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Retirees Celebrate Social Security, Medicare & Medicaid Birthdays

To mark the 84th Anniversary of Social Security and the 54th Anniversary of Medicare & Medicaid, area retirees with the Rhode Island Alliance for Retired Americans celebrated two very important birthdays in North Providence on Wednesday, August 7, 2019 with RI Senator, Sheldon Whitehouse, RI Congressman, David Cicilline, Richard Fiesta, National Alliance Executive Director , representatives from Senator Jack Reed and Congressman Langevin, Helen Mulligan, Center for Medicare & Medicaid, Catherine LeBlanc, Public Affairs Specialist, Social Security and the Northeastern Alliance Chapter Presidents.

The event focused on how Social Security, Medicare & Medicare have helped senior citizens with money in retirement. However the benefits to recipients has not kept up with their cost of living. Retirees are having a hard time making ends meet, while the wealthy & corporations receive government welfare in the form of giant tax breaks.

The meeting also shined a light on the role of skyrocketing prescription drug prices as the biggest driver of rising Medicare costs and how we need to negotiate prices. Another option is the importation of prescription drugs.

Senator Whitehouse spoke about a proposed bill that would give Social Security recipients a 3% COLA tied into the cost that Social Security recipients pay for goods they purchase.

Congressman Cicilline talked about the Trump proposed $845 billion in cuts to Medicare in his 2020 budget and cuts to Social Security, & Medicaid.

Rich Fiesta talked about the Alliances commitment to control prescription drug cost, increases in Social Security and Medicaid.

These very important programs are vital for recipients to live on. These three programs are not **"ENTITLEMENTS"** they are **hard earned benefits** that recipients worked for and contributed to Social Security, Medicare & Medicaid with the promise that it would be there for them when they retired and do not contribute one penny to the Federal deficit.

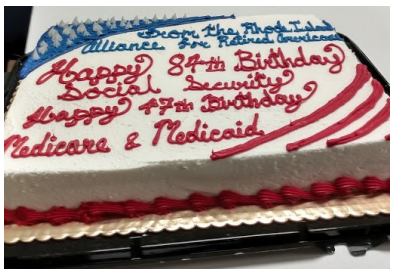
Helen Mulligan talked about issues with Medicare Advantage plans. She also talked about how there are scams to get people to have generic testing done to get Medicare to pay.

Cathy LeBlanc talked about how Social Security now calculates recipients for te 35 years of earnings. This is important for the recipients that are involved in the Windfall Elimination Provision (WEP). Senator Brady has introduced Legislation to repeal the WEP. She also talked about scams where scammers are trying to get Social Security numbers.

Each of the ARA Northeastern Chapter President gave reports on activates that they are working on in their states.

Rich Fiesta presented Senator Whitehouse and Congressman Cicilline with Alliance for Retired Americans 2019 Hero Award Certificates. Hero Award Certificates were also given to the representatives from Senator Reed and Congressman Langevin.

A box lunch was served, thank you RI AFL-CIO for picking up the cost. We also served coffee and the Birthday cake.



Birthday Cake

Hero Award Certificate
To
Senator Whitehouse

Hero Award Certificate
To
Congressman Cicilline

Top Social Security questions and answers

The **New York Times** answered the top Social Security questions from its readers.

Question 1. Is Social Security in good financial shape?
Question 2. How do Social Security spousal benefits work?
Question 3. Will I get benefits for the rest of my life and will they be taxed?

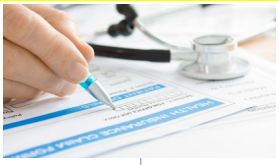
...**Read More on these three questions.**

New Report Examines Medicare Advantage Supplemental Benefit Policies

A new **report** from the AARP Public Policy Institute examines changes to Medicare Advantage (MA) supplemental benefit policies and the implications for people with Medicare.

MA plans have long been able to offer benefits beyond what is required by law. However, the **Balanced Budget Act of 2018** and recent regulatory decisions, including those in the **2019 Part C and D final rule** and the **Final Call Letter for 2019,** have greatly increased this authority.

Among the reforms with significant consequences for consumers are those that expand the array of benefits



MA plans can offer and grant the insurers more latitude to design and target those packages. While these changes could result in plan offerings that work well for some people with Medicare, they also have the potential to introduce additional complexity and confusion into the plan-selection process.

The evolving landscape may also increase the potential for plans to include discriminatory or other poorly aligned incentives as insurers experiment with the offerings to find the most profitable approach. As a result, this suite of updates could make it more difficult for people with Medicare to choose the best, most affordable coverage for their unique circumstances. This is especially troubling given the **well-documented deficiencies** of many Medicare decision-making tools.

AARP discusses these and other considerations and recommends ways the Centers for Medicare & Medicaid Services (CMS) can prioritize beneficiaries in the roll-out and adoption of these changes; namely by strengthening its plan oversight and monitoring methods.

The Medicare Rights Center shares AARP's concerns and supports the outlined policy improvements. With some of the new MA plan changes taking effect in 2019—and with the full range to be in place next year—it is urgent that CMS prepare robust consumer protection and plan compliance systems.

Looking ahead, we recognize that while some of the new policies may benefit people with Medicare, others may not. Accordingly, we will remain actively engaged in the implementation process and in the development of future reforms, to ensure the beneficiary perspective is considered throughout.

Read the report.

GAO Report Finds Medicare Plan Finder Needs Significant Improvements

Medicare Plan Finder (MPF) is a primary way for people with Medicare to understand and compare their coverage choices. MPF should allow beneficiaries, caregivers, and unbiased counselors to find the coverage that best serves the needs of the individual. **A new report** from the U.S. Government Accountability Office (GAO) agrees with previous research on MPF that the tool has significant problems that interfere with its usefulness.

GAO is an independent, nonpartisan agency that examines how taxpayer dollars are spent and provides Congress and federal agencies with objective, reliable information. In response to a request from Congress, GAO conducted a review of MPF as a resource for beneficiaries and to discover both its usability and the completeness of its information.

