

August 27, 2023 E-Newsletter



Message from the Alliance for Retired Americans Leaders

White House Marks the Inflation Reduction Act's One-Year Anniversary



Robert Roach,
President, ARA

President Biden called the Inflation Reduction Act (IRA) "one of the most significant laws" ever enacted at a White House ceremony

Wednesday, the anniversary of the day he signed it into law. The IRA is especially significant for older Americans because it lowers drug prices and health care costs, saving Medicare beneficiaries and taxpayers **\$98.5 billion** over the next ten years.

Alliance President Robert Roach, Jr. and Maryland/DC Alliance member Pam Parker attended the White House event.

The Centers for Medicare & Medicaid Service



Joseph Peters
ARA
Sec.-Trea.

The Centers for Medicare & Medicaid Services (CMS) issued an anniversary **fact sheet** highlighting the

accomplishments of the legislation over the last year in lowering drug prices. Specifically, the IRA:

- Allows Medicare to negotiate directly with participating drug companies to improve access to innovative treatments for people with Medicare and lower costs for the Medicare program;
- Ensures that people with Medicare pay no more than \$35

for a month's supply for each covered insulin product under Medicare prescription drug coverage, Traditional Medicare, or Medicare Advantage;

- Lowers Medicare Part D prescription drug costs and redesigns the prescription drug program. For example, people enrolled in Medicare prescription drug coverage who have very high drug costs will no longer have to pay cost-sharing for their prescription drugs in the catastrophic phase of the program starting in 2024, and the IRA caps annual out-of-pocket prescription drug costs at \$2,000 for 2025;

- Makes adult vaccines, recommended by the Advisory Committee on Immunization Practices, available at no cost for people with Medicare prescription drug coverage starting January 1, 2023, and later in 2023 for people with Medicaid coverage.

"President Biden deserves a great deal of credit, especially for requiring drug corporations

to negotiate better prices with Medicare," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "Many leaders before him tried and failed to deliver on that provision, and seniors have benefited as a result of his success."

More Americans are Dipping into Retirement Savings Early



Rich Fiasta,
Executive
Director, ARA

An increasing number of Americans are **withdrawing retirement funds** early to pay for credit card debt, medical bills, home improvements, buying a car or a house, or to make ends meet right now. Early withdrawals are dangerous financially, because not only is that money unavailable later, the withdrawal triggers some significant taxes and penalties.

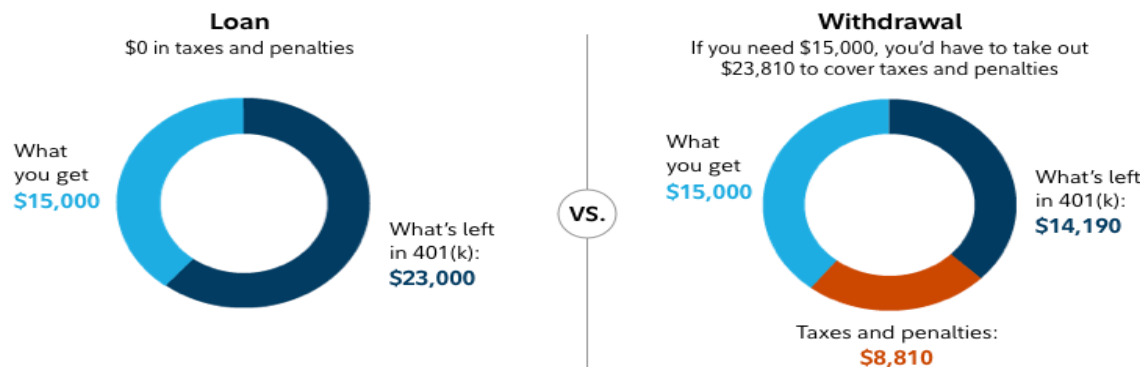
In the second quarter of this year, the number of people taking hardship withdrawals from their 401(k) was up 12% compared to the first three

months of the year, and that measure leapt 36% year over year, according to a new **survey** from Bank of America, which tracks about 4 million clients' employee benefit programs.

Borrowing from retirement savings was also up. The percentage of 401(k) participants who got a loan from their workplace plan in the second quarter was 2.5%, up from 1.9% in the first three months of 2023.

"Too many Americans are simply unable to cover necessary expenses without jeopardizing their future," said **Richard Fiasta, Executive Director of the Alliance**. "We must address the problem of stagnant wages. All jobs should pay enough so people can cover today's expenses without jeopardizing their savings."

Immediate impact of taking 15,000 from a 38,000 account balance



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COLA Update 2024 : Next Year Social Security Increase Dates

COLA Update 2024: Next Year Social Security Increase Dates. One of the most anticipated times for retirees in the United States is the annual Cost of Living Adjustment (COLA) announcement. Each year, the Social Security Administration increases the retirement and Supplemental Security Income checks based on this adjustment, making it an essential event for retirees.

Understanding the key dates associated with the COLA can help retirees get an approximate idea of the increase in Social Security checks for the upcoming

year.

CPI-W Increase in Specific Months:

The COLA increase in Social Security checks is determined by the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). To calculate the final check amount, the government considers the inflation and CPI-W increase for the months of July, August, and September. Keeping track of general price increases during these months can provide retirees with an approximate estimation of the upcoming COLA increase.



However, it's important to note that any projected amount is merely indicative until the official announcement.

Official Announcement of COLA 2024:

The official announcement of the 2024 COLA is expected in October 2023. During the middle of that month, retirees will learn the exact percentage of the COLA increase. Last year's increase was 8.7%, but this year's figure may vary, possibly decreasing to 3%, depending on economic factors and inflation rates.

First Check with the New COLA:

The first Social Security check reflecting the 2024 COLA will be issued in January, specifically the Supplemental Security Income payment. However, it's essential to understand the timing irregularity associated with this payment. As January 1st is a holiday, the payment is sent earlier, meaning the first check with the COLA already applied will arrive in 2023. Nevertheless, for all practical purposes, it will be considered a 2024 calendar year payment.

Veterans Health System Surpasses 400K Employees as Record Hiring Continues

The Veterans Health Administration has added nearly 49,000 new employees this fiscal year as demand spikes amid a deluge of claims and new enrollment from the **PACT Act**.

It is closing in on a total goal of 52,000 hires by Sept. 30. The majority are in occupations that Under Secretary for Health Dr. Shereef Elnahal calls the "Big Seven" -- jobs that directly affect patient care and services, including physicians, nurses, licensed practical nurses, nursing assistants, medical support, food service workers and housekeepers.

During a roundtable with reporters Tuesday, Elnahal said

the VHA has hired 27,296 employees in those positions with an end goal of 30,000, part of the total 52,000 amount for the fiscal year.

"I'm really proud of all of our network leaders and medical center directors for executing on this, and we're working as hard as we can not only to bring more folks on board, but to improve the hiring process itself," Elnahal said during the roundtable.

