Rhode Island Alliance for Retired Americans ©

All Rights Reserved
RI ARA 2019©

RI ARA

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

August 18, 2019 E-Newsletter

Publication 2019 Issue 34
Published in house by the
RI ARA

Congress is considering big changes to the way you retire. Here's what could make the cut

- When Congress returns from recess, it will have a slew of proposals to consider, including some that could have a big impact on your retirement.
- New proposals aim to fix legacy issues by expanding access to retirement savings, making Social Security solvent and protecting income in multi-employer pensions.

Whether the bills get the green light depends on whether they can generate bipartisan support and motivate both sides of Congress to act.

A string of pending proposals on Capitol Hill could change the way current and future retirees live.

But that's assuming they can first get through both Houses of Congress.

And time is ticking as August recess has already begun. After that, there's just four months left to the year.

Even if pushing the changes through a Democratic majority in the House of Representatives and the Republican-held Senate proves too difficult, some of the existing proposals could be revisited by lawmakers in the future.

"Often that's still progress, even though you might not see the fruits of that labor for a couple of years," said Jamie Hopkins, director of retirement research at Carson Group and professor at Creighton University Heider College of Business.

Here's a rundown of retirement-related legislation on the table and their chances of passing.

The Secure Act

When the Secure Act sailed through the House of Representatives on May 23 by a 417-3 vote, it looked like it would be fast-tracked in the Senate.

Months later, progress on that side of Congress is **still elusive**.

The Secure Act would include a bevy of changes to existing retirement rules. Its main goal: to expand access to retirement savings.

Social Security 2100 Act

In July, the House Ways and Means Committee held a hearing on a new bill introduced by Rep. John Larson, D-Conn., called the **Social Security 2100 Act**.

Social Security's trust funds are set to run out by 2035, at which point only 80% of promised benefits will be payable.

The Social Security 2100 Act looks to fix that by extending the solvency of the program into the next century.

It also includes other changes, notably increasing payroll taxes while avoiding benefit cuts entirely.

Rehabilitation for Multiemployer Pensions Act

Many so-called multiemployer pension plans are on the brink of **running out of money.**

The House passed its answer to that problem, the Rehabilitation for Multiemployer Pensions Act, on July 24 in a 264-169 vote.

The new bill would let pensions borrow money to remain solvent so that they can continue to pay retirees. The legislation would create a Pension Rehabilitation Administration within the Treasury Department and a trust fund from which the loans would be distributed.

More proposals on Medicare and Social Security

Some other bills in early stages of consideration are:

The **Health Savings for Seniors Act**, a bipartisan bill, introduced by Reps. Ami Bera, D-Calif., and Jason Smith, R-Mo., in July. This bill would allow individuals who are on Medicare to continue to contribute to health savings accounts. Currently, they are prohibited from doing so.

Another proposal by Rep. Kevin Brady, R-Texas, the **Equal Treatment of Public Servants Act**, would enable public workers to get larger Social Security benefits. A current rule, the Windfall Elimination Provision, reduces their benefits based on how much pension income they receive…

More proposals on Medicare and Social Security

Some other bills in early stages of consideration are:

The **Health Savings for Seniors Act**, a bipartisan bill, introduced by Reps. Ami Bera, D-Calif., and Jason Smith, R-Mo., in July. This bill would allow individuals who are on Medicare to continue to contribute to health savings accounts. Currently, they are prohibited from doing so.

Another proposal by Rep. Kevin Brady, R-Texas, the **Equal Treatment of Public Servants Act**, would enable public workers to get larger Social Security benefits. A current rule, the Windfall Elimination Provision, reduces their benefits based on how much pension income they receive.

Both bills were introduced in recent weeks.

.**Read More each subject**

CMS Proposes Hospital Transparency Rules

The Centers for Medicare & Medicaid Services recently announced a proposal designed to increase hospital price transparency. Under the draft rule, hospitals would be required to publicly disclose the price they negotiate with each insurer for almost every service, drug, and supply they provide to patients.

If that sounds like a lot to sift through to figure out which facility is right for you, it is. Although this proposal comes amid widespread calls for more transparency and clarity around health care pricing and is intended to lower costs as well as improve consumer decision-making, it also raises significant questions about how much information is useful and in what formats.

Even though the rule would require the data to be searchable, the underlying information would necessarily contain tens of thousands of potential charges—from room and board to the costs of surgical supplies to the cost of each aspirin. To make an informed choice, a person would have to know all of the services he or she would require in advance—potentially down to how many sutures would be needed to close a yet-to-be-made incision. The consumer would then need to look up each of those services, cross reference them with their insurer and specific plan to find the negotiated rate, and then add them up. They would need to do this for each hospital they are considering utilizing. Aside from these complexities, the proposal's ability to lower costs and aid consumers has other inherent limitations. For example, only certain medical needs are "shoppable" in this way. If a person is being rushed to the hospital because they are having a heart attack, the relative cost of cardiac care at the area hospitals is not going to be known, never mind going to direct the ambulance.

There is some hope that the publication of these prices alone, aside from patient's shopping efforts, could lead to lower costs. Yet, results from studies point in both directions, in part because behavioral responses can be difficult to predict. As a result, it remains to be seen if increasing transparency in this manner gives large employers and insurers more negotiating power with hospitals and therefore the ability to drive down prices, or if it instead drives prices up by bringing them in lock-step across competing hospitals.

The Medicare Rights Center appreciates efforts to address the problem of high and rising health care costs. We support efforts to increase transparency and provide more information to beneficiaries, but strongly caution against systems that rely on beneficiaries to be "smart shoppers" in times of medical crisis.

Read the CMS Fact Sheet.

