

Supreme Court Dismisses Latest Challenge to the Affordable Care Act

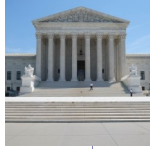
The U.S. Supreme Court once again **upheld the Affordable Care Act (ACA)** as the law of the land, determining that the plaintiffs in California v. Texas lacked standing to sue. Lack of standing means that the plaintiffs could not show that they were harmed by the law they were challenging, which bars any ability to sue in federal court.

From the beginning, many experts and observers **dismissed the lawsuit as frivolous and inconsistent with settled law.** Despite this widely held belief, the case **progressed through federal court,** and the Trump administration, instead of defending the law, **wholly embraced the poor legal reasoning** and attacked the law in court.

Now, the Supreme Court has found that those initial impressions of the case's validity

were sound. The plaintiffs argued that because Congress had zeroed out any penalty for failing to enroll in health coverage, the ACA law that required such coverage had become more coercive, not less, and was unconstitutional. The court found that "[n]o plaintiff has shown such an injury" or a "particularized individual harm" from any "allegedly unlawful conduct." The court emphasized that "[Our] cases have consistently spoken of the need to assert an injury that is the result of a statute's actual or threatened enforcement, whether today or in the future."

Despite its frivolity, this threat to the ACA would have had massive implications for the American health care system. A full repeal would have damaged Medicare; ended expansion



Medicaid; opened millions of Americans up to loss of coverage due to pre-existing conditions; and put hospitals, especially in rural areas, at risk of closure.

Medicare Rights is happy to see this result, though we remain frustrated that this case was not immediately rejected by lower courts as patently invalid. The ACA continues to be the law of the land and we urge prompt dismissal of any additional frivolous lawsuits that put health coverage at risk for millions of people.

We also urge Congress and the Biden administration to build upon the successes of the ACA, working together to ensure greater affordability and access to care and coverage for everyone in the United States. The ACA improved Medicare by lowering prescription drug costs

and improving preventive care, but we must do more to bolster the program for older adults and people with disabilities, including expanding benefits, further lowering and capping medication costs, and improving access to supports for people with lower incomes.

Note:

The predecessor to the ACA was the Massachusetts Health Care reform called Romney Care.

Dr. Joseph Boffa, RIARA HealthLink Wellness Director, who teaches Statistics and Epidemiology at Boston University and a member of the Massachusetts Alliance for Retired Americans, was part of the analytical team that did the original cost projections. The analysis he performed was for the Division of Health Care Finance and Policy of Massachusetts.

'Social Security doesn't even cover my entire rent. 'How retirees say Congress should change benefits

It's no secret that Social Security is underfunded, and many Americans are struggling to scrape by on their monthly benefit checks.

Now, congressional leaders have raised a key question on reforming the program.

"Should we vote now or should we kick the can down the road?" said Rep. John Larson, D-Conn., during a House Ways and Means Social Security subcommittee meeting this week.

Larson, who serves as chair of the subcommittee, posed the question to Julian Blair, a Washington, D.C., resident, retiree and veteran, who testified during the hearing.

"Congressman, I say we should have voted yesterday," Blair said.

The exchange highlights the issue facing lawmakers now that President Joe Biden is in office, with Democrats also controlling the House and Senate: How soon can they address Social Security reform?

Biden ran on a campaign platform touting big Social Security changes. Among his proposals is raising the minimum Social Security benefit to 125% of the federal poverty level. He also wants to eliminate rules that reduce benefits for those who also have certain kinds of pension



income, known as the Windfall Elimination Provision and Government Pension Offset.

Larson has also put forward his own proposal, called the Social Security 2100 Act, which aims to expand benefits while extending the program's solvency into the next century.

Both Biden's and Larson's plans would require some payroll tax increases, particularly for high earners, with the goal of providing bigger benefits to lower earners.

"To the shame of this nation, millions have worked all their lives, paid into a system and

receive a below-poverty-line check from Social Security," Larson said at the hearing.

Currently, 4-in-10 Social Security beneficiaries rely on those benefits for most of their income, Larson said. The average retired worker receives \$18,500. Yet others receive payments below the poverty line — \$12,880 — particularly women and minorities.

For Americans collecting Social Security who struggle to make ends meet, changes to increase the minimum benefit and get rid of rules that reduce monthly checks for those who also have pension income cannot come soon enough... [Read More](#)

ADD YOUR NAME

Get The Message Out: SIGN THE GPO/WEP PETITION!!!!

Private sector can't fix health care; we need government

Was it a press release, or a declaration of war?

How else to explain the media and market frenzy that followed the announcement, issued on Jan. 30, 2018, that Amazon, Berkshire Hathaway, and JPMorgan Chase — three of the nation's largest, most high-profile, and best-run companies, then with some \$534 billion in revenues between them — were teaming up to take on the ever-more-expensive, ever-more-complex problem that is American health care.

To those who had toiled in the

world of employer-sponsored health care for decades, trying but never really succeeding to come up with new ways to control costs and improve outcomes ... the statement, from three powerful CEOs, was cause for celebration.

Five months in, the team announced another star would lead the venture: Atul Gawande, the surgeon and influential New Yorker writer whose clear-eyed analysis of America's dysfunctional health care system

HEALTH CARE



had earned him the admiration of Barack Obama and Buffett. In March 2019, the venture finally got a name,

Haven.