The VA embarked on a hiring spree last year to accommodate increased demand related to the PACT Act, which expanded benefits and health care services to combat veterans across several



generations.

A PACT Act provision gave veterans who had never enrolled in VA health care; served in a theater of operations after Nov. 11, 1998; and were discharged or released between Sept. 11, 2001, and Oct. 1, 2013, a **special one-year window to enroll in VA health care**.

As a result, **113,719 additional veterans have signed up**, with more expected by the deadline of Sept. 30.

To ensure that the VA hospitals and clinics could handle the influx of new patients, it aimed to hire 52,000 employees during fiscal 2023, the highest growth for the administration in 20 years.

The VA health care system provided more than 91 million outpatient appointments to 9 million veterans enrolled in VA care last year, according to the agency.

While many of the new employees will provide care and services within VA medical centers and clinics, some of the Big Seven employees -- medical support assistants -- have been hired to support the department's community care program, which allows veterans to receive care from non-VA providers when treatment is not available at a VA facility or the wait times for appointments are too long....**Read More**

North Carolina Hospitals Have Sued Thousands of Their Patients, a New Report Finds

North Carolina hospitals — led by the state's largest public medical system — have sued thousands of their patients since 2017, according to a **new analysis** that sheds additional light on the aggressive tactics U.S. hospitals routinely use to collect from people who fall behind on their bills.

The report, produced by the state treasurer and Duke University School of Law researchers, and related **patient interviews** offer harrowing accounts of people pursued for tens of thousands of dollars and often surprised by liens that hospitals placed on family homes.

In some cases, spouses were targeted after their partners died. In others, patients interviewed by

researchers said they'd been surprised to learn about property liens only after they tried to sell their homes or after a parent who owned the home died.

"I know my house will never be mine. It is going to be the hospital's," said Donna Lindabury, 70, whose home was targeted by Charlotte-based Atrium Health, which won a \$192,000 judgment against her and her 79-year-old husband over his 2009 heart surgery. Interest on the debt represented more than half of the couple's balance.

Lindabury said the hospital originally told them they could get assistance with the bills, but then denied their applications for aid. "People, where their God is



money, they just don't care," she told researchers.

The North Carolina findings reinforce **an investigation by KFF Health News and NPR**, which found that most U.S. hospitals maintain policies to aggressively pursue patients for unpaid bills, using tactics such as lawsuits, selling patient accounts to debt buyers, and reporting patients to credit rating agencies.

Nationwide, **about 100 million people** — 41% of adults — have some form of health care debt, according to a KFF poll. Medical debt is most widespread in the South, where chronic disease is more prevalent and many states haven't expanded their Medicaid

safety net through the Affordable Care Act. (North Carolina expanded Medicaid only this year.)

The North Carolina state treasurer released the new report as a growing number of states, including North Carolina, are working to expand protections for patients, often in the face of hospital industry lobbying.

"It's just another example of hospitals putting profits ahead of patients. It's like an onion. The more you peel it back, the more you cry," said Treasurer Dale Folwell, a Republican who for years has challenged hospital pricing and debt collection practices. "They should stop breaking people's kneecaps to collect these debts."...**Read More**

Hospitals dropping Medicare Advantage because of concerns with patient care

St. Charles Health System, a large hospital system in central Oregon likely will not continue to participate in Medicare Advantage, reports KTVZ.com. The hospital system's leaders are concerned about patient care in Medicare Advantage. People with Medicare who want to know they have access to the best hospitals, including access to cancer centers of excellence, should switch to traditional Medicare.

St. Charles is not alone; many hospitals are dropping Medicare Advantage. St. Charles' CEO says that the hospital system has been considering dropping Medicare Advantage plans for some time because of mounting concerns. He reports that his hospital system is not alone. Hospital systems throughout the country are concerned about patient care in Medicare Advantage.

In the CEO's words: "The

reality of Medicare Advantage in Central Oregon is that it just hasn't lived up to the promise. A program intended to promote seamless and higher-quality care has instead become a fragmented patchwork of administrative delays, denials, and frustrations. The sicker you are, the more hurdles you and your care teams face. Our insurance partners need to do better, especially when nurses, physicians and other caregivers are reporting high levels of burnout and job dissatisfaction." The American Hospital Association (AHA), the trade association for most hospitals reports that it "is increasingly concerned about certain (Medicare Advantage) plan policies that restrict or delay patient access to care, which also add cost and burden to the health care system." To make matters



worse, it appears that some Medicare Advantage plans are engaged in **fraud** as well as inappropriate **delays and denials of care and coverage**.

St. Charles hospital executives see higher rates of denials of care in Medicare Advantage and long arduous processes for getting Medicare Advantage plans to approve medically necessary care. St. Charles health system is considering whether it will renew Medicare Advantage contracts with PacificSource, Humana, HealthNet and WellCare.

The bottom line: With traditional Medicare, your treating physicians call the shots, deciding what care is medically reasonable and necessary, and Medicare covers that care, without second-guessing and coming between you and your doctors. With Medicare Advantage, many insurance

companies second guess treating physicians and deny care or delay care, endangering patient health. The Office of the Inspector General has reported **widespread and persistent inappropriate delays and denials of care and coverage in Medicare Advantage**. But, the Centers for Medicare and Medicaid Services has so far refused to identify the bad actors or sanction them appropriately, putting older adults and people with disabilities at serious risk.

Healthy patients in Medicare Advantage should be fine. But, even if you are healthy today, you could need complex care tomorrow and your insurance should cover that care. That's why we have health insurance. In some Medicare Advantage plans, you might not get needed care in a timely manner, if at all, regardless of whether you need it.

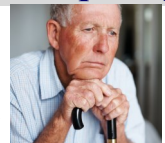
Prescription drug shortages and quality issues are a growing concern

Imagine yourself in the hospital and the hospital being out of the critical chemotherapy drugs you need. That sounds like something more out of the Soviet Union than the United States, but almost every hospital in the US is facing prescription drug shortages. Prescription drug shortages are leading to drug rationing, treatment delays and, sometimes, no treatment possibility, reports Stat News.

One new survey of 1,100 hospital pharmacists from the American Society of Health-System Pharmacists found that one in three hospitals are

rationing drugs or not providing critical treatments. Virtually all hospital pharmacists report inadequate supplies of some prescription drugs. Treatments for syphilis, different cancers, severe pain are hard to come by. More than eight in ten hospital pharmacists say hospitals are rationing care or switching to alternative treatments.

Pharmacists are forced to buy different drugs or different concentrations of drugs or getting their drugs from pharmacies that manufacture the drugs through compounding. The consequences



are not only dire for some patients but causing almost three in four pharmacists to pay more for drugs. And, the situation is getting worse.

What's responsible for these shortages? Everything from climate issues and increased demand, to quality issues.