As part of the review, GAO surveyed multiple stakeholders, including advocacy organizations like Medicare Rights and State Health Insurance Assistance Program (SHIP) directors. SHIPs provide unbiased one-on-one counseling to Medicare beneficiaries and their families to help them find the right coverage for their circumstances.

During its review, GAO found that MPF is difficult for people with Medicare to use, in part due to its overly complex navigation and abundance of health insurance industry jargon that many beneficiaries do not understand. The report also notes that the information supplied via the tool is incomplete. For example, there is no way for beneficiaries to compare prices between Original Medicare—with or without a Medigap supplemental plan and/or a Part D drug plan—and a Medicare Advantage plan; and MPF also does not allow users to search for Medicare Advantage plans by participating providers, so there is little ability to see which plans include which doctors in their networks—a priority for many people with Medicare who want to keep their current providers.

The SHIP directors GAO surveyed reported that it is challenging for beneficiaries to find information in MPF and that even trained SHIP counselors can struggle at times. This finding is in line with **other research from the National Council on Aging and the Clear Choices Campaign from 2018** that reviewed MPF's ease-of-use and concluded "the site is overwhelming, information is poorly presented, and the user design is potentially misleading—all of which confuses beneficiaries and can contribute to many making poor plan selections."

Medicare Rights has **long encouraged** improvements to MFP. As GAO notes in their report, a redesign of MFP is underway that may mitigate some of the problems beneficiaries currently have. However, the federal government is also increasing the burden on people with Medicare by adding new complexities to the Medicare program, making decision-making harder than ever. Without solid information, tools, and assistance, people with Medicare cannot make the best choices for their individual circumstances. MPF must be robust, unbiased, and user friendly to ensure beneficiaries have access to the information they need.

Read the GAO report.

Read our call for updates to Medicare Plan Finder.

Read the report from the National Council on Aging and the Clear Choices Campaign on the need for improvements.

The Democratic debates suffer from a nasty case of Plan-itis

Drew Altman is president and chief executive of the Henry J. Kaiser Family Foundation.

This week's **Democratic debates** have had a nasty case of Plan-itis, especially when it comes to health care. It's important that candidates have plans for what to do about health-care costs and coverage. But we're way too focused on the details of candidates' policy plans, and it's not serving the voters' needs well.

Every big health reform plan has tradeoffs and winners and losers — no exceptions. It's not really a huge contribution to voters for debate moderators to find elements of the candidate's plans they can nail them on. Voters don't focus on the details of plans; they use them as proxies or signals to figure out what candidates are really about and how they differ from other candidates. What voters really need to know is where candidates would take the health system, how they differ from other candidates on direction and basic choices and what that says about the kind of president they would be.

No plan proposed today will become law in any recognizable form. The details of any plan — the role of private insurance, new taxes, consumer cost sharing or how much providers are paid — will all be subject to heavy negotiation and compromise as they are written into legislation, get a score from the Congressional Budget Office and face scrutiny from the two parties and lobbyists.

Many candidates, if nominated, will also do the time honored pivot toward the center for the general election, modifying their approach to appeal to independents and swing voters in critical states.

We also know that issues — health care or any other — are only one factor voters care about. The fact that health care is the top issue in the election does not mean it will be the top factor in the vote. In the 2018 midterm elections, 73 percent of voters said a candidate's character and experience was a top factor; 66 percent said the candidate's support or opposition to President Trump was most important; and 66 percent voted based on their party affiliation.

We **recently conducted focus groups** with likely voters in swing districts across the country. Some conclusions: Voters are not tuned into the details — or even the broad outlines — of the health policy debates going on in Washington and on the campaign trail, even though they say health care will be at least somewhat important to their vote. Many had never heard the term "Medicare-for-all," and very few had heard about Medicare or Medicaid buy-in proposals.

When asked what they knew about Medicare-for-all, few offered any description beyond "everyone gets Medicare," and almost no one associated the term with a single-payer system or national health plan.

One focus group participant said: "You listen to it but it all sounds like the teacher on Snoopy – wah wah wah."

Overall voters were focused almost entirely on their out-of-pocket costs, not the merits of policy proposals, which they could not easily connect to their own difficulty paying medical bills.

Nothing will be more important than the details of plans when — and if — we get to legislation. For now, the most important thing voters need to know is whether a candidate is for a single national health plan such as Medicare-for-all or is instead for building on the Affordable Care Act and setting up a new public plan as an option. That tells voters where candidates stand on the role of government and on spending, as well as where they are on the ideological spectrum relative to other candidates. Both approaches signal that candidates want a greater role in expanding government involvement in our health-care system, but the former falls on the progressive side of the Democratic Party whereas the latter leans toward the more moderate wing. Drawing out these basic differences rather than focusing on details or gotcha questions could provide an enormous public service.

The voters, it seems, are smarter than the experts, the pundits and the media. They are looking for fundamental differences between the candidates. They don't have Plan-itis.

Trump Administration has new plans for Medicare

As the Centers for Medicare and Medicaid Services (CMS) continues to **mislead people** about their health plan options and steer them into Medicare Advantage plans, the **Wall Street Journal** reports that President Trump has new plans for Medicare. It's hard to believe President Trump's executive order on Medicare will benefit enrollees; President Trump favors cutting close to $1 trillion from Medicare and is strongly against improving and expanding it to everyone in the US.

Trump proposed **$845 billion in cuts to Medicare** in his 2020 budget. These cuts would increase costs to people in the program. Moreover, he is misleading people about Medicare for All. Contrary to Trump's claims, Medicare for All, like Medicare, is social insurance. It is public insurance, available to everyone, which would continue to allow them to use the private doctors and hospitals they want to use. It is different from private insurance because it is **cost-effective**, with less than two percent in administrative costs. It also reins in provider rates and guarantees people access to care.

Senator **Bernie Sanders'** and Congresswoman **Pramila Jayapal's** Medicare for All proposals would improve benefits for people with Medicare today, including eyeglasses, hearing aids and dental services as well as **long-term services and supports**, including home care and nursing home care. And, it eliminates all cost-sharing from Medicare. There would be no more premiums, deductibles or coinsurance.

