Rhode Island Alliance for Retired Americans®

RI ARA

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"NOW, more than ever!!!"

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Message from Alliance *for* Retired Americans Leaders

Study: Medicare Would Have Saved $26.5 Billion if Drug Price Negotiation Had Been in Effect Between 2018 and 2020

Robert Roach, Jr
President, ARA

Medicare's negotiations with the pharmaceutical industry to determine drug prices are set to conclude at the end of August 2024, with the new prices taking effect beginning in 2026.

The specific savings are not yet known, but researchers recently conducted a **simulation** to determine the extent of Medicare savings if the Inflation Reduction Act (IRA) of 2022 had been the law between 2018 to 2020. The results, published in JAMA Health Forum, concluded that Medicare spending could have been reduced by 5%, or $26.5 billion.

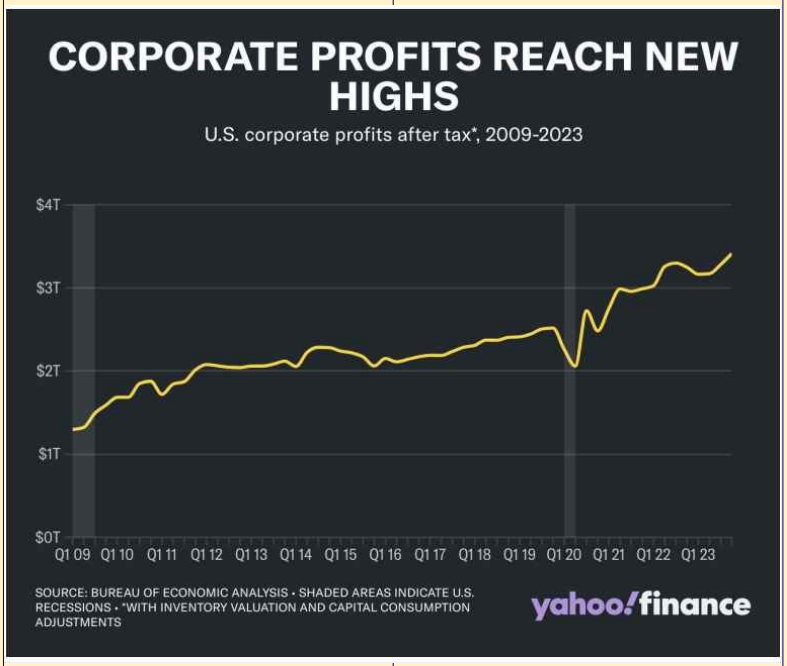
The researchers used Medicare parts B and D data as well as the drugs' list prices to simulate both the selection of drugs and negotiated ceiling prices.

"This study shows why the pharmaceutical industry fought so hard to prevent Medicare from negotiating lower prices," said **Robert Roach, Jr., President of the Alliance**. "Reining in drug prices is essential to strengthening the Medicare system.

" The Inflation Reduction Act (IRA) allows 10 drugs for the first year of selection (2026), 15 drugs in both the second and third years, and 20 drugs annually in the subsequent years following.

New Research Links Skyrocketing Corporate Profits and Inflation

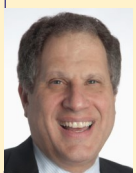
New government data shows that in the fourth quarter of 2023, corporate profits **reached $2.8 trillion**, an all-time high — and profit margins for corporations during the quarter were above 15%, a level not seen since the 1950's.



At the same time, a recent report from Groundwork Collaborative calculated that corporate profits drove 53% of inflation from April to September 2023.

Robert Reich, Secretary of Labor from 1993 to 1997 in the cabinet of President Bill Clinton, says that prices remain high because corporations got hooked on price-gouging and don't want to give it up. And Sen. Warren told Yahoo Finance in a statement that "giant corporations are fueling nearly half of all inflation by playing tricks on the American people."

"The Alliance supports President Biden's plan to raise the corporate tax rate to 28% and ensure that billion-dollar corporations pay at least 21% of their income in taxes," said **Richard Fiesta, Executive Director of the Alliance**. "It's high time corporations and the wealthy pay their fair share."



Rich Fiesta,
Executive
Director, ARA

Trump Promises to Extend Tax Cuts for Billionaires

During a private speech delivered at the home of billionaire hedge fund investor John Paulson last Saturday, Trump **promised to extend his 2017 tax cuts** beyond their 2025 expiration date.

Since the law's changes were implemented, billionaire wealth in the United States has doubled. That is partly because the law cut the top income tax rate from 39.6 percent to 37 percent and made a permanent cut in the corporate tax rate from 35 percent to 21 percent.

According to the Institute on Taxation and Economic Policy, an extension of the tax bill would result in the wealthiest one percent of Americans receiving an **average tax cut of $25,650** in one year, while the poorest 20 percent would see a dismal average tax cut of just $100.

In addition, a 2023 Congressional Budget Office (CBO) **analysis** requested by Senators Sheldon Whitehouse (RI) and Ron Wyden (OR) showed that Republicans' plan to permanently extend the Tax Cuts and Jobs Act (TCJA) and the tax breaks would add $3.5 trillion to the deficit within the next decade.

"Contrary to Republican claims that the tax cuts would pay for themselves, the Trump tax cuts added trillions to America's debt," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "We literally cannot afford another Trump presidency.

Joseph Peters, Jr.
Secretary
Treasurer ARA

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More Health Systems Likely to Drop Out of Medicare Advantage, Analyst Predicts

Medpage Today
Story by Joyce Frieden

More health systems are going to be opting out of Medicare Advantage (MA) plans, George Hill, a managing director at Deutsche Bank in Boston, predicted Monday at a "Wall Street Comes to Washington" webinar hosted by the Brookings Institution.

"I think you're going to see more large provider organizations threaten to opt out of networks, particularly as it relates to MA," Hill said, adding that there are a number of reasons for this. "Prior authorizations are the problem, claims denials are a huge problem, delayed payments and rates are the problem -- barriers in access to care in all varieties are the problem."

Health systems' actions in this area won't necessarily be "all or none," he continued. "There are a lot of intermediate steps. Maybe there's a flagship hospital that can't be used by an MA patient. Maybe there's some type of clinic or some type of service that can't be used by them, or some other type of steerage that goes on ... Given the [financial] pressure that the Medicare Advantage plans felt like they were under in 2023, are going to be under in 2024, and expect to be under in 2025, this is a problem that gets worse before it gets better."

Jailendra Singh, managing director at Truist Securities in New York City, said the disputes between MA plans and health systems "are always about rates ... Hospitals claim that MA plans don't reimburse at the same level [as traditional] Medicare, and that they can delay or deny care through prior authorization, or impose other limitations." Telehealth is a good example, he said. "Payers still believe it should be way cheaper than when you provide care in the four walls of the clinic, whereas providers keep saying, 'we are spending the same amount of time and resources; we should be paid really close to the same level.'"