The Food and Drug Administration's response is unsatisfying. As of now, the FDA is not acting to ensure patients get treatments that are safe. It is permitting Intas Pharmaceuticals to continue to import chemotherapy treatments

notwithstanding its finding of "a cascade of [quality] failures" where its drugs are manufactured. The **FDA reported** that an Intas analyst poured "acetic acid in a trash bin containing analytical balance strips," in order to destroy records.

Quality issues at plants in China and India are particularly concerning. Many generic drugs and chemotherapy ingredients are produced in these plants. What's pretty clear is that some chemotherapy treatments are of questionable quality.

If you think you can't afford long-term healthcare, here are some options

Even if you can afford to buy long-term-care insurance, the coverage keeps shrinking.

As you near retirement, you may worry that the cost of long-term care can sabotage your future. Spending thousands of dollars a month on home health aides or an assisted-living facility can sink your retirement plans, especially if you need such care for many years.

In theory, a sensible solution is to buy long-term-care insurance. These policies help pay for at-home care, assisted-living

communities or nursing homes.

In practice, however, these insurance products lack the scope of protection they used to offer. Many insurers have stopped selling long-term-care policies because misguided pricing and faulty underwriting standards led to high losses.

"The product that everyone wants no longer exists," said Thomas West, senior partner at SEIA in Tysons Corner, Va. "Most of the long-term-care



insurance on the market right now has priced itself out for people with modest assets. They can't afford it."

A 55-year-old male buying \$165,000 of long-term-care benefits that kick in immediately (i.e., with no waiting period) could expect to pay about \$900 a year for a barebones policy, according to the American Association for Long-Term Care Insurance. Adding an inflation guard to the policy that raises benefit levels by 3% a year would

increase the premium to \$2,100 annually. A 55-year-old female would pay \$1,500 and \$3,600 a year for the same benefits.

Keep in mind that the cost to renew a policy can increase substantially. Over the past two decades, some angry policyholders have protested after facing huge year-over-year premium hikes. To calm the public outcry, some insurers have scaled back the cost — and occasionally lowered their rates — while cutting back benefits....[**Read More**](#)

Dear Marci: When can I buy a Medigap?

Dear Marci,
I signed up for Medicare a few months ago, and now I want to enroll in a Medigap, too. When can I buy a Medigap?
-Jerome (Wichita, KS)

Dear Jerome,
Medigaps, sometimes called Medicare supplemental insurance, are health insurance policies that offer standardized benefits to work with Original Medicare. They are sold by private insurance companies and are designed to cover your deductibles, coinsurance, and copayments. If you have a Medigap, it pays part or all of certain remaining costs after Original Medicare pays first. But your question brings up a great point: Medigap enrollment rules are different from Original Medicare enrollment rules. If you want to purchase a Medigap policy, you need to learn the best time to buy one in your state. In

most states, insurance companies are only required to sell you a policy at certain times and if you meet certain requirements. If you miss your window of opportunity to buy a Medigap, your costs may go up, your options may be limited, or you may not be able to buy a Medigap at all. Under federal law, you have the right to buy a Medigap policy if you:

- ◆ Are 65 and enrolled in Medicare
- ◆ And, you buy your policy during a protected enrollment period.
- ◆ There are two federally protected times to purchase a Medigap:
- ◆ **Open enrollment period:** Generally, the best time to enroll in a Medigap policy is during your open enrollment



Dear Marci

period. Under federal law, you have a six-month open

enrollment period that begins the month you are 65 or older and enrolled in Medicare Part B.

- ◆ **Guaranteed issue right:** If you miss your open enrollment period, you can also buy a Medigap when you have a guaranteed issue right. If you are age 65 or older, you have a guaranteed issue right within 63 days of when you lose or end certain kinds of health coverage.
- ◆ **You can read more about the open enrollment period and guaranteed issue rights here.** At times when you have the right to buy a Medigap policy, an insurance company cannot:
- ◆ Deny you Medigap coverage
- ◆ Or, charge you more for a policy because of past or

present health problems
Before you buy a Medigap, check to see if your state offers additional protections. For instance, residents of New York and Connecticut can buy a policy throughout the year, not just at select times. These two states also require insurers to sell to people with Medicare who are under age 65. Call your **State Health Insurance Assistance Program (SHIP)** or Department of Insurance to learn more about your right to purchase a Medigap policy in your state. Even if you don't have a guaranteed right to buy a Medigap in your state, you may still be able to buy a policy if a company agrees to sell you one. However, know that companies can charge you a higher price because of your health status or other reasons. I hope this helps!

-Marci

Rising Drug Prices Demonstrate Need for Inflation Reduction Act's Changes

This week marked the one-year anniversary of the signing of the Inflation Reduction Act (IRA), landmark legislation that allows Medicare to **negotiate drug prices for the first time and penalize manufacturers who raise prices faster than inflation**, among other changes. The Congressional Budget Office **estimates \$100 billion in savings** for drug price negotiation alone. For beneficiaries, two new reports show the urgent need for these improvements.

Starting in 2026, 10 Part D drugs with the highest spending will be available at a price

negotiated between Medicare and the manufacturer. In 2027, negotiation will encompass an additional 15 drugs, then, in 2028, Part B drugs will be added to the mix. Starting in 2029, the number of additional drugs negotiated each year will top out at 20. Similarly, the manufacturer penalties for **price hikes beyond inflation** have not gone fully into effect, though Medicare has already reduced cost-sharing on some drugs to reflect differences between the list price and the price Medicare would have paid if prices had merely kept up with inflation.



A KFF report shows that, despite Part D covering over 3,000 drugs, a very small number of drugs are responsible for a large amount of spending. In 2021, the top 10 drugs (Eliquis, Revlimid, Xarelto, Trulicity, Januvia, Jardiance, Imbruvica, Humira (Cf) Pen, Lantus Solostar, and Ozempic) accounted for \$48 billion, 22%, of Part D spending. This is more than double the \$22 billion spent on the top 10 drugs in 2018 and far above inflation.

An AARP report also highlights just how quickly drug prices have increased, showing that prices for 25 top Part D

drugs have more than tripled since they were introduced and accounted for \$80.9 billion in Part D spending in 2021.

These numbers show the importance of bringing down the cost of the most expensive drugs and limiting price increases across the board to ensure that people with Medicare can afford their needed medication. Medicare Rights strongly supports these and other efforts to improve the affordability of health care and the well-being of the people Medicare serves.

Read the KFF report.
Read the AARP report (PDF).

Elder Fraud: How to Recognize (and Avoid) Scams at Any Age

Do you know anyone who has been affected by elder fraud? Seniors are certainly not the only people who fall prey to scams and schemes, but they are attractive targets for fraudsters—for a number of reasons: They often own their homes, have a nest egg of savings, and are more trusting of strangers than younger generations. Plus, elderly fraud victims are frequently reluctant to admit they've been scammed because

they are ashamed or fearful of being seen as incapable of managing their own affairs.

Every year, hundreds of thousands of people of all ages get duped by cunningly deceitful con artists. And according to a study in the **Journal of General Internal Medicine**, nearly one in 20 adults over age 60 have been financially exploited at some point in their senior years.



