about a half owe less than $2,500. But, one in four adults owe their health care providers more than $5,000. It is extremely likely that many of them will be in debt for the rest of their lives.

Medical debt is the largest debt Americans bear–58 percent of all debt recorded in the US. People pay that debt in different ways. Fifty million adults pay their medical debt through payment plans with their health care providers. Ten percent of adults owe medical debt to a family member or friend. About 18 percent of adults pay their medical debt through their credit cards.

Levey says that medical debt keeps families from securing other basic necessities. Poll data finds that more than six in ten people with medical debt cut back on food and clothing. Nearly half spend all their savings to pay off their debt. About one in six are pushed into bankruptcy.

An independent analysis found that people with complex and chronic conditions bear a heavy proportion of medical debt. People with heart disease, stroke and cancer can have three or four times the amount of debt than others in better health.

Likely thanks to Medicare, people over 65 are half as likely to experience medical debt as people under 30. The Affordable Care Act relies on corporate health insurers to cover people’s care and allows these corporate insurers to profit wildly in the process. As a result, people with coverage through their state health insurance exchanges can experience severe medical debt. Deductibles alone can be unaffordable.

To collect on debt, hospitals engage collection agencies, which in turn go after patients with abandon. To escape debt, specialists are saying that cancer patients are forgoing treatment. Levey profiles one person who is harassed about a bill that she doesn’t owe over and over and over again. When will this insanity end?

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**Image:** For more information, visit [Rhode Island Alliance for Retired Americans](http://www.facebook.com/groups/354516807278/). 

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Senior Citizens Update for June 25, 2022

Bill to Reduce Insulin Costs Revealed in the Senate

Last week U.S. Senators Jeanne Shaheen (D-N.H.) and Susan Collins (R-Maine) – Co-Chairs of the Senate Diabetes Caucus – announced their new bipartisan legislation, the Improving Needed Safeguards for Users of Lifesaving Insulin Now (INSULIN) Act, to lower the skyrocketing costs of insulin. The new, bipartisan legislation builds on Shaheen’s and Collins’ previous efforts to reduce insulin costs by increasing measures to encourage insulin manufacturers to reduce list prices, while extending patient protections that will foster competition and broader access to desperately needed insulin products.

It is estimated that one in every three seniors lives with diabetes. The disease is one of the leading causes of death in the United States, claiming over 100,000 lives in 2021, and is also the most expensive chronic condition in the nation, costing a total of $327 billion per year. The rising cost of insulin presents a barrier to care for a growing number of Americans living with diabetes. Out-of-pocket costs increase with list prices, and for people without insurance, the costs are untenable. According to the Kaiser Family Foundation, Part D enrollees spent nearly $1 billion out-of-pocket on insulin in 2019, four times the amount spent in 2007.

The bill would place a $35 monthly cap on the cost of insulin for patients with private insurance as well as those enrolled in Medicare, though it would not afford the same protections to the uninsured. The bill also seeks to make insulin more accessible by cracking down on previous authorization requirements that can force patients to jump through hurdles to get insurers to help pay for medications.

The bill further aims to reduce the overall price of insulin, not just how much patients pay for it. The senators are targeting discounts that drug companies provide to insurers and middlemen that have been accused of driving up the costs of drugs at the point of sale.

Senate Majority Leader Chuck Schumer (D-N.Y.) said he’ll bring the bipartisan measure capping the out-of-pocket cost of insulin at $35 per month to the Senate floor soon for a vote.

So far, the only Republican to announce support is Collins, well short of the 10 GOP votes that Democrats will need to avert a filibuster and pass the measure using the normal legislative process.

Majority Leader Schumer and Sen. Joe Manchin (D-W.Va.) are also discussing capping insulin costs in a partisan budget bill that would require just 50 Democrats to pass the Senate. That bill would block insurers and pharmaceutical benefit managers from collecting rebates on insulin products kept at their 2021 Medicare Part D net prices—effectively allowing drug makers to keep a larger share of revenue.

If you live in a state with at least one Republican Senator, TSCL urges you to contact them and urge them to support the Collins-Shaheen Insulin bill.

* * *

Other Bills to Lower Prescription Drug Costs Waiting for Senate Action

As a reminder, the House of Representatives has already passed two pieces of legislation that would lower prescription drug costs. The first bill is the Elijah Cummings Lower Drug Costs Now Act (H.R.3), which would save Medicare some $450 billion over ten years, mainly by allowing the program to negotiate prices directly with Big Pharma.

The second bill is the Build Back Better Act, a very large bill with many provisions, one of which would enable Medicare to negotiate the prices of up to 10 drugs per year starting in 2023, with that number eventually rising to up to 20 drugs per year. The Congressional Budget Office estimates federal budget savings from the drug pricing provisions would be $297 billion over ten years.

