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On Social Security's 84th Birthday, New Reports Show Importance of Expanding Benefits

August 14th was the 84th anniversary of President Franklin D. Roosevelt signing the Social Security Act into law on August 14th, 1935.

To mark the anniversary, Social Security Works has released a series of reports showing how important Social Security is to beneficiaries in all 50 states, the District of Columbia and US territories. To view the reports, go to:**https://socialsecurityworks.org/2019/08/12/social-security-works-for-america-2019/**

"Today marks 84 years of success for our nation's Social Security system. As our reports show, Social Security is an essential protection for nearly 63 million Americans including veterans, children, people with disabilities, seniors, and many others.

They receive $941.3 billion in benefits, much of which is spent in their local communities. Social Security is the lifeblood of many small businesses, always present and always supporting jobs that stay in America.

The **Social Security 2100 Act,** which is co-sponsored by **210 House Democrats**, protects and expands Social Security's modest benefits. Nearly **every Democrat running for President** also supports expanding, not cutting, Social Security's modest benefits.

Unfortunately, not a single House Republican has co-sponsored the Social Security 2100 Act.

They've also refused to release a plan of their own, indicating that their actual plan is to allow benefits to be automatically cut by 20 percent due to a projected shortfall around the year 2035.

As our newly released reports show, this benefit cut would be devastating to families around the country, as well as local economies. Given that nearly half of Americans aged 55 and older have no retirement savings, now is the time to expand benefits – never cut them."

– Alex Lawson, Executive Director of Social Security Works

"The 50 State reports released today by Social Security Works, in honor of Social Security's 84th birthday, clearly demonstrate Social Security's economic impact across the country. That is why it is imperative that we strengthen and enhance the program. The Social Security 2100 Act would ensure that Social Security remains solvent beyond this century while expanding benefits for millions of Americans."

– Congressman John Larson (D-CT), Sponsor of the Social Security 2100 Act

Faithless elector: A court ruling just changed how we pick our president

A federal appeals court ruled late Tuesday that presidential electors who cast the actual ballots for president and vice president are free to vote as they wish and cannot be required to follow the results of the popular vote in their states.

The decision could give a single elector the power to decide the outcome of a presidential election — if the popular vote results in an apparent Electoral College tie.

"This issue could be a ticking time bomb in our divided politics. It's not hard to imagine how a single faithless elector, voting differently than his or her state did, could swing a close presidential election," said Mark Murray, NBC News senior political editor.

It hasn't been much of an issue in American political history because when an elector refuses to follow the results of a state's popular vote, the state simply throws the ballot away. But Tuesday's ruling says states cannot do that.

The decision, from a three-judge panel of the 10th U.S. Circuit Court of Appeals in Denver, is a victory for Micheal Baca, a Colorado Democratic elector in 2016. Under state law, he was required to cast his ballot for Hillary Clinton, who won the state's popular vote. Instead, he crossed out her name and wrote in John Kasich, a Republican and then the governor of Ohio.

The secretary of state removed Baca as an elector, discarded his vote and brought in another elector who voted for Clinton. In a 2-1 decision, the appeals court said the nullification of Baca's vote was unconstitutional.

When voters go to the polls in presidential races, they actually cast their votes for a slate of electors chosen by the political parties of the nominees. States are free to choose their electors however they want, Tuesday's ruling said, and can even require electors to pledge their loyalty to their political parties.

But once the electors are chosen and report in December to cast their votes as members of the Electoral College, they are fulfilling a federal function, and a state's authority has ended. "The states' power to appoint electors does not include the power to remove them or nullify their votes," the court said.

Because the Constitution contains no requirement for electors to follow the wishes of a political party, "the electors, once appointed, are free to vote as they choose," assuming that they cast their vote for a legally qualified candidate**...Read More**

Trump Administration Releases Updated "Public Charge" Rule

On Monday, the Department of Homeland Security finalized a "public charge" **rule** that could greatly harm families and prevent people with Medicare from accessing the services and supports they need to thrive. The new policy is set to become effective on October 15, 2019.

Part of federal immigration law for over a hundred years, the public charge inadmissibility test was designed to identify people who may depend on the government as their main source of support. If the government finds that a person is "likely to become a public charge," it can deny that person admission to the United States or lawful permanent resident status.

Under this longstanding policy, a forward-looking test is applied—where the government assesses whether a person will be deemed a public charge in the future. In part, this includes evaluating an individual's potential "primary dependence" on select public benefits like cash assistance programs—such as Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF)—and institutional long-term care. It also considers a number of other factors—age, income, education and skills, health, and family size—to make a final determination based upon the "totality of the circumstances."

The new rule marks a dramatic departure from this system. It adds parameters to the current circumstantial factors—such as an income threshold, penalties for being over 61 years old or having a disability, consideration of credit scores and history, and an English proficiency standard—that will create barriers for many applicants, including older adults and people with disabilities.

Perhaps most notably, it also significantly expands the array of public assistance the government may consider in making a public charge determination. This assessment will now include many previously excluded programs that promote health and well-being, such as Medicare Savings Programs, food and housing assistance, and Medicaid.

These changes represent a damaging increase in both the scope and punitive effect of public charge. The final rule will make it much more difficult for immigrants to pursue citizenship, reunite with their families, and access the services they need to fully participate in their communities.

Already, there have been **reports** of immigrant families abandoning needed assistance out of fear that their immigration status could be jeopardized. Even though the final rule is not yet effective—and legal challenges are underway which could delay its implementation date—its release this week makes it likely that even more people will forego vital care, food, and shelter, leading to poorer health outcomes and exacerbating economic and social disparities.