For its part, the Centers for Medicare & Medicaid Services (CMS) has begun scrutinizing the number of diagnostic codes that MA plans are assigning to patients, Hill said; the plans get higher payments for enrollees with more diagnoses. "You'll see a lot of other diagnostic coding that goes into these beneficiaries, which then doesn't show up as treatment," he said. "I think CMS recognizes that and is working on that now."

He added that people with knowledge of Capitol Hill have been telling him, "'Don't be surprised if the populist Republicans actually want to go after MA,' with the thesis being they don't like what supplemental benefits cover, and they don't like the idea that Medicare is covering all this stuff that it was never intended to cover."

Panelists also discussed the recent "unwinding" -- eligibility re-determinations -- that state Medicaid programs had to do once the COVID-19 public health emergency ended. "More Medicaid beneficiaries lost coverage than expected," with about 80% of disenrollments reportedly due to administrative reasons, said Ann Hynes, managing director at Mizuho Americas in Boston.

Despite the disenrollments, "people are still getting health insurance" through the Affordable Care Act exchanges or through their employer, now that they no longer have the Medicaid option, Hynes said. "Exchange growth is very strong this year, and I also would be surprised as [commercial insurers] report earnings, if you see an uptick in just regular commercial growth ... We haven't seen a huge uptick in the uninsured, so I think it is settling out."

One of the reasons so many people were disenrolled may be that Medicaid plans are having difficulty reaching them, Hill said, noting that when he was at a health insurance industry conference recently, "you heard state administrators talk about [how] 'mail is dead,' and people aren't answering phone calls from people they don't know. So if the state Medicaid agency is calling you, what does that mean? What we've seen is younger, healthier, people get 're-determined out' while the older, sicker people are going to pay much closer attention to their healthcare" and make more of an effort to stay in the program.

The high cost of prescription drugs, such as GLP-1 inhibitors that are now being used for weight loss, also came under discussion. Whether employers choose to cover such drugs will vary from one to the next, Hynes said. "Employers who tend to have an employee who stays with them longer term" -- such as automakers or other large employers -- "I think they're more willing to do a carve-out and a test" to see whether it's cheaper to provide employees with access to weight-loss drugs and possibly avoid some obesity-related illnesses, or to not cover the drugs and let providers manage obesity in other ways, she said.

Hill had another idea. "I feel like it's rare that anyone ever gets to say this, but could this be a case of PBMs [pharmacy benefit managers] to the rescue?" he said. "The only people [who could blunt] the impact of the high cost of GLP-1 drugs are probably the PBMs." He noted that hepatitis C drugs were a case in point. "Those drugs are basically free now" thanks to the PBMs, "as opposed to drugs that came on the market at a $90,000 list price."

Elder Theft and Scams are at an All-Time High

Older adults are less likely to spot the warning signs of scams early on or reach out for help when they've fallen victim.

Whether it's by impersonating government officials or claiming to offer financial assistance, scammers are unrelenting in their attempt to con seniors.

Older adults are less likely to be tech-savvy and more likely to be home during the day to answer phone calls or reply to emails. They may have accrued a lifetime of savings, their own home, and a promising credit score.

But elder fraud isn't only a hazard for the older population. Family members may lose property or assets if they were co-signed on a fraudulent loan with the elder victim. This can also lead to credit scores plummeting for anyone involved.

In this article, we'll review the types of scams that ensnare seniors and what you can do to keep your elderly loved ones safe.

What Is Elder Fraud? Why Do Scammers Target Seniors?
Elder fraud is any scam that **targets older adults** and exploits them for monetary gain, such as **financial fraud** or **identity theft**.

Typically, a scammer will deceive senior citizens with false promises of goods or services. Once they gain their trust, scam artists go after financial details, health insurance, or even physical possessions. Scammers target senior citizens for several reasons, including:

- They're more trusting of others — especially people who claim to be looking out for them.
- They often have considerable savings or valuable possessions. This makes them lucrative targets for scammers.
- They're often not tech-savvy and easier to **scam online**, over the phone, or on social media.
- They may have cognitive or physical impairments preventing them from exercising their best judgment.
- They might feel like they can't report the scam out of fear of losing their independence or being seen as incompetent.

Even worse, most cases of elder abuse are committed by friends, family, or those in routine close proximity to the victims. For example, a **family member** could open a credit card in their elderly relative's name**….Read More on each of these SCAMS.**

Final Rule Limits Broker Compensation, Requires Important Plan Improvements

Late last week, the Centers for Medicare & Medicaid Services (CMS) finalized a rule for Medicare Advantage (MA) and Part D prescription drug plans that will have a number of positive effects for enrollees and the program. This includes limiting insurance broker payments to make rates more rational and the playing field between plans more even; curtailing sales of some beneficiary information between marketing organizations; improving network adequacy for behavioral health; boosting enrollee awareness of the supplemental benefits available to them; and strengthening alignment between Medicare and Medicaid in MA plans for people who are dually eligible for both programs.

As we **noted in January**, this final rule is a part of annual changes to how MA and Part D plans operate. We were **largely supportive** of the proposed updates and most of them were finalized as written.

The most noteworthy aspect of the final rule revolves around broker compensation. Brokers and agents receive commissions to sell MA and Part D plans. These amounts are capped, but MA plans found workarounds. One common practice is to pay brokers "administrative fees" on top of commissions, essentially rewarding them for steering. Starting with the Fall Open Enrollment period in 2024, the final rule eliminates these fees, leveling the playing field for MA plans and better centering beneficiary needs and preferences. While we supported this proposal, it does not address the enormous commission difference between selling MA plans and standalone Part D, with or without an accompanying Medigap policy. This leaves a significant incentive in place for brokers to steer people with Medicare toward MA plans, even when individuals would do better or prefer to stay in Original Medicare. We encourage CMS to address this imbalance….**Read More**

Medicare Rights President Urges Caution for Telehealth in Testimony Before Congressional Health Subcommittee

On April 10, 2024, Medicare Rights Center President Fred Riccardi testified at a hearing of the U.S. House Committee on Energy & Commerce, Subcommittee on Health, titled "**Legislative Proposals To Support Patient Access To Telehealth Services.**"

The COVID-19 outbreak spurred significant changes in Medicare telehealth. Early in the pandemic, it was clear that Medicare beneficiaries were at high risk. Policymakers responded quickly, temporarily relaxing restrictions so more beneficiaries could obtain telehealth through more types of technology, from more providers, and at more locations, than ever before.

The COVID-related changes represent the biggest shift in Medicare telehealth since those services were created over 25 years ago. They were critical during the pandemic, helping many beneficiaries access care safely and responsibly, likely leading to **improved health outcomes.**

Though initially set to expire with the COVID-19 public health emergency (PHE) period and other since-passed deadlines, Congress extended many of these flexibilities through the end of 2024, to allow time for deliberate policymaking and to avoid abrupt care disruptions.