The project officially sputtered to an end earlier this year. Even with its star power, Haven couldn't break the black box that is U.S. health care.

So, did Haven make a difference? Some argue the effort undermined progress by raising the obvious question: If they

couldn't do it, who can? In a recent Kaiser Family Foundation survey of very large employers, 85% of top executives think government support will be necessary to control costs and provide coverage.

Gawande goes further and has recently argued that the employer-sponsored system can't be fixed. Noting how many Americans lost their health insurance in a global pandemic, he said, "A job-based system is a broken system."

Federal Government Moves to Guarantee Access to Drugs

Keeping the U.S. drug supply chain secure, robust, and resilient is essential for the health and national security, and economic prosperity of the United States during emergencies like the COVID-19 pandemic and for the provision of day-to-day health care.

Earlier this year President Biden signed an Executive Order to secure America's critical supply chains. The Executive Order directed the Administration to launch an immediate 100-day

review and strategy development process to identify and address vulnerabilities in the supply chains of four key product sectors, including pharmaceuticals

The federal government will work with the private sector and Congress to implement the recommendations and develop a strategy to create a robust and resilient pharmaceutical and active pharmaceutical ingredient supply chain, including



facilitating adoption of novel methods for commercial production of pharmaceuticals and biologics.

Last week, as part of the Executive Order effort, the Administration announced a set of actions designed to ensure the U.S. has access to the pharmaceuticals necessary for economic security, health security, and national defense.

- ◆ The plan includes fostering international cooperation and promoting research and

development that establishes innovative manufacturing processes and production technologies to strengthen supply chain resilience

- ◆ The U.S. aims to diversify its drug supply chain, relying on a geographically diverse set of manufacturers
- ◆ Another critical feature of the plan is the redundancy of the supply chain, such as the existence of multiple manufacturers for each product and its precursors

Hearing On "Equity in Social Security: In Their Own Words"

The Social Security Subcommittee of the House Committee on Ways and Means held a hearing to discuss the problems facing seniors and the vital roll Social Security plays in the well-being of America's seniors.

A number of Social Security recipients told their stories to the members of the subcommittee and explained the problems they face, as well as their desires for improvements to the program.

Of course, members of the subcommittee also spoke, including the opening remarks of the subcommittee chairman John Larson (D-Conn.). Here are a few of his comments:

"We are here today because of COVID, and its consequences. Consequences that have worsened the inadequacies that have existed for a long time in our Social Security system.

Today we are going to be hearing from people in their own words about Congress's neglect

to help the very citizens we are sworn to serve.

Now I say neglect, because it's been 38 years since Congress has done anything to strengthen Social Security and 50 year since we have improved its benefits.

50 years!

Social Security is by far and away the nation's most successful and popular insurance program.

However, current benefits, as we will learn today, are inadequate, unfair, and in many cases discriminatory, because of systemic economic inequities.

Benefits haven't kept pace with the cost of living and all changes that have occurred over the last 50 years. ...

65 million Americans currently rely on Social Security benefits, yet many still struggle just to make ends meet, to the shame of the nation, millions have worked all their lives, paid into a system, and receive a below poverty line



check from Social Security.

Millions!

Do you know what the poverty line is? It's \$12,880. Who could live on that?

Yet, millions of your fellow Americans, receive below poverty level checks adding to the wealth disparity and further eroding the middle-class.

Look, nobody gets wealthy off of Social Security. It's a subsistence level program.

Here are the facts:

- 4 in 10 beneficiaries rely on Social Security for the majority of their income.
- The average retired worker receives just \$18,500 year in Social Security benefits.
- For women, that number is even lower, it's \$16,000 a year.

Let's be clear about this, this is the responsibility of the Ways and Means Committee, and specifically this subcommittee.

We can no longer kick the can down the road."

Chairman Larson also mentioned the Know Your Social Security Act and heralded it as a great bill. But it hasn't been reintroduced. Also, he did not mention his own bill, the Social Security 2100 Act, which he introduced in the previous Congress but has not done so in this Congress.

Congressman Bill Pascrell (D-N.J.) was very blunt when he said that all the talk about fixing Social Security is just platitudes. While both sides of the aisle know it needs to be fixed and say they want to fix it, nothing is really being done.

After the hearing TSCL contacted Chairman Larson's office to ask why he hasn't reintroduced his Social Security 2100 bill yet and we look forward to hearing from him about this. We have been urging him to do so for weeks now and we hope he will do it now.

This Is Pre-Retirees' Top Retirement Concern

By the time your 50s roll around, you may be ready to really focus on your retirement countdown and start firming up plans for your senior years. But as that milestone approaches, you may also encounter your share of financial concerns, ranging from **not having enough money in savings** to the impact of taxes.

But if there's one thing pre-retirees aged 50 and over are really worried about, it's healthcare costs, including long-term care. In fact, that's their top money-related concern going into retirement, according to a recent Edward Jones and Age Wave study. And when we dig

into what those expenses might cost, it's easy to see why.

Healthcare is a whopper

You might think that once you get on Medicare, your healthcare costs will shrink. Well, think again.

Fidelity reports that the average male-female couple retiring this year will spend **\$300,000** on healthcare during retirement, and that figure doesn't include long-term care. When we break that down by gender, we see that men will spend an average of \$143,000 on healthcare in retirement, while women, due to their longer lifespans, will spend \$157,000.