However, the Senate has yet to act on either of these bills because there are not enough votes to pass them.

The positive news is that Sen. Joe Manchin and Majority Leader Schumer have met to discuss a so-far elusive budget reconciliation bill that the pivotal West Virginia Democrat says must address high inflation with deficit reduction, energy production and lower drug prices. Schumer told reporters Wednesday there are several issues still to work out with Manchin, whose support the Democrats need to get the 50 votes necessary in the evenly divided Senate.

* * *

Drug Company Studies Biased Toward High-Priced Medicines

A new report in the British Medical Journal has found that studies paid for by drug companies are more likely to conclude that a medicine’s benefits outweigh its costs than are independent analyses. By one measure, industry-sponsored studies were twice as likely to conclude that a drug was cost effective.

The finding, based on a review of nearly 8,200 cost-effectiveness analyses, reinforces longstanding concerns about the biases of drug company-backed research. The study’s authors note that skewed studies can affect coverage decisions that might lead to higher drug prices.

This is an important issue because when public and private insurers weigh whether to cover a drug, they often use these so-called cost-effectiveness studies to evaluate whether a treatment’s price tag is offset by overall savings to the health care system.

TSCL Works With Congressional Office to Pass Social Security Fairness Act

At the request of Congresswoman Abigail Spanberger’s (D-Va.) office, TSCL is working to gain more Congressional support for H.R. 82, The Social Security Fairness Act.

TSCL strongly endorses this legislation.

We are contacting TSCL supporters whose Representatives had previously co-sponsored the bill but have yet to do so this year.

The bill corrects two provisions, the Windfall Elimination Program (WEP) and the Government Pension Offset (GPO), that unfairly reduce or even eliminate the Social Security benefits of millions of Americans who have devoted their careers to public service, as well as having worked other jobs that withheld payroll taxes from their wages for Social Security benefits.

Social Security Fairness Has A New and Improved Website

Social Security Fairness (ssfairness.org) has a new and improved website.

Repeal the Government Pension Offset and Windfall Elimination Provision!

If you earn even part of a public pension from a government job that doesn’t pay into Social Security (FICA), you can lose part or all of your earned Social Security retirement benefits.

Government Pension Offset (GPO)

If you are married to someone who is earning Social Security, you will probably lose all Social Security spousal or survivor retirement benefits due to you from taxes paid by your spouse during the marriage.

Windfall Elimination Program (WEP)

An amount up to half the value of your pension can be cut from the Social Security you have earned in other work in which you paid the required FICA taxes.

Please visit this new website for more information on the efforts to REPEAL the WEP/GOP.
Given the number of cases against corporate health insurers for violating their contractual obligations with Medicare, the issue is not whether there will be more, but which health insurers will be found culpable, when, and will the federal government protect enrollees from the bad actors. The FTC is now taking a deep look into the largest Pharmacy Benefit Managers (PBMs), all of whom are linked in one way or another to a health insurance company covering Medicare benefits. What would the FTC or anyone else need to find for Congress to step in to remove PBMs and private insurers from the administration of Medicare benefits? Pharmacy Benefit Managers are middlemen that work in collaboration with the Medicare Part D health insurers. PBMs negotiate rebates and fees with drug manufacturers, they also decide which drugs go on the health insurers’ list of covered medicines, where people can buy their prescriptions, what they pay out of pocket, and a slew of related policies. PBMs pay pharmacies to fill prescriptions for Part D enrollees.

Most recently, the law firm of Frier Levitt announced a significant victory on behalf of a minority and woman-owned specialty pharmacy, Mission Wellness, against CVS Caremark. CVS Caremark is a Pharmacy Benefit Manager (PBM) serving the Medicare population through Medicare Part D. Mission Wellness prevailed on its claim that CVS Caremark imposed unreasonable “direct and indirect remuneration” or DIR fees on it.

In arbitration, Frier Levitt obtained an award of more than $3.6 million for breach of contract. CVS Caremark was ordered to return all the DIR fees it had received from Mission Wellness as well as to pay attorneys’ fees and interest. But, to date, CVS Caremark has not paid the amount awarded.

If you think that the CVS Caremark breach of contract does not affect you, think again. When a Medicare contracting entity fails to pay health care providers what they are due, providers reconsider whether they will continue treating people with Medicare. Mission Wellness lost money as a result of the DIR fees, while it was a member of Caremark’s Part D network.

You might wonder why CMS isn’t looking out more for people with Medicare and continues to pay CVS Caremark to provide Medicare Part D benefits. According to Frier Levitt: “Caremark refused to provide the required discovery throughout the arbitration, including discovery necessary to “audit” Caremark’s calculations of medication adherence, which serves as the basis for its recoupment of DIR fees. Even after being sanctioned by the Arbitrator, Caremark refused to provide the basis for the DIR methodology.”