Where Tourism Brings Pricey Health Care, Locals Fight Back

In an area where average emergency room claims reached 842% of Medicare rates, residents of a Colorado county found relief by joining forces and negotiating prices directly with the local hospital.

Colorado's ski resort areas in Summit County have **a high cost of living**, among the highest in the country. The people who visit these places — Keystone, Breckenridge and Copper Mountain -— can afford it.

Many of those who live and work there can't, especially when they get sick.

In addition to expensive rent, they pay some of the steepest health insurance premiums in the nation. Hospital costs are also pricey, with most business generated by tourists, skiers and outdoors enthusiasts.

But locals may soon get a break after a group, fed up with the costs, negotiated a deal with the hospital system. The group, which came to be known as the Peak Health Alliance, expects to be able to offer its members premiums next year that are at least 20% less than current rates.

About 6,000 people, among them individuals as well as employees of local businesses and the county government, can buy coverage through the alliance, which cut a deal for a discount of about one-third off the local hospital's list prices (although at least one expert thinks they could have done a lot better).

"It wasn't for the faint of heart," said Tamara Drangstveit, who ran a county social services organization before becoming Peak's **executive director** and, effectively, one of the lead negotiators.

Fed up with high hospital prices even after insurers' negotiated discount, more employers are cutting out insurance middlemen and engaging in what is known as "direct contracting" with medical providers. They cut their own deals.

Direct contracting is a hot topic among employers because they are "up in arms about insurers not keeping prices in check," said Chapin White, a Rand Corp. researcher who studies the tremendous variation in hospital prices. The citizens here in Colorado are taking the approach to the grassroots level.

What Peak did — starting with painstakingly gathering data about exactly what hospitals in the region were being paid by insurers, employers and consumers — might be an answer for some.

Such efforts may be helped by **Congress,** which is considering barring secrecy clauses in hospital and insurance contracts that can prevent employers from learning exactly how much insurers pay. The Trump administration is also considering **proposals** to require more public disclosure of negotiated hospital prices.

And, according to **press reports**, the experience with Peak may go statewide. Colorado's insurance commissioner and Gov. Jared Polis say they are considering an alliance that could bring together state employees, individuals and private employers in a similar health care purchasing network.

"It feels like the curtain is going up on health care costs and prices," said Cheryl DeMars, CEO of The Alliance, a group of 240 self-insured private sector employers that directly contracts with hospitals in Wisconsin, northern Illinois and eastern Iowa.

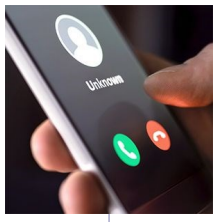
While interest is growing, experts caution that direct contracting won't work in many places….**Read More**

NEW GUIDELINES TAKE AIM AT PHONE SCAMS

It's been a busy summer in the ongoing battle against robocalling and phone scams. On May 23, the U.S. Senate overwhelmingly approved the Telephone Robocall Abuse Criminal Enforcement and Deterrence ("TRACED") Act by a 97-1 vote. **The legislation** grants the Federal Communications Commission (FCC) stepped-up enforcement power to levy heavy penalties, including significant fines, against violators.

Read More

In addition, on June 6 the FCC voted unanimously to grant telecommunications companies the authority to proactively identify and block robocallers.



The agency will hold a summit with carriers in July to identify a framework for implementing these **new guidelines**, and has committed to pursuing "aggressive enforcement action" against robocallers.

This federal intervention should provide welcome relief to consumers, coming as it does amidst estimates that nuisance calls will grow from 29 percent of all phone calls in 2018 to as much as 45 percent of all calls this year. And new types of scams continue to pop-up with alarming regularity.

Among the new tricks: "neighbor spoofing," in which fraudsters alter their phone number to look like a legitimate call from nearby, and the "one ring" scam, which involves robocallers hanging up after one ring, hoping to trick the victim into calling back. Variations of this scam rely on phony voicemail messages urging you to call a number with an unfamiliar area code to schedule a delivery, resolve a bogus legal issue, or notify you about a sick relative.

While the latest government action offers powerful remedies to deter bad actors, there are steps you can also take to protect yourself. Here are a few simple tips to help thwart the scammers:

- Familiarize yourself with **call blocking options** for your cellphone.
- Don't answer or return any calls from numbers you don't recognize.
- List your phone number on the **National Do Not Call Registry**. While this will not prevent unscrupulous callers from contacting you, it can help to limit the number you receive.
- If your number is on the registry and you receive unwanted calls, **report them**. This can help expose and catch callers who are engaging in fraud.

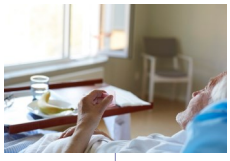
Class-Action Lawsuit Seeks To Let Medicare Patients Appeal Gap in Nursing Home Coverage

Medicare paid for Betty Gordon's knee replacement surgery in March, but the 72-year-old former high school teacher needed a nursing home stay and care at home to recover.

Yet Medicare wouldn't pay for that. So Gordon is stuck with a $7,000 bill she can't afford — and, as if that were not bad enough, she can't appeal.

The reasons Medicare won't pay have frustrated the Rhode Island woman and many others trapped in the maze of regulations surrounding something called "observation care."

Patients, like Gordon, receive observation care in the hospital when their doctors think they are too sick to go home but not sick enough to be admitted. They stay overnight or longer, usually in regular hospital rooms, getting some of the same services and treatment (often for the same problems) as an admitted patient — intravenous fluids, medications and other treatment, diagnostic tests and round-the-clock care they can get only in a hospital.



But observation care is considered an outpatient service under Medicare rules, like a doctor's appointment or a lab test. Observation patients may have to **pay a larger share** of the hospital bill than if they were officially admitted to the hospital. Plus, they have to pick up the tab for any nursing home care.