The Medicare Rights Center continues to oppose this expanded definition. Policies must be changed to make health care and other essential services more accessible, affordable, and available to those in need—not less so. No one should be forced to choose between their and their family's well-being and the stability of their immigration status.

Decades ago, the government clarified that immigrant families can participate in essential health and nutrition programs without fear that doing so would harm their immigration case. Once DHS' rule becomes effective, families will no longer have that assurance. We urge the Trump administration to immediately rescind this unconscionable rule.

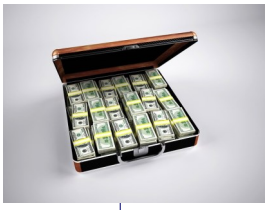
Advocates across the country are working together to fight back against the public charge rule change. Learn more and get involved today!

Read the final rule.

Medicare could have saved billions had enrollees used more generics

Stat reports on new findings in the **Annals of Internal Medicine** revealing that Medicare and older adults would have saved billions had more people used generic drugs instead of brand-name drugs. Why aren't more older adults taking generic drugs when they're available?

Generic drugs are chemically identical to brand-name drugs in critical ways. They also tend to cost a lot less than brand-name drugs. But, Medicare does not require people to take generics when available, and many doctors prescribe brand-name drugs, even though they cost more. **Pharma** does its best to **incentivize doctors** to prescribe brand-name drugs.



In the six years between 2011 and 2017, Medicare spent more than $13 billion on Nexium, which treats acid reflux. Had Medicare paid for Prilosec instead of Nexium, it would have spent $700 million during that time period, literally a $12.7 billion savings. Savings to older adults would have been $690 million.

Based on the available data, Nexium is no better at treating acid reflux**,** nor is it safer, than **Prilosec**. In fact, newer drugs present **unknown safety risks** that older drugs do not have. There is no data comparing the efficacy or safety of these two drugs. Medicare Part D insurers apparently have not steered enrollees towards generic drugs when available and appropriate, as much as they might have. In some cases, it is **not in their financial interest** to do so. Rather, they get paid by **pharmacy benefit managers** or drug makers to promote brand-name drugs. And, Medicare does not require them to encourage, let alone require, people to use generic drugs.

In addition, the pharmaceutical industry has managed to shape state laws to maximize their profits. Pharmacies are often not permitted to substitute generics for brand-name drugs.

More Links

Millions safely import low-cost drugs from abroad

Prescription drug costs soar for people with Medicare Part D

Six tips for keeping your drug costs down if you have Medicare

Lawsuit Seeks to Improve Medicare Beneficiary Access to Nursing Facilities

Medicare only covers Skilled Nursing Facility (SNF) care under certain circumstances. A beneficiary must have Medicare Part A, require SNF care, and have a qualifying hospital stay. A qualifying hospital stay is at least three consecutive days in the hospital as an admitted inpatient.

It is that last requirement that often turns out to be more complicated than most people expect. Quite often, a patient may go to the hospital and remain there for several days without ever being admitted as an inpatient. This type of stay, usually called an "observation stay," looks exactly like an inpatient admission from the patient's perspective. However, despite those appearances, an observation stay is considered to be "outpatient."

Because an observation stay is not officially considered an inpatient stay, it does not count as a qualifying hospital stay for purposes of Medicare SNF coverage—which means Medicare will not pay for any subsequent SNF care. This leaves patients on the hook for the entire cost of a needed SNF stay—potentially thousands of dollars. Beneficiaries unable to afford this care may self-discharge against medical advice and return home before they are physically or mentally ready, and potentially suffer further devastating and expensive acute health effects.

Currently, people with Medicare cannot appeal the decision to classify a hospital stay as an outpatient stay, but a court case—Alexander v. Azar—may change that. In 2011, seven plaintiffs filed a class action lawsuit to try to gain the right to appeal the decision to classify them as outpatients in observation stay instead of as inpatients who would potentially be eligible for SNF coverage. After many twists and turns, the case has finally made it to trial this week in a Connecticut court. If successful, the lawsuit would ensure that beneficiaries can appeal decisions made by hospitals that reduce their eligibility for Medicare coverage of SNF care.

Medicare Rights supports this lawsuit. Observation stays are a rising problem. Far too many people with Medicare have hospital stays that are at least three days long, only to find out later that those days were spent as an outpatient. Such beneficiaries may still need SNF care to ensure their safety and well-being, but are unable to afford it in the absence of Medicare coverage.

We also support legislative solutions, such as counting observation stays toward the three day requirement and eliminating the requirement entirely. The current rules usurp the provider's role in determining what follow-up care is medically necessary and in the best interest of the patient and must be updated to better ensure beneficiary health and economic security.

Read more about the lawsuit.

Read the judge's decision to allow Alexander v. Azar to proceed.

Read more from the Center for Medicare Advocacy and Justice in Aging on the need for appeals rights.

What The Trump Home Dialysis Plan Would Really Look Like

Mary Epp awoke from a deep sleep to the "high, shrill" sound of her dialysis machine's alarm. Something was wrong.

It was 1 a.m. and Epp, 89, was alone at home in Marion Junction, Ala. No matter. Epp has been on home dialysis since 2012, and she knew what to do: Check the machine, then call the 24/7 help line at her dialysis provider in Birmingham, Ala. to talk to a nurse.

The issue Epp identified: Hours before, a woman she hired to help her out had put up two small bags of dialysis solution instead of the large ones, and the solution had run out.

The nurse reassured Epp that she'd had enough dialysis. Epp tried to detach herself from the machine, but she couldn't remove a cassette, a key part. A man on another 24/7 help line run by the machine's manufacturer helped with that problem.

Was it difficult troubleshooting these issues? "Not really: I'm used to it," Epp said, although she didn't sleep soundly again that night.