Long-term care is even more outrageous

While healthcare could eat up a lot of your savings during retirement, long-term care could be downright catastrophic. The average annual cost for an assisted living facility is \$51,600, according to Genworth's most recent cost-of-care study. For a nursing home, expect to spend an average of \$93,075 a year for a shared room, and \$105,850 for a private room.

It's worth noting that the cost of assisted living rose 6.15% between 2019 and 2020. Nursing-home care rose at a rate of 3.24% for shared rooms and

3.57% for private.

How to cover those costs

If paying for healthcare and long-term care is your primary financial concern, at least as far as your senior years go, then the good news is that there are strategies you can employ to cover those expenses.

First, if you're eligible to contribute to a **health savings account**, or HSA, then do your best to max one out. HSA contributions not only go in tax-free but also grow tax-free, and withdrawals are tax-free provided they're used to cover qualified medical expenses....[Read More](#)

Schumer backing plan to add dental, vision and hearing coverage to Medicare

Senate Majority Leader Charles Schumer (D-N.Y.) on Sunday threw his support behind a push, led by Sen. Bernie Sanders (I-Vt.), to add dental, vision and hearing coverage to Medicare. "There is a gaping hole in Medicare that leaves out dental, vision, and hearing coverage. This is a serious problem," Schumer wrote on Twitter. "I'm working

with @SenSanders to push to include dental, vision, and hearing Medicare coverage in the American Jobs and Families Plans," he added.

"There is a gaping hole in Medicare that leaves out dental, vision, and hearing coverage. This is a serious problem. I'm working with Senator Sanders to push to include



dental, vision, and hearing Medicare coverage in the American Jobs and Families Plans."

Schumer, during a news conference on Sunday, made the case for expanding Medicare coverage to include dental, vision and hearing, noting the "more serious medical problems" a lack of coverage causes.

"If you talk to family medicine or primary care doctors, they will tell you with certainty that ignoring medical issues related to dental, vision and hearing often devolves into far more serious medical problems for people — especially seniors — that cost more to treat and are harder to remedy," Schumer said....[Read More](#)

States lack power to take on health insurers and guarantee affordable health care

So far, President Biden has done little to move forward with health insurance reform at the federal level; most states lack the will and the skill to take on the health insurance industry and guarantee affordable health care to their residents. Those few states with the skill and the will to undertake health care reform, appear to lack the power and the resources even to offer their residents the option of public health insurance. We likely will need democracy reform coupled with federal action if we are ever going to get guaranteed affordable health care coverage for all.

So, **what's going on in the states?** Julia Rock reports for the Daily Poster. Spoiler alert: Tremendous and effective pushback from the health insurance industry and its allies.

During the last round of health reform, the public health

insurance option was intended to be an alternative to private health insurance; it was to be administered directly by the government and modeled on Medicare. It has taken on every which size and shape since then. A true public option should have provider rate regulation, an unrestricted provider network and very low administrative costs. That does not appear to be the model any state is considering.

Washington state was first to pass legislation offering residents a "public option." But, the option is hardly "public." It works through private insurers, offering state-administered private insurance to people and it does not require hospitals to accept the public insurance. It has enrolled less than 1 percent of the population.

Washington is now working



on a fix, requiring all hospitals that take Medicaid patients to accept people enrolled in its public plan. Will it pass? Will the hospitals accept public option patients?

A public health insurance option was up for consideration in Colorado. Colorado would have relied on a non-profit it established to administer the public plan, which would make it less likely to focus on profit maximization and more likely to focus on good health outcomes than a for-profit insurer. The state would set provider rates and require all providers to accept them. Standardization of provider rates is needed across the country and could be valuable if the rates are set fairly. An unrestricted provider network is also important, particularly for people with complex conditions. But, again,

the insurance industry lobbyists succeeded at keeping it from happening.

As it was originally designed, Colorado would give insurers two years to voluntarily lower their premiums before implementing its public option. But, Colorado's "public option" is not going forward. Instead, under proposed legislation, the insurers will have until 2025 to lower their premiums by 15 percent (after adjusting for medical inflation) in the individual and small group markets. If not, Colorado might regulate payment rates for these insurance plans.

Insurers can make up for lower premiums with higher deductibles. So, it's not clear to me that the Colorado law accomplished much of anything....[Read More](#)

AARP Report Highlights Increase in Retail Prices for Brand Name Prescription Drugs

An updated **report** from the AARP Public Policy Institute shows the growth in retail prices for many brand name prescription drugs continues to significantly outpace general inflation, contributing to problems with prescription drug affordability for people with Medicare.

From 2019 to 2020, retail prices for 260 brand name drugs widely used by older adults grew by 2.9%, more than twice the country's general inflation rate (1.3%). Over the last 16 years, the entire period during which AARP has been publishing this report series, brand name drug prices have routinely increased much faster than general inflation.

These price changes have meaningful consequences for people with Medicare. In 2020, the typical cost of a brand name medication was \$6,600. With older adults taking an average 4.7 prescription drugs every month, this translates to an

annual retail cost of more than \$31,000—higher than the median annual income for a Medicare beneficiary (\$29,650).

Notably, the average annual cost of one brand name drug would have been nearly \$3,700 lower in 2020 (\$2,911 vs. \$6,604) had the drugs' price changes been limited to the rate of general inflation between 2006 and 2020.