In sharp contrast, Trump is working to give Medicare Advantage plans–the private plans that contract with the federal government to offer Medicare benefits–more bells and whistles that will help them enroll more members. The data show that they are costing taxpayers at least **$10 billion a year more** than we should be paying them. Trump is not calling for them to pay back that money.

Trump is also working to bring more transparency to the health care system. He wants hospitals to disclose the rates they charge insurers. More health care transparency is always good, but it's not clear how it would help people with Medicare or anyone else directly.

Misguided Trump Administration Rule Would Take Basic Food Assistance From Working Families, Seniors, and People With Disabilities

The Trump Administration today proposed changes in a key SNAP (food stamps) rule which, if implemented, would take away basic food assistance from an estimated 3.1 million people, mainly working families with children, seniors, and individuals with disabilities. The proposed rule would make it harder for struggling people to make ends meet. It comes in the aftermath of the President's 2017 tax law, which conferred large new benefits on the highest-income households.

Federal law includes a provision that lets states strengthen SNAP's rules to encourage work and saving among low-income households — two goals that have long had strong bipartisan support — through a policy called broad-based categorical eligibility (BBCE). States can use BBCE to raise SNAP income eligibility limits somewhat so that many low-income working families that have difficulty making ends meet, such as because they face expenses for costly housing or child care that consume a sizeable share of their income, can receive help affording adequate food. This policy also lets states adopt less restrictive asset tests so that families, seniors, and people with a disability can have modest savings without losing SNAP.

The Administration's proposal would dramatically narrow this policy. As a result, many SNAP households, including many near-poor working families, seniors, and people with disabilities, would be cut off of basic food aid. Children from families who would lose their SNAP benefits under the proposed rule would also lose access to free lunches and breakfasts at school. The Administration estimates that, if implemented, this policy would terminate SNAP eligibility for 3.1 million people and cut SNAP benefits by $3 billion a year, or roughly $25 to $30 billion over ten years.

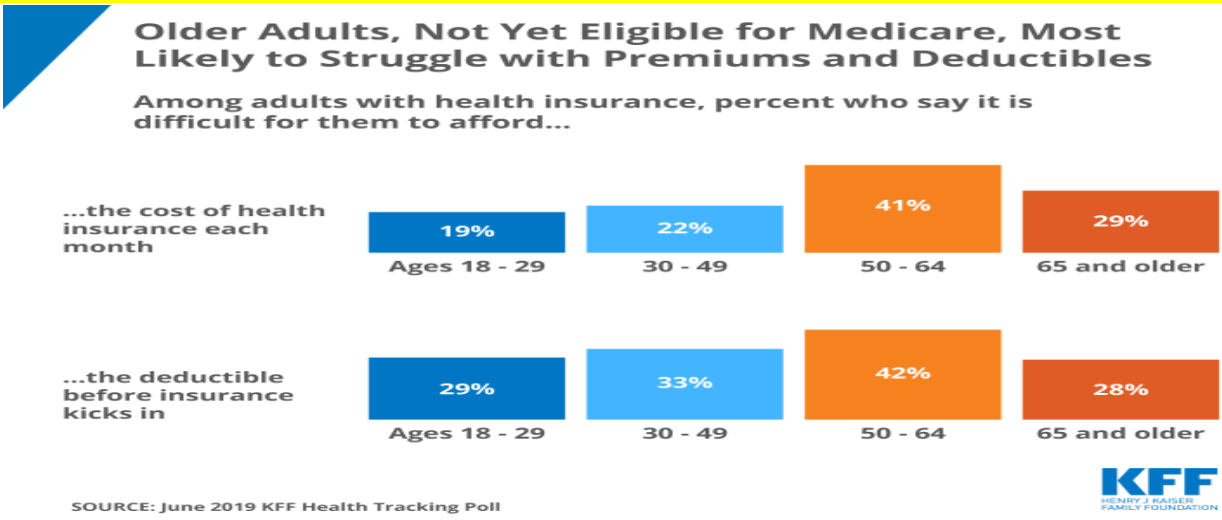
This rule would be particularly harsh for working families with incomes close to SNAP's gross income threshold of 130 percent of the poverty line, who would be at risk of being cut off of SNAP if they got a modest wage increase or worked slightly more hours. Taking SNAP away from these families could discourage some recipients from earning additional income. The proposed rule would weaken SNAP's role in supporting work while making it harder for families that struggle to get by on low wages to meet their basic needs.

The change also would penalize families with children, seniors, and people with disabilities who have modest savings by eliminating their food assistance. Building modest assets allows low-income families to avoid accumulating debt and to be better financially prepared for old age and unforeseen events, such as a home or car repair or the loss of a job in a recession. It is especially important for seniors and people with disabilities who live on fixed incomes, whose savings can help them avert a financial crisis or weather an emergency that would otherwise push them deeper into poverty or could lead to homelessness.

In trying to make a case for the proposal, the Administration argues that states are approving households for SNAP under BBCE without checking their incomes or assessing their need for food assistance. The claim is incorrect. To receive SNAP, *all* households, including those eligible under BBCE, must apply, be interviewed, and document that their monthly income and expenses, such as high housing and child care costs, leave them with too little disposable income to afford a basic, adequate diet. Indeed, the Department of Agriculture's own data show that only about *0.2 percent* of SNAP benefits went in 2017 to households with monthly disposable incomes — net income after deducting certain expenses like high housing and child care costs — above the poverty line. SNAP has some of the most rigorous program integrity standards and systems of any federal program.

With this rule, the Administration is seeking to implement through executive action a harsh policy that Congress rejected in the 2018 farm bill. Instead of punishing working families if they work more hours or must incur high child care costs in order to work, or penalizing seniors and people with disabilities who save a modest amount for emergencies, the President should seek to assist them with policies that help them afford the basics and save for the future.