Yesterday's hearing featured 15 bills before the Committee that seek to make some changes permanent or otherwise expand coverage.

Medicare Rights recognizes that telehealth holds great promise. Based on our experience counseling people, we know that not all beneficiary experiences with the PHE's expansions have been positive. Some callers to our national helpline have enjoyed greater access to care, while others have been left behind. We are also concerned about **gaps in data**. The value of these telehealth services to beneficiaries and their impact on health care disparities remain largely unexamined, though existing research suggests inequities between **in-person and remote care quality**, as well as in **telemedicine access** across a range of demographic and geographic factors….**Read More**

Congress Likely to Kick the Can on Covid-Era Telehealth Policies

Nearly two hours into a Capitol Hill hearing focused on rural health, Rep. Brad Wenstrup emphatically told the committee's five witnesses: "Hang with us."

Federal lawmakers face a year-end deadline to solidify or scuttle an array of covid-era payment changes for telehealth services that include allowing people to stay in their homes to see a doctor or therapist.

During **the hearing** in early March, Wenstrup and other House members offered personal anecdotes on how telehealth, home visits, and remote monitoring helped their patients, relatives, and constituents. Wenstrup, a Republican from Ohio who is also a podiatric surgeon and a retired Army reservist, told the audience: "Patients are less anxious and heal better when they can be at home."

Most of the proposals focus on how Medicare covers telehealth services. But the rules affect patients on all types of insurance plans because typically private insurers and some government programs follow Medicare's example. Without congressional action, virtual health care services like audio-only calls or meeting online with specialty doctors — such as an occupational therapist — could end. The bills would also continue to allow rural health clinics and other health centers to offer telehealth services while waiving a requirement for in-person mental health visits.

Telehealth use ballooned in the early months of the covid-19 pandemic and grew into a household term. The practice has become a popular issue for lawmakers on both sides of the aisle.

In one **U.S. Census Bureau survey** conducted from April 2021 to August 2022, Medicare and Medicaid enrollees reported using telehealth visits the most — 26.8% and 28.3%, respectively. The survey of nearly 1.2 million adults also found that Black patients and those earning less than $25,000 reported high rates of telehealth use. Notably, people of color were more likely to use audio-only visits.

Ensuring access to telehealth services "is the best public policy," said Debbie Curtis, a vice president of McDermott+Consulting, a Washington, D.C.-based health care lobbying firm. "It's the best business outcome. It's the best patient care outcome."

But it's a presidential election year and Congress is a "deadline-driven organization," Curtis said. She expects that Congress will be "kicking the can" past the November election.

Kyle Zebley, senior vice president of public policy at the American Telemedicine Association who also lobbies on Capitol Hill, said Congress "might well be in that lame-duck period." "This is no way to run a health care system on a popular bipartisan issue," he said….**Read More**

Home healthcare for elderly sees largest price increase ever

The Hill
Story by Alejandra O'Connell-Domenech

Costs for home healthcare for the elderly and bed-ridden have gone up by **14.2 percent** over the past year, according to new Consumer Price Index data released Wednesday.

That represents the largest percent increase in home healthcare costs during a 12-month period since the Bureau of Labor Statistics began collecting data on such costs in 2005.

The United States has an aging population, and the need for care among the nation's roughly **73 million Baby Boomers** is driving up the cost of nursing homes, assisted living facilities and home healthcare.

About 70 percent of American adults aged 65 and older will need some form of long-term care in the future, according to the **Administration for Community Living**.

There are two main types of in-home care providers for the elderly or bed-bound: home health aides who help with personal care and homemaker aides who assist with household chores.

The prices for these aides' services vary by need and location, but in 2023 the median cost for a home health aide was $33 an hour and that for a homemaker aide was $30 an hour, according to insurance company **Genworth**.

The reason behind the striking increase in in-home care costs stems from shortages in the country's home health workforce coupled with rising wages for these workers, according to Marc Cohen, co-director for the Leading Age Long Term Services and Supports Center at the University of Massachusetts-Boston.

In 2022, there were about 4.8 million direct care workers, a category that include home health aides, according to an analysis from **KFF**. These workers helped 9.8 million people at home, 1.2 million in residential care facilities and 1.2 million in nursing homes.

The direct care sector is expected to add over 1 million new jobs by 2031, according to that same analysis. But those additional jobs will not be enough to meet the country's rising eldercare needs.

Medicare Part D plans can make it hard to get prescription drugs

As you might already know, Medicare Part D plans can make it hard to get the prescription drugs you need. That's not to say you shouldn't have Part D coverage because it could protect you from out-of-control prescription drug bills. But, you still might spend less paying for your drugs out of pocket with a discount coupon from GoodRx or through Costco mail order or from a **verified pharmacy abroad**.

First, the good news. Beginning next year, your out-of-pocket costs for drugs that Medicare Part D covers will be capped at $2,000 a year. The Inflation Reduction Act, one of President Biden's big accomplishments is responsible for that limit as well as negotiated drug prices for some of the highest cost drugs in Medicare.

But, corporate health insurers offering Part D like to make money, so they are finding ways to shift more costs on to their enrollees.Part D insurers are making it hard for their enrollees to fill certain prescriptions. Either these insurers are not covering certain medicines altogether or they are forcing people to go through multiple hoops before they will pay for certain drugs, according to a recent **Health Affairs study**.

For the most part, if a Part D plan does not cover a drug, then that drug is not subject to the $2,000 out-of-pocket cap.

How do Medicare Part D insurers limit their prescription drug spending and/or boost their revenue?

1. They don't include certain drugs on their formulary; they now don't cover 30 percent of drugs, up from 21 percent 13 years ago. Apparently, they are now not covering come drugs that treat cancers and autoimmune disorders.
2. They promote brand-name drugs for which they get large rebates from pharmaceutical manufacturers and make copays for generic substitutes more expensive or simply don't cover generics.
3. They restrict access to drugs through prior authorization requirements. In 2o2o, they restricted access to 44 percent of them.
4. They require the use of generics and won't cover brand-name alternatives.

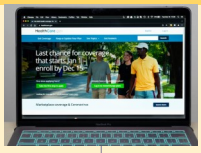
Why does the government permit these restrictions?

After Public Push, CMS Curbs Health Insurance Agents' Access to Consumer SSNs

Until last week, the system that is used to enroll people in federal Affordable Care Act insurance plans inadvertently allowed access by insurance brokers to consumers' full Social Security numbers, information brokers don't need.

That raised concerns about the potential for misuse.

The access to policyholders' personal information was one of the problems cited in a **KFF Health News article** describing growing complaints about rogue agents enrolling people in ACA coverage, also known as Obamacare, or switching consumers' plans without their permission in order to garner the commissions. The consumers are often unaware of the changes until they go to use their plan and find their doctors are not in the new plan's network or their drugs are not covered.