If policymakers have their way, older adults with serious, irreversible kidney disease will increasingly turn to home dialysis. In July, the Trump administration made that clear in **an executive order** meant to fundamentally alter how patients with kidney disease are managed in the U.S.

Changing care for the sickest patients — about 726,000 people with end-stage kidney disease — is a top priority. Of these patients, 88% receive treatment in dialysis centers and 12% get home dialysis.

By 2025, administration officials say, 80% of patients newly diagnosed with end-stage kidney disease patients should receive home dialysis or kidney transplants. Older adults are sure to be affected: Half of the 125,000 people who learn they have kidney failure each year are 65 or older.

Home dialysis has potential benefits: It's more convenient than traveling to a dialysis center; recovery times after treatment are shorter; therapy can be delivered more often and more readily individualized, putting less strain on a person's body; and "patients' quality of life tends to be much better," said Dr. Frank Liu, director of home hemodialysis at the Rogosin Institute in New York City.

But home dialysis isn't right for everyone. Seniors with bad eyesight, poor fine-motor coordination, depression or cognitive impairment generally can't undertake this therapy, specialists note. Similarly, frail older adults with multiple conditions such as diabetes, arthritis and cardiovascular disease may need significant assistance from family members or friends.

The burden of providing this care shouldn't be underestimated. In a recent **survey of caregivers providing complex care** to family members, friends or neighbors, 64% identified operating home dialysis equipment as hard — putting this at the top of the list of difficult tasks.

What experiences do older adults have with home dialysis? Several seniors doing well on home-based therapies were willing to discuss this, but they're a select group. Up to a third of patients who try home dialysis end up switching to dialysis centers because they suffer complications or lose motivation, among other reasons...**Read More**

Bi-partisan Senate drug bill would lower price of new drugs

The public wants Congress to **bring down prescription drug costs**, and Congress appears to be taking this issue seriously. A bi-partisan Senate drug bill would lower the price of new prescription drugs that were developed with federal dollars. Senators Chris van Hollen and Rick Scott recognize the insanity behind allowing pharmaceutical companies to profit wildly from the sale of new drugs developed with taxpayer dollars, as most new drugs are.

The van Hollen Scott **We PAID Act** would limit the price drug companies can charge for drugs developed with research funding from the National Institutes of Health or any other federal agency. If taxpayers are funding the research, they should have a say in the price. But, just to say it, the We PAID Act does nothing to address the price of the hundreds of overpriced drugs already on the market that were developed with taxpayer dollars.

Of note, between 2010 and 2016, **210 new drugs came to market**. Every single one of them was developed with NIH funding.

According to **Vox**, if passed, the law would only affect pricing for about one in five new prescription drugs. It would not affect prices of drugs already on the market. The focus is on drugs with patents derived from research funded by the NIH.

In some cases, the drugmakers hold the patents. In other cases, the federal government holds the patents and licenses them out to drug companies. In still other cases, individuals hold the patents, which were developed with government support.

We PAID would affect the price of Humira, which treats Crohn's disease and Enbrel, which treats autoimmune diseases.

We PAID would set up a new nonprofit organization that would set reasonable prices on new drugs with patents developed with federal dollars. To determine a reasonable drug price, first, the National Academies of Science, Engineering and Medicine would look at the price of the drug in other countries, how much money was invested in research and development and distribution costs. Then a diverse committee, including industry people, would take the data and set a "fair list price." Price increases on all drugs with prices set by committee could not be more than inflation.

If a drugmaker did not adhere to the established price, the drug would go generic. And, the pharmaceutical company could not license any federal patents.

Another bi-partisan bill introduced by Senators Wyden and Grassley would bring down out-of-pocket drug costs for people with **Medicare Part D**. The issue with that bill is that it does not bring down the cost of the drug. If out-of-pocket costs come down, Medicare Part D drug premiums would go up.

Republicans and Democrats in Congress have stacked the deck in favor of pharmaceutical companies through laws that effectively give them monopoly pricing power on drugs they bring to market, even when taxpayer dollars have funded their efforts. It's time lawmakers leveled the playing field.

Prescription drug prices are STILL going through the roof

Yesterday it was revealed that a promising new rheumatoid arthritis drug is coming onto the market. The catch -- it will cost $59,000 a year!!! That's nuts.

That's why we need you to take a moment and send a message to Capitol Hill.

We're about 5,100 signatures away from our target. We need a show of strength to counter the millions that the pharmaceutical lobbyists are spending to prevent change.

If everyone pitches in, we can force them to act. Please help us out and send a message to your member today.

A majority of Americans -- Democrats, Republicans and Independents -- agree that the system needs to be changed, but Congress isn't acting.

Tell Congress: Take Action to Lower Drug Prices

1 in 5 older Americans say high prescription drug costs kept them from taking their medicine as prescribed within the past year. Yet, wealthy pharmaceutical corporations continue to jack up drug prices while they make billions of dollars in profits.

Enough is enough. Send a message to your lawmakers telling them to bring much-needed relief to Americans by taking action to lower drug prices.

Send your letters here

Without pensions, more people rely on Social Security

Axios reports that, increasingly, companies are doing away with pensions. As a result, younger adults are unlikely to have pensions, putting their retirement security at risk. Most probably, they will rely heavily on Social Security.

Millennials and members of Generation Z are at greatest risk of not having adequate retirement savings. Pensions give workers guaranteed income in retirement. But, most companies today do not want to assume the cost of pensions, which provide defined benefits –guaranteed annual income. Pensions put the companies at risk if the stock market drops or retirees live long lives. Instead, companies may offer defined contribution plans, which do not guarantee a fixed amount of income each year.