Prescription drug price hikes also affect Medicare's financing. The Medicare Payment Advisory Commission (MedPAC) has **consistently** cited high prices as a key reason for growth in Medicare Part D spending. From 2013 to 2018 alone, Part D spending on prescription drugs **increased** by 26%. The commissioners **attributed** "nearly all of the growth...to higher prices rather than an increase in the number of prescriptions filled by beneficiaries."

And the consequences are not



limited to Medicare. As AARP notes, "Spending increases driven by high and growing drug prices will affect all Americans in some way. Those with private health coverage will pay more in cost-sharing and higher premiums for their health care coverage."

Immediate action is needed to reform the nation's drug pricing system in ways that will strengthen Medicare and improve beneficiary well-being. Absent such interventions, unaffordability will continue to rise, as will the risks to patients and programs. An ever-growing number of Americans could be priced out of needed **medications** and **coverage**, leading to worse health outcomes and higher costs in the future. At the same time, policymakers could seek to control government spending through program changes that threaten beneficiary health and financial security.

Medicare Rights supports comprehensive efforts to lower prescription drug prices, including the Elijah E. Cummings Lower Drug Costs Now Act (**H.R. 3**). This important bill would help protect beneficiaries against burdensome spending, in part by reducing program and out-of-pocket costs. As part of any final bill, we also urge lawmakers to fill longstanding gaps in Medicare coverage, modernize the Part D appeals process, and remove barriers to Medicare's low-income assistance programs. Together, these policies would achieve monumental coverage and affordability gains, better ensuring that all people with Medicare have meaningful access to care.

Read the report, **[Rx Price Watch Report: Trends in Retail Prices of Brand Name Prescription Drugs Widely Used by Older Americans, 2006 to 2020.](#)**

Watchdog: Nursing home deaths up 32% in 2020 amid pandemic

Deaths among Medicare patients in nursing homes soared by 32% last year, with two devastating spikes eight months apart, a government watchdog reported Tuesday in the most comprehensive look yet at **the ravages of COVID-19** among its most vulnerable victims.

The **report from the inspector general of the Department of Health and Human Services** found that about 4 in 10 Medicare recipients in nursing homes had or likely had COVID-19 in 2020, and that deaths overall jumped by 169,291 from the

previous year, before the coronavirus appeared.

"We knew this was going to be bad, but I don't think even those of us who work in this area thought it was going to be this bad," said Harvard health policy professor David Grabowski, a nationally recognized expert on long-term care, who reviewed the report for The Associated Press.

"This was not individuals who were going to die anyway," Grabowski added. "We are talking about a really big number of excess deaths."

Investigators used a generally accepted method of



estimating "**excess**" **deaths in a group of people after a**

calamitous event. It did not involve examining individual death certificates of Medicare patients but comparing overall deaths among those in nursing homes to levels recorded the previous year. The technique was used to estimate deaths in Puerto Rico after Hurricane Maria in 2017 and in New York City after the first coronavirus surge last spring. It does not attribute a cause of death but is seen as a barometer of impact.

Death rates were higher in every month last year when

compared with 2019. The report documented two spikes with particular implications for government policy and for protecting the most vulnerable in future outbreaks of life-threatening illnesses. In April of last year, a total of 81,484 Medicare patients in nursing homes died. Then eight months later, after lockdowns and frantic efforts to expand testing — but before vaccines became widely available — nursing home patients accounted for a staggering 74,299 deaths in December... **Read More**

Legislation to help "Notch Victims" is Introduced

Many of TSCL's supporters are older and less affluent. And some of them are "Notch Victims," individuals who receive lower Social Security benefits because they were born between the years of 1917 and 1926.

Just years before they retired these individuals learned they

would have significantly lower benefits than they expected because of amendments to the Social Security Act that were signed into law in 1977 and which have compounded over time.

For many years TSCL has led the fight to provide additional



compensation to those affected. We are pleased and grateful that Rep. Grace Meng (D-N.Y.) has once again introduced legislation, H.R. 3839, to remedy this situation. It would allow workers who reach age 65 after 1981 and before 1992 to choose

either lump sum payments over four years totaling \$5,000 or an improved benefit computation formula under a new 10-year rule governing the transition to the changes in benefit computation rules enacted in the Social Security Amendments of 1977.

This Medicare scam is having a 'resurgence.' Here's what to look for

Be on the lookout, again, for a scam by people looking to steal Medicare information.

The Better Business Bureau said they are seeing a "resurgence" of scammers claiming to offer "free" genetic testing kits that allegedly screen for heart conditions or cancer.

However, that call is a scam to steal Medicare information for fraudulent billing or identity theft.

"You get a call from someone claiming to be from Medicare or an official-sounding organization. The caller claims to be providing free genetic testing kits. All you need to do is agree to receive a kit in the mail, swab your cheek, and return the vial. The test will tell

you if you have a genetic predisposition to heart disease, cancer, or another common condition," the BBB said. "The caller insists that the test will be totally covered by Medicare."

If you agree, the scammer will then say that they need your Medicare ID number and a lot of personal information before they mail the kit.

"Targets of this scam report being asked extensive questions about their health, such as family medical history and previous diagnoses," the BBB said.

This scam has had plenty of iterations: scammers have gone door-to-door or set up tables at health fairs.