Right now, the FTC is investigating CVS Caremark and other PBMs in the Medicare Part D program regarding recoupment of DIR fees. The biggest PBMs are part of corporations that include health insurance companies and pharmacies. The FTC wants to know what fees PBMs charge pharmacies that are not in their networks, what they do to incentivize patients to use their pharmacies, their prior authorization policies, how rebates and fees from drug manufacturers affect which drugs are on a formulary and what people pay, and more.

Supreme Court defers to Biden administration on Medicare payments to low-income hospitals

John Aloysius Cogan, Jr. writes for Scotusblog on a new Supreme Court decision that defers to the Biden administration regarding Medicare payments. In Becerra v. Empire Health Foundation, the Supreme Court opted not to undo the Chevron doctrine, which gives executive agencies significant power over interpreting statutes. In this case, the court let a regulation interpreting statutes. In this case, the court let a regulation

 decisão written by Elena Kagan, reversed a 9th Circuit decision that rejected the department of Health and Human Services’ interpretation of how to calculate payments to hospitals serving low-income populations. I won’t go into the details, but the takeaway is that HHS’ decision to count every hospital patient entitled to Medicare Part A in its calculation of its DSH (disproportionate share hospital)

Supreme Court defers to Biden administration on Medicare payments to low-income hospitals

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For years, Medicare has paid hospitals serving low-income populations a higher rate than other hospitals because people with low-incomes tend to be in a worse health than other people and have higher health care costs. The special rate is based on the hospital’s share of Medicare and Medicaid patients. The Supreme Court, in a 5-4 decision written by Elena Kagan, reversed a 9th Circuit decision that rejected the department of Health and Human Services’ interpretation of how to calculate payments to hospitals serving low-income populations. I won’t go into the details, but the takeaway is that HHS’ decision to count every hospital patient entitled to Medicare Part A in its calculation of its DSH (disproportionate share hospital)

Tough Choices: When It's Time to Move From Home to Assisted Living

While 8 in 10 Americans ages 65 and older say they want to age in their homes, it's not always possible when health declines. Knowing when a loved one needs a more supportive environment, such as assisted living, continuing care retirement community or a nursing home, can be challenging. Though “aging in place” remains a cherished goal, seniors are fretting less about it these days, a recent Associated Press/NORC Center for Public Affairs poll found.

An expert in geriatric mental health offers some guidelines for knowing if independent living is still realistic or if someone needs more care, whether through moving or a home visitation service.

Dr. Molly Camp is an associate professor of psychiatry at University of Texas Southwestern Medical Center in Dallas. In a center news release, she said there are five domains to consider:

Personal needs and hygiene: Basic self-care activities, including bathing, dressing and toileting, must be met. A person’s ability to get in and out of tubs and showers and their risk of falling should be considered.

Home environment: Consider the ability to handle basic maintenance and repairs, as well as access to electricity and water, a sufficiently sanitary living environment and how to avoid safety hazards, such as structural deficiencies.

Necessary activities: Assess whether your loved one can complete complex, essential tasks such as transportation, shopping, meal preparation, cleaning and using technology.

Medical self-care: Your loved one should be able to manage their medications, care for minor wounds and self-monitor for illness.

Financial affairs: Evaluate whether the person has the ability to pay bills on time, track other finances, avoid exploitation, and enter into binding contracts when needed.

Of course, Camp noted, family members may be able to help manage finances and home visitation programs may be able to help with chores such as cleaning and cooking.

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Planning ahead for the unexpected should include making a written will, living will, durable power of attorney and a health care proxy. All of these documents will help ensure that your wishes are honored when you cannot act for yourself.

More than one in three people over 60 do not have a will. If you are among them, you should consider engaging an attorney to prepare one for you or writing one on your own. There are many online tools that can help if you decide to prepare your will without the aid of an attorney. You can find a Just Care post on how to make your own will here. If you already have a will, you should check it periodically to make sure that it’s up to date.

If you have a will, you will need an executor. The executor is the person who oversees the execution of your will, taking care of your property, paying any debts you may have, and distributing your property as you have detailed in your will. The executor is usually a close family member or friend.

You also want to identify someone who has durable power of attorney and put that in writing. The durable power of attorney gives a person you trust control over your finances and anything else you’d like—to the extent you desire—if you are not able to act on your own behalf. So, for example, if you are unable to pay your bills, your durable power of attorney would be able to do so on your behalf.

Your health care proxy and living will collectively are the two parts of what is called an advance directive. Your health care proxy is someone you trust to act on your behalf and express your wishes in a medical emergency, if you cannot speak for yourself. For example, do you want to be kept alive on a ventilator or not if your brain is no longer functioning? You can download a health care proxy form online here. A living will states your wishes about your health care if you cannot speak for yourself.