Older Adults, Not Yet Eligible for Medicare, Most Likely to Struggle with Premiums and Deductibles



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Drugmakers Now 'Masters' At Rolling Out Their Own Generics To Stifle Competition

When PDL BioPharma's $40 million blood-pressure medicine faced the threat of a generic rival this year, the company pulled out a little-known strategy that critics say helps keep drugs expensive and competition weak.

It launched its own generic version of Tekturna, a pill taken daily by thousands. PDL's "authorized" copycat hit the market in March, stealing momentum from the new rival and protecting sales even though Tekturna's patent ran out **last year**.

PDL's version sold for $187 a month versus $166 for the competing generic, made by Anchen Pharmaceuticals, according to Connecture, an information technology firm. PDL's brand-name Tekturna runs about $208 a month.

The plan is "to maximize profit at this point," Dominique Monnet, PDL's CEO, told stock analysts in March. With the boost of PDL's house generic, "the economics would still be very favorable to us" even against the generic rival and even if prescriptions plunged for the brand, he said.

Lawmakers who created the modern generic-drug industry in the 1980s never imagined anything like this — brand-pharma companies maximizing profits by appearing to compete with themselves.

But it goes on all the time. In fact, there are now nearly **1,200 authorized generics** approved in the U.S., according to the Food and Drug Administration. While these might look like products that would push prices down, authorized generics can be as profitable as, if not more profitable than, brand-name drugs.

"Authorized generics are not generic drugs," Dr. Sumit Dutta, chief medical officer for drug-benefit manager OptumRx, told Congress in April. "The marketing and production of authorized generics is exclusively controlled and directed by brand-drug manufacturers. They do nothing to promote competition."

Last year, authorized generics appeared at the rate of about once a week. High-profile examples in recent years included **Mylan's generic version of the EpiPen** anti-allergy injector, introduced to soothe public outrage after the company raised the brand price 400%. In March, Eli Lilly said it would launch a less expensive **generic of its Humalog** insulin, whose branded list price has also soared.

Of all the ways drug companies try to protect sales as patents expire — changing doses, adding ingredients, seeking approval to treat new diseases — authorized generics are by far the most profitable, returning $50 for every dollar invested, research firm **Cutting Edge Information calculated in 2015**.

Brand-drug companies say authorized generics increase competition even if they're not an independent product.

This "reduces prices and results in significant cost savings," said Holly Campbell, spokeswoman for the Pharmaceutical Research and Manufacturers of America, or PhRMA, the brand-drug lobby. "Congress should reject attempts to delay, restrict or prohibit authorized generics."...**Read More**

SCL Legislative Update for Week Ending August 2, 2019

There was still much happening with Social Security and Medicare during a week that was dominated by the Democratic Presidential Candidate Debates. New proposals for Medicare were revealed and lowering the cost of prescription drugs remained a Senate and Administration priority. Legislation supported by The Senior Citizen League continued to gain traction.

On Monday Sen. Kamala Harris (D-CA) released a health-care plan that is a revision of her previous position on the sharply divided issue. In her plan, the Senator proposes a government-run system that would still allow for private insurance as long as it follows Medicare's coverage rules. At a glance, the plan seems to be a middle ground between Sen. Bernie Sanders's Medicare-for-All proposal and former vice president Joe Biden's desire to build on the current system.

Also on Monday, the Senate Finance Committee approved the Prescription Drug Pricing Reduction Act (no bill number available at this time). This bill, if passed into law, would lower drug prices using several different factors including a maximum out of pocket cost and penalizing drug companies for raising prices faster than inflation. Later in the week, President Trump doubled down on his plan to import drugs from Canada. The President's plan would allow states, wholesalers, and pharmacies — under the watchful eye of the Food and Drug Administration — to create pilot programs to import medicines from Canada. Several states are raring to go; Florida, Colorado, Maine, and Vermont, had already passed laws to import medicines, but were waiting for the Trump administration to give a thumbs-up on their ideas.

This weeks' biggest story was the two night Democratic Presidential Debate in Detroit, MI. The main topic of debate seemed to be Medicare. All ten candidates hoped to use Medicare reform as their standout medium for the debate. The Senior Citizens League is withholding its focus on each individual plan as the number of candidates narrows down.

Ironically, with all the Medicare news flow this week, Tuesday also marked the 54th anniversary of Medicare. On July 30, 1965, President Lyndon B. Johnson signed Medicare into law, dedicating it to former President Harry Truman, who "planted the seeds of compassion."

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

Canadians worried by plan to let Americans import drugs

OTTAWA (AP) — A Trump administration plan to let Americans legally import cheaper prescription drugs from Canada is causing concern among Canadians who that fear it could cause shortages of some medications — as well as surprise by officials who say they weren't consulted about a possible influx of U.S. drug-buyers.

The plan is a "clear and present danger" to the health and well-being of Canadians who need prescription medications, said John Adams, the volunteer chairman of the Best Medicines Coalition, a non-profit organization representing 28 national patient organizations.

Adams told The Canadian Press the existing supply of drugs in Canada is not always sufficient to meet the current needs of Canadians, let alone a sudden surge in demand from south of the border.

Diabetes Canada is one of more than a dozen organizations that signed a letter urging the Canadian government to safeguard the country's drug supply.

"It's clear to us that whatever measures need to be put in place to prevent, for example, large-scale importation by online pharmacies or large-scale importation by large U.S. states, has to be put in place because Canada is not structured to produce an amount of medications required for a population that size," Kimberley Hanson, executive director of Diabetes Canada, told the CBC.

The Trump administration's announcement also came as a surprise to Canadian health officials.

Health Minister Ginette Petitpas Taylor's office said while U.S. and Canadian officials have "mutual interest" in fostering lower drug prices, details of Wednesday's announcement by U.S. Health and Human Services Secretary Alex Azar were not discussed beforehand.

"While we're aware of ongoing state-led initiatives to import Canadian drugs, we weren't consulted on specifics," the office said in a statement.

Prime Minister Justin Trudeau pledged Thursday that Health Canada will ensure there is a "steady and solid supply" of medications for Canadians regardless of external or international pressures.