To avoid financial risk, companies are selling people's pensions to insurance companies, putting workers' savings at risk instead. If the insurance company fails or a person's benefit was not calculated correctly, the person loses.

Only 81 of the Fortune 500 companies offered a pension plan in 2017. Twenty years ago, 288 offered a pension plan. And many pension funds today do not have the funding they may need to pay out what they are supposed to pay out.

Retirement savings accounts, including 401(k) plans come with no guarantees and often with fees. They provide less security than pensions, as they fluctuate with the stock market. If the stock market drops, 401(k) plans are likely not to generate the income expected.

Some people buy **annuities**. But they have costs and risks as well. The most cost-effective way to promote retirement security is by strengthening **Social Security**

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

Veteran Benefits for Assisted Living

Find out if you qualify for VA financial benefits that can help cover the cost of senior living.

IF YOU SERVED

THE United States of America as a member of the armed services, you may be entitled to certain benefits that could make some aspects of getting older a little easier. Namely, the U.S. Department of Veterans Affairs offers some funding programs that can help offset the cost of certain kinds of care later in life. For some people, this sort of benefit can be a real help when **weighing how to pay for assisted living** or other long-term care options.

"Veterans and their spouses have multiple financial benefits that can help cover the cost of **assisted living,**" says Rick Wigginton, senior vice president of sales at Brookdale Senior Living, a Tennessee-based company that has more than 800 senior living and retirement communities across the United States.

Wigginton says that Brookdale, like many other senior living companies, seeks to "help many veterans maximize these benefits, which in some cases can really reduce the cost of senior living." **Senior living options can get expensive**. Every little bit that can help offset these sometimes-large costs is often a welcome relief for families.

Still, Wigginton makes a point to note that "the VA will not pay for a veteran's rent," in an assisted living facility. However, VA benefits "may pay for some of the extra services they need such as nursing assistance, help with bathing and toileting and possibly even meals." This is the same as with Medicare, the federal health insurance program for adults 65 and over. Medicare does not cover the cost of assisted living facilities, but might cover some qualified medical expenses incurred by people who live in assisted living communities.

Aid & Attendance and Housebound

While there are a range of benefits that may kick in depending on your specific service history and eligibility, Wigginton says "the most commonly used benefits are the Aid & Attendance Pension and the Survivor's Pension, which is for spouses of a deceased veteran with wartime service."

The VA's **Aid & Attendance and Housebound** program is part of the pension benefits paid to veterans and survivors. The VA reports that these Aid & Attendance and Housebound benefits "are paid in addition to monthly pension, and they are not paid without eligibility to pension," meaning that you can't access this benefit if you're not a pensioned veteran or survivor of a pensioned veteran.

Aid & Attendance kicks in when you meet one of several potential conditions, including:

- Requiring the aid of another person to perform personal functions such as bathing, dressing, eating, toileting or staying safe from hazards in your daily environment.
- Being disabled to be point of being bedridden, beyond what would be considered normal recovery from a course of treatment such as surgery.
- Being a patient in a nursing home because of physical or mental incapacity.

Having very poor eyesight (5/200 corrected visual acuity or less in both eyes) or a field of vision limited to 5 degrees or less.

Individuals may qualify for Housebound benefits, which are added to your standard monthly pension, when you are "substantially confined to your immediate premises because of permanent disability," the VA reports. Eligibility for the program is determined on a case by case basis and involves a thorough review by the VA. "There are certain qualifications for each of these benefits," Wigginton says, "starting with length of service. The Aid & Attendance Pension can provide a single veteran with up to $1,881 per month and a married veteran could get up to $2,230 each month. Unfortunately, many qualified veterans are underserved each year because they do not know what benefits are available."

Getting the word out about these benefits to retired or discharged service members is important because these benefits can be significant, says Roxanne Sorensen, an Aging Life Care specialist and owner of Elder Care Solutions of WNY in Rochester, New York, a case management consultancy. It's money you earned while serving your country, and she says this federal money can help her clients "stretch what their investments or savings can do." VA benefits can perhaps "buy them a year or two instead of having to utilize all their checking, savings and annuities. I always try to tap into the VA system if possible, as that's a really great way of putting someone into assisted living or assisting with **nursing home** placement," she says.

Given that it's impossible to know how long you'll live or how much money you'll need, it's important to maximize the money you've saved so that you can afford high-quality care for as long as possible. If VA benefits can help you do that, so much the better.

Applying for VA Benefits

"Applying for veteran benefits can be complicated," Wigginton says, but Brookdale partners with an organization called Patriot Angels that has specialized expertise in assessing eligibility and procuring benefits for veterans. "That's really the easiest route to take, as they'll walk you through the process," he says.

But you can always apply on your own as well or work with a company that helps veterans apply for benefits. To get started in applying for basic veteran's health benefits, you'll need several documents, including:

- Your most recent tax return.
- Account numbers for your current health insurance provider.
- Social Security numbers for yourself and your spouse.

An application for health benefits from the VA called the **10-10EZ form**.

If you want to see whether you have access to Aid & Attendance and Housebound benefits, that involves a separate application. Each state has its own Pension Management Center that processes Aid & Attendance and Housebound benefits applications. You'll need to gather several documents to help fill out an application form and then mail the completed paperwork off to the PMC to see whether you qualify. This process can be complex and confusing, so you may want to connect with a VA social worker for help and guidance through the process. There are also private consultancies that may assist veterans with navigating the process. But watch out for scams – you should work only with a VA-accredited individual or organization. You can check the **VA's database** to find out if someone you're considering working with is accredited…..**Read More on Documents you should have on hand in order to fill out the application forms.**

Raising SNAP Benefits Would Have Powerful Effects on Food Security, Poverty, Health

We recently **explained** why SNAP benefits don't adequately help families afford a healthy diet. Our new **paper** and **brief** summarize extensive research showing that raising benefits could have powerful effects for SNAP participants and their families, including:

Raising food spending. SNAP participants not only **spent** more on food after the 2009 Recovery Act temporarily **raised** SNAP benefits, but they also **spent** more on other necessities such as housing and transportation — as the benefit boost enabled them to re-direct more of their limited funds that they were previously spending on food. When the increase ended in November 2013, reducing benefits, SNAP households **lowered** their food spending by 12 percent more than eligible but non-participating households.