Medicare's nursing home benefit is available only to those admitted to the hospital for three consecutive days. Gordon spent three days in the hospital after her surgery, but because she was getting observation care, that time didn't count.

There's another twist: Patients might want to file an appeal, as they can with many other Medicare decisions. But that is not allowed if the dispute involves observation care.

Monday, a trial begins in federal court in Hartford, Conn., where patients who were denied Medicare's nursing home benefit are hoping to force the government to eliminate that exception. A victory would clear the way for appeals from hundreds of thousands of people.

The class-action lawsuit was filed in 2011 by seven Medicare observation patients and their families against the Department of Health and Human Services. Seven more plaintiffs later joined the case.

"This is about whether the government can take away health care coverage you may be entitled to and leave you no opportunity to fight for it," said Alice Bers, litigation director at the Center for Medicare Advocacy, one of the groups representing the plaintiffs.

If they win, people with traditional Medicare who received observation care services for three days or longer since Jan. 1, 2009, could file appeals seeking reimbursement for bills Medicare would have paid had they been admitted to the hospital. More than 1.3 million observation claims meet these criteria for the 10-year period through 2017, according to the most recently available government data.

Gordon is not a plaintiff in the case, but she said the rules forced her to borrow money to pay for the care. "It doesn't seem fair that after paying for Medicare all these years, you're told you're not going to be covered now for nursing home care," Gordon said.

No one has explained to Gordon, who has hypoglycemia and an immune disease, why she wasn't admitted. The federal notice hospitals are required to give Medicare observation patients didn't provide answers.

Even Seema Verma, the head of the Centers for Medicare & Medicaid Services, is puzzled by the policy. "Better be admitted for at least 3 days in the hospital first if you want the nursing home paid for," she said in a tweet Aug. 4. "Govt doesn't always make sense. We're listening to feedback." Her office declined to provide further explanation...**Read More**

Trump Administration Proposes ACA Changes That Would Weaken Nondiscrimination Protections

On June 14, the Department of Health and Human Services (HHS) issued a **proposed rule** that would significantly weaken the Affordable Care Act's (ACA) nondiscrimination protections. Section 1557 of the ACA makes it illegal for providers that receive federal funding to discriminate in the provision of health care on the basis of race, color, national origin (including language access), age, disability or sex. HHS is now seeking to limit those protections, changes that would put many already vulnerable populations—including older adults, people with disabilities, people with limited English proficiency, and LGBTQ individuals—at risk of losing access to care.

Importantly, HHS's proposal is not yet final. Public comments are being accepted through **Tuesday, August 13**, so there's still time to make a difference.

The regulations implementing Section 1557 of the ACA clarify how key nondiscrimination protections apply to health care, including the rights and responsibilities of individuals and health care providers. While the proposed rule would not change the underlying law, it would greatly narrow the scope of the existing HHS implementing regulations, likely reducing access to care for millions and jeopardizing it for millions more. If finalized, the proposed rule would, in part:

- ♦ · Eliminate the current regulatory prohibition on discrimination based on gender identity, as well as specific health insurance coverage protections for transgender individuals;
- ♦ · Increase religious freedom exemptions for health care providers;
- ♦ · Eliminate the protections that prevent health insurers from varying benefits in ways that discriminate against certain groups, such as people with HIV or LGBTQ people;
- ♦ · Weaken protections that provide access to interpretation and translation services for individuals with limited English proficiency;
- ♦ · Exempt many insurance companies and many health plans from nondiscrimination requirements;
- ♦ · Eliminate the requirement for hospitals, doctors, insurers, and other health care providers to tell people about their rights, including the right to auxiliary aids and services at no cost, how to ask for such aids/services, and how to make a complaint if they encounter discrimination;
- ♦ · Make it more confusing to prove discrimination and go to court; and
- ♦ · Narrow the scope of the remaining protections by limiting the activities and entities to which they would apply.

These and other aspects of the proposed rule would substantially dilute, and in many cases entirely eliminate, existing safeguards against discrimination. In so doing, the Trump administration would likely increase discrimination in health care, as well as consumer fear; make it harder for individuals to know their rights, interact with the health system, and seek legal recourse; and undermine the ability of many consumers to obtain timely, affordable, high-quality care. This could lead to worse health outcomes, greater suffering, and higher costs both for individuals and the health care system as a growing number of treatable conditions would likely progress into expensive emergencies.

Medicare Rights urges the Administration to withdraw this rule immediately, and to instead work to build upon current law protections so that all Americans can avoid discrimination as well as understand and exercise their rights.

How you can help

Learn more:

More information about the proposed rule and its potential impacts is below.

Submit comments: Tell HHS to maintain the ACA's important nondiscrimination protections. Not sure what to say? Our partners at Justice in Aging have created **template comments** that may be helpful.

Spread the word: Amplify your voice by sharing this alert widely! Let your friends, colleagues, and networks know you've taken action, and encourage them to do the same.

Submit Comments

Links to additional information about the WEP and the GPO

Frequently Asked Questions

Read answers to the *frequently asked GPO and WEP questions*

Links to Other Information Centers

- ♦ **Social Security Online information on the WEP and the GPO (SSA)**
- ♦ **The financial condition of Social Security (SSA)**
- ♦ **The National Education Association on GPO and WEP (NEA)**
- ♦ **California Retired Teachers Assn. on GPO and WEP (CalRTA)**

The required SSA form to warn employees about the GPO/WEP

SSA 1945 Form

Congressional Research Service Reports

Windfall Elimination Provision (WEP) 2019 Analysis

The Government Pension Offset (GPO)

Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381

riarajap@hotmail.com • http://www.facebook.com/groups/354516807278/

Coordinating Care Of Mind And Body Might Help Medicaid Save Money And Lives

Modern medicine often views the mind and body on separate tracks, both in terms of treatment and health insurance reimbursement. But patients with psychological disorders can have a hard time managing their physical health.