The Trump administration said Wednesday it will create a way for Americans to legally import lower-cost prescription drugs from Canada for the first time, reversing years of refusals by health authorities at a time of public outcry over high prices for life-sustaining medications.

The plan still has to go through time-consuming regulatory approval and could face court challenges from drugmakers.

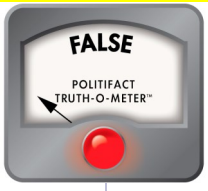
"The landscape and the opportunities for safe linkage between drug supply chains has changed," Azar said. "That is part of why, for the first time in HHS's history, we are open to importation. We want to see proposals from states, distributors, and pharmacies that can help accomplish our shared goal of safe prescription drugs at lower prices."

Doctors Argue Plans To Remedy Surprise Medical Bills Will 'Shred' The Safety Net

"What Congress is considering would cut money that vulnerable patients rely on the most. That means seniors, children and Americans who rely on Medicaid would be hurt. ... Tell Congress we can end surprise billing without shredding the safety net."

Chances are, you or someone you know has gotten a surprise medical bill. **One in six** Americans have received these unexpected and often high charges after getting medical care from a doctor or hospital that isn't in their insurance network.

It's become a hot-button issue in Congress, and high-profile legislation has been introduced in both the House and Senate to make the medical providers and insurers address the billing question and take the consumers out of the dispute. That means doctor specialty groups, hospitals and insurers are among the stakeholders that could be financially affected by the outcome.



The effort has caught the attention of Physicians for Fair Coverage, a coalition formed by large companies — firms such as US Acute Care Solutions, U.S. Anesthesia Partners and US Radiology Specialists — that serve as corporate umbrellas for medical practices. The group is running a $1.2 million **national commercial** about these congressional efforts. The ad began airing in mid-July.

The ad issued a warning: "What Congress is considering would cut money that vulnerable patients rely on the most. That means seniors, children and Americans who rely on Medicaid would be hurt."

We wondered: Will any of the surprise billing proposals being debated in Congress really affect Medicaid and these patients — "shredding the safety net," as the ad claims? So we dug in.

We reached out to Physicians for Fair Coverage (PFC) to find out the basis for this claim, but the phone number listed on their website no longer worked. Several emails and a direct message on Twitter later, we connected with Forbes Tate Partners, the public relations firm that produced the ad. We were then referred to Megan Taylor, a spokeswoman for PFC.

"When we talk about the safety-net, we're talking about the health care system that the uninsured and underinsured rely on — like emergency departments, where two-thirds of the acute care is provided to uninsured Americans and where half of the acute care provided to Medicaid and Children's Health Insurance Program patients is delivered," Taylor wrote in an email.

To be sure, studies have shown that ERs see a large share of vulnerable patients. But independent experts we spoke with still didn't follow the ad's logic.

"I'd like to think that I'm fairly well-informed about surprise billing legislation, but I'm struggling to understand what argument they are even trying to make here," Benedic Ippolito, a research fellow at the American Enterprise Institute who has **testified before a Senate committee on this issue**, wrote in an email.

Focusing On The Real Trouble Spot

The surprise medical bill legislation is an effort to help consumers who generally mistakenly thought they were getting health services covered by their insurers but instead find themselves dealing with an out-of-network provider. **Read More**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

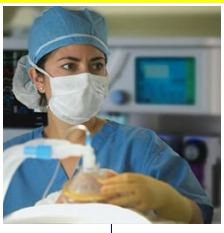
If You Smoke Pot, Your Anesthesiologist Needs To Know

DENVER — When Colorado legalized marijuana, it became a pioneer in creating new policies to deal with the drug.

Now the state's surgeons, nurses and anesthesiologists are becoming pioneers of a different sort in understanding what weed may do to patients who go under the knife.

Their observations and initial research show that marijuana use may affect patients' responses to anesthesia on the operating table — and, depending on the patient's history of using the drug, either help or hinder their symptoms afterward in the recovery room.

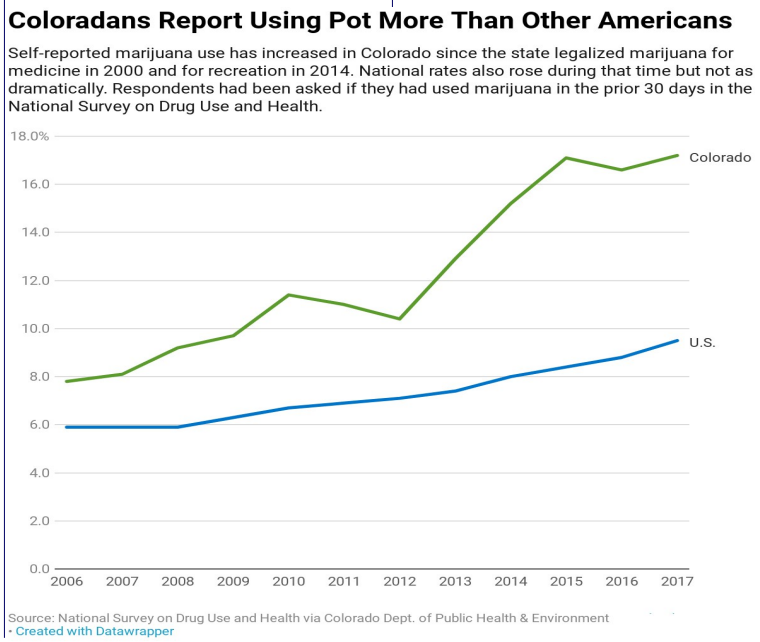
Colorado makes for an interesting laboratory. Since the state legalized marijuana for medicine in 2000 and allowed for its recreational sale in 2014, more Coloradans are using it — and they may also be more willing to tell their doctors about it.



Roughly **17% of Coloradans said they used marijuana** in the previous 30 days in 2017, according to the National Survey on Drug Use and Health, more than double the 8% who reported doing so in 2006. By comparison, just 9% of U.S. residents said they used marijuana in 2017.