However, by arming yourself with information and being aware of common scams, you can take steps to avoid becoming an unfortunate statistic.

This article provides details on some of the most common scams that North Americans need to watch out for, including a few deals that fall within the law but require extra scrutiny. It also gives practical tips on how you

can protect yourself from various scams and what you can do if you end up becoming the victim of a fraud.

- ◆ **11 common scams and how to avoid them**
- ◆ **Lawful deals to be wary of**
- ◆ **What to do if you are the victim of a scam**
- ◆ **Where to report a scam**

If you need long-term care services, how will you get them?

The majority of older adults will need long-term care services at some point. But, caregiving costs for older adults are super high, stemming from significant labor and facility costs, along with high demand. If you need long-term care services, how will you get them?

More and more people are looking for adult day care, assisted living facility care and nursing home care. For many of them, relying on volunteer caregivers, such as friends and family, is not possible. But, the cost of paid care is prohibitive, swallowing up years of savings quickly. Caregiving costs increased more than 20 percent between 2012 and 2019 and

continue to rise. Medicare does not pay for long-term care services. At best, Medicare will cover **100 days in a rehab facility or nursing home** for people who need daily skilled nursing or therapy services. And, most **Medicare Advantage plans inappropriately deny coverage** for rehab and nursing care beyond a few days.

But, a stay in a rehab or nursing facility can cost thousands of dollars if you have to pay out-of-pocket. The average cost of a nursing home stay is now more than \$9,000 a month. The average cost of a stay in an assisted living facility is more than \$4,500 a month.



Caregiving costs are a lot higher in some states than others. In Massachusetts, average costs for a nursing home stay can be more than \$15,000 a month. An assisted living facility stay can cost well over \$8,000 a month.

More than four in five households with someone over 65 need some type of care. Almost a quarter of them have significant care needs, including round the clock care. Almost two in five need help, though not round the clock. Only about one in five of them need minimal care, such as help getting groceries and cooking.

Living costs are a financial stressor for many retirees,

including those who do not need care. More than 40 percent of these baby boomers have no retirement savings. Unless they have Medicaid, they generally must rely on their **Social Security benefits** to pay for any long-term care needs they might have because they have no other coverage.

The typical retiree receives about \$1,782 each month in Social Security benefits. State benefits are few and far between. **Washington State** is the first to launch a long-term care program to help with the costs of nursing home and other long-term care services and supports.

Seniors believe Medicare needs overhaul but still feel entitled to current benefits

A recent survey from eHealth, an independent Medicare insurance adviser, released new data that shows 84% of respondents believe Medicare needs reform, but just 12% think changes should impact their current coverage.

While concerned about the long-term viability of the program, which could begin running a deficit in several years, most of those surveyed agreed to pass responsibility onto future generations, as 46% of people think younger generations should pay more or accept reduced benefits.

By 2031, **the Centers for Medicare & Medicaid Services projects** Medicare will

not be able to cover benefits for its enrollees. When asked whether they'd be willing to see benefits reduced or costs increased to ensure Medicare's future, 22% were not sure and 59% flatly responded, "No."

Despite a consensus that Medicare needs to be changed to ensure its future sustainability, respondents did not agree on the best way to reform the program. The most popular response (47%) said payroll contributions should



be increased, followed by raising the eligibility age for future beneficiaries (21%).

Forty percent said none of the solutions presented to them were acceptable.

Concern about Medicare is bipartisan. Around three-quarters of Democrat and Republican voters worry about Medicare, but Republican voters are much harsher with the government's leadership on the issue. Nearly two-thirds of Republican voters give the federal government a failing grade, while nearly three-quarters of Democratic voters

give the government a passing grade.

Unsurprisingly, respondents were more concerned about Medicare's future if they make less than \$25,000 per year versus a person who makes more than \$100,000 per year. However, 40% of people wish they'd had a stronger understanding of Medicare when they first enrolled.

The report was based on a survey of 3,582 beneficiaries enrolled in Medicare plans, eHealth said.

Do I Have to Repay Medicaid When I Sell My House?

If you're a retired homeowner looking to move, you may be worried about Medicaid taking money from the sale of your current house. Fortunately, this fear is misplaced.

I'm 75 years old and have been receiving Medicaid QMB benefits with Medicare for the last seven years. I own my home and one vehicle in Idaho. I plan on selling my house and **not** buying another, putting the sale money in a savings account. I will be moving to Louisiana where I'll either be residing free with friends or renting a home. I know I will lose QMB benefits, but will be able to manage quite well with the money from the house sale. However, if Medicaid recovers

the benefits paid, I will not be able to manage. So, my question is, given these circumstances, will Medicaid take my savings from the house's sale?

Response:

The Qualified Medicare Beneficiary (QMB) program covers Medicare premiums, deductibles and copayments for lower-income beneficiaries. It's a form of Medicaid eligibility and individuals who receive both Medicare and Medicaid are often referred to as "dual eligibles."

There are actually a few different forms of the benefit with different income limits ranging from \$1,235 to \$1,660 a month for individuals and from \$1,992 to \$2,239 per month for



couples, with higher thresholds in Alaska and Hawaii. There's also a higher threshold for Medicare beneficiaries who are continuing to work.

As you know, there's also a countable asset limit QMB of \$9,090, significantly higher than the usual Medicaid limit of just \$2,000. As you also know, in most instances, the home of a Medicaid recipient is not counted against this limit. But when you sell it, you'll have cash and no longer be eligible for Medicaid or QMB coverage.

Under the Medicaid program, states are required to seek recovery from the estates of people who have received Medicaid for the benefits paid on

their behalf after age 55 or for nursing home care at any age. This is referred to as "estate recovery" and only comes into play after the beneficiary has died. So, it would not affect you since you're planning to sell your home during your life.

In addition, there's no estate recovery for Medicaid benefits paid out under the QMB program. Therefore, there will be no claim by Medicaid for your home for two reasons. First, because you'll still be alive and any claim by the state will be premature. And, second, because you're only receiving QMB benefits, so there's no claim in any case.

New Medicare Proposal Would Cover Training for Family Caregivers

The federal government is proposing having Medicare pay professionals to train family caregivers how to perform tasks like bathing and dressing their loved ones, and properly use medical equipment.

Even with extensive caregiving experience, Patti LaFleur was unprepared for the crisis that hit in April 2021, when her mother, Linda LaTurner, fell out of a chair and broke her hip.

LaTurner, 71, had been diagnosed with early-onset dementia seven years before. For two years, she'd been living with LaFleur, who managed insulin injections for her mother's Type 1 diabetes, helped her shower and dress, dealt with her incontinence and made sure she was eating well.

In the hospital after her mother's hip replacement, LaFleur was told her mother

would never walk again.

When LaTurner came home, two emergency medical technicians brought her on a stretcher into the living room, put her on the bed LaFleur had set up and wished LaFleur well.

That was the extent of help LaFleur received upon her mother's discharge.