Further reducing food insecurity. Participating in SNAP **reduces food insecurity** — i.e., the struggle to afford enough food for an active, healthy life year-round — and raising or lowering SNAP benefits can affect participants' food security. For example, evidence **suggests** that the Recovery Act's SNAP benefit increase reduced the most severe form of food insecurity, when participants take steps such as skipping meals because they lack funds for food, among SNAP participants by about a third. As inflation eroded the buying power of this increase from 2009 to 2011, very low food security among SNAP participants **rose** by 17 percent, erasing nearly half of the improvement associated with the Recovery Act's benefit increase. And after the increase ended, food insecurity among households that consistently participated in SNAP **rose** by 8 percent more — and very low food security rose by 14 percent more — than among other low-income households.

Making SNAP even more effective in reducing poverty. SNAP kept 7.3 million people out of poverty in 2016, including 3.3 million children, our **analysis** using the Supplemental Poverty Measure (which counts SNAP as income) and correcting for underreporting in government surveys found. SNAP lifted 1.9 million children above *half* of the poverty line that year — more than any other program. It had the **greatest anti-poverty impact** in 2009, when the Recovery Act temporarily boosted benefits, which suggests that raising benefits could reduce poverty further. A National Academy of Sciences expert **panel** recently proposed raising SNAP benefits as part of a package of policies to cut child poverty in half.

Helping participants afford healthier food and potentially improving their health. Raising benefits would help participants **afford** healthier food. Studies also link SNAP participation with **improved health**: for example, participants report **better health** than non-participants, and elderly participants are **less likely** to forgo their full prescribed medication due to cost. Through these and other effects, evidence suggests that SNAP **reduces** health costs. Raising benefits could bring even more improvements; for example, **research** links the Recovery Act benefit increase and reduced hospital admissions.

In short, raising SNAP benefits would allow participants to afford more — and healthier — food and be less likely to be food insecure, and it might contribute to better health.

Center on Budget and Policy Priorities

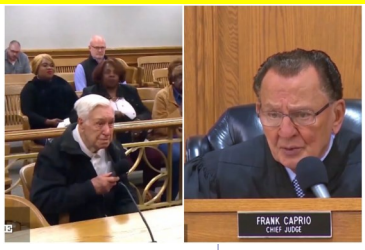
96-Yr-Old Got Speeding Ticket While Rushing Cancer-Stricken Son to Doc, Judge Let Him Off

The judge hailed the nonagenarian for still taking care if his boy, who was 63-years-old.

Known for his compassionate verdicts, a municipal judge in United States has won hearts again by dismissing a speeding ticket against a 96-year-old man who was rushing his cancer-stricken son to a doctor.

In a video which has gone viral on social media, the man is seen taking a seat in the courtroom as Judge Frank Caprio tells him that he has been charged with a "school zone violation, which means that you were exceeding the speed limit in a school zone."

The man pleads that he is 96-years-old and drives "slowly" and "only when I have to."



"I was going to the blood work for my boy. He's handicapped," he is heard saying, trying to hold back his tears.

The judge asks the man if he was taking his son to the doctor, to which he replies: "Yeah, I take him for blood work every two week because he's got cancer."

Judge Frank Caprio then praises the senior citizen for being a good man.

"You really are what America is all about. Here you are in your 90s and you are still taking care 5 laughter all around the courtroom.

"You are setting a bad example for my kid. You are putting a lot of pressure on me," he jokes, before wishing the elderly man all the best and dismissing the case against him.

In 2017, Judge Frank Caprio became an unlikely Internet star after several videos went viral, showing him delivering judgments with what the Associated Press called a "mix compassion, humor and a rotating cast of the poor souls who have been ticketed in the city of Providence."

"I may be adding just a little bit more understanding toward the United States system of government and how it works, that we are a decent peace-loving people, and not how we're being portrayed in other parts of the world," the news agency had quoted Judge Frank Caprio as saying.

Watch video on Google Chrom:

To see more of Judge Caprio

To see more of Judge Frank Caprio go to **caughtinprovidence.com**

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

America's Obesity Epidemic May Mean Some Cancers Are Striking Sooner

Since the turn of the century, American obesity rates have skyrocketed. And now a new study indicates that as the nation's waistlines expand, cancers long linked to obesity are striking the middle-aged more than ever before.

The finding follows a review of data on more than 6 million white, black and Hispanic cancer patients diagnosed between 2000 and 2016.

The upshot: Across all races, men and women between the ages of 50 and 64 now face a greater risk of developing obesity-associated cancers than in the past, compared with their younger and older peers.

Why? "Cancer is not a light switch," said study author Dr. Nathan Berger, a professor of experimental medicine with Case Comprehensive Cancer Center at Case Western Reserve University School of Medicine in Cleveland. "The development of cancer from mutation to diagnosis is a 10- to 20-year process," roughly the time it takes for a young obese person to reach middle age.

"And for many types of cancer, that process is definitely accelerated by obesity," Berger added. "Basically, what we think is happening is that people who in the past would have developed cancer in their late 60s or 70s are now showing up with cancer in their 50s and 60s."