Agent Joshua Brooker told KFF Health News it was relatively easy for agents to access full Social Security numbers through the federal insurance marketplace's enrollment platforms, warning that "bad eggs now have access to all this private information about an individual."

On April 1, the morning the article was posted on NPR's website, Brooker said, he got a call from the Centers for Medicare & Medicaid Services questioning the accuracy of his comments.

A CMS representative told him he was wrong and that the numbers were hidden, Brooker said April 7. "I illustrated that they were not," he said.

After he showed how the information could be accessed, "the immediate response was a scramble to patch what was acknowledged as 'problematic,'" Brooker posted to social media late last week.

Brooker has followed the issue closely as chair of a marketplace committee for the National Association of Benefits and Insurance Professionals, a trade group.

After some phone calls with CMS and other technical experts, Brooker said, the federal site and direct enrollment partner platforms now mask the first six digits of the SSNs.

"It was fixed Wednesday evening," Brooker told KFF Health News. "This is great news for consumers."

An April 8 written statement from CMS said the agency places the highest priority on protecting consumer privacy. "Upon learning of this system vulnerability, CMS took immediate action to reach out to the direct enrollment platform where vulnerability was identified to make sure it was addressed," wrote Jeff Wu, acting director of the Center for Consumer Information & Insurance Oversight at CMS….**Read More**

Out-of-network care: Don't trust your insurer to pay the bills

MultiPlan, a data analytics firm, works with UnitedHealthcare and many big insurers to calculate the amount insurers should pay for out-of-network care. As Chris Hamby reports for the **New York Times**, MultiPlan and the insurers make more money for themselves, the less they pay for employees' care. So, many working people can't trust their insurer to pay for their out-of-network care.

Are MultiPlan and the insurers simply "containing" costs for employers or profiting wildly at the expense of working people? Profiting wildly. The less they pay for workers' out-of-network care, the more revenue they generate for themselves. In 2023, MultiPlan advised insurers not to pay $23 billion in health care bills they claim were provider overcharges.

How insurers benefits from out-of-network coverage, an example: The oncologist charges $100,000 for out-of-network care. MultiPlan says the appropriate charge is $5,000. The insurer pays $5,000. The employer saves. And, MultiPlan and the insurer receive a fee from the employer that is a high percentage of the "savings."

What's most insane about this whole scheme is that in many cases the fees that MultiPlan and the insurer collect are way more than the physician or hospital receives as payment for services from the insurer! UnitedHealthcare charges employers around 30 to 35 percent of the difference between what the provider bills and what the insurer pays. MultiPlan receives an additional fee. The cancer patient could be stuck with a $95,000 bill. The less the employer pays, the more MultiPlan and the insurer earn in fees.

How does MultiPlan calculate the insurers' payment? Somehow, MultiPlan claims that the amount it determines to be the fair out-of-network rate is "defensible, repeatable and completely transparent" and independent of insurance company influence." Orwellian, to say the least. And, don't assume that your employer's insurer doesn't rely on MultiPlan. MultiPlan calculates out-of-network payments for more than 60 million people enrolled in 100,000 different health plans.

What happens to the patients? They are likely to be stuck paying whatever the difference is between what the insurer pays and the physician bills. They are also likely to forgo needed care down the road for fear of incurring more bills.

Who's watching the store for employees? Honestly, no one. Regulators do not get involved with employer health plans, for the most part.

Fool me twice? 15 years ago, the New York Attorney General intervened to stop a similar UnitedHealthcare scheme: "A payment system riddled with conflicts of interest had been shortchanging patients, and at its core was a data company called Ingenix, a subsidiary of UnitedHealth." They lower their payments to providers inappropriately. requiring patients to pay more. UnitedHealth paid $350 million and new regulations were implemented to prevent this from happening again.

Medicare Advantage plans get $16 billion increase in 2025

The battle over how much more the administration will pay insurers offering Medicare Advantage plans in 2025 is over. According to the Centers for Medicare and Medicaid Services (CMS), insurers will get a $16 billion increase. The insurers are playing with the numbers to suggest they are getting a cut, when, as it is, they are receiving **$83 billion more** this year than they should be.

The insurers were hoping that the CMS final rate notice, issued last week, would give them an increase over the CMS proposed rate. Social Security Works, People's Action, Be a Hero, Public Citizen and many other advocates and experts called for cuts, given the massive overpayments to the insurers. Even with the massive overpayments, some insurers are denying and delaying care inappropriately and they are failing to pay money due hospitals, physicians, home health agencies, rehab facilities and nursing homes for services provided with their approval. It's not clear when or how Congress will step in to address the insurer overpayments,

inappropriate care denials, and failure to pay providers in Medicare Advantage. A recent story in **Newsweek** focuses on the fact that insurers are not paying **nursing homes** appropriately. The American Medical Association has not spoken out against the insurers offering Medicare Advantage for not paying physicians appropriately, though it has highlighted the sometimes **deadly consequences of prior authorization**, a tool the Medicare Advantage plans use to inappropriately delay and deny care.

Meanwhile, the American Hospital Association continues to speak out about the failings of Medicare Advantage plans. And, **many hospitals have cancelled their Medicare Advantage contracts**.

Will the insurers cut extra benefits in Medicare Advantage plans? Time will tell. It's hard to believe they will. Few enrollees take advantage of them. And, they are a marketing hook. Insurers are still making a fortune off of Medicare Advantage.

Almost 1 in 4 People Disenrolled From Medicaid Are Now Uninsured

Nearly a quarter of Americans who lost their pandemic-era Medicaid coverage say they're now without any health insurance, a new survey finds.

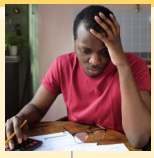
More than half (54%) of these currently uninsured adults cited cost as the reason keeping them from having coverage.

The survey of 1,227 adults was conducted this February and March by KFF (formerly known as the Kaiser Family Foundation). It included people who said they had Medicaid coverage in early 2023 -- prior to the repeal of pandemic-era eligibility rules on April 1, 2023.

About one in five (19%) of all people who had been on Medicaid in early 2023 were disenrolled at some point later that year, the survey found.

Seventy percent of that group said they subsequently went through a temporary period of being uninsured.

Most did eventually gain insurance: Forty-seven percent managed to re-apply and get reinstated on Medicaid, while another 28% said they found insurance via their work,



Medicare, the Affordable Care Act's marketplace or military-based health care. More than a third of people who sought to regain some kind of coverage said they found the process difficult, the survey found, and nearly half (48%) called it stressful.

Long phone call wait times, excessive paperwork and trouble figuring out what paperwork was needed were common complaints.

Speaking to *CBS News*, **Kate McEvoy**, executive director of the National Association of Medicaid Directors, said that millions of people are currently being redetermined for eligibility, and that has swamped some state call centers.

According to McEvoy, states did try to reach out to enrollees prior to the post-pandemic changes in eligibility, using media campaigns, texts, emails, and apps.