"While genetic testing is a legitimate service – some victims do actually receive a genetic testing kit – the scammers are trying to commit fraud by billing Medicare for the unnecessary tests. For the victims, these cons can lead to medical identity theft and, in some instances, a bill for thousands of dollars. Consumers should always consult with their primary care doctor before agreeing to tests," the BBB said.

Here's how to protect yourself from Medicare fraud, according to the Better Business Bureau

- ◆ Be wary of any lab tests at senior centers, health fairs, or in your home.

- ◆ Be suspicious of anyone claiming that genetic tests and cancer screenings are "free" or "covered by Medicare." If a product or test is truly "free," you will not have to provide your Medicare number.

- ◆ Don't share your Medicare number.

- ◆ Do not trust any name or phone number. Con artists often use official-sounding names or appear to be calling from a government agency or related area code.

- ◆ Medicare will never call you to confirm your personal information, your Medicare number, or ask questions about your personal health. Report Medicare fraud to [Medicare.gov](http://www.Medicare.gov).

Dear Marci: How do I appeal a pre-service denial from my Medicare Advantage Plan?



Dear Marci,
My primary care physician recommended I start outpatient physical therapy. She submitted a special request to my Medicare Advantage Plan for this treatment, but it was denied! How do I file a pre-service appeal with my Medicare Advantage Plan?
-Daniela (Brooklyn, NY)

Dear Daniela,

If your Medicare Advantage Plan denies coverage for a health service or item before you have received the service or item, you can appeal to ask your plan to reconsider its decision. Follow the steps below if you feel that the denied health service or item should be covered by your plan. You can also view this chart for a brief outline of the [Medicare Advantage appeal process](#).

- ◆ Before you can start your appeal, you will need to get an official written decision from your plan, called a Notice of Denial of Medical Coverage. Sometimes you first learn that your plan will not cover a service or item when you or your doctor

calls to confirm coverage before the service is provided. If the plan tells you that the service or item will not be covered, they should also send you a Notice of Denial of Medicare Coverage. You should receive this written denial within 14 days.

If you don't receive a Notice of Denial of Medicare Coverage within two weeks (or 28 days if your plan extended its decision deadline), you can file an appeal without it. Start your appeal by sending a letter to your plan explaining that it has been two weeks since you initially requested an item or service, and you have not received a denial notice. If possible, include a doctor's letter of support. You may also want to file a grievance.

- ◆ You can request a fast (expedited) appeal if you or your doctor feel that your health could be seriously harmed by waiting the standard timeline for appeal decisions. If your plan approves your request to expedite, it should issue a decision within 72 hours. For



this and the following levels of appeal, your doctor can ask that the plan follow the expedited timeline.

- In some cases, your plan can extend its decision deadline up to 14 days. You should be notified if this happens.
- ◆ Start your appeal by following the instructions on the Notice of Denial of Medical Coverage. Make sure to file your appeal within 60 days of the date on this notice. You will need to send a letter to your plan explaining why you need the service or item. You may also want to ask your doctor to write a letter of support, explaining why you need care and addressing the plan's reason for denial. Your plan should make a decision within 30 days. If you file an expedited appeal, your plan should make a decision within 72 hours.
- If you have a good reason for missing your appeal deadline, you may be eligible for a [good cause extension](#).
- If the appeal is successful, your service or item will be covered. If you appeal

is denied, you should receive a written denial notice. Your plan should also automatically forward your appeal to the next level, the Independent Review Entity (IRE). [There are several further steps in the appeals process](#) that you may follow if your appeal continues to be denied.

Remember to keep good records of all your communications throughout the appeals process. You should submit all requests in writing, and keep fax transmission reports, mail information by certified mail, or return receipts. Write down the details of any phone calls you make related to your case, including what you discussed, who you spoke to, and the date and time of the call. If you need assistance understanding the coverage rules surrounding a health service or item, or help completing your appeal, you can contact your [State Health Insurance Assistance Program \(SHIP\)](#) for assistance by calling 877-839-2675.

-Marci

The Hard Realities of a ‘No Job, No Job’ Mandate for Health Care Workers

Christopher Richmond keeps a running tab on how many workers at the ManorCare skilled nursing facility he manages in western Pennsylvania have rolled up their sleeves for a covid-19 vaccine.

Although residents were eager for the shots this year, he’s counted only about 3 in 4 workers vaccinated at any one time. The excuses, among its staff of roughly 100, had a familiar ring: Because covid vaccines were authorized only for emergency use, some staffers worried about safety. Convenience mattered. In winter, shots were administered at work through a federal rollout. By spring, though, workers had to sign up online

through a state program — a time-sucking task.

ManorCare urges every worker to be immunized against covid but turnover has vexed that effort. Managers at ProMedica, a nonprofit health system that operates ManorCare and senior care facilities in 26 states, faced a workforce conundrum familiar to all manner of providers during the pandemic: how to persuade essential workers to get vaccinated — and in a way that didn’t drive them away. Raises and bonuses, costing millions of dollars, did not move the needle to 100%.

Animus toward the vaccine created turmoil for some providers. Dr. Eric Berger, a pediatrician in Philadelphia who



opened his practice more than a dozen years ago, enforced mandatory shots in May and saw six of his 47 staff members walk out. Berger said he worked for months to educate resistant workers. In April, he learned that several, women in their 20s and 30s, had attended a private karaoke party. Within days, four staffers were infected with covid.