"It has been destigmatized here in Colorado," said Dr. **Andrew Monte**, an associate professor of emergency medicine and medical toxicology at the University of Colorado School of Medicine and UCHealth. "We're ahead of the game in terms of our ability to talk to patients about it. We're also ahead of the game in identifying complications associated with use."

One **small study of Colorado patients published in May** found **marijuana users required more than triple** the amount of one common sedation medicine, propofol, as did nonusers. ….**Read More**



Infusion Treatments — Needed or Not — Can Deplete Patients' Wallets

Shannon Wood Rothenberg walked into her annual physical feeling fine. But more than a year later, she's still paying the price.

Routine bloodwork from the spring 2018 visit suggested anemia, of which she has a family history. Her doctor advised pills. After two months with no change, the doctor sent Rothenberg to a hematologist who could delve into the cause and infuse iron directly into her veins.

So last July, the 48-year-old public school teacher went twice to a cancer center operated by Saint Joseph Hospital in Denver, where she received infusions of Injectafer, an iron solution.

When the bill arrived in March, after prolonged negotiations between the hospital and her insurer, Rothenberg and her husband were floored.

The hospital had billed more than $14,000 per vial. Since her treatment was in-network, though, her insurance plan negotiated a much cheaper rate: about $1,600 per vial. She received two vials. Insurance paid a portion, but Rothenberg still owed the hospital $2,733, based on what was still unpaid in her family's $9,000 deductible.

"I have twins who are going to college next year. I'm already a bit freaked out about upcoming expenses," she said. "I don't have $2,700 sitting around."

About 9 million Americans on Medicare have gotten iron infusions each year since 2013, the first year for which data is available; that's almost one for every five people covered by the government insurance program for people over 65. Anemia, the principal outgrowth of low iron levels, can cause headache, fatigue and irregular heartbeat. People with certain medical conditions, such as inflammatory bowel disease and kidney failure, are prone to low iron levels and anemia, which can be severe.

In other countries, doctors usually would not be so quick to resort to iron infusions — especially in healthy patients like Rothenberg, who have no underlying disease and no obvious symptoms.

"It would be extremely unlikely that IV iron would be administered" in Britain, said Richard Pollock, a health economist at the London-based Covalence Research Ltd. who studies iron products.

But one key difference between this country and others is that American physicians and hospitals can profit handsomely from infusions. Under Medicare, doctors are paid in part based on the average sales price of the prescribed drug, which critics say gives them an incentive to pick the newer, more expensive option.

For those with private insurance, hospitals and doctors can mark up prices even more. Intravenous infusions, generally administered in a hospital or clinic, also generate a "facility fee."

That creates a financial incentive to favor the most expensive infused treatments rather than pills or simple skin injections that patients can use readily at home. ..**Read More**

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It's Not Just College Kids: Many Seniors Are Binge Drinking, Too

Binge drinking is often associated with young adults, but according to a new study, more than 10% of people over 65 do it, too.

Among seniors, binges are most common in men and those who use cannabis, researchers found. Experts said the trend is troubling, because older people should actually be cutting back on alcohol.

"Many organizations, such as the U.S. National Institute on Alcohol Abuse and Alcoholism [NIAAA], recommend lower drinking levels as people get older or have more chronic diseases," said lead researcher Dr. Benjamin Han, an assistant professor of geriatric medicine at NYU Langone Health in New York City.

Other studies have documented increasing alcohol consumption in the United States and worldwide, he said.

Binge drinking is generally defined as consuming five or more alcoholic drinks at a time. NIAAA suggests seniors cap their alcohol intake at three drinks a day.

Because the new study used the higher cutoff, it may actually underestimate how common binge drinking is among U.S. seniors.

Han isn't sure why binge drinking is on the rise among older people, but he has a theory.

"It is possible," he said, "that the increase in binge drinking is partly driven by increases by older women."

Although their male counterparts are more likely to binge, older women are catching up. Binge drinking among older men remained relatively stable between 2005 to 2014.

Han says doctors should screen older adults for "unhealthy alcohol use, including binge drinking, even if it is not frequent."

For the study, his team collected data on nearly 11,000 U.S. adults 65 and older who took part in the National Survey on Drug Use and Health between 2015 and 2017.

Of those, 10.6% had binged in the past month, the study found. That was up from previous studies. Between 2005 and 2014, between 7.7% and 9% of older Americans were binge drinkers.

Blacks and people with less than a high school education were more likely to do so, the researchers found.

They found no link between binge drinking and mental disorders or a higher incidence of chronic diseases. Among senior binge drinkers, the most common chronic diseases were high blood pressure (41%), heart disease (23%) and diabetes (18%).

Still, researchers warned that excessive drinking can make chronic diseases worse and lead to accidents.

That binge drinking is increasing is worrisome, said Dr. James Garbutt, medical director of the Alcohol and Substance Abuse Program at the University of North Carolina at Chapel Hill.

"By definition, binge drinking means drinking to the point of intoxication," said Garbutt, who wasn't involved with the study. "In older adults, that increases risks of falls, other accidents, blackouts, cognitive impairment, depression and suicide."

Plus, alcohol makes high blood pressure worse and is a significant factor for dementia, he said.

"It seems we need to educate older adults about these risks and encourage them that if they are going to drink alcohol, to limit intake to one to two standard drinks and try not to drink daily," Garbutt said.

If people find they can't drink without a binge, they should talk with their doctor or a counselor and consider a period of abstinence to see how they feel, he said.

"Reducing or stopping drinking could be one of the best things they do for their health, and many are surprised at how good they feel," Garbutt said.

The report was published July 31 in the *Journal of the American Geriatrics Society*.

More information

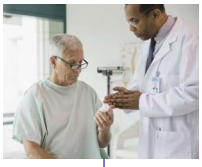
For more on binge drinking, head to the **U.S. Centers for Disease Control and Prevention**.

What to Know About Prediabetes, Prehypertension, and Other Prediseases

When you get a health screening—for high blood pressure or diabetes, for example—you might be told you have prehypertension or prediabetes. But what does that mean?

What is sometimes called a "predisease" is diagnosed when a screening result isn't quite normal but is below the threshold for disease.