She didn't know how to change her mother's diapers or dress her since at that point LaTurner could barely move. She didn't know how to turn her mother, who was spending all day in bed, to avoid bedsores. Even after an occupational therapist visited several days later, LaFleur continued to face caretaking tasks she wasn't sure how to handle. "It's already extremely challenging to be a caregiver for someone living with dementia. The lack of training in how to



care for my mother just made an impossible job even more impossible," said LaFleur, who lives in **Auburn, Washington**, a **Seattle** suburb. Her mother passed away in March 2022.

A new proposal from the Centers for Medicare & Medicaid Services addresses this often-lamented failure to support family, friends and neighbors who care for frail, ill and disabled older adults. For the first time, it would authorize Medicare payments to health care professionals to train informal caregivers who manage medications, assist loved ones with activities such as toileting and dressing, and oversee the use of medical equipment.

The proposal, which covers both individual and group training, is a long-overdue recognition of the role informal

caregivers – also known as family caregivers – play in protecting the health and well-being of older adults. About 42 million Americans provided unpaid care to people 50 and older in 2020, according to a **[much-cited report](#)**.

"We know from our research that nearly 6 in 10 family caregivers assist with medical and nursing tasks such as injections, tube feedings and changing catheters," said Jason Resendez, president and CEO of the National Alliance for Caregiving. But fewer than 30% of caregivers have conversations with health professionals about how to help loved ones, he said.

Even fewer caregivers for older adults – only 7% – report receiving training related to tasks they perform, according to a 2019 report in **[JAMA Internal Medicine](#)**. . . . **[Read More](#)**

The average retiree spends \$4,345 on monthly expenses

The average retiree spends \$4,345 on monthly expenses — and burns 75% of that on these 4 things. **How does your own spending stack up?**

The average American 65 years of age and up **[earns an annual pre-tax income](#)** of \$55,335, and that same group spends \$52,141 yearly, or \$4,345 a month, according to the Bureau of Labor Statistics (BLS).

Watch for these four categories of spending that eat into monthly

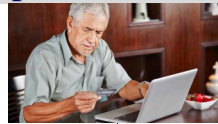
expenses.

1. Housing

Home costs represent the largest expense for retirees, accounting for 36% of their annual expenses, BLS figures show. Retirees who want to gain a leg up may want to consider downsizing as house prices remain high.

2. Transportation

If you aren't working as much or even at all, you might want to swap the car for public transit or



a bicycle.

Transportation is the second-largest spending category, making up \$7,160 in annual expenses for retirees, according to BLS figures.

3. Health care

Health spending makes up \$7,030 in annual spending for retirees. One way to cut costs when health issues arise is to get easily affordable preventative care. That means staying up to

date on screenings and vaccinations.

4. Food

At \$6,490, food expenditures account for over 12% of annual expenses for those 65 and over. Meal planning is one way to avoid overspending since it involves shopping for food items as opposed to regularly eating out — which can be an expensive habit.

Inflation Reduction Act and Affordable Care Act Working Together to Lower Health Care Costs

In advance of this week's one-year anniversary of the Inflation Reduction Act (IRA), the Biden-Harris administration released a set of **[fact sheets](#)** last month highlighting health care cost savings achieved under the IRA and the Affordable Care Act (ACA) in each of the fifty states and the District of Columbia.

The fact sheets include information about a broad range of health care costs for people with Medicare and across the health care market. The reports detail state-by-state projected savings on Part D out-of-pocket costs — especially for insulin and vaccines — as well as information about the number of people enrolled in Medicare, Medicaid,

CHIP, or Marketplace coverage in 2023 as compared to before the implementation of the Affordable Care Act.

These fact sheets help us understand the impact of policy changes in real life — decreased uninsurance rates and lower prescription costs for large numbers of people.

For example, the fact sheet for New York tells us that Medicare Part D enrollees in New York **[spent an average of \\$303 out-of-pocket on drugs](#)** in 2022. The IRA's changes to the prescription drug benefit are expected to save New Yorkers a total of nearly \$197 million in 2024 and over \$446 million in



2025.

If the IRA's insulin and vaccine provisions had been in effect in 2020, New Yorkers would have saved over \$36 million on insulin and \$9 million on vaccines.

Since its implementation, the ACA has had a huge impact on health insurance coverage for people in New York. The total uninsured rate was cut in half, from 10.7% in 2013 to 5.2% in 2021.

Many New Yorkers are receiving coverage through the Marketplace, with 214,000 residents signing up in 2023. For 2022, the average subsidy per month for those receiving a subsidy was \$362, and the

average monthly premium after subsidies was \$403.

The ACA allowed states to offer Medicaid to additional populations. New York expanded Medicaid coverage effective January 1, 2014. As of September 2022, nearly 433,000 newly eligible adults were enrolled in the program.

At Medicare Rights, we applaud these advances in coverage and affordability. As **[additional IRA changes are implemented](#)**, their effects will be felt by more and more people with Medicare. We will continue to urge the administration and Congress to build on these successes and prioritize access to affordable, high-quality care.

Representative takes aim at prior authorizations in Medicare, Medicare Advantage

A physician lawmaker is joining the fight against prior authorizations (PAs) that bog down medical care, frustrating physicians and patients alike – and sometimes jeopardizing treatments.

Rep. Mark Green, MD (R-Tennessee), **announced** he has reintroduced the “Reducing Medically Unnecessary Delays in Care Act” to address PAs in Medicare and Medicare Advantage plans. The bill also has changes in store for PAs for prescription drugs under Medicare.

“A physician should be the one determining a patient’s course of treatment. Prior authorization is a roadblock to care – equivalent to a bureaucrat in the waiting room,” Green said in a statement.

“Medicare and Medicare Advantage plan administrators should not be able to exercise a unilateral veto over a doctor’s

prescribed treatment,” he said. “It is this kind of red tape that creates frustration for healthcare providers and patients alike. We know that preauthorization leads to delays in care and worse health outcomes for patients – it’s time to put patients first. Preauthorization doesn’t do that.”

The proposed legislation would require that board-certified physicians in relevant specialties make decisions about patient treatment, according to Green’s office.

“It would also direct Medicare, Medicare Advantage, and Medicare Part D plans to comply with requirements that restrictions must be based on medical necessity and written clinical criteria, as well as additional transparency obligations,” his official summary said.



The bill is the latest among calls to reform the process that health insurance companies use for approving health care procedures. The concept appears to have widespread support among **lawmakers in the House and Senate**, along with **physicians** and **patients**, but congressional action has been slow coming.

Green’s legislation gained a statement of support from Medical Group Management Association (MGMA) Senior Vice President of Government Affairs Anders Gilberg. He called it an important step to reform PA in the government health insurance programs.

Earlier this year, MGMA published **its findings about PA**, from a survey of medical practices. PA is nearly ubiquitous because 95% of respondents treat patients covered by Medicare

Advantage plans, and 75% reported increasing numbers of those patients.