Keep your will, health care proxy, living will and durable power of attorney in a safe place. Make copies to share with your loved ones. Talk to the people you love and trust about your wishes. It’s advisable to tell them who you’ve named as your executor, health care proxy, and durable power of attorney. They can be the same or different people.

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**House passes bill to create health agency focused on biomedical innovation**

The House passed a bill on Wednesday to create a new health agency centered on expediting biomedical innovation in an effort to find innovative mechanisms to detect and treat a range of diseases including cancer.

The legislation, dubbed the Advanced Research Projects Agency–Health Act, passed in a 336-85 vote, with all “no” votes coming from Republicans. Six Republicans and two Democrats did not vote.

The bill calls for establishing the Advanced Research Projects Agency-Health (ARPA-H) within the Department of Health and Human Services.

The goal of the agency, according to the legislation, is to “foster the development of new, breakthrough capabilities, technologies, systems, and platforms to accelerate innovations in health and medicine that are not being met by Federal programs or private entities.”

The bill also says the new agency would work to expand “transformational health technologies,” which lawmakers say would dramatically change the act of detecting, diagnosing, mitigating, preventing, treating and curing significant diseases and medical conditions.

To achieve these goals, the bill would direct the new agency to discover and promote new health science advances and develop new analytical techniques to help with early detection and intervention of diseases.

Rep. Diana DeGette (D-Colo.) on the House floor said the new agency will help “make the impossible possible.”

“Like DARPA, this entity is gonna be focused on producing research on things that frankly may be too risky for the private sector. It’s gonna move at a faster pace than the current structure,” Upton said.

“There may be a high failure rate, but its successes are gonna have the potential to be absolutely ground-breaking, answering the prayers of millions,” he added.

The Biden administration threw its support behind the bill earlier this week. In a statement of administration policy, the Office of Management and Budget said the bill “will provide a novel pathway to catalyzing transformative health breakthroughs that cannot readily be accomplished through traditional research or commercial

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**Grown Children Who Ignore Their Parents: Seniors and Family Estrangement**

*By Publisher | Last updated February 24, 2022*

Grown children who ignore their parents can provoke a great deal of emotional distress and even physical health problems in older loved ones. And adult children whose older or elderly parents don’t communicate with them can undergo similar feelings of loss and bewilderment. Although some seniors struggle with feeling abandoned, others face the opposite problem—realizing that cutting off contact with a family member is the best course of action to protect their own well-being.

These topics can be hard to talk about. Whether you’re feeling ignored or dealing with family estrangement, the emotions can take a toll. And many people feel too ashamed to seek help. If you’re experiencing an estranged relationship with a parent or child, the following information can help you explore why there is a division, and how to handle it.

**Contents**

- When you feel ignored
- Family estrangement
- When grown children stop talking to their parents

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Supreme Court sides with insurer in dialysis coverage case

The Supreme Court ruled 7-2 Tuesday that a group health plan in Ohio didn’t violate federal law by offering limited coverage for outpatient dialysis in a case brought by DaVita, one of the largest dialysis providers in the United States.

*The court sided* with Marietta Memorial Hospital’s employee health plan, with Justice Brett M. Kavanaugh writing in the majority opinion that while the plan pays lower reimbursement rates for dialysis than for other treatments, it does not discriminate against patients with end-stage renal disease because it offers the same level of coverage for all patients with kidney disease in keeping with federal law.

The plan only covers dialysis providers as “out of network” and reimburses them at a lower rate, leading DaVita to file a lawsuit in 2018.

The decision reversed a 6th Circuit ruling that the plan violated the Medicare Secondary Payer Act, which allows Medicare to be the “secondary” payer to an individual’s private insurance for certain services, including dialysis for end-stage renal disease patients. DaVita argued the plan violated that statute.

Under the law, group health plans aren’t allowed to take Medicare coverage into consideration when designing their benefits, and they can’t offer different benefits to patients with more advanced stages of kidney failure.

Congressional intent was to keep health plans from forcing kidney disease patients into Medicare.

But DaVita argued the plan violated both parts of the statute by offering lower levels of coverage for dialysis and because it had a bigger impact on patients with end-stage renal disease.

Marietta argued that its plan applied coverage uniformly to individuals with and without end-stage renal disease and didn’t consider Medicare coverage when designing its plan.

The court agreed — a win for insurers that will likely have a significant impact on group health plan coverage of dialysis services.

Neither the statute nor DaVita offers a basis for determining when coverage for outpatient dialysis could be considered inadequate,” the majority opinion read. “And neither the statute nor DaVita supplies an objective benchmark or comparator against which to measure a plan’s coverage for outpatient dialysis.”

Siding with DaVita would create “judicial and administrative chaos” with courts trying to determine adequate reimbursement rates, the opinion read.