In the report, published online Aug. 14 in *JAMA Network Open*, Berger and his colleagues pointed out that American obesity rates shot way up between 1988 and 2016.

Citing U.S. Centers for Disease Control and Prevention figures, the team noted that obesity rates more than doubled among 20- to 39-year-olds during that time. They also jumped from about 28% to 43% among those aged 40 to 59, and increased from 24% to 41% among those aged 60 and older.

At the same time, another 2014 CDC analysis found that 40% of all diagnosed cancers were linked to being overweight or obese.

That doesn't surprise Dr. Howard Burris, president of the American Society of Clinical Oncology. "The connection between obesity and cancer has been talked about for years," he said, likely driven by chronic inflammation and factors such as smoking and drinking, which often go hand-in-hand with excess weight.

Obesity also leads to increased insulin and insulin growth factor production, alongside increased estrogen production, both of which can increase cancer risk, Burris explained.

On the list of obesity-linked cancers are hormonal cancers, such as breast, ovarian and thyroid cancer. "But it turns out that obesity is also linked to gastrointestinal cancers, such as gallbladder cancer, and liver, stomach and colorectal cancer," said Burris, who was not part of the latest study. He also cited kidney cancer as yet another obesity-linked disease.

For the study, Berger and his team tracked shifting trends for all obesity-linked cancers, alongside cancers not linked to obesity.

During the study period, obesity-linked cancer rates shot up dramatically among the 50 to 64 set, rising anywhere from 25% among white women to nearly 200% among Hispanic men. But those rates did not rise as significantly among those aged 20 and 49, and actually dropped among seniors aged 65 and up.

The study authors acknowledged that cancer screening improvements may have led to earlier detection rates. And they noted that several factors they didn't explore might have had an impact on cancer trends, including smoking, poverty and a family history of cancer….**Read More**

Many Diabetes Patients At Risk Of Hypoglycemia, Research Shows

Suffering from diabetes can lead to other types of health conditions, some minor and some more serious than others. One such condition is hypoglycemia that translates to low blood **sugar**. Per a new study, people with diabetes are more likely to develop it, as opposed to previous knowledge that only those with type 1 diabetes have an increased risk of it.

The research comes along with a surprising revelation concerning diabetes treatment and how the United States may be at danger due to "over-treating" it. Per the study, which is made by Mayo Clinic in Rochester, MN, many people are apparently receiving too much of glucose lowering therapy.

As a condition, diabetes is characterized by high or an overflow of blood sugar, and so lowering those levels is an important part of treating it. However, the research revealed how the U.S. may be lowering it too much that could lead to hypoglycemia, which is what happens when our blood sugar levels are abnormally low.

"Hypoglycemia, or low blood glucose, is one of the most common serious adverse effects of diabetes therapy, causing both immediate and long term harm to [people] who experience it," lead researcher Dr. Rozalina McCoy explained. "Severe hypoglycemia, defined by the need for another person to help the patient treat and terminate their hypoglycemic event, is associated with increased risk of death, cardiovascular disease, cognitive impairment, falls and fractures, and poor quality of life."

To do the research, Dr. McCoy and her colleagues used data from the National Health and Nutrition Examination Survey from the years 2011-2014. They also used information from the OptumLabs Data Warehouse.

From these, they were able to find out that between the years mentioned above, around 2.3 million people suffering from diabetes received intensive treatment that is higher than the recommended amount.

According to Dr. McCoy, overtreatment is just as harmful as undertreatment and warns that the dangers of overtreatment should be highlighted more.

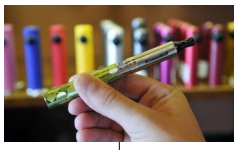
Furthermore, she also said that healthcare providers should be responsible enough to hit the balance in the middle whenever they treat conditions, be it diabetes or not.

Potential links to lung illnesses and e-cigarettes under investigation: CDC

Federal health officials are investigating potential links between lung illnesses and e-cigarettes amid the soaring popularity **of so-called vaping among young people**.

Since June 28, there have been at least 94 cases reported across several states involving people with "severe pulmonary disease" possibly tied to vaping, with the majority of those affected being teenagers and young adults, according to the U.S. Centers for Disease Control and Prevention.

At least 30 of those cases were reported in Wisconsin, the CDC said in a statement Friday.



The CDC said it is working with health departments in Wisconsin, Illinois, California, Indiana and Minnesota to investigate a potential link between breathing problems and the use of e-cigarettes, which are thought to be healthier than traditional means of smoking.

"Additional states have alerted CDC to possible (not confirmed) cases and investigations into these cases are ongoing," the statement said. "There is no conclusive evidence that an infectious disease is causing the illnesses."

While some cases in each of the states are similar and appear to be linked to e-cigarette product use, more information is needed to determine what is causing the illnesses, the CDC said.

The U.S. Food and Drug Administration also is investigating reports of seizures among e-cigarette users.

Seizures are a potential side effect of nicotine toxicity, but a recent uptick in "reports of adverse experiences with tobacco products that mentioned seizures occurring with e-cigarette use (e.g., vaping) signal a potential emerging safety issue," the FDA said in April.

Live-In Senior Care: Is It a Good Idea?

THERE ARE MANY different ways of addressing care needs in older adults. From home-based care offered by family or a visiting aide to **assisted living** or nursing homes, there's a care solution that can work for just about every senior and every family.

One option is live-in senior home care. This type of care features a **full-time caregiver** who lives in the home of a senior, much like some families hire a live-in nanny to care for small children. This type of care is best suited for seniors who need around-the-clock care, especially at night. If the caregiver needs to wake up several times a night to tend to a senior or help them take medication, a live-in caregiver might be the right solution.