Who decides on treatment? A full **72% of medical groups** reported the clinicians assigned to complete their peer-to-peer reviews by the plans are not from a relevant specialty to the treatment or disease in question, according to MGMA. That results “in dangerous delays and flat-out denials.”

“The increase in utilization of overly burdensome prior authorization requirements by health plans leaves medical groups struggling to ensure patients continue to maintain access to medically necessary care,” Gilberg said. “MGMA looks forward to working with our partners in Congress to ensure that no health plan can stand in the way of life-saving healthcare simply to increase their bottom lines.”

A Peek at Big Pharma’s Playbook That Leaves Many Americans Unable to Afford Their Drugs

America’s pharmaceutical giants **are suing this summer** to block the federal government’s first effort at drug price regulation.

Last year’s Inflation Reduction Act included what on its face seems a modest proposal: The federal government would for the first time be empowered to negotiate prices Medicare pays for drugs — but only for 10 very expensive medicines beginning in 2026 (an additional 15 in 2027 and 2028, with more added in later years). Another provision

would require manufacturers to **pay rebates** to Medicare for drug prices that increased faster than inflation.

Those provisions alone could reduce the federal deficit by \$237 billion over 10 years, the Congressional Budget Office has calculated. That enormous savings would come from tamping down drug prices, which are costing an **average of 3.44 times** — sometimes 10 times — what the same brand-name drugs cost in other developed countries,



where governments already negotiate prices. These small steps were an attempt to rein in the only significant type of

Medicare health spending — the cost of prescription drugs — that has not been **controlled or limited by the government**. But they were a call to arms for the pharmaceutical industry in a battle it assumed it had won: When Congress passed the Medicare prescription drug coverage benefit (Part D) in 2003, **intense industry**

lobbying resulted in a last-minute insertion prohibiting Medicare from negotiating those prices.

Without any guardrails, prices for some existing drugs have soared, even as they have fallen sharply in other countries. New drugs — some with minimal benefit — have enormous price tags, buttressed by lobbying and marketing.

AZT, the first drug to successfully treat HIV/AIDS, was labeled “the most expensive drug in history” in the late 1980s....**Read More**

Social Security Widowed Benefits: How much of a spouse's Social Security can a widow get?

When a person's husband dies, the last thing the wife left behind will want to think about will be **Social Security Widow Benefits**, but it is important to look into this quite soon after the death, as this could be important financially.

When the time is right for the widow to investigate Social Security Widow Benefits, the main question is whether the deceased's benefits can be claimed. Here, in this **guide to Social Security Widow Benefits**, we'll answer some of the main questions for widows in

the **USA**.

Can a widow collect both her and her husband's Social Security?

It is not possible for a widow to claim her deceased husband's benefits in addition to her own retirement benefits.

That's because you can only collect one of either your own retirement benefits or survivor benefits.

If you are a widow and eligible for both, you'll be able to receive whichever has the higher amount.

In other words, if you already collect retirement benefits and



then your husband dies, you won't be able to get survivor benefits if they're lower than your own retirement benefits. You'd only get survivor benefits if the amount is higher.

How much are Social Security Widow Benefits?

If you do collect survivor benefits, the amount will depend on how much the deceased contributed during their career.

The Social Security Administration gives the following as examples of how much Social Security Widow Benefits might be:

- ◆ If you're a surviving widow at full retirement age or older: 100% of the deceased worker's benefit amount.
- ◆ If you're a surviving widow at age 60, through full retirement age: 71 to 99% of the deceased worker's basic amount.
- ◆ If you're a surviving widow with a disability aged 50 through 59: 71%.
- ◆ If you're a surviving widow at any age, caring for a child under age 16: 75%.

Five ways to stay healthy and feel better longer, as you age

We are all getting older. And, the older we get, the more likely we are to suffer from one or more chronic conditions, everything from joint pain to cancer. **Consumer**

Reports recommends ways to stay healthy and feel better longer, as you age. As you might expect, it's all about exercising frequently, eating well, getting enough sleep, and staying socially engaged.

Of course, many good things come with age. Being older means being wiser. It also usually means being happier. But, a lot happens as to your body as you age. Avoiding alcohol and not smoking and keeping a healthy weight, exercise, along with eating well, good sleep and social engagement can all slow down the aging process and improve every aspect of your health.

How to care for your aging body?

Your heart: Minimize your risk of a heart attack and heart disease. Keep your blood flowing efficiently. Exercise and healthy eating can help a lot. Don't smoke. Get a good night's sleep

and a maintain a healthy weight. Of course, it all is a lot harder to do than it appears, but it can minimize your risk of a heart attack.

Your brain: Minimize your risk of dementia. By the time you're 50, you likely will experience some cognitive decline, including slower processing of information. Your eyesight and hearing can also begin to fail. But, you are likely to be more creative and productive as you move into your 50s and 60s because of all the knowledge and wisdom you have accumulated.

You might be able to delay or prevent dementia, according to the CDC, by being good to your heart. Again, exercise, not smoking and drinking, and eating a Mediterranean diet can make a difference. So can having a positive outlook about growing older and feeling useful.

Don't bother taking supplements. There's no evidence that they help and there's evidence that certain ingredients found in some supplements can



be dangerous to your health.

Your digestive system: Keep your gut and liver working well. Your liver helps to keep toxins out of your body. And, when your gut is working properly, you have regular bowel movements. You keep constipation and reflux at bay.

To address digestive issues, you should try changing up your diet. Foods with fiber, such as avocados and oats, could be helpful. If you have GERD, try stopping drinking alcohol, not smoking and having dinner early so that your food is digested before you go to sleep.

Your hormones: Focus on maintaining growth and sex hormones, which tend to diminish as you age. That can mean you also lose muscle and bone strength. As you lose growth and sex hormones, you might also lose some energy, sleep less well and have less of a sex drive.

Again, both aerobic and strength exercises can help increase your growth hormone and testosterone levels, along

with a good night's sleep.

Your muscles and bones: Focus on maintaining muscle and bone strength, as well as keeping your balance and endurance. By the time you're in your late 30s, you will begin losing bone and muscle strength. However, if you exercise regularly, you can hold onto a lot of that strength. And, you can also keep your endurance. Balancing exercises are also helpful.

Eating more protein and calcium can help with muscle strength and bone health. You can get protein from quinoa, nuts, lentils and soy as well as from seafood, poultry and meat.

Your skin: Take care of your skin. Most people will see signs of aging under their eyes with a loss of collagen. You might also get sun spots. No matter what your skin color, sunscreen is really important. You might also try using retinoids at night. They will dry out your skin, while encouraging production of new skin cells and boosting collagen.

Most Alzheimer's Patients May Be Ineligible for Newly Approved Drugs

Two recently approved treatments offer newfound hope for patients in the early stages of Alzheimer's disease, but most people who could benefit will likely be deemed ineligible, a new study finds.