“Group health plans cover services for many different health issues at varied rates. Those rates may reflect negotiations with third parties, the needs of a particular plan’s beneficiaries, and other factors such as geography,” the opinion said. “Courts would be entirely at sea in trying to determine an appropriate benchmark or comparator for outpatient dialysis.”

The court also ruled that the plan did not take into account Medicare eligibility for end-stage renal disease patients by paying lower reimbursement rates.

Under the law, a plan can’t end coverage, limit coverage or charge higher premiums for patients who have Medicare because of an end-stage renal disease diagnosis.

“Because the plan provides the same outpatient dialysis benefits to all plan participants, whether or not a participant is entitled to or eligible for Medicare, the plan cannot be said to ‘take into account’ whether its participants are entitled to or eligible for Medicare,” Kavanaugh wrote. [Read More]

New Guidelines Have Some Stroke Patients Dropping Aspirin. That Could Be Dangerous

After decades where millions of Americans who were at risk for cardiovascular trouble were told a daily low-dose aspirin would guard against strokes and heart attacks, new guidelines issued this spring recommend that the strategy is not worth the bleeding risks in those over 60.

That's been plenty confusing for patients who aren't sure what is the safest course forward.

Diane Manzella, a Southern California resident, is among them.

Manzella, now 80, had a transient ischemic attack (TIA), often called a "mini stroke," about 20 years ago. These attacks can be a harbinger of a future major stroke.

Then she had a second TIA last month -- after stopping her daily dose of aspirin several months ago.

Experts at Cedars-Sinai in Los Angeles have heard from other confused stroke patients about the new guidelines.

"Both in the hospital setting as well as our clinic spaces, our patients are hearing, seeing the news and they are having family members telling them, 'You need to stop your aspirin. Hey, it causes harm,' because the general public does not know the difference between primary and secondary prevention," said Dr. Shlue Song, director of the Comprehensive Stroke Center at Cedars-Sinai.

The U.S. Preventive Services Task Force made its *final recommendations* tightening the use of low-dose aspirin usage in late April. Soon after, the American Heart Association (AHA) noted that those changes aligned with its *2019 guidelines*.

For now, the recommendations are that people with a history of heart attack, atrial fibrillation, stroke or stenting should continue to take their low-dose aspirin. But for people with no history of heart disease or stroke, taking low-dose aspirin is not recommended for preventing heart attack or stroke ("primary prevention"), especially in adults who have a higher risk for bleeding.

Certain middle-aged adults may benefit from low-dose aspirin therapy, the AHA noted, if they are at high risk for heart attack or stroke due to risk factors such as smoking, high blood pressure, type 2 diabetes, high cholesterol or a significant family history of heart disease. Those individuals should get specific treatment advice from their doctors.

*Aspirin still an option for some*

"The task force recommends a discussion with the doctor to see if the benefits outweigh the risk. There is a marginal risk reduction with aspirin in the 40- to 59-year age range and the physician or the clinical team member needs to really make sure that the bleeding risk does not outweigh the potential benefit here," Song said.

Aspirin can harm people with stomach ulcers or bleeding issues in the gut, which is among the reasons it shouldn't be taken unless there is another reason to do so, Song explained.

Doctors may screen for symptoms such as heartburn or changes in stool before making a decision to use aspirin for primary prevention, she said.

"If a patient's doctor has recommended low-dose aspirin - or any preventive medication -- the patient shouldn't discontinue taking it without discussing it with their physician," Song said in a *question-and-answer session*.

Cedars-Sinai posted recently to help patients understand the guidelines...[Read More]
Seniors Struggle with Dental Care

What we commonly think of as “health care” is not the only Issue Seniors grapple with. According to the Centers for Disease Control and Prevention (CDC), older Americans with the poorest oral health tend to be those who are economically disadvantaged, lack insurance, and are members of racial and ethnic minorities. Being disabled, homebound, or institutionalized (e.g., seniors who live in nursing homes) also increases the risk of poor oral health. Adults 50 years and older who smoke are also less likely to get dental care than people who do not smoke. Many older Americans do not have dental insurance because they lost their benefits upon retirement and the federal Medicare program does not cover routine dental care. Oral health problems in older adults include the following:

- **Untreated tooth decay.** Nearly all adults (96%) aged 65 years or older have had a cavity; 1 in 5 have untreated tooth decay.
- **Gum disease.** A high percentage of older adults have gum disease. About 2 in 3 (68%) adults aged 65 years or older have gum disease.
- **Tooth loss.** Nearly 1 in 5 of adults aged 65 or older have lost all their teeth. Complete tooth loss is twice as prevalent among adults aged 75 and older (26%) compared with adults aged 65-74 (13%). Having missing teeth or wearing dentures can affect nutrition, because people without teeth or with dentures often prefer soft, easily chewed foods instead of foods such as fresh fruits and vegetables.
- **Oral cancer.** Cancers of the mouth (oral and pharyngeal cancers) are primarily diagnosed in older adults; median age at diagnosis is 62 years.
- **Chronic disease.** People with chronic diseases such as arthritis, diabetes, heart diseases, and chronic obstructive pulmonary disease (COPD) may be more likely to develop gum (periodontal) disease, but they are less likely to get dental care than adults without these chronic conditions. Also, most older Americans take both prescription and over-the-counter drugs; many of these medications can cause dry mouth. Reduced saliva flow increases the risk of cavities. That’s why Kaiser Health News and National Public Radio have teamed up and begun a yearlong investigative project that explores “the scale, impact, and causes of the health care debt crisis in the United States.”

About 4 in 10 adults report having medical or dental debt, a Kaiser Family Foundation poll has found, a share that roughly translates into an estimated 100 million adults. Many expect repaying the debt to take years, and about 1 in 5 say they do not expect to ever pay it all off.

The problem drives millions of Americans from their homes or into bankruptcy, but the consequences are not just financial. About 1 in 7 people with health care debt say they have been denied access to a hospital, doctor, or other provider because of unpaid bills. The toll of medical debt tends to fall most severely on the poor, the sick, and people of color, the investigation reveals.

Besides cutting spending on food and other essentials, millions are being driven from their homes or into bankruptcy. And medical debt is piling additional hardships on people with cancer and other chronic illnesses.

In addition, much of the medical debt is hidden as monthly installments paid via credit card, loans from family, and payment plans arranged directly with hospital and doctor’s offices.

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**CDC Panel Urges Seniors to Get New, More Potent Flu Shot This Fall**

A U.S. Centers for Disease Control and Prevention vaccine advisory panel on Wednesday voted to recommend that Americans 65 and older get the new, more potent flu shots because the regular shot doesn't offer enough protection. The more powerful vaccines might also offer more or longer protection for seniors with weakened immune systems who don't respond as well to traditional shots. The choices include Fluzone High-Dose, Fluad with an immune booster and Flublok, the Associated Press reported. The CDC usually adopts the panel's recommendations. This is the first time the federal government has backed a preferred vaccine for older adults. The agency urges all Americans aged 6 months and older to get a flu shot every season. Flu vaccines aren't 100% effective, and are substantially less effective in seniors. But the new shots appear to work better than the regular shot, especially in preventing hospitalizations for flu.

"These influenza vaccines are better, but are not yet the home run that we would love to have," panel member Dr. Helen Keipp Talbot, of Vanderbilt University, in Nashville, Tenn., said during the meeting, the AP reported.

About 80% of those on Medicare get the high-dose vaccines each year, officials said. The new vaccines cost three times more than standard flu shots, but they are covered by insurance, according to the AP.

During last winter's flu season, the vaccine was only 35% effective in adults and 44% effective in children in preventing symptoms severe enough to see a doctor, the AP reported.

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**Just 1 in 4 Patients Get Rehab After Heart Attack, Cardiac Surgery**

Medically supervised exercise programs can do heart patients a lot of good, but few people of color take part in them -- regardless of income, new research finds.

The study, of more than 100,000 U.S. patients, found that while all were eligible for **cardiac rehabilitation**, only about one-quarter actually attended. Enrollment was particularly low among Asian, Black and Hispanic patients, including those with high incomes. Researchers called the persistent disparities "disappointing," especially since cardiac rehab can have major benefits, including a longer life. Cardiac rehab is considered a standard of care for patients recovering from a heart attack or heart procedure, and for those with certain chronic conditions such as heart failure and chest pain caused by clogged heart arteries. Supervised exercise is the cornerstone, but programs also offer counseling on diet, smoking cessation and the psychological aspects of heart disease, including **depression** and **anxiety**.

Yet for years, studies have shown that few eligible patients actually enroll in cardiac rehab.

The new study, published June 22 in the **Journal of the American Heart Association**, is no exception. It found that of over 107,000 eligible patients, only about 26% attended at least one cardiac rehab session. Rates were especially low among Asian, Black and Hispanic patients, who were anywhere from 19% to 43% less likely to attend than white patients were... **Read More**

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Need a Pill to Help You Sleep? You're Far From Alone, Survey Finds

If you struggle to fall asleep at night, you are not alone. About 28% of Americans say insomnia is taking a toll on their daily lives, and about 64% say they take sleep aids to help them fall asleep or stay asleep.

"Chronic insomnia is a dangerous public health problem," said Jennifer Martin, a licensed clinical psychologist and president of the American Academy of Sleep Medicine (AASM).

"When left untreated, chronic insomnia can lead to a range of long-term health issues, including depression, Alzheimer's disease, type 2 diabetes and more, and can impact nearly every aspect of your life," Martin said an AASM news release.