Ignoring a troubling sign, such as **rising blood pressure**, can be dangerous. But treatment—especially if your numbers are borderline—can come with risks that outweigh the benefits. "There's a very large pool of people that fit in these predisease ranges who quite likely will never go on to have any serious health consequences at all," says Jenny Doust, Ph.D., a professor of clinical epidemiology at Bond University in Queensland, Australia.



Here, what you need to know about these so-called prediseases—and what you can do about them.

Prediabetes

♦ **What is it?**

Prediabetes means your blood sugar levels are higher than normal but not as high as in full-blown type 2 diabetes.

♦ **How serious is it?**

The Centers for Disease Control and Prevention says that about 84 million Americans have prediabetes, about a third of the country. But studies vary widely on how many go on to develop diabetes, and how quickly it happens. A 2016 analysis published in the journal Diabetes Care estimated that only about 2 percent of people with prediabetes develop diabetes each year. And a comprehensive evidence review found that over a period of up to 11 years, 17 to 59 percent of people with prediabetes reverted to normal blood sugar levels.

♦ **What should you do?**

Although the American Diabetes Association says medications can be an option for people with prediabetes, don't jump to them, advises Michael Hochman, M.D., director of the Gehr Family Center for Health Systems Science at the Keck School of Medicine at USC. They're not harmless. In a major clinical trial, scientists found that aggressive treatment for diabetes resulted in a higher death rate than standard care.

Instead, opt for lifestyle changes. Prediabetes should be "a wake-up call," Hochman says. Increase your exercise and try to lose weight if you need to. Consider **checking your blood sugar levels** regularly.

Prehypertension

♦ **What s it?**

♦ **How Serious is it?**

♦ **What should I do?**

….Read More Prediseases

Healthy lifestyle associated with lower risk of dementia

.Following a healthy lifestyle is associated with a lower risk of dementia in cognitively healthy older adults at varying levels of genetic risk for Alzheimer's disease and related dementias, according to a study published online July 14 in *JAMA*. Funded in part by NIA, the study is the first to examine the relationship between multiple genetic risk factors for dementia and multiple lifestyle factors.

Researchers led by the University of Exeter Medical School, UK, analyzed data from 196,383 participants, age 60 and older, who did not have cognitive impairment or dementia when they joined the UK Biobank study between 2006 and 2010. Using polygenetic risk scores based on previously published Alzheimer's disease genome-wide association studies, researchers sorted participants into levels of genetic risk for dementia (low, intermediate, and high). Participants were also assigned a healthy lifestyle score (favorable, intermediate, and unfavorable) based on self-reports of their current smoking status, regular physical activity, healthy diet, and moderate alcohol consumption.

Over a median 8 years of follow-up, 1,769 participants developed dementia. The researchers found that in participants at high genetic risk for dementia, a favorable lifestyle was associated with lower dementia risk than in those with an unfavorable lifestyle. However, scores for genetic risk and healthy lifestyle were independently associated with dementia risk—that is, following a healthy lifestyle was associated with lower dementia risk for participants at all levels of genetic risk, but higher levels of genetic risk were still associated with increased risk of incident dementia at every level of lifestyle.

The authors noted that additional research is necessary given some of the study's limitations. The participants studied were limited to those of European ancestry, and they volunteered rather than being randomly selected from a sampling frame, making it difficult to generalize to other populations. Also, the average age of the participants at the end of the follow-up period was 72, so the incident dementia cases were relatively low despite the large number of participants tracked. Finally, the crucial lifestyle variables were self-reported by participants rather than being objectively observed.

Scorching Pavement Sends Some to the ER With Burns

Make sure rubber, not your skin, meets the road: When skin touches sunbaked pavement, serious burns can quickly set in.

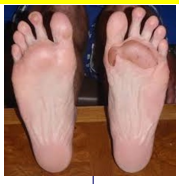
In sizzling regions like the Southwestern United States, all it takes for a severe burn is 2 seconds of unprotected skin-on-asphalt contact, experts say.

"Our research shows that in our city, the risk starts when the ambient temperature reaches 95 degrees Fahrenheit, and goes up from there," said Dr. Paul Chestovich, a Las Vegas burn surgeon and co-author of a new pavement burn study.

At highest risk are children, he said, and anyone who might fall or collapse outdoors. That includes seniors, the homeless, people who are drunk or drugged, and those who suffer a stroke or seizure. Diabetics can also run into trouble, because many have a neuropathic condition that interferes with heat sensation on the soles of their feet.

All of these scenarios have turned up at the UMC Lions Burn Care Center in Las Vegas, where Chestovich is an emergency physician. He is also an assistant professor at University of Nevada, Las Vegas.

In the July/August issue of the *Journal of Burn Care & Research*, Chestovich and his colleagues reported that the burn center treated 173 pavement-related burns between 2013 and 2017. About 14% of the cases involved additional injuries, sometimes from a car crash. The rest were stand-alone pavement burns.



More than 88% occurred after the thermometer hit 95 degrees, the findings showed. But risk really spiked once temperatures topped 105 degrees.

That's because pavement is heat-absorbing, so a 110-degree day can result in 150-degree pavement.

And with 158 degrees hot enough to fry eggs, the study's message is clear: Pavement burns are not your run-of-the-mill summer burn.

"A first-degree burn, commonly called a sunburn, just injures the top layer of skin, or epithelium," Chestovich said. Though painful, such minor burns can be treated with over-the-counter pain medications.

By contrast, a second-degree burn blisters into the skin's deeper base. These can require topical antibiotics and even surgery to remove dead tissue or a graft to cover damaged skin with healthy tissue.

"A third-degree burn damages the skin in its entirety," Chestovich said. Such burns can require multiple surgeries and leave lasting scars.

Fourth-degree pavement burns -- which hit muscle, deep tissue and bone -- are rare but not unheard of.

"We have seen hot pavement cause fourth-degree burns in cases when there was extended contact, usually a person lying unconscious on pavement for an extended period of time," Chestovich said.