There are two general ways that a live-in caregiver arrangement can be set up::

1. **Live-in caregivers who maintain their own, separate residences.** In this type of caregiving situation, there are actually two or more live-in caregivers who rotate the nights they work. Each caregiver will spend a night (or more) in the home of the senior and then trade off with the other caregiver when they go "off-shift."
2. **Live-in caregivers who live only in the home of the person they care for.** In these situations, the caregiver probably doesn't have his or her own separate residence, but lives in the home of the senior full-time. This person is usually the sole night-time caregiver for the senior, but may have support from a visiting nurse or aide during the day so that he or she can have some off hours to attend to his or her own personal needs or work another job during the day. In some cases, the senior may go to adult day care during the day, and the caregiver typically has a couple nights a week off.

In both situations, the live-in caregiver needs to have a private room in which to sleep. In addition, the senior typically covers the cost of food while the caregiver is on duty. The caregiver's duties can range widely depending on the senior's specific needs. Typically, a live-in caregiver will perform tasks similar to a home health aide, which may include helping the senior with bathing and dressing, housekeeping, administering medications, making meals and running errands.

"Home care is the largest entity within senior care," says Eleonora Tornatore-Mikesh, chief experience and memory care officer at Inspīr, a new senior living community in Manhattan. "About 70% of seniors are cared for in the home-care sector." Finding the right combination of care can take some effort and patience, whether that care is round-the-clock or only part time.

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When considering whether to hire an hourly visiting aide or a live-in senior caregiver, one approach isn't necessarily always better than another, Tornatore-Mikesh says. Rather, "it all depends on the situation."

Families need to carefully consider what's best for the senior from a variety of angles – health, overall wellness and family stress – to find the right solution. For some, a live-in caregiver may be the best option…

Pros and Cons of Live-In Senior Care

According to a widely cited **2010 study from AARP**, the vast majority of adults aged 65 and older want to remain in their homes for as long as possible. But when that desire comes into conflict with increasing health problems or a rising need for assistance in completing the tasks of daily living – . ....**Read More**

Social activity in your 60s may lower dementia risk by 12%

New research over a 28-year follow-up period finds significant evidence that frequent social contact at the age of 60 can lower the risk of developing dementia later on.

The link between having a rich social life and brain health has received much attention in the scientific community.

Some studies have suggested that levels of social interaction can **predict cognitive decline**and even **dementia,** while others have shown that group socializing can prevent the harmful effects of aging on **memory**.

New research examines the link between social contact and dementia in more depth. Andrew Sommerlad, Ph.D., from the Division of Psychiatry at University College London (UCL), in the United Kingdom, is the first and corresponding author of the new study.

Sommerlad and colleagues started from a critical observation of existing studies. They say that numerous findings have suggested that frequent social contact can protect the brain, either by helping to build a "**cognitive reserve**," or by reducing **stress** and promoting more healthful behaviors.

Many longitudinal studies have found an increased risk of dementia and cognitive decline in people with a smaller social network or less frequent social contact. However, the authors note, most of these studies had a follow-up period of fewer than 4 years.

Furthermore, a lot of these observational findings could be biased by reverse causation, which means that social isolation may be an effect rather than a cause of dementia.

In light of the above, Sommerlad and colleagues decided to investigate the link between dementia and social contact over a much longer period — 28 years.

The results appear in the journal ***PLOS Medicine***....**Read More**

Ten tips for checking your blood pressure at home

Doctors are increasingly recommending that patients check their blood pressure at home to diagnose high blood pressure (hypertension) and make treatment decisions. Seeing the pattern of your blood pressure at home allows a doctor to make a more informed decision about treatment than a single test at the doctor's office.

To ensure appropriate treatment, it's important that you take appropriate steps when you monitor your blood pressure. Mistakes in your technique at home could misdirect the doctor to prescribe you too much, too little, or the wrong type of medication.

If you've been advised to monitor your blood pressure at home, follow these ten tips to ensure your data is accurate:

At your doctor's visit:

1) **Learn your numbers.** Ask your doctor what your target blood pressure is. Targets can differ by as much as 20 points, depending on age and medical condition. Ask your doctor how often to check, and what results require an urgent call to the office, or a visit to the emergency room.
2) **Bring your machine to the doctor at least once**. The office can check your machine against office measurements. Make sure that your cuff size is correct: a cuff that's too small will overestimate your pressure and a cuff too large will underestimate it.
3) **Relax.** It's common for your blood pressure at the office to be higher than your results at home. This is called "white coat hypertension," and is probably a result of the mild anxiety you may feel at the doctor's office. That's why doctors often recommend patients check their blood pressure at home. Doctors sometimes recommend further testing with another method, if available, for patients with white coat hypertension; this method is called ambulatory blood pressure monitoring.

At home:

4) **Plan in advance.** No smoking, caffeine or exertion 30 minutes before. Empty your bladder. Rest for 5-10 minutes before you start.
5) **Know the correct body position.**
   - ♦ Sit upright with your back supported and your feet on the floor. Don't cross your legs or rest them on an ottoman.
   - ♦ Rest your arm at the level of your heart (for example, on pillows, books, or on a table). If your arm is too low—for example, lying in your lap–your results could overestimate your pressure.
6) **Consistently measure either the right or left arm.**
7) **Stay still and quiet** while the machine runs.
8) **Repeat the cycle once.**
9) **If you get a high number, don't panic.** Expect some normal variations between days. Remember things like emotion, stress, exertion, or pain temporarily raise blood pressure, and this is not necessarily the same as poorly controlled blood pressure. Your blood pressure will typically be a little higher in the morning than the evening. Use your doctor's guidelines to know what your action plan should be for high numbers.
10) **Check your blood pressure regularly, if your doctor has recommended home monitoring**.