However, "until the moment your coverage is at stake, it's hard to penetrate people's busy lives," she said….**Read More**

Worker Benefit for Your Age Group?

The Motley Fool

According to the latest Social Security Administration statistical snapshot, the average retired worker collects a monthly benefit of $1,839, which works out to just over $22,000 per year.

If you're curious, the maximum possible Social Security benefit in 2023 is $3,627 at full retirement age, or $4,555 per month for those who wait until age 70 to start collecting. So, the average beneficiary gets roughly half of the maximum possible full retirement age benefit.

However, you might be surprised to know that the average retired worker benefit from Social Security varies considerably among different age groups of retirees. Here's a breakdown of the average Social Security benefit by age, so you can see how you compare.

The average retired worker's benefit by age

The overall average doesn't tell the full story, as there is quite a difference among retirees of different ages. Let's take a look at two tables with data from the Social Security Administration for benefits as of the end of 2022.

The first is the average monthly benefit for retired workers ages 62 through 70. Keep in mind that this is the range of ages at which retired workers can choose to **start collecting their benefits**. Notice how big a difference early claiming of benefits makes for those in the lower age ranges.

As mentioned, the youngest age group has the lowest average benefit, and this isn't a surprise. After all, by definition, everyone who is 65 and under and is collecting a retired worker benefit started collecting it well before their full retirement age. It's also worth noting that all the age groups from 66 through 85 have an average benefit that is within a pretty tight range.

However, there's a bit of a drop in the older age ranges. A possible explanation is the way inflation is calculated for Social Security purposes (using the Consumer Price Index for Urban Wage Earners and Clerical Workers, or CPI-W). This index doesn't change in the exact same way as the Consumer Price Index for All Urban Consumers (CPI-U), which is the index that covers most of the U.S. population.

If you're not retired yet, here's what you can do to raise your benefit

If you're already collecting Social Security, there's not a lot you can do to boost your monthly benefit. But if you haven't started yet, waiting for as long as you can before collecting can make quite a difference. For example, if you were entitled to a $2,000 monthly benefit at a full retirement age of 67, you'd only get $1,400 per month if you decided to start at 62. But if you wait until 70, you'd get a monthly check for $2,480.

Of course, it isn't practical or necessary for everyone to wait until 70 to start collecting Social Security. But even if you can hold off for just a few additional months, it can have quite an effect.

Age	Average Monthly
62	$1,275
63	$1,365
64	$1,412
65	$1,505
66	$1,720
67	$1,845
68	$1,848
69	$1,820
70	$1,963

Age Range	Average Monthly
62-65	$1,414
66-70	$1,845
71-75	$1,927
76-80	$1,883
81-85	$1,823
86-90	$1,698

Michigan Alliance Goes to Court to Defend Vote by Mail

The Michigan Alliance for Retired Americans and the Detroit Downriver Institute of the A. Philip Randolph Institute (DAPRI) have filed an intervention in a lawsuit to defend against the Republican National Committee's (RNC) attempts to make it more difficult for voters to cast an absentee ballot in the state.

The RNC lawsuit asks the Court to invalidate the Secretary of State's guidance regarding the verification of signatures on absentee voter ballot applications and carrier envelopes. This threatens to introduce confusion and uncertainty into the signature verification process, and to disenfranchise absentee voters based on minor and inconsequential differences between signatures.

Michigan Alliance for Retired Americans®

The Michigan Alliance intervened in the lawsuit so that members and constituents are able to exercise their right to vote by mail.

"This lawsuit is a blatant attempt at voter suppression," said Jim Pedersen, President of the Michigan Alliance. "Older voters are the most likely to vote by absentee ballot and should not be at risk of having their ballot being rejected because of an alleged minor difference in their signatures."

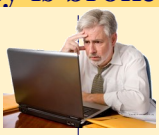
"This constant attack on the voters rights in Michigan is a shameless attempt at intimidation and harassment," added Andrea A. Hunter, Detroit/Downriver APR-President. "This voter suppression tactic will most definitely affect our handicapped, elderly and non-transit citizens who depend on absentee voting."

'Social Security is broke beyond belief'

Many Americans aren't saving enough for retirement — and they're relying on Social Security benefits to get by in retirement. But that may not be a sound strategy.

"Social Security is broke beyond belief," Laurence Kotlikoff told **The Brink**, Boston University's research news website. "Its unfunded liability is $65.9 trillion — twice the size of official government debt."

The "retirement planning evangelist" and professor of economics at Boston University says that paying for all projected benefits through time requires "an immediate and permanent hike" in the employer-employee FICA tax from 12.4% to 17%. The Federal Insurance Contributions Act (FICA) tax is a combined employer-employee federal payroll tax.



Without it, Social Security payments are **on track to be reduced as soon as 2034**.

Even if Social Security benefits are still paid out in full, many Americans face complicated hurdles in the system.

"For far too many of America's seniors with any but the simplest situations, negotiating the complexities and outright scams of the Social Security system on their own is nigh impossible," Kotlikoff told The Brink. "Kafka could not have designed a more complex set of provisions with hidden catch-22s **that can haunt you — in the form of clawbacks — decades after you start collecting benefits.**"

Given these issues, it might be a good idea to reduce your dependence on Social Security and take charge of your own retirement. One way to do this is by maxing out your contributions to tax-advantaged retirement accounts, such as your **401(k)**....**Read More**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Company Behind Defective CPAP Machines Must Make Changes Before U.S. Production Resumes

Philips Respironics, the company responsible for the recall of millions of defective sleep apnea machines since 2021, must overhaul its production of the machines before it can resume making them in the United States, federal officials announced Tuesday.

Under a settlement reached with the company, Philips must revamp its manufacturing and quality control systems and hire independent experts to vet the changes. Philips must also continue to replace, repair or provide refunds to all U.S. customers who got defective devices, the **court order** stated.

The action helps resolve one of the biggest medical device recalls in history, which has **dragged on for nearly three years** and involved 15 million devices worldwide, the U.S. Food and Drug Administration said.

"The finalization of this decree is a significant milestone. Throughout this recall, we have provided patients with important health information by issuing numerous safety communications and have taken actions rarely used by the agency to help protect those impacted by this recall," **Dr. Jeff Shuren**, director of the FDA's Center for Devices and Radiological Health, said in an agency **news release**. "Today's action is a culmination of those efforts and includes novel provisions aimed at helping ensure that patients receive the relief they have long deserved."

Most of the devices that have been recalled are continuous positive airway pressure (CPAP) machines. These devices force air through a mask to keep a patient's mouth and nasal passageways open during sleep. Left untreated, sleep apnea can increase the risk of heart attack.

With the recalled machines, foam inside the machine can break down over time, leading users to inhale tiny particles and fumes while they sleep.

Jeffrey Reed, of Marysville, Ohio, experienced sinus infections and two bouts of pneumonia during the seven years he used a Philips CPAP machine.