So some Medicaid programs, which provide health coverage for people with low incomes, have tried to **coordinate patients' physical and mental health care.**

The goal is to save state and federal governments money while improving the health of patients like John Poynter of Clarksville, Tenn.

Poynter has more health problems than he can recall. "Memory is one of them," he said, with a laugh that punctuates the end of nearly every sentence.

He is recovering from his second hip replacement, related to his dwarfism. Poynter gets around with the help of a walker, which is covered in keychains from places he has been. He also has diabetes and struggles to manage his blood sugar.

But most of his challenges, he said, revolve around one thing: alcoholism.

"I stayed so drunk, I didn't know what health was," Poynter said, with his trademark chuckle.

Nevertheless, he often used Tennessee's health system back when he was drinking heavily. Whether because of a car wreck or a glucose spike, he regularly visited hospital emergency rooms, where every bit of health care is more expensive.

The Case For Coordination Of Mind-Body Care

Tennessee's Medicaid program, known as TennCare, has more than 100,000 patients in circumstances similar to Poynter's. They've had a psychiatric inpatient or stabilization episode, along with an official mental health diagnosis — depression or bipolar disorder, maybe, or, as in Poynter's case, alcohol addiction.

Their mental or behavioral health condition might be manageable with medication and/or counseling, but without that treatment, their psychological condition is holding back their physical health — or vice versa.

"They're high-use patients. They're not necessarily high-need patients," said Dr. Roger Kathol, a psychiatrist and internist with Cartesian Solutions outside Minneapolis. He consults with hospitals and health plans working to integrate mental and physical care.

As **studies have shown**, these dual-track patients end up consuming way more care than they would otherwise need. "So, essentially, they don't get better either behaviorally or medically," Kathol said, "because their untreated behavioral health illness continues to prevent them from following through on the medical recommendations." For example, a patient's high blood pressure will never be controlled if an active addiction keeps them from taking hypertension medication.

Coordinating mental and physical health care presents business challenges because, typically, two different entities pay the bills, even within Medicaid programs. That's why TennCare started offering incentives to reward teamwork.,,,**Read More**

To Save Money, American Patients And Surgeons Meet In Cancun

CANCUN, Mexico — Donna Ferguson awoke in the resort city of Cancun before sunrise on a sweltering Saturday in July.

She wasn't headed to the beach. Instead, she walked down a short hallway from her Sheraton hotel and into Galenia Hospital.

A little later that morning, a surgeon, Dr. Thomas Parisi, who had flown in from Wisconsin the day before, stood by Ferguson's hospital bed and used a black marker to note which knee needed repair. "I'm ready," Ferguson, 56, told him just before being taken to the operating room for her total knee replacement. For this surgery, she would not only receive free care but would receive a check when she got home.

The hospital costs of the American medical system are so high that it made financial sense for both a highly trained orthopedist from Milwaukee and a patient from Mississippi to leave the country and meet at an upscale private Mexican hospital for the surgery.

Ferguson gets her health coverage through her husband's employer, Ashley Furniture Industries. The cost to Ashley was less than half of what a knee replacement in the United States would have been. That's why its employees and dependents who use this option have no out-of-pocket copayments or deductibles for the procedure; in fact, they receive a $5,000 payment from the company, and all their travel costs are covered. Parisi, who spent less than 24 hours in Cancun, was paid $2,700, or three times what he would get from Medicare, the largest single payer of hospital costs in the United States. Private health plans and hospitals often negotiate payment schedules using the Medicare reimbursement rate as a floor. Ferguson is one of hundreds of thousands of Americans who seek lower-cost care outside the United States each year, with many going to Caribbean and Central American countries. A key consideration for them is whether the facility offers quality care.

In a new twist on medical tourism, North American Specialty Hospital, known as NASH and based in Denver, has organized treatment for a couple of dozen American patients at Galenia Hospital since 2017.

Parisi, a graduate of the Mayo Clinic, is one of about 40 orthopedic surgeons in the United States who have signed up with NASH to travel to Cancun on their days off to treat American patients. NASH is betting that having an American surgeon will alleviate concerns some people have about going outside the country, and persuade self-insured American employers to offer this option to their workers to save money and still provide high-quality care….**Read More**

RI ARA HealthLink Wellness News

Federal Experts' Advice On HPV Vaccine Could Leave Adults Confused

Vaccination decisions are usually pretty straightforward. People either meet the criteria for the vaccine based on their age or other factors or they don't. But when a federal panel recently recommended an update to the human papillomavirus (HPV) vaccine guidelines, it left a lot of uncertainty.

The **panel recommended** that men and women between ages 27 and 45 decide — in discussion with their health care providers — whether the HPV vaccine makes sense for them.

But some public health advocates criticize that advice because it doesn't provide doctors and patients clear guidance about who in this expansive age group are good candidates. They worry that many people may get immunized who won't benefit, adding needless cost to the health care system and possibly shortchanging people overseas, where the vaccine is in short supply.

"My concern is that there will be a whole lot of people or doctors recommending this vaccine," said Debbie Saslow, managing director of HPV and gynecological cancers for the American Cancer Society. "But I think that the benefit is so small and we just don't have guidance."

The human papillomavirus is the **most common sexually transmitted infection** in the United States; nearly everyone who's sexually active will get it at some point. People typically clear the virus on their own and often don't even realize they've been infected. But in some people, HPV remains in the body **and may cause several types of cancer** as well as genital warts.

Every year, HPV causes **more than 33,000 cancers**, including more than 90% of cervical cancers as well as cancers of the vagina, vulva, penis, anus and the area at the back of the throat called the oropharynx, according to the Centers for Disease Control and Prevention.