It appears that pavement burns may be becoming more common. The Lions Burn Care Center has seen an increase in recent years, but it's not clear why. It could be due to gradually rising temperatures, but also might simply owe to a population increase, Chestovich said.

If you suffer a pavement burn, Chestovich cautioned against self-treating with cold water or ice, which could make matters worse. He suggested wrapping the affected skin in a clean dressing, and immediately seeking care at a hospital or qualified burn center.

Fortunately, "most patients usually can and do recover," said Dr. Nicholas Vasquez, a spokesman for the Arizona chapter of the American College of Emergency Physicians. "But it depends on the size of the burn and the severity. The bigger and the more severe, the longer the recovery."

The best strategy is prevention, said Vasquez, an emergency physician with Chandler Regional Medical Center in Arizona. He was not involved in the study.

"Pavement burns are really part of a larger problem, which is that people are poorly adapted to deal with heat," he noted. "All of our adaptive measures are related to cold: Putting on clothes, finding shelter, because in terms of evolution, cold has been our biggest threat. But heat-related emergencies are a serious business."

So, be practical. "When it's hot out, stay aggressively hydrated and out of direct sunlight," Vasquez said. "Only expose yourself to it when you have to."

More information

The U.S. National Institute of General Medical Sciences has more on **burns.**

Gout: What To Avoid To Beat Symptoms

A very painful form of inflammatory arthritis, gout can be considered a lifestyle disease plaguing people who have high insulin levels, a high sugar diet and drink too much alcohol. These people also tend to be sedentary.

Gout still has a reputation as a "disease of the rich" because it mainly affects those who can afford expensive foods such as meat, sugared foods and wine.

Gout is caused by an abnormally high level of uric acid in the blood, a condition called hyperuricemia. This occurs when a body produces uric acid, which is a waste product from digestion, faster than a body can excrete it.

In some instances, uric acid

can congeal to form sharp crystals in joints and connective tissue. The constant pressure exerted by these crystals on joints and connective tissue causes sharp pain and swelling.

Gout most commonly starts as an inflammation in the big toe. It also affects lower temperature joints such as the ankles or knees. Gout, however, can attack any of your joints.

Your intestines and kidney normally help excrete a healthy amount of uric acid. But factors such as disease or an infection can prevent these organs from doing their job.

In small amounts, uric acid is a beneficial antioxidant in your bloodstream. In large amounts, however, too much uric acid can trigger hyperuricemia.

Symptoms of gout to watch out for include severe and sudden pain, tenderness, redness and swelling in the joints. Attacks occur suddenly and are more common in the evening. The swelling and pain are excruciating and could last a few days to a week or more.

Because it's strongly linked to dietary choices, gout is one of the most treatable types of arthritis. Recent studies have identified the excessive consumption of alcohol and sugars, especially fructose in added sugars, as the real causes of gout.

Fructose is a type of sugar comprising some 50 percent of table sugar and high-fructose corn syrup (HFCS), an ingredient in foods such as peanut butter. Scientists have expressed fears the excessive intake of fructose might cause metabolic disorders such as obesity, type 2 diabetes, heart disease and even cancer.

At this juncture, it's important to clarify that **fructose from added sugars** is bad for you. Fructose from fruits isn't.

Doctors say the harmful effects of fructose apply to Western diets with their excess calories and added sugars. It doesn't apply to natural sugars found in fruits and vegetables.

Normal Brain vs. Brain With Dementia

YOU DON'T NEED TO BE A brain specialist to notice certain differences in images of a healthy older person's brain compared to that of someone with dementia. Narrowed, depleted folds on the brain's surface, the presence of blotchy plaques, twisted fibers and significant shrinkage are clearly visible. What you can't see is how brain changes like these affect how people's minds work.

In a program from the National Press Foundation and funded by AARP, "Understanding the Latest on Dementia Issues," journalists heard from a spectrum of dementia experts, including researchers, gerontologists, family caregivers and a brilliant engineer who described her personal journey with **early-onset Alzheimer's.** In addition, a leading neuroscientist detailed how normal brain aging is very different than changes arising from dementia and not something to be feared.

While some presentations were sobering, others were reassuring – and all highlighted just how complex dementia and **brain aging** are. Here are a few takeaways:

Dementia Brain Changes

- **Protein plaques and tangles infiltrate the brain in Alzheimer's.**
- **Hippocampus involvement affects memory.**
- **Inability to make new memories causes many problems.**
- **Alzheimer's disease shrinks the brain.**
- **Dementia progresses in stages.**

Of course, many factors contribute to dementia development. Genetics play a major role. Alzheimer's risk rises, in part, depending on whether you have any copies of the **ApoE4 gene,** and how many. Another gene called TREM2 is being studied for its role in inflammatory action in the brain. Other genetic connections exist.

Recent disappointments in large clinical trials of Alzheimer's drugs have scientists looking at other potential pathways in dementia development. The goal is to find more effective treatments for the disease. Studies should target dementia much earlier in the process by including more participants who have mild cognitive impairment, Turner says. Ideally, long-term prevention trials would recruit normal participants who don't have dementia at all but face a higher risk.

Normal Brain Aging

When it comes to comparing the normal, healthy brains of older and younger adults, younger brains do function differently in some ways – although not necessarily always better.

It's actually a "wonderful" time to be old, says Darlene Howard, a professor emerita at Georgetown University whose research focuses on changes in cognitive and neural systems during aging. The "gray tsunami," with a larger proportion of people ages 65 and older in the population than ever before, is helping drive a host of changes.

Increased political clout and camaraderie, emerging technology like smart homes, better hearing aids, improved cataract surgery, universal access like ramps for everyone from parents pushing strollers to people with walkers and a society that's more accepting of diversity all represent advantages for elders, Howard says.

Fresh perspectives on the aging brain are also emerging. Decades of research from Howard and her peers offer encouragement. Their results counter traditional thinking about what's lost or preserved, what gets worse or improves and what's inevitable versus avoidable as you get older. As for normal brain aging compared to dementia effects, she says, "They're very different beasts."...**Read More**