"I worry about my long-term health," Reed told the *Associated Press*. "I used this machine for years and no matter what money I might get out of this, what's going to happen?"

Reed received a newer Philips device after returning his old machine, but he prefers a competitor's device.

"I don't trust the company," Reed said. "I don't want to use it."

Reed is one of more than 750 people who have filed personal injury lawsuits against the company over the devices. Those cases have been consolidated in a federal court in Pennsylvania, the *AP* reported.

As Bans Spread, Fluoride in Drinking Water Divides Communities Across the US

Regina Barrett, a 69-year-old retiree who lives in this small North Carolina city southeast of Charlotte, has not been happy with her tap water for a while.

"Our water has been cloudy and bubbly and looks milky," said Barrett, who blames fluoride, a mineral that communities across the nation have for decades added to the water supply to help prevent cavities and improve dental health.

"I don't want fluoride in my nothing!" said Barrett, echoing a growing number of people who not only doubt the mineral's effectiveness but also believe it may be harmful despite decades of data pointing to public health and economic benefits.

In February, the Board of County Commissioners in Union County, whose seat is Monroe, voted 3-2 to stop adding fluoride to drinking water at the Yadkin River Water Treatment Plant, the only water source wholly owned and operated by the county.

But the decision came after heated discussions among residents and county officials.

"My children had the blessing of growing up with fluoride in their water and … they have very little dental issues," said Commissioner Richard Helms ahead of the vote. A fellow commissioner saw it differently: "Let's stop putting something in the water that's meant to treat us, and give people the freedom to choose," said David Williams.

Barrett's water comes from the city of Monroe, not the Yadkin facility. So, for now, she will continue to drink water enhanced with fluoride. "I'm suspicious as to why they add that to our water," she told KFF Health News….**Read More**

Chemicals Stored in Your Garage Could Raise Odds for ALS

Volatile and toxic chemicals commonly stored in garages can increase the risk of amyotrophic lateral sclerosis (ALS).

Gasoline or kerosene, gas-powered equipment and lawn care chemicals represented the top three risk factors for ALS found in garages, researchers report.

Exposures to each of these increased ALS risk around 15%, results show.

Other chemicals found in garages that significantly increase ALS risk include pesticides, paint and woodworking supplies, researchers said.

These risks were more prominent in homes with attached garages. The flow of air from attached garages into the living space is likely behind this, researchers said.

"Especially in colder climates, air in the garage tends to rush into the house when the entry door is opened, and air flows occur more or less continuously through small cracks and openings in walls and floors," said senior researcher **Stuart Batterman**, a professor of environmental health science at the University of Michigan School of Public Health.

"Thus, it makes sense that keeping volatile chemicals in an attached garage shows the stronger effect," Batterman added in a university news release.

The most modern building codes tackle this problem by specifying measures to reduce or eliminate these air flows, Batterman added.

For the study, researchers assessed chemical exposures in the homes of more than 600 people with and without ALS. The degenerative disease affects the ability of the brain to control muscles in the body.

They found that, overall, the storage of chemicals is significantly associated with ALS risk.

The new study was published recently in the journal ***Amyotrophic Lateral Sclerosis and Frontotemporal Degeneration***.

This finding jibes with earlier studies that found higher concentrations of pesticides in the blood of people with ALS, and also linked pesticides to worse survival odds for ALS, researchers said.

"With each study, we better understand the types of exposures that increase the risk of developing ALS," said senior researcher **Dr. Eva Feldman**, director of the ALS Center of Excellence at the University of Michigan.

"We now need to build on these discoveries to understand how these exposures increase ALS risk," Feldman added.

New Treatment Could Be Advance Against Cervical Precancers

Women who undergo regular Pap smears are no doubt familiar with the possibility of "precancerous" cells being detected.

These cells -- called cervical intraepithelial neoplasias (CINs) -- can progress to full-blown **cervical cancers**, but a new trial suggests that a vaginal suppository containing the drug imiquimod can halt that process.

The treatment might also help women diagnosed with advanced CIN avoid the most common therapeutic option, surgery.

"The imiquimod treatment was patient-friendly and easy to use, since it could be applied by the patient without requiring an office visit," added study lead author **Dr. Sangini Sheth**. She's associate professor of obstetrics at the Yale School of Medicine in New Haven, Conn.

Her team presented the findings this week at the annual meeting of the American Association for Cancer Research in San Diego. Their study was published simultaneously in the journal ***Clinical Cancer Research***.

As Sheth's team explained, CIN can present in three grades -- CIN1, CIN2 and CIN3 -- all involving the emergence of abnormal cells at the entrance to the cervix. As is the case with cervical cancers, CIN is very often caused by infection with the human papilloma virus (HPV).

Imiquimod is already approved as a topical skin cream to treat genital warts and works by stimulating an immune response. Sheth's team wanted to see if it might also help eliminate CIN when used as a vaginal suppository.

They focused on a group of 133 women who'd been diagnosed with CIN at grades 2 or 3. They did not include women with less severe CIN1, since these cases often regress on their own over time and do not require surgery.

"With CIN1, we don't do surgery, we advise the patients to come back and see us in 6 to 12 months, so we can repeat the pap smear," senior study author **Dr. Alessandro Santin** explained in a Yale news release.

"For CIN2, it is different," he said. Santin is professor of obstetrics, gynecology and reproductive sciences at Yale….**Read More**

AI May Bring a Better Blood Test for Ovarian Cancer

Using AI to track fragments of tumor-associated DNA in the blood, scientists say they may be close to an accurate test for a silent killer: Ovarian cancer.

It's the fifth leading cause of cancer death in the United States. Ovarian tumors are often lethal because they typically doesn't cause symptoms in their early, more treatable stages.

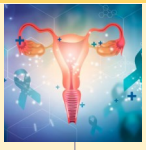
"Ovarian cancer is an incredibly deadly disease with no great biomarkers for screening and early intervention," said senior study author **Dr. Victor Velcu**lescu, co-director of the Cancer Genetics and Epigenetics Program at the Johns Hopkins Kimmel Cancer Center in Baltimore.

His team presented its findings Tuesday at the American Association for Cancer Research (AACR) annual meeting, in San Diego.

A highly accurate "liquid biopsy" blood test for ovarian tumors has long been a Holy Grail of cancer research.

In the study, the Hopkins team focused on tiny fragments of the tumor's genetic material present in patients' blood.

"Because cancer cells are rapidly growing and dying and have chaotic genomes as compared to healthy cells, patients with cancer have different patterns of DNA



fragments in their blood than patients without cancer," explained study co-first author **Jamie Medina**, a postdoctoral fellow at Kimmel.

"By carefully analyzing these fragments across the entire human genome, we can detect subtle patterns indicating the presence of cancer," he said in an AACR news release.

The researchers left it to an artificial intelligence program to analyze the DNA blood "fragmentomes" of women with and without ovarian cancer. The AI program combined that data with measurements of blood levels of two ovarian cancer biomarkers, proteins called CA125 and HE4.