Berger, who had seen in-office costs for protective equipment soar, then set a deadline for shots. He looks back with steely resolve over the last-minute “I quit” texts he received — and the hassle of finding a new receptionist and billing and medical assistants.

“Fortunately, we had some

wonderful people who put in extra time,” he said. “It’s been stressful, but I think we did the right thing.”

Brittany Kissling, 33 and a mother of four, was one of the hesitant workers at Berger’s practice who decided — largely for financial reasons — to get vaccinated. The clinic manager couldn’t afford to lose her job. But she said she was nervous and that most of the workers who left recoiled at being told vaccinations were not negotiable. “I was a no-show my first time,” Kissling said about her first vaccine appointment. “I was scared. There were a lot of unknowns.”...[Read More](#)

Pandemic Swells Medicaid Enrollment to 80 Million People, a ‘High-Water Mark’

The pandemic-caused recession and a federal requirement that states keep Medicaid beneficiaries enrolled until the national emergency ends swelled the pool of people in the program by more than 9 million over the past year, according to a report released Thursday.

The latest figures show Medicaid enrollment grew from 71.3 million in February 2020, when the pandemic was beginning in the U.S., to 80.5 million in January, according to a [KFF analysis of federal data](#). (KHN is an editorially

independent program of KFF.)

That’s up from about 56 million in 2013, just before many states expanded Medicaid under the Affordable Care Act. And it’s double the 40 million enrolled in 2001.

Medicaid, once considered the ugly duckling compared with the politically powerful and popular Medicare program, now covers nearly 1 in 4 Americans. In New Mexico, the ratio is more than 1 in 3.

Together, Medicaid and Medicare cover 43% of Americans.



More than three dozen states since 2014 have used billions in ACA funding to expand coverage beyond traditional Medicaid populations to cover adults with incomes below 138% of the federal poverty level, or about \$17,800. At the end of 2020, 14.8 million newly eligible adults were enrolled in Medicaid because of the ACA.

States that have seen at least an 80% increase in Medicaid enrollment since 2013 are Kentucky (157%), Nevada (129%), Alaska (94%), Colorado (92%), Montana (88%), Oregon

(85%) and New Mexico (80%).

Although Medicaid has often been criticized for having too few physicians who accept its low reimbursement rates, state officials say they have weathered the surge with few complaints from enrollees about accessing health services. One key reason is the dramatic downturn in people seeking medical care during the pandemic because they were mitigating their risks of contracting covid....[Read More](#)

FBI Elderly Common Scams and Crimes

Each year, millions of elderly Americans fall victim to some type of financial fraud or confidence scheme, including romance, lottery, and sweepstakes scams, to name a few. Criminals will gain their targets’ trust and may communicate with them directly via computer, phone, and the mail; or indirectly through the TV and radio. Once successful, scammers are likely to keep a scheme going because of the prospect of significant financial gain.

Seniors are often targeted because they tend to be trusting and polite. They also usually

have financial savings, own a home, and have good credit—all of which make them attractive to scammers.

Additionally, seniors may be less inclined to report fraud because they don’t know how, or they may be too ashamed at having been scammed. They might also be concerned that their relatives will lose confidence in their abilities to manage their own financial affairs. And when an elderly victim does report a crime, they may be unable to supply detailed information to investigators.



With the elderly population growing and seniors racking up more than \$3 billion in losses annually, elder fraud is likely to be a growing problem.

Common Elder Fraud Schemes

- ◆ Romance scam
- ◆ Tech support scam
- ◆ Grandparent scam
- ◆ Government impersonation scam.
- ◆ Sweepstakes/charity/lottery scam
- ◆ Home repair scam
- ◆ TV/radio scam

caregiver scam

◆ **Family/caregiver Protect Yourself**
Recognize scam attempts and end all communication with the perpetrator

How to Report

If you believe you or someone you know may have been a victim of elder fraud, contact your local [FBI field office](#) or [submit a tip online](#). You can also file a complaint with the FBI’s [Internet Crime Complaint Center](#).
.....[Read More](#)

Device Makers Have Funneled Billions to Orthopedic Surgeons Who Use Their Products

Dr. Kingsley R. Chin was little more than a decade out of Harvard Medical School when sales of his spine surgical implants took off.

Chin has patented more than 40 pieces of such hardware, including doughnut-shaped plastic cages, titanium screws and other products used to repair spines — generating \$100 million for his company SpineFrontier, according to government officials.

Yet SpineFrontier's success arose not from the quality of its goods, these officials say, but because it paid kickbacks to surgeons who agreed to implant the highly profitable devices in hundreds of patients.

In March 2020, the Department of Justice **accused** Chin and SpineFrontier of illegally funneling more than \$8 million to nearly three dozen spine

surgeons through “sham consulting fees” that paid them handsomely for doing little or no work. Chin had no comment on the civil suit, one of more than a dozen he has faced as a spine surgeon and businessman. Chin and SpineFrontier have yet to file a response in court.

Medical industry payments to orthopedists and neurosurgeons who operate on the spine have risen sharply, despite government accusations that some of these transactions may violate federal anti-kickback laws, drive up health care spending and put patients at risk of serious harm, a KHN investigation has found. These payments come in various forms, from royalties for helping to design implants to speakers' fees for promoting devices at medical meetings to stock holdings in



exchange for consulting work, according to government data.