More than **40 types** of HPV affect the genital area. Merck's Gardasil 9, the vaccine used in the United States, provides protection against nine types, which together **are associated** with the majority of HPV-related cancers and cause 90% of genital warts.

Because HPV is so common among people who are sexually active, the best time to vaccinate is before people start having sex and risk being exposed to the virus. The CDC's Advisory Committee on Immunization Practices **recommends HPV vaccination** for all 11- and 12-year-old girls and boys. Catch-up immunizations for young people outside that age window are recommended through age 21 for men and 26 for women (the proposed HPV vaccine update would change the catch-up vaccination guideline for men to align it with the age-26 cutoff for women).

In its June meeting, the **immunization committee,** which includes public health experts, recommended widening the vaccination window to include adults between 27 and 45.

But rather than give the thumbs-up for everyone in that age group, the panel said people should engage in "shared clinical decision-making" with their health care professional to decide if the vaccine is right for them

"ACIP made this type of recommendation because most people in this age group are not likely to benefit from getting the vaccine," Kristen Nordlund, a spokeswoman for the CDC, wrote in an email.

The vaccine won't protect people against types of HPV to which they've already been exposed, and many sexually active people have been exposed to at least some HPV types by their late 20s.

That makes it tougher for the vaccine to have an impact in this age group. According to an economic modeling study presented at the ACIP meeting, under current guidelines that recommend immunization through age 26, 202 people would have to be vaccinated to prevent one case of HPV-related cancer. .**Read More**

Medicare to cover breakthrough gene therapy for some cancers

WASHINGTON (AP) — Expanding access to a promising but costly treatment, Medicare said Wednesday it will cover for some blood cancers a breakthrough gene therapy that revs up a patient's own immune cells to destroy malignancies.

Officials said Medicare will cover CAR-T cell therapies for **certain types of lymphoma and leukemia** , uses that are approved by the Food and Drug Administration. The cost can run to hundreds of thousands of dollars per patient, not counting hospitalization and other expenses.

Medicare Administrator Seema Verma said the decision will provide consistent and predictable access nationwide, opening up treatment options for some patients "who had nowhere else to turn."

CAR-T uses gene therapy techniques to turbocharge the patient's own immune system cells, reprogramming them to harbor a "receptor" that zeroes in on cancer, and then to grow hundreds of millions of copies. The revved-up immune cells are returned to the patient's bloodstream and can continue to fight cancer for months or years.

Although side effects can be severe, studies have shown the treatment to be highly effective against certain types of cancers. Researchers are working to add more types to that list.

Medicare has been weighing the decision for months. The program often sets the tone for private insurance as well.

In its announcement, Medicare said it will cover CAR-T when the treatment is provided in institutions that are enrolled with the FDA in a special program to promote safety. It will also cover the treatment for other uses, if they are recommended by agency-approved medical research literature.

CAR-T uses a different strategy than other gene-therapy techniques. Instead of trying to fix disease-causing genes, it focuses on the patient's immune system, specifically the T cells that battle foreign substances in the body. The problem with cancer is that malignant cells can often evade detection by the patient's T cells. CAR-T helps the body's own T cells do a better job of spotting tumors.

Medicare covers more than 60 million seniors and people with disabilities.

Heart-Healthy Habits Good For Your Brain

Want to reduce your risk of dementia? Take care of your heart.

That's the takeaway from a new study that suggests good heart health in middle age could lower your odds for problems with thinking and memory later in life.

The study included nearly 7,900 British adults who did not have heart disease or dementia at age 50. Over an average 25-year followup, 347 cases of dementia were diagnosed among participants. Average age at diagnosis: 75.

After taking other factors into account, researchers linked a higher score at age 50 on seven healthy habits outlined in the American Heart Association's "Life Simple 7" with a lower risk of dementia later in life.

The Life Simple 7 assesses smoking, diet, physical activity, fasting blood sugar, blood cholesterol, blood pressure and body mass index (a measure of body fat based on height and weight).

Dementia rates were 1.3 per 1,000 person years among participants who had high scores on heart healthy habits, compared to 3.2 per 1,000 for low-scorers, according to the study published Aug. 7 in the *BMJ*.

A better score at age 50 was also associated with higher overall brain and gray matter volumes in MRI scans 20 years later.

Though the study could not prove that heart-healthy living actually caused dementia risk to drop, the researchers said their findings support public policies to improve heart health in middle age. They pointed out that dementia is a progressive disease that can start 15 to 20 years before symptoms appear.

"Our findings suggest that the Life's Simple 7, which comprises the cardiovascular health score, at age 50 may shape the risk of dementia in a synergistic manner," the study team wrote. "Cardiovascular risk factors are modifiable, making them strategically important prevention targets."

The lead author is Severine Sabia of the French National Institute of Health in Paris and University College London.

More information

The Alzheimer's Association has more on **brain health**.

7 'simple' steps for heart health may also stave off dementia

New research suggests that "Life's Simple 7" steps for maintaining heart health may also be a useful tool for predicting dementia risk and preventing the neurological condition.

The lead author of the new study is Séverine Sabia, of the department of Epidemiology of Ageing and Neurodegenerative Diseases at Inserm, a public research institution affiliated with the Université de Paris in France.

Sabia and her colleagues set out to examine the link between the American Heart Association's (AHA) guidelines for optimal cardiovascular health — which they dub "Life's Simple 7" — and the risk of developing dementia later in life.

"**Life's Simple 7**" are modifiable risk factors which, according to the AHA, can help keep **heart disease** at bay.