They hoped this mix could produce "a new high-performance approach for early detection of ovarian cancer," Velculescu explained.

The study involved 134 women with ovarian cancer, 204 women without cancer and 203 women with benign adnexal (ovarian) masses.

The results were impressive: The test had a specificity of 99%, meaning there were almost no women who received a false-positive result from their screening....**Read More**

Adding Vaccine to Immunotherapy for Liver Cancer Shows Promise in Early Trial

A custom-made anti-tumor vaccine added to standard immunotherapy was twice as likely to shrink liver cancer as when a patient received immunotherapy alone, a new study shows.

The vaccine could help liver cancer patients live longer, as fewer than one in 10 survive five years after their diagnosis, the researchers noted.

In fact, about 8% of patients who received the new vaccine had a complete response, with no evidence of cancer left, the results showed.

"We are at an exciting time in new therapy development. Personalized vaccines are the next generation of vaccines that are showing promise in treating difficult cancers," said researcher **Dr. Elizabeth Jaffee**, deputy director of the John Hopkins Kimmel Cancer Center in Baltimore.

For the study, researchers recruited 38 patients with hepatocellular carcinoma, the most common type of liver cancer.

All of the patients received the custom vaccine along with **pembrolizumab** (Keytruda), an **immunotherapy** drug that helps activate the immune system to attack cancer cells.

The vaccine was made from a liver tumor biopsy taken from each individual patient. Researchers analyzed the tumor to figure out which mutated genes are causing it, and then they crafted a personalized vaccine to target a patient's cancer.

Each vaccine can include up to 40 genes. The vaccine helps the immune system locate the cancer based on these genes, and then destroy it.

Researchers described the therapy as a "one-two punch," as the immunotherapy drug activates the immune system and the vaccine teaches it to identify and kill a person's cancer.

In the lab, researchers found evidence that immune cells created in response to patients' cancer had in fact traveled to the tumor and attacked cancer cells there.

Researchers also found that patients who received vaccines targeting the greatest number of mutated proteins responded the best to the therapy.

"The study provides evidence that a personalized cancer vaccine can enhance clinical responses to anti-PD-1 therapy," said lead researcher **Dr. Mark Yarchoan,** an associate professor of oncology at the Johns Hopkins University School of Medicine.

The findings were published April 7 in the journal *Nature Medicine* and were presented over the weekend at the American Association for Cancer Research annual meeting in San Diego.

"A larger, randomized clinical trial will be needed to confirm this finding, but the results are incredibly exciting," he said in a meeting news release.

Many Older Americans Get Care Outside of Doctor's Office, Poll Finds

Most seniors have embraced "doc-in-a-box" strip mall clinics and urgent care centers as a means of getting prompt medical care, a new poll has found.

About 60% of people ages 50 to 80 have visited an urgent care center or a retail health clinic during the past two years -- even though those sorts of options weren't available earlier in their lives.

"The rapid rise in availability of these kinds of clinics, which typically offer walk-in convenience, expanded hours and self-scheduling of appointments in locations close to home, work or shopping, has transformed the American health care landscape in less than two decades," said **Dr. Jeffrey Kullgren**, director of the University of Michigan National Poll on Healthy Aging.

Urgent care centers are the most common alternative source of care for seniors and the middle-aged, with 47% visiting one at least once and 23% going more than once within the past two years.

And 28% said they have gone to a retail health clinic, a same-day office typically located in a strip mall, workplace or vehicle.

Three-quarters of seniors (75%) who have gone to an alternative clinic said they're likely to go again sometime within the next two years, poll results show.

Also, 43% of people who hadn't gotten care at an alternative clinic said they are likely to do so in the next two years.

However, most older adults with a primary care doctor said they prefer the quality of care and sense of connection at their regular clinic.

About 52% of those who'd gone to an alternative clinic said the quality of care was better with their regular doctor, and 67% said they felt more of a connection with their primary care doctor.

On the other hand, 43% said the alternative clinic was more convenient than their usual provider.

"With the nationwide shortage of primary care providers, it's important to understand how this age group, with generally higher medical needs, views and uses this type of care," Kullgren added in a Michigan news release.

Of those who went to an alternative clinic, 44% said they wanted to avoid going to an emergency room and 35% said they needed a vaccine, test or physical exam.

"Access to timely and convenient care was critical for older adults during the pandemic, and our research shows alternative care options will continue to be in demand for the long-term," said **Susan Reinhard**, senior vice president and director of AARP Public Policy Institute. The AARP participated in the new survey.

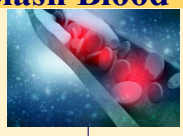
The poll was conducted online and via phone in July and August 2023, among 2,657 adults ages 50 to 80.

New Drug Could Slash Blood Triglyceride Levels

A new drug can slash triglyceride levels nearly in half by targeting a genetic driver of high fat levels in the bloodstream, researchers said.

The injectable drug, olezarsen, lowered triglyceride levels by 49% at the 50 milligram (mg) dose and by 53% at the 80 mg dose compared to a placebo, researchers reported April 7 in the ***New England Journal of Medicine***. The findings were presented simultaneously at the American College of Cardiology's annual meeting in Atlanta.

The drug also reduced blood levels of two other contributors to clogged arteries, apolopoprotein B and "bad" cholesterol, results show.



Olezarsen inhibits the activity of APOC3, a gene that typically restrains the liver's ability to filter triglycerides out of the bloodstream, the researchers said.

"These findings indicate that targeting APOC3 is a promising new pathway for lowering triglycerides and potentially reducing the risk of heart attack and stroke," said researcher **Dr. Brian Bergmark**, of the Brigham and Women's Hospital Division of Cardiovascular Medicine.

Triglycerides are fatty particles in the bloodstream that contribute to the risk of heart disease, both on their own and in combination with "bad" LDL cholesterol, according to Harvard Medical School.

For the study, researchers recruited 154 adults already on cholesterol-lowering therapy. They were split into three groups and assigned to either take a placebo or a low or high dose of olezarsen, through injections administered every four weeks for a year.

Either dosage of olezarsen reduced triglyceride levels by about the same amount.

The drug also reduced levels of apolipoprotein B -- a protein that transports unhealthy cholesterol in the bloodstream -- by about 18%, and cut back levels of unhealthy cholesterol by 23% to 25%.

Researchers said larger and longer-term studies are needed to further assess olezarsen, particularly the drug's ability to prevent **heart attacks** and strokes.

Pandemic's Effect in Isolating Older Americans May Not Be Over

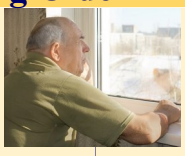
COVID-19 lockdowns prompted countless American seniors to become socially isolated.

Now, new research finds that many have still not fully rejoined society.

More than half of older adults still spend more time at home and less time out socializing in public, even though the pandemic has passed, researchers found.