Alzheimer's affects about 6.7 million Americans age 65 and older. But only about 8% to 17% of older adults with early signs of the disease meet the eligibility criteria as determined by clinical trials for the drugs, Leqembi and Aduhelm, researchers say.

The vast majority would be disqualified because of chronic health conditions and brain scan abnormalities common in older adults.

Leqembi and Aduhelm are monoclonal antibody treatments. Because of the tremendous need for Alzheimer's treatments, they received accelerated approval by the U.S. Food and Drug Administration, with Leqembi (lecanemab) given traditional

FDA approval in July.

"Understandably, there's wide interest in new and emerging treatment options for Alzheimer's disease. Prior to recently, we hadn't had a new approved drug for Alzheimer's disease in more than 20 years, and it's a devastating disease," said study co-author **Dr. Vijay Ramanan**, an assistant professor of neurology at the Mayo Clinic in Rochester, Minn.

These new medications are a good step forward, Ramanan said.

Leqembi was shown in clinical trials to delay progression of Alzheimer's disease.

"One of the big challenges that's facing the field is to translate what we have learned from the clinical trials to real world practice," Ramanan said.

That's what this study worked to do, using 237 people in the Mayo Clinic Study of Aging,



ages 50 to 90. All had mild cognitive impairment or mild dementia, and their brains showed increased amounts of amyloid- β plaques, hallmarks of Alzheimer's disease.

Using specific inclusion criteria -- body mass index and scores on thinking and memory tests -- researchers found about 47% of these individuals would meet qualifying criteria.

But then they looked at other clinical trial exclusions, which included stroke, heart disease, a history of cancer, or signs of small brain bleeds or injuries on brain scans.

When those were factored in, the researchers discovered only 8% of the study participants would have been eligible for the Leqembi trial.

Without the thinking and memory tests, 17% of those with mild cognitive impairment would have been eligible.

For Aduhelm (aducanumab), 44% of participants would have met the required characteristics, but after excluding for certain health issues, just 5% would have been eligible.

"Clinical trials are not perfect, but they do provide an initial evidence base for use of diagnostics and treatments," Ramanan said.

He noted a consensus that's building in the field -- that appropriate use of medications should in many ways mirror the conditions under which the drug was tested in clinical trials.

"Understanding how well those criteria actually apply to the general population is important information to be able to counsel both clinicians and patients appropriately on what they can expect," Ramanan said. **Read**

More

Breast Cancer Screening May Not Be Worth It for Women Over 70

The risks of screening mammograms to catch breast cancer may outweigh the benefits for certain women aged 70 or older, new research indicates.

The main risk? Overdiagnosis and treatment of a breast cancer that likely wouldn't have caused any symptoms during a woman's lifetime.

"For women who are on the younger end of the age range and who are generally healthy, the risk of overdiagnosis from screening may be acceptably low," said study author **Dr. Ilana Richman**, a general internist and health services researcher at Yale Cancer Center in New Haven, Conn. "For older women and those with other serious medical conditions, the risks of overdiagnosis are higher and may outweigh the benefits of screening."

The American Cancer Society recommends that women aged 55 and older undergo mammograms

every two years or continue annual screening, and it states that such screening should continue as long as a woman is in good health and expected to live for 10 or more years.

The study, which included close to 55,000 women aged 70 years and older who had been recently screened for breast cancer, found that the risk of overdiagnosis increased with age. Specifically, about 31% of breast cancers picked up among women aged 70 to 74 were considered overdiagnosed. In women aged 74 to 84, up to 47% of breast cancers were overdiagnosed. The risk of overdiagnosis was highest in women aged 85 and older, the study showed.

"Women who are diagnosed with breast cancer typically undergo treatments including surgery, and possibly radiation,



chemotherapy and long-term medications," Richman said. "What this means is that some women end up getting these relatively intensive treatments for a breast cancer that never would have caused symptoms."

The findings were published Aug. 8 in the ***Annals of Internal Medicine***.

The value of early detection with a mammogram is improved quality of life and reduced risk of dying from breast cancer, said **Dr. Marisa Weiss**, chief medical officer and founder of Breastcancer.org.

"For women aged 70 and older who are expected to live another 5 to 10 years, and without other significant active [diseases or conditions], mammography remains important," said Weiss. "It can improve their quality of life by finding a cancer before it grows and spreads, potentially causing symptoms such as pain,

bleeding and malodorous fluid discharge in the breast area or other parts of the body."

Women who've lived to age 70 and older and are in relatively good health are more likely to live a lot longer, she noted.

"They know that there are risks with each procedure, and are often willing to take the risk of overdiagnosis to avoid the risk of underdiagnosis," Weiss said.

That's exactly how **Susan Salenger**, 80, sees it. The Petaluma, Calif.-based author of *Sidelined: How Women Can Navigate a Broken Healthcare System*, gets her screening mammogram every year – without fail. "I am hoping that if I do get breast cancer, I catch it early," she said. "Not only am I too anxious to skip a mammogram, I am also proactive about my health and would want all the information and to participate in any treatment decisions..." [**Read More**](#)

Could Ativan Pose Harm to People Battling Pancreatic Cancer?

Sometimes patients with pancreatic cancer are prescribed the benzodiazepine lorazepam (Ativan) for anxiety, but that may be harming their health.

A new study found this treatment was linked to worse outcomes, with shorter survival times and faster disease progression.

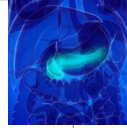
Alternatively, those who took alprazolam (Xanax) had a significantly longer progression-free survival than patients who did not.

"When we study response to therapy, we think of treatments like chemotherapy or

immunotherapy, but patients are also given a lot of medicines for anxiety and pain," explained senior study author **Michael**

Feigin, an associate professor of pharmacology and therapeutics at Roswell Park Comprehensive Cancer Center, in New York. "We wanted to understand the impact of some of these palliative care drugs on the tumor."

Benzodiazepines relieve anxiety, insomnia and seizures by suppressing the central nervous system. Cancer patients are often prescribed these drugs



to help deal with issues stemming from their disease or treatment.

To study the impact of that, the researchers first evaluated how many patients take benzodiazepines during cancer treatment.

Among patients treated at Roswell Park for prostate, pancreatic, ovarian, kidney, head and neck, endometrial, colon, breast or brain cancer, as well as melanoma, nearly 31% received benzodiazepines. About 41% of patients with pancreatic cancer received the drugs, the highest rate seen in the study.

After adjusting for other factors, benzodiazepine use was associated with a 30% lower risk of pancreatic cancer-related death.

However, the picture changed when they looked at specific benzodiazepines and pancreatic cancer outcomes.

Apart from short-acting benzodiazepines used as part of surgical anesthesia, the two most commonly used benzodiazepines were lorazepam (Ativan), which 40 of these patients were prescribed, and alprazolam (Xanax), which 27 patients were taking... [**Read More**](#)

U.S. COVID Hospitalizations Rise for Fourth Straight Week

New hospitalizations for Americans with severe COVID are climbing once again.