Health policy experts and regulators have focused for decades on pharmaceutical companies' payments to doctors — which research has shown can influence which drugs they prescribe. But far less is known about the impact of similar payments from device companies to surgeons. A drug can readily be stopped if deemed harmful, while surgical devices are permanently implanted in the body and often replace native bone that has been removed.

Every year, a torrent of cash and other compensation flows to these surgeons from manufacturers of hardware for spinal implants, artificial knees and hip joints — totaling more than \$3.1 billion from August 2013 through the end of 2019, a

KHN analysis of government data found. These bone specialists make up a quarter of U.S. doctors who have accepted at least \$100,000 or more, and two-thirds of those who raked in \$1 million or more, from the medical device and drug industries last year, the data shows.

“It is simply so much money that it is staggering,” said Dr. Eugene Carragee, a professor of orthopedic surgery at the Stanford University Medical Center and **critic** of the medical device industry's influence. Much of the money is deemed to be compensation for consulting duties or medical research, or royalties for inventing, or fine-tuning, new surgical tools and techniques. In some cases, it pays for trips or splashy junkets or rewards surgeons for promoting products to their peers.... **[Read More](#)**

U.S. to Spend \$3.2 Billion to Help Develop Antiviral Pills for COVID

After spending billions to speed the creation of COVID-19 vaccines, the United States said Thursday that it will now devote \$3.2 billion to the development of antiviral pills that could stop the new coronavirus before it does its worst damage.

Along with "accelerating things that are already in progress" for COVID-19, the new program would also encourage treatments for other viruses, Dr. Anthony Fauci said when announcing the new program during a White House briefing.

"There are few treatments that exist for many of the viruses that have pandemic potential," he said, including Ebola, dengue, West Nile and Middle East respiratory syndrome.

But he added, "vaccines clearly remain the centerpiece of our arsenal."

One antiviral drug, remdesivir, and three antibody therapies are now approved to treat COVID-19. But all of those drugs have to be delivered via IV at hospitals or medical

clinics.

What is needed is a convenient pill that patients could take when symptoms first appear. Some drugmakers are testing such medications, but initial results aren't expected for several more months, the *Associated Press* reported. The new federal funds will speed those tests and support research, development and manufacturing of the pills.

Last week, the United States said it would buy 1.7 million doses of an experimental antiviral pill from Merck and Ridgeback Biotherapeutics if it is shown to be safe and effective. A large study of the drug, molnupiravir, should deliver results this fall. Early research suggests the drug may reduce the risk of hospitalization if used shortly after infection, the *AP* reported.

The federal government may seek similar deals for two other antivirals that are in late trials, Dr. David Kessler, the chief science officer of the Biden



administration's COVID-19 response team, told *The New York Times*.

The hope "is that we can get an antiviral by the end of the fall that can help us close out this chapter of the epidemic," Kessler said.

One of the drugs the government is eyeing is AT-527, developed by Atea Pharmaceuticals. The compound is already used to treat hepatitis C, and early studies suggested it might also work against COVID-19. Roche has partnered with Atea to test it in people, and the companies are currently running a late-stage clinical trial, the *Times* reported.

The other drug was created by Pfizer scientists, adapted from a molecule first designed in the early 2000s as a potential drug for SARS. After being abandoned for years, the Pfizer researchers decided to modify the molecule's structure so it would work against the new coronavirus's protease. More than 200 Pfizer scientists

worked on the molecule, known as PF-07321332, the *Times* reported.

The drug had initially been designed to be taken intravenously, but the researchers tweaked its structure to work as a pill. When mice were given the pill, it reached high enough levels in the body to block the coronavirus. Pfizer launched a clinical trial in March to study its safety in people, and expects to move to later-stage testing next month, the *Times* said.

Until this week, the only medicines shown to boost survival were steroids given to patients sick enough to need extra oxygen and intensive care. But on Wednesday, U.K. researchers reported that one of the antibody combinations successfully reduced deaths in a large study of hospitalized COVID-19 patients, the *AP* reported.

Red Cross Warns of Severe Blood Shortage

There's a severe blood shortage in the United States due to a recent surge in trauma cases, organ transplants and elective surgeries, the American Red Cross says.

The Red Cross is appealing to Americans to roll up their sleeves and donate blood immediately.

"Our teams are working around the clock to meet the extraordinary blood needs of hospitals and patients — distributing about 75,000 more blood products than expected over the past three months to meet demand — but we can't do it without donors. Every two seconds, someone in the U.S.

needs blood," said Chris Hrouda, president of Red Cross Biomedical Services.

Red cell demand from hospitals with trauma centers is 10% higher than in 2019, which is five times higher than the growth in demand from other facilities that provide transfusions, according to a Red Cross news release.

Between 20% and 40% of trauma deaths that occur after hospital admission involve massive bleeding. In such cases, saving a life could require hundreds of blood products, depending on injury severity.

Hospitals' need for blood is



American Red Cross also on the rise as they deal with many patients who delayed care due to the COVID-19 pandemic.

"Some hospitals are being forced to slow the pace of elective surgeries until the blood supply stabilizes, delaying crucial patient care. As we return to pre-pandemic activities and resume travel to visit loved ones, we want people to remember the needs of patients this summer and the power so many of us have to help save lives," Hrouda explained.