Making lifestyle changes along these seven parameters can improve a person's cardiovascular health, the AHA advises. Life's Simple 7 are:

1. manage **blood pressure**
2. manage **cholesterol**
3. lower blood sugar
4. stay physically active
5. follow a healthful diet
6. lose weight
7. stop smoking (or don't start)

In the new research, Sabia and her team looked at how well people adhered to these steps at 50 years of age. They also examined the link with dementia over the following 25 years. The research team published its findings in ***The BMJ***.

Studying heart health and dementia risk

As the authors note in their paper, previous studies have already pointed to Life's Simple 7 as potential guidelines for preserving brain health into older age. However, the existing evidence has so far been inconclusive.

So, for the current study, Sabia and team examined data on 7,899 participants who were 50-year old British men and women. All of the individuals had taken part in the Whitehall II Study — an analysis of sociobehavioral factors on long term health.

At the start of the study, the participants were in perfect cardiovascular health and did not have dementia. The Whitehall II Study started in 1985–1988 and Sabia and team followed the dementia cases through to 2017.

Over the average follow-up period of 25 years, 347 of the 7,899 participants developed dementia at an average of 75 years old.

The researchers measured the adherence to the seven parameters by using a three point score for each of them.

In total, the "cardiovascular health score was the sum of seven metrics (score range 0–14), and the researchers categorized these into poor (scores 0–6), intermediate (7–11), and optimal (12–14) cardiovascular health."

A healthy heart may keep the brain healthy

After adjusting for potential confounders, the research revealed that a high adherence score to the seven cardiovascular parameters correlated with a lower risk of dementia later.

Specifically, in the group with a poor cardiovascular score, dementia occurred at a rate of 3.2 cases per 1,000 person years.

In the group with an intermediate cardiovascular score, the rate was 1.8 per 1,000 person years, while only 1.3 cases of dementia occurred per 1,000 person years among those who scored the highest.

Importantly, higher adherence to Life's Simple 7 at 50 years of age also correlated with a higher brain volume and higher grey matter volume at the average age of 70 years, as **MRI scans** reflected.

However, the study is observational and cannot establish causality. The participants also reported their own adherence to the cardiovascular parameters, which may have increased bias.

Nevertheless, "Our findings suggest that the Life's Simple 7, which comprises the cardiovascular health score, at age 50 may shape the risk of dementia in a synergistic manner," write the authors.

"Cardiovascular risk factors are modifiable, making them strategically important prevention targets," add Sabia and colleagues, concluding:

"This study supports public health policies to improve cardiovascular health as early as age 50 to promote cognitive health."

Shots for Safety

Vaccines aren't just for kids, a doctors' group says.

"Many adults are not aware that they need vaccines throughout their lives and so have not received recommended vaccinations," Dr. Robert McLean, president of the American College of Physicians, said in a college news release.

"Adults should get a seasonal flu shot and internists should use that opportunity to make sure their patients are up to date on the latest recommended immunizations," he advised.

Along with an annual flu shot, other important adult vaccinations include: Tdap to protect against tetanus, diphtheria and whooping cough; pneumococcal to protect against pneumococcal pneumonia, bacteremia and meningitis; HPV (human papillomavirus) to prevent cervical, anal and other cancers; hepatitis B; and herpes zoster to help prevent shingles.

Each vaccine should be given according to guidelines from the U.S. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP).

"Vaccines are safe, effective and help prevent illness, hospitalization and even death, especially among the elderly and those with chronic conditions and weakened immune systems," McLean said.

"Physicians should conduct a vaccine needs assessment with their patients regularly. People who cannot get a flu shot or other vaccines for medical reasons should talk to their internist about other ways of protecting themselves," McLean recommended.

August is National Immunization Awareness Month.

The latest ACIP-approved adult immunization schedule and recommendations appear in the *Annals of Internal Medicine*.

Earlier this year, ACIP recommended raising the upper age for catch-up vaccination against HPV in men to age 26 years -- the same as in women -- and recommended that patients aged 27 to 45 talk to their doctor about receiving the vaccine.

ACIP also recommended that the 13-valent pneumococcal conjugate vaccine (PCV13) be given "based on shared clinical decision making" in adults 65 and older who do not have a weakened immune system and who have not previously received PCV13.

All adults 65 and older should receive the 23-valent pneumococcal polysaccharide vaccine (PPSV23), according to ACIP.

ACIP's recommendations must be reviewed and approved by the CDC. The final recommendation will be published in an upcoming issue of the CDC's *Morbidity and Mortality Weekly Report*.

Click on each of the links below for more information.

- **Flu**
- **Pneumococcal Disease**
- **Tetanus and Diphtheria**
- **Shingles**
- **Measles, Mumps, and Rubella**
- **Side Effects of Shots**
- **Shots for Travel**

For More Information About Shots and Vaccines

American Lung Association
1-800-586-4872 (toll-free)
info@lung.org
www.lung.org

Centers for Disease Control and Prevention (CDC)
1-800-232-4636 (toll-free)
1-888-232-6348 (TTY/toll-free)
cdcinfo@cdc.gov
www.cdc.gov

National Heart, Lung, and Blood Institute
1-301-592-8573
nhlbiinfo@nhlbi.nih.gov
www.nhlbi.nih.gov

National Institute of Allergy and Infectious Diseases
1-866-284-4107 (toll-free)
1-800-877-8339 (TTY/toll-free)
ocpostoffice@niaid.nih.gov
www.niaid.nih.gov

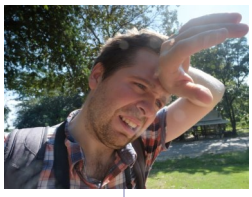
How to Help Your Heart Weather Extreme Heat

As extreme heat events become more common, you need to know how to protect your heart.

Hot temperatures and high humidity can lead to dehydration, which causes the heart to work harder and puts it at risk, according to the American Heart Association (AHA). Staying hydrated makes it easier for the heart to pump blood to your muscles.