Checking it only when you are feeling bad can be misleading. But, do not become overly obsessed with checking if your blood pressure is alright. Two to three times a week is usually sufficient, unless your doctor recommends otherwise. Light headedness may indicate your blood pressure is too low, so do check in that instance. Low blood pressure is a frequent problem for older patients leading to falls or other problems, so it is important to note when this happens. Record your numbers in a log with the date and time, and bring the log to your next doctor's appointment.

As the price of insulin skyrockets, people with diabetes are switch to affordable insulin, and it's causing deadly consequences

.The death of a man with Type 1 diabetes who had switched from a $1,200-a-month prescription insulin to a $25 per vial, over-the-counter insulin highlights a little-discussed aspect of the autoimmune disease: switching types of insulin can be dangerous if not done properly.

There are about 29 million Americans known to have one of the two types of diabetes. The 1.25 million people in the US who have Type 1 diabetes need to inject insulin to live.

Among them was Josh Wilkerson, a dog kennel supervisor who died in June after falling into a vegetative state. His family said he had multiple mini-strokes and fell into a diabetic coma after switching to an affordable $25-per-vial insulin in order to save money for his wedding. In most states, the insulin, known as ReliOn, is available over the counter at places like Walmart. People with diabetes generally require one to six vials a month, and the option was far cheaper than the $1,200-a-month insulin he had been prescribed.

A healthy body would normally produce insulin, but for those with Type 1 diabetes, the body kills the cells used for its production. Insulin differs by type, depending on how quickly it gets absorbed, how long it lasts, and when it peaks, **according to the American Diabetes Association.** Switching types has to be done with care to ensure it works for a patient.

Not all insulin is the same

Insulin has **gone through several modifications over the years.** The newer analog form, which has quicker onsets and can be more quickly absorbed, comes at a higher cost, forcing many people to use an older, over-the-counter form of the drug, known as human insulin.

Human insulin (or synthetic insulin) mimics insulin in humans, and starts working about half an hour to four hours after injection. Human insulin takes more time to become effective than the prescribed "analog" insulin. **Analog insulin is genetically altered to create more rapid-acting** and uniform-acting insulin. It starts acting around 20 minutes after injection and lasts four hours.

Nes Mathioudakis, an endocrinologist and associate professor of medicine at Johns Hopkins School of Medicine, told INSIDER that human insulin is still used for patients unable to afford analog insulin.

He said the key to safely switching from analog to human insulin is to speak with a doctor.

"You have to have a clear conversation about how the medications differ," he said. "How do you take the human meal-time insulin as opposed to what the patient was taking before."

Getting the proper dose of insulin is crucial for people with diabetes

Unlike medicines like over-the-counter pain medication ibuprofen, taking one brand of insulin is completely different from another.

For people living with diabetes, getting the proper dose of insulin at the right time is crucial for glucose at the right level.

"We can't make a uniform recommendation because every patient had a different blood-glucose profile, but the considerations are making sure you understand what the new type of insulin is replacing, how to convert the dose, and when to take it," Mathioudakis told INSIDER.

According to the ADA, **many factors can affect blood-glucose levels**, including diet, exercise, illness, stress, and where and when insulin is injected.

"I was lucky during my run of high blood sugars and did not end up in diabetic ketoacidosis"

Mary Williams, a Texas-based diabetes advocate who was diagnosed with Type 1 in 1993, told INSIDER that she has had first-hand experience with insulin changes.

She first started using analog insulin in 1996, but after a job change in 2009, she went back to human insulin because she didn't have health insurance and she couldn't afford the high price of analog.

Nine months into using human insulin, she forgot to eat on a busy day. While taking a nap before work, she went into a severe hypoglycemic episode because her blood sugar had dropped so low her brain started hemorrhaging.

Six months later she was able to get back on health insurance and start using analog insulin again.

But in 2015, she found herself in a similar situation during another job switch. Unable to afford an endocrinologist, she did the switch to human insulin on her own.

Two months later, she had another severe hypoglycemic episode. She had been waking up at 3 a.m. to check her blood-glucose levels nightly to ensure she wouldn't crash while sleeping, but one night she turned off her alarm without checking her blood-glucose levels.

"It was our dachshund who woke my husband up by standing on his chest. He thought she needed to go outside, but when she wouldn't get off the bed and leave my side he became concerned. He said he walked over to my side of the bed and felt my arm. I was starting to go into seizures. I was drenched in sweat and my body was extremely stiff," she said.

Her husband called 911, and EMTs found her blood-glucose level was at 32 mg/dL. **The US National Library of Medicine reports** that anything below 70 is dangerous, and anything lower than 54 is cause for immediate action.

"I was lucky during my run of high blood sugars and did not end up in diabetic ketoacidosis (DKA)," she told INSIDER.

Ken Inchausti, a spokesman for Novo Nordisk, which sells human insulin at affordable, over-the-counter rates, told INSIDER that human insulin "is safe and effective and is used by millions of Americans who depend on it for the treatment of type 1 and type 2 diabetes."

"This tragic story highlights the need for education concerning the appropriate use of human insulin. It also demonstrates that all insulins are not interchangeable without medical supervision and that any change in medication, including insulin, should be done under the supervision of a healthcare professional," he said.

More Links for Diabetes info:

Understanding Diabetes

Common types

Gestational diabetes

A condition in which women develop diabetes during pregnancy.

Diabetes insipidus

A condition that results from an imbalance of water in the body.

Type 1 diabetes

A chronic condition where the pancreas produces little or no insulin.

Type 2 diabetes

Results from insufficient production of insulin, causing high blood sugar.