Fear of infection and worries about increasingly hostile interactions between people are the key reasons for seniors' retreat from civic life, results show.

"The pandemic is not over for a lot of folks," said lead researcher **Jessica Finlay**, an assistant professor of geography at University of Colorado Boulder.



"We found that the pandemic fundamentally altered neighborhoods, communities and everyday routines among aging Americans, and these changes could have long-term consequences for their physical, mental, social and cognitive health," Finlay said in a university news release.

For the study, Finlay and her colleagues surveyed nearly 7,000 people over 55 from all 50 states. The researchers check in with surveys annually, asking open-ended questions about how people are spending their time post-pandemic.

About 60% of participants said they spend more time in their home following the pandemic, results show. Meanwhile, 75% said they are dining out less and 62% said they are visiting cultural and arts venues less, according to the survey. More than half said they go to church or the gym less than before the pandemic.

"[My friends and I] would get together every month for a luncheon at different restaurants. We had been doing that for 15 years," Shirley, a 74-year-old city dweller, told the researchers. "There would be 10 or 15 of us that would go. We haven't gone since the pandemic, and that I do miss."

Although these results come from a poll two years ago, the most recent survey taken in spring 2023 showed similar trends, researchers said. More than half of seniors report that their routines remain altered post-pandemic.

The findings were published recently in the journal ***Wellbeing, Space and Society***.

There are signs that seniors are taking steps to create a "new normal."

At least 10% of seniors report exercising outdoors more frequently now, results show….**Read More**

Stopping Aspirin a Month After Stent Implant Helps Heart Patients

People who've survived a heart attack and have been given a stent may be better off quitting low-dose aspirin a month after the procedure, a new study finds.

The strategy is "beneficial by reducing major and minor bleeding through one year by more than 50 percent," said study lead author Dr. Gregg Stone, a professor of medicine (cardiology) and population health science and policy at the Icahn School of Medicine at Mount Sinai, in New York City.

"Moreover, there was no increase in adverse ischemic [artery-blocking] events" when folks stopped using aspirin early, "meaning continuing aspirin was causing harm without providing any benefit," Stone added.

His team presented its findings Sunday at the American College of Cardiology (ACC) annual meeting in Atlanta. The study was published simultaneously in ***The Lancet.***

For folks who've had a **heart attack** or are at very high risk of experiencing one, low-dose daily aspirin is often given to cut their odds for blocked arteries.

However, long-term use of aspirin is also tied to another health danger: Bleeding.

So, the duration of aspirin use has long been up for debate.

In the new trial, outcomes were tracked for up to a year in over 3,400 heart patients treated at 58 centers in four countries. All the patients had undergone non-surgical, catheter-guided placement of a heart stent to open up a blocked artery.

At the beginning of the trial, all patients got a standard anti-clotting drug, **ticagrelor** (Brilinta), plus low-dose aspirin. But a month in, 1,700 patients had their aspirin replaced by a placebo pill, while the other half continued on the ticagrelor-aspirin dual therapy.

The result: Stopping use of aspirin appeared to cut the risk for bleeding by more than half (55%), Stone's group found. They report that 35 cases of bleeding emerged among the group that stopped aspirin early, versus 78 cases among patients who carried on with the blood thinner.

What's more, stopping aspirin didn't raise patient's odds for a clot or related cardiovascular "events" such as death, heart attack, stroke, bypass graft surgery, or the need for a new stent. These types of events occurred among 61 patients who quit aspirin early versus 63 cases among those who kept taking the drug, the researchers said.

So, "discontinuing aspirin in patients with a recent or threatened heart attack who are stable one month after [stent placement] is safe and, by decreasing serious bleeding, improves outcomes," Stone said in an ACC news release.

Based on the new trial, he said that "it is my belief that it's time to change the guidelines and standard clinical practice such that we no longer treat most [heart attack] patients with dual antiplatelet therapy" for more than a month after a stent is implanted.

Instead, "treating these high-risk patients with a single potent platelet inhibitor such as ticagrelor will improve prognosis," Stone added.

U.S. Medical Drug Shortages Reach Record High

Americans are facing more shortages of the drugs they need for medical care than ever before, a national pharmacy database shows.

The American Society of Health-System Pharmacists (ASHSP) and the University of Utah Drug Information Service started tracking drug shortages as far back as 2001.

Their latest **data** shows that things haven't been this bad in all the years they've kept records.

A record high of 323 different meds were in short supply during the first quarter of 2024, the groups found. That's worse than the last peak for drug shortages -- 320 in 2014, according to the data.

It doesn't have to be this way, said ASHSP CEO **Paul Abramowitz**.

"It's long past time to put an end to drug shortages," he wrote in a blog post on Thursday. "All drug classes are vulnerable to shortages. Some of the most worrying shortages involve generic sterile injectable medications, including cancer chemotherapy drugs and emergency medications stored in hospital crash carts and procedural areas. Ongoing national shortages of therapies for attention-deficit hyperactivity disorder also remain a serious challenge for clinicians and patients."

The database relies on information from practitioners, patients and others that is then confirmed with drugmakers.

Other classes of meds with notable shortages: central nervous system stimulants, antimicrobials, hormone agents and intravenous fluids, the new data showed.

According to U.S. government data, the average drug shortage typically lasts for about 18 months.

However, more than half of the shortages on the current list have persisted for over two years, according to **an analysis** by health consulting firm IQVIA.

Shortfalls in the supply of a drug can occur for many reasons, such as supply chain disruptions or increased consumer demand (as is happening now with popular new weight-loss drugs).

Recognizing the problem, the U.S. Department of Health and Human Services last week published new policy suggestions on how to prevent drug shortages, *CNN* reported...**Read More**

The Safety Of Older Adults Aging In Place

An increasing number of older U.S. adults are choosing to age in place and grow older in their homes within a traditional community. Aging in place may offer a number of benefits, such as the ability to maintain one's independence while being surrounded by familiar objects, family and friends. However, choosing to age in place requires certain considerations and planning, and may pose potential challenges, risks and safety concerns for older adults and their loved ones.

A recent Forbes Health survey conducted by OnePoll of 1,000 U.S. adults age 65 and older who are electing to age in place examines their main concerns about growing older at home, as well as the concerns of their family members and friends. The survey also explores home modification options to improve safety for people aging in place, whether individuals are aging in place on their own or with assistance and attitudes toward alternative housing options like assisted living communities or nursing homes. Some key survey findings include:

- Over 50% of survey respondents are aging in place on their own (as opposed to living with family members in their own homes), and this percentage increases with age. Just below half of respondents ages 65 to 69 (47%) report living alone, while 55% of people ages 70 to 74, and 56% of people at least 75 years old say the same.
- Most older adults choose to age in place because they feel happier in their own homes (84%).

Other reasons for aging at home include feeling safer (60%), wanting to remain close to family and friends (49%), the affordability of aging at home (45%) and not wanting to pack and relocate their household belongings (36%)….**Read More**