The number of patients being admitted to hospitals has grown for each of the past four weeks, U.S. Centers for Disease Control and Prevention **data** shows. Southeastern states have been hit the hardest.

In the week ending Aug. 5, the United States had 10,320 newly hospitalized patients. That's a 14.3% increase, but it's still much lower than last summer's

peak of more than 42,800 in a week.

The Southeastern region that includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee had nearly 4.6 new patients hospitalized with COVID-19 per 100,000 residents. Overall, the country saw just over 3 new patients per 100,000 residents.

Cases occurring at nursing homes were also high.

Severe COVID recently seems



to have been striking seniors ages 75 and up most often. But according to nationwide **emergency room data**, children up to the age of 11 have also been frequently seen in the ER and have now tied with seniors.

In the region that includes Arkansas, Louisiana, New Mexico, Oklahoma and Texas, children's visits to the ER are exceeding that of adults, at least for those ages 0 to 11, *CBS News* reported.

The variant EG.5 is now the dominant variant in the country, comprising **17.3% of U.S. infections**.

Fall's expected booster shots will target the XBB variant, but will also likely provide some protection against EG.5, which is a descendant of the XBB variant.

Still, the World Health Organization has warned that EG.5 could soon outcompete other XBB variants... [**Read More**](#)

COVID May Help Trigger High Blood Pressure

COVID-19 patients face a markedly greater risk for developing persistently high blood pressure, even if they never had blood pressure concerns before, new research indicates.

The rise in risk seen among otherwise heart-healthy patients also appeared to be notably greater among COVID patients than in influenza patients.

The findings, said senior study author **Tim Duong**, are the "first to my knowledge." Duong is a vice chair of research at the Albert Einstein College of Medicine and Montefiore Medical Center in New York City.

He stressed that the increased

risk seen among COVID patients is not limited to those with severe illness.

At an average six months after initial infection, just over a fifth of patients who had been hospitalized with COVID developed high blood pressure, despite no prior blood pressure problems, the study found.

That figure fell to just below 11% among COVID patients who were never hospitalized, Duong said.

The findings were published Aug. 21 in the journal **Hypertension**.

A prior history of high blood pressure does tend to boost the



risk of more serious COVID symptoms and hospitalization. The new study focused on patients with no prior heart or vascular complications.

Researchers reviewed the medical records of more than 45,000 COVID patients. Of those, roughly 28,500 had no history of high blood pressure.

All were initially infected with COVID between March 2020 and August 2022. All had a follow-up exam three to nine months after their initial diagnosis.

Of the 5,562 hospitalized COVID patients with no prior blood pressure issues, nearly 1,500 returned for a follow-up.

Among that group, nearly 21% had developed persistently high blood pressure.

Of the 23,000 non-hospitalized COVID patients with no prior blood pressure concerns, just over 5,500 were seen at follow-up.

Among this group, nearly 11% had also newly developed persistently high blood pressure.

Researchers then compared that data to nearly 14,000 influenza patients. None had been infected with COVID during the study time frame, and about 11,500 had no history of high blood pressure....[Read More](#)

More Americans Grow Old Alone, and Faltering Minds Bring Risks

An estimated 26 million Americans 50 and older live alone, and researchers estimate that more than 4 million have dementia or cognitive impairment.

That means a large number of older Americans are at risk for medication mix-ups, unsafe driving, wandering and missing important medical appointments. And, a new study warns, the U.S. health care system is ill-equipped to address the needs of this population.

"Our study is significant because it provided, for the first time, strong evidence that it is much more difficult to care for patients with dementia who live alone," said lead author **Elena Portacolone**, an associate professor at the Institute for Health & Aging at the University of California, San Francisco. "As a result, in the United States,

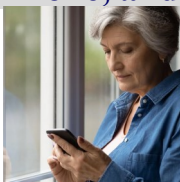
patients with dementia who live alone may not receive the best possible care."

For the study, her team interviewed 76 health care

providers in California, Michigan and Texas. They ranged from doctors to home care aides.

Providers raised concerns about mentally impaired patients who lived alone, noting they were isolated, lacked advocates, had incomplete medical histories, required difficult interventions and had unmet needs. Many had no emergency contacts listed and were sometimes ignored by medical professionals until a serious health episode occurred. Those living alone were most likely to be women, poorer and without a partner.

These factors increase their risk for untreated medical conditions, self-neglect, malnutrition and



falls, the study said. **Kate Wilber**, chair of the USC Leonard Davis School of Gerontology in Los Angeles, reviewed the findings.

"Over 80% of long-term services and support for people is provided by friends and family, and if someone doesn't have friends and family, either living with them or in the community, they need care, especially if someone's living with dementia as the disease progresses," she said.

"One of the reasons people avoid care, avoid providers coming in is they don't want to have their freedom taken away, and there's a great fear of being placed in a nursing home," Wilber explained.

That, she added, is a likely outcome if someone at high risk is living alone.

Costs are also a factor. The study estimated that only 21% of cognitively impaired adults who live alone are covered by Medicaid, leaving most of these adults ineligible for subsidized services like home-care aides. In addition, aides are usually provided only for a limited time after a severe medical episode, the study noted.

"Millions and millions of dollars are spent by the government of the United States in research to delay or treat dementia," Portacolone said. "Given the needs of older adults who live alone with dementia, it would be wise to devote resources for programs supporting older adults who live alone with dementia, as well as the professionals doing everything they can to care for this population."...[Read More](#)

Skiping Aspirin After Heart Attack Raises Odds for Recurrence

If you've had a heart attack, your doctor likely told you to take a low-dose aspirin daily to stave off a second heart attack or stroke, but most people don't follow through with this advice over the long-term.

Those folks who don't take daily low-dose aspirin consistently are more likely to have another heart attack, stroke or die compared with their counterparts who consistently take aspirin, a **new study** shows. Aspirin keeps platelets from clumping together, which can

help prevent or reduce the blood clots that can cause heart attacks and strokes.

"Most people should be on lifelong aspirin after a heart attack," said **Dr. Deepak Bhatt**, director of Mount Sinai Heart and professor of cardiovascular medicine at the Icahn School of Medicine in New York City.

"Long-term adherence to medication is a problem worldwide, including in the USA, and this is true even for inexpensive drugs such as aspirin,



which can be lifesaving in heart attack patients," said Bhatt, who had no role in the research.

The study was led by **Dr. Anna Meta Kristensen** of Bispebjerg and Frederiksberg Hospital in Frederiksberg, Denmark.

The researchers followed more than 40,100 people aged 40 or older who had a first-time heart attack from 2004 through 2017. The study team checked up on aspirin use two, four, six, and eight years after their heart attacks to see who was still taking

daily aspirin regularly. Anyone using other blood thinners was not included in the study.

Denmark keeps a national registry of medication use including aspirin. People on aspirin for 80% or less of the time were considered to be non-adherent or not taking aspirin as prescribed. By contrast, folks who took aspirin more than 80% of the time were considered adherent....[Read More](#)