To mark the "shortest night of the year," June 21, AASM took the covers off a new survey about insomnia. It included 2,010 adults across the United States. Of the nearly two in three taking sleep aids, 23% use prescription medications, 27% use melatonin and 20% use marijuana or CBD (cannabidiol). About 37% said their use of sleep aids had increased during the COVID-19 pandemic.

The AASM suggested that people who suspect they have chronic insomnia should work with their health care provider to find the best treatment choice.

Though noting that melatonin can help, AASM said the supplement should not be used to treat adults with chronic insomnia. Melatonin and sleep aids are not a "one-size-fits-all" remedy, the group added. There are many reasons people have trouble sleeping.

"Developing healthy sleep hygiene habits can help someone who has a mild or short-term case of insomnia, but if symptoms persist into the daytime and inhibit your quality of life, it's time to seek support from your doctor," said Michael Grandner, a licensed clinical psychologist and president of the Society for Behavioral Sleep Medicine.

Sleep specialists can make an accurate diagnosis for ongoing sleep problems and develop a proper treatment plan for each patient, Grandner said.

The recommended first-line treatment for chronic insomnia is cognitive behavioral therapy (CBT).

CBT combines behavioral strategies, such as setting a consistent sleep schedule and getting out of bed when you are struggling to sleep, and cognitive strategies, such as replacing fears about sleeplessness with more helpful expectations.

Recommendations developed through CBT are tailored to each patient's individual needs and symptoms.

Martin explained that "cognitive behavioral therapy can help patients by providing customized strategies for individuals of all ages who are suffering from insomnia," and it can produce meaningful improvements and is cost-effective.

Researchers Spot Sign of Alzheimer's Risk That Scammers Love

Could the way a senior handles his or her money offer clues about their risk for Alzheimer's disease?

Yes, according to a new study involving dozens of elderly men and women that found a higher likelihood to give away money to anonymous individuals correlated with a poorer performance on the kinds of tests that screen for dementia.

The study did not, however, assess the mental state of seniors who might decide to more freely donate to a recognized charitable cause, stressed lead researcher Gali Weissberger, who conducted her work while a postdoctoral fellow at the University of Southern California's Keck School of Medicine. She is now a senior lecturer with the interdisciplinary department of social sciences at Bar-Ilan University in Ramat Gan, Israel.

"We do not want to send the message that altruism is a negative behavior by any means," Weissberger noted. "It can be a very deliberative and positive use of one's money."

But spotting a possible link between an increased desire to give away money and heightened Alzheimer's risk could prove useful, she noted. It could help physicians and caregivers better screen for the sort of telltale behavior that indicates both a developing health issue and an increased vulnerability to financial scams and exploitation.

In a recent issue of the Journal of Alzheimer's Disease, Weissberger's team reported on its work with 67 seniors.

At an average age of 69, none of the participants had a previous diagnosis of dementia or any form of mental health decline. All were given $10 to spend, and then paired up with an anonymous person in an online setting. That money could then be split up as each participant wished -- either to be kept or given away -- with allocations made in single dollar amounts.

In turn, all participants completed standard thinking tests -- such as story and word recall tasks -- designed to spot signs of early-stage Alzheimer's. The upshot: Those who gave away the most money to someone they didn't know fared the worst on the tests....Read More

Race, Gender Matter in Receiving Timely Heart Attack Care

Despite improvements in treatment for heart attacks, care lags behind for women.

Women are still less likely to receive timely care, according to a new study that reviewed 450,000 patient records for two types of heart attacks.

"Heart attack treatments have come a long way but timely access to appropriate care is still an issue, especially for female patients," said lead author Dr. Juan Carlos Montoy, an assistant professor of emergency medicine at the University of California, San Francisco.

The research, published June 21 in the Annals of Emergency Medicine, included both ST-elevation myocardial infarction (STEMI) and non-ST-elevation myocardial infarction (NSTEMI) in California hospitals between 2005 and 2015.

For the study, the researchers defined timely treatment as day of hospital admission for STEMI patients and within three days of admission for NSTEMI patients.

In 2005, 50% of men and 35.7% of women with STEMI cases received timely angiograms. These scans are used to assess narrowing or blockages in veins or arteries or show blood flow through the heart.

For NSTEMI cases, timely angiography happened in 45% of men's cases and 33.1% of women's, the study found. While timely care and survival rates were better in 2015, women's care still lagged.

About 76.7% of men with STEMI and 66.8% of women received timely angiograms, the study found. For those with NSTEMI, 56.3% of men and 45.9% of women received timely care.

Black, Hispanic and Asian patients were less likely than white patients to receive timely angiogram scans, and that changed little over time, the authors said....Read More
Acupuncture Might Ease Tension Headaches

Acupuncture may help prevent tension headaches. Folks with chronic tension headaches who received 20 true acupuncture sessions over two months had fewer headache days than people who received a superficial acupuncture technique, and these improvements lasted for close to eight months.