"If you're a heart patient, older than 50 or overweight, you might need to take special precautions in the heat," said AHA President Dr. Robert Harrington.

"Certain heart medications like angiotensin receptor blockers [ARBs], angiotensin-converting enzyme [ACE] inhibitors, beta blockers, calcium channel blockers and diuretics, which deplete the body of sodium, can exaggerate the body's response to heat and cause you to feel ill in extreme heat," said Harrington, a cardiologist who heads the Department of Medicine at Stanford University in California.



If you have heat-related concerns about these medications, discuss them with your doctor. Never stop taking medications on your own.

Infants and the elderly are also at increased risk of heat-related problems, but everyone needs to take precautions in extreme heat.

"It is easy to get dehydrated as you may not be aware that you're thirsty," Harrington said in an AHA news release. "If you're going to be outside, it's important to drink water even if you don't think you need it. Drink water before, during and after going outside in hot weather."

Here are some other important hot weather precautions.

- Avoid the outdoors between noon and 3 p.m., when the sun is usually at its strongest. When outside, wear lightweight, light-colored clothing made of breathable fabrics such as cotton, or a newer fabric that repels sweat. Wear a hat and sunglasses. Apply a water-resistant sunscreen with at least SPF 15 every two hours.
- To stay hydrated, drink a few cups of water before, during and after exercise. Avoid caffeine and alcohol. Take regular breaks. Stop for a few minutes in shade or a cool place, hydrate and start again.

More information

The U.S. Centers for Disease Control and Prevention outlines how to **prevent heat-related illness**.

SOURCE: American Heart Association, news release, July 18, 2019

Despite Cancer Screening, 'Oldest Old' Have Low Survival Odds: Study

The oldest Americans have higher cancer screening rates but lower cancer survival rates than younger seniors, a new report shows.

Those 85 and older -- a group dubbed the oldest old -- are also less likely to have cancer surgery than their counterparts between 65 and 84 years of age.

Adults aged 85 and up are the fastest-growing age group in the United States, yet relatively little is known about how they're affected by cancer.

"More research on cancer in the oldest Americans is needed to improve outcomes and anticipate the complex health care needs of this rapidly growing population," the study authors wrote in the Aug. 7 issue of the journal *CA: A Cancer Journal for Clinicians*.

To learn more, researchers analyzed data from nationwide and international cancer registries.

Nationwide, the report projects, the United States will have 140,690 cancer diagnoses this year among its oldest age group and 103,250 cancer deaths. The most common cancers in the oldest old -- lung, breast, prostate and colorectal -- are the same as those in the general population.

Cancer rates among the oldest old peaked around 1990 and have since declined, reflecting decreases in prostate and colorectal cancers, and more recently in breast cancer in women and lung cancer in men, the study showed.

Prostate and lung cancers are the most common causes of cancer death in Americans 85 and older, representing 40% of cancer deaths. Among women, lung cancer is the leading cause of cancer death (19%) followed by breast cancer (13%). Colorectal cancer ranks third for both women (12%) and men (9%).

Adults aged 85 and older are less likely to be diagnosed at an early stage of cancer than those in younger seniors. For example, 57% of breast cancers in the oldest old are diagnosed at an early stage, compared with 68% in 65- to 84-year-olds. For prostate cancer, the rates are 41% and 77%, respectively.

Though the potential harm of screening outweighs the benefit for many people age 85 and older, the age group has surprisingly high screening rates, according to the report.

In 2015, more than one-third of women in that age group reported having a mammogram within the past two years, and 18% reported recent cervical cancer screening tests.

More than half of the oldest men and women had either a stool screening test within the past year or a sigmoidoscopy or colonoscopy within the past five to 10 years. Nearly 30% of the oldest men reported having a PSA test within the past year, the study found.

But the oldest old were less likely have surgery for cancer than those between 65 and 84. For example, 65% of breast cancer patients 85 and older had surgery, compared with 89% of younger seniors.

Carol DeSantis, principal scientistist in the American Cancer Society's Surveillance and Health Services Research Program, led the study.

"The rapid growth and diversification of the population aged 85 years and older will increase demand and complexities for cancer care and could have a substantial impact on medical care resource allocation," the authors said in a cancer society news release.

"There is an urgent need to develop a more comprehensive evidence base to guide treatment decisions for these understudied patients with cancer through increased enrollment in clinical trials and to leverage research designs and infrastructure for generating evidence on older adults with cancer," they added.

Adults Need Vaccines, Too

Vaccines aren't just for kids, a doctors' group says.

"Many adults are not aware that they need vaccines throughout their lives and so have not received recommended vaccinations," Dr. Robert McLean, president of the American College of Physicians, said in a college news release.

"Adults should get a seasonal flu shot and internists should use that opportunity to make sure their patients are up to date on the latest recommended immunizations," he advised.

Along with an annual flu shot, other important adult vaccinations include: Tdap to protect against tetanus, diphtheria and whooping cough; pneumococcal to protect against pneumococcal pneumonia, bacteremia and meningitis; HPV (human papillomavirus) to prevent cervical, anal and other cancers; hepatitis B; and herpes zoster to help prevent shingles.

Each vaccine should be given according to guidelines from the U.S. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP).

"Vaccines are safe, effective and help prevent illness, hospitalization and even death, especially among the elderly and those with chronic conditions and weakened immune systems," McLean said.

"Physicians should conduct a vaccine needs assessment with their patients regularly. People who cannot get a flu shot or other vaccines for medical reasons should talk to their internist about other ways of protecting themselves," McLean recommended.

August is National Immunization Awareness Month.

The latest ACIP-approved adult immunization schedule and recommendations appear in the *Annals of Internal Medicine*.