Exactly how acupuncture helps put the brakes on chronic tension headaches isn't fully understood, but researchers do have their theories.

For one, "the acupuncture procedure provides relaxation to the patients with tension-type headaches, which helps to relax the scalp muscles," explained study author Dr. Ying Li, a researcher at Chengdu University of Traditional Chinese Medicine in Chengdu, China.

The study included 218 people who had tension-type headaches at least 15 days a month.

Fully 68% of those in the true acupuncture group reported at least a 50% reduction in the number of headache days they experienced each month. That compares to half of those in the superficial acupuncture group.

True acupuncture aims to achieve what is known as a "deqi" sensation, which is characterized by tingling, numbness, heaviness. Superficial acupuncture does not go deep enough for this to happen.

For study participants who received true acupuncture, headache days decreased from 20 per month to seven. By contrast, headache days decreased from 23 days per month to 12 days per month among participants who received superficial acupuncture.

Now, Li and colleagues plan to study how cost-effective acupuncture is for tension-type headaches when compared with conventional treatments.

The new study was published online June 22 in the journal Neurology. For people with frequent tension-type headaches, preventive treatments to reduce headache frequency are available. But not everyone responds well to these drugs, and some people prefer to avoid them, said Dr. Brian Grosberg, director of the Hartford HealthCare Headache Center in Hartford, Conn.

"Depending on the medication that is used too frequently, caution may be necessary with the medication's effect on the liver, kidney and gastrointestinal systems," said Grosberg, who reviewed the new study findings.….Read More

Women Still Underrepresented in Many Clinical Trials

To ensure that all kinds of patients get drugs and devices that are safe and effective for them, they need to be represented in clinical trials, but a new study shows that representation of women in key disease areas continues to lag.

Researchers from Brigham and Women's Hospital (BWH) in Boston examined female participation in adult cardiovascular, psychiatric and cancer clinical trials, and found that the percentage of women enrolled did not reflect the proportion of women affected by the disease.

"Though there are overall improvements in the participation of women in clinical trials, they are still underrepresented in studies that they rightfully belong in," said study co-author Dr. Primavera Spagnolo, of the Connors Center for Women's Health and Gender Biology and the department of psychiatry at BWH.

"To ensure that results of clinical research benefit all the individuals affected by a disease, clinical trial populations should align more closely with the demographics of the population affected by disease," Spagnolo said in a hospital news release.

For the study, the research team analyzed data from ClinicalTrials.gov, a database of both private and public clinical research, for the four years spanning 2016 to 2019. The investigators assessed the average number of women enrolled for the specified disease areas and per trial.

In 1,433 trials with over 302,000 participants, the researchers found that about 41% of participants were female. Breaking that down further, the investigators found that while 49% of the cardiovascular disease patient population is female, just under 42% of trial participants were female. Similarly, while 51% of cancer patients are female, just 41% of clinical trial participants were female.

The gap was especially stark in psychiatry clinical trials, where about 42% of trial participants were female while 60% of psychiatry patients are female…..Read More

COVID Boosters Raise Antibody Levels by 85% in Nursing Home Residents

Getting a COVID-19 booster shot can significantly increase an at-risk person's immunity and protect against the contagious Omicron variant.

New research focusing on nursing home residents and their caregivers found a third dose of vaccine boosted antibodies by more than 85%, with high levels of Omicron-specific immunity.

The study authors said the results underscore the importance of boosters for all older adults.

"There are tens of millions of community-dwelling older adults similar to the nursing home population but are living at home," said lead author Dr. David Canaday, a professor of infectious diseases at Case Western Reserve University School of Medicine in Cleveland.

"This data shows this group of frail, older adults with similar clinical and functional limitations would benefit immensely from a booster vaccination," he said in a university news release.

Canaday noted that the data also shows that health care workers received a significant surge in antibody levels after a booster. Many are healthy, middle-aged adults similar to the general population. While nursing homes have been severely affected by the pandemic, about 1 in 8 of residents and 1 in 9 staffers had not been fully vaccinated, according to the AARP.

This study included 85 nursing home residents and 48 health care workers in Ohio. They were tested after their initial vaccine series, as well as just before and two weeks after their booster shots.

The findings build upon previous research published last fall that found nursing home residents and health care workers lost more than 80% of their immunity about six months after the two-dose vaccine series.

Current vaccination recommendations from the U.S. Centers for Disease Control and Prevention say people age 5 and older should get a booster, and those 50 and older should get a second. Those who are 12 and up and are moderately or severely immunocompromised should also get a second booster.

Researchers continue to study responses to the second booster shot in nursing home residents.