Earlier this year, ACIP recommended raising the upper age for catch-up vaccination against HPV in men to age 26 years -- the same as in women -- and recommended that patients aged 27 to 45 talk to their doctor about receiving the vaccine.

ACIP also recommended that the 13-valent pneumococcal conjugate vaccine (PCV13) be given "based on shared clinical decision making" in adults 65 and older who do not have a weakened immune system and who have not previously received PCV13.

All adults 65 and older should receive the 23-valent pneumococcal polysaccharide vaccine (PPSV23), according to ACIP.

ACIP's recommendations must be reviewed and approved by the CDC. The final recommendation will be published in an upcoming issue of the CDC's *Morbidity and Mortality Weekly Report*.

The U.S. Centers for Disease Control and Prevention has more on **adult vaccines**.

SOURCE: American College of Physicians, news release, July 30, 2019

Urinary Tract Infection or Dementia: Which One Do I Have?

URINARY TRACT infections are an all-too-common, painful nuisance or worse for younger adults, particularly women. Unfortunately, you don't necessarily outgrow UTIs in older age. For instance, more than 16% of women older than 65 reported having had a UTI within the past year, increasing to nearly 30% in women over 85, according to figures reported in the March 2014 issue of Infectious Disease Clinics of North America. UTIs also increase in older men.

As you age, UTIs may affect you differently. For some seniors, dementia can further complicate UTI prevention and detection.

Your urinary tract includes your urethra, bladder, ureters and kidneys. Urine, which is made in the kidneys, flows down through the ureter tubes to be stored in the bladder. When you pee, urine passes through the urethra, another tube, and out of the body. Cystitis is infection of the bladder, and urethritis is infection of the urethra. A urinary tract infection can involve any part of this system. Although most UTIs affect the lower urinary tract, advanced UTIs can involve the kidneys, which is more serious.

Staying one step ahead of urinary tract infections is a never-ending struggle for adult children of vulnerable older parents. "It's something that caregivers grapple with all the time," says Amy Goyer, national family and caregiving expert with AARP and author of "Juggling Life, Work, and Caregiving." With UTI, she adds, "It's sometimes very hard to detect."

Goyer should know. She was the devoted caregiver for several family members, including her late mother, who was affected by **stroke**, and her late father, who had Alzheimer's disease. Both **developed UTIs** despite their daughter's best efforts, and both suffered lingering consequences.

For the last 15 years of her life, Goyer's mother had constant **urinary tract infections**, with symptoms that outwardly seemed unrelated. "The first clue would be that she would fall," Goyer says. At first, it wasn't clear what was going on. Eventually, she was able to figure out that her mother was having difficulties related to UTIs.….**Read More**

Depression, Alzheimer's Might Be Part of Same Process in Some Aging Brains: Study

New research is untangling the complex relationship between symptoms of depression and losses in memory and thinking that often emerge together with Alzheimer's disease.

In fact, the new data suggests that "depression symptoms themselves may be among the early changes in the preclinical stages of dementia syndromes," explained study lead author Dr. Jennifer Gatchel. She works in the division of geriatric psychiatry at Massachusetts General Hospital in Boston.

In the study, researchers examined brain scans and other data gathered over seven years from 276 older adults enrolled in the Harvard Aging Brain Study. All of the participants were still living independently in the community at the beginning of the study and were considered healthy.

However, the analysis revealed a significant link between worsening depression symptoms and mental decline over two to seven years, and both of these trends seemed to be linked to a buildup of amyloid protein in brain tissue.

The slow accumulation of amyloid has long been known as a hallmark of Alzheimer's disease.

"Our research found that even modest levels of brain amyloid deposition can impact the relationship between depression symptoms and cognitive [thinking] abilities," Gatchel said in a hospital news release.

The new insight that depression symptoms might be part of the Alzheimer's process could further research into the prevention or treatment of the illness, she added.

It "raises the possibility that depression symptoms could be targets in clinical trials aimed at delaying the progression of Alzheimer's disease," Gatchel said, so "further research is needed in this area."

The researchers stressed that not all older adults with depression and amyloid buildup will have memory and thinking declines, however. That suggests that other factors -- for example, brain metabolism, or the volume of the brain's memory center, the hippocampus -- could link depression and mental decline.

Other mechanisms -- including brain degeneration caused by the protein tau (another protein long associated with Alzheimer's), high blood pressure and inflammation -- might play a role and need to be investigated.

Overall, the findings suggest that depression could have multiple causes and might also "work synergistically with amyloid and related processes to affect cognition over time in older adults," Gatchel said.

Two experts in brain health agreed that the study could further dementia research and treatment.

"This is very helpful research in that it identifies behavioral manifestations that may precede a diagnosis of dementia," said Brittany LeMonda, a clinical neuropsychologist at Lenox Hill Hospital in New York City. "It may alert providers to look into mood changes and depression as early symptoms of an underlying dementia and may allow patients to be diagnosed earlier," she added.

"Whereas in the past, depression and dementia were viewed as separate conditions that could co-occur in the same individual, we have learned now that mood and cognitive symptoms may actually be symptoms of the same underlying condition with shared pathology," LeMonda explained.

Dr. Gayatri Devi is a neurologist and psychiatrist who specializes in memory disorders at Northwell Health in New York City. She said that "depression has long been known to be a risk factor for Alzheimer's disease and other dementias, but one question that clinicians contend with is whether depression is a symptom of cognitive loss or whether it is the cognitive impairment that leads to depression."

The new research gets closer to solving that puzzle, Devi said, "and underscores that not only is it important to treat late-life depression, physicians should also be alert to, and evaluate for, cognitive loss in such persons and address that separately, as well."

The new research was published online Aug. 9 in *JAMA Network Open*.

More information

The Alzheimer's Association offers resources on **brain health**.