Type O is the blood type most urgently needed by hospitals because it's the one most often

used in transfusions, but the Red Cross said that all blood types are welcomed.

There is also an emergency need for platelets, the clotting portion of blood. Nearly half of all platelet donations are given to patients undergoing cancer treatments.

To schedule an appointment to give blood or platelets, use the Red Cross Blood Donor App, visit RedCrossBlood.org or call 1-800-RED CROSS (1-800-733-2767).

Those who donate with the Red Cross between June 14 and June 30 will receive a \$5 Amazon.com gift card by email.

In 11 States, Seniors' Low Vaccination Rates a 'Powder Keg' for New Cases

U.S. health experts warn there is a ticking time bomb in 11 states where 20 percent or more of seniors still haven't gotten a COVID-19 vaccine.

Top priority for vaccinations was given to Americans aged 65 and older because they are far more vulnerable to serious illness and death from the virus than younger people are. Accordingly, this age group does have the highest rate of vaccination: 87 percent have received at least one dose, compared with 60 percent for people aged 18 to 64, and 31 percent for those aged 12 to 17, data from the U.S. Centers for

Disease Control and Prevention show.

But in the 11 states where vaccination rates are lower among seniors, those who haven't gotten a shot pose a public health risk as social distancing restrictions are stripped away.

Most of the 11 states are in the South: Alabama, Arkansas, Louisiana, Mississippi, North Carolina and Tennessee, *The New York Times* reported. Georgia, Idaho and Missouri are at the 20 percent threshold. West Virginia and Wyoming have more than 20 percent of people 65 and over without one dose.



"The 20 percent lines up pretty well with a group of people, especially in the South, who say, 'No way, no how am I getting vaccinated,'" Dr. Michael Saag, associate dean for global health at the University of Alabama at Birmingham, told the *Times*.

"Convincing them that it is in their own interest is a tough nut to crack," Saag noted. "For the state of Alabama and other Southern states, this is not for a lack of effort or resources. This is about a population resistant to receiving the message."

Older people have felt more

threatened from the coronavirus, experts say, so they have been among the most receptive to the vaccines. After older age groups were given priority when the first vaccines were authorized for emergency use in December, the proportion of those dying started dropping immediately, the *Times* reported.

Now, those aged 50 and older account for the bulk of COVID-19 deaths and the virus continues to kill hundreds of people daily....[Read More](#)

How Healthy Are the New Plant-Based 'Fake Meats'?

More and more Americans are seeking out healthier, greener and more ethical alternatives to meat, but are plant-based alternatives like the Impossible Burger and Beyond Meat truly nutritious substitutes?

The answer is yes, according to new research funded by the U.S. National Institutes of Health. It found the imitation meats to be a good source of fiber, folate and iron while containing less saturated fat than ground beef. But the researchers said they also have less protein, zinc and vitamin B12 — and lots of salt.

"Switching from ground beef to a plant-based ground beef

alternative product can be a healthy choice in some ways," said lead researcher Lisa

Harnack, of the University of Minnesota School of Public Health, in Minneapolis.

Her advice: Read the Nutrition Facts label and choose a product that best matches your health and nutrition goals.

For example, if you're limiting sodium to control high blood pressure, steer clear of products that are high in salt, Harnack said.

"If you're watching saturated fat intake for heart health, read the label to make sure you're choosing a product that is low



in saturated fat," she said. "A few products contain as much or nearly as much saturated fat as ground beef."

For the study, Harnack's team used a University of Minnesota food and nutrient database that includes 37 plant-based ground beef alternative products made by nine food companies.

The products analyzed are from Amy's Kitchen, Inc.; Beyond Meat; Conagra, Inc.; Impossible Foods Inc.; Kellogg NA Co.; Kraft Foods, Inc.; Marlow Foods Ltd.; Tofurky; and Worthington.

Although these plant-based products can be healthy

alternatives to beef, Harnack hopes their manufacturers will make them even healthier by keeping salt to a minimum.

"Food companies should work to optimize the nutritional quality of their products, especially with respect to the amount of salt and other sodium-containing ingredients used in formulating veggie burgers and other plant-based ground beef alternative products," Harnack said.

Samantha Heller, a senior clinical nutritionist at NYU Langone Health in New York City, reviewed the findings....[Read More](#)

Survivors' Plasma Helps Blood Cancer Patients Battle COVID-19

Giving COVID-19 survivors' blood plasma to blood cancer patients hospitalized with COVID-19 significantly improves their chances of survival, a new study finds.

"These results suggest that convalescent plasma may not only help COVID-19 patients with blood cancers whose immune systems are compromised, it may also help patients with other illnesses who have weakened antibody responses to this virus or to the vaccines," said study co-first author Dr. Jeffrey Henderson. He is an associate professor of medicine and of molecular microbiology at Washington University School of Medicine in St. Louis.

"The data also emphasize the

value of an antibody therapy such as convalescent plasma as a virus-directed treatment option for hospitalized COVID-19 patients," Henderson explained in a university news release.

Plasma from COVID-19 survivors is called convalescent plasma because it contains high levels of antibodies against the coronavirus that causes COVID-19.

Cancer patients may be at a higher risk of death from COVID-19 due to a weakened immune system. Giving them convalescent plasma is meant to boost their immune system's ability to fight the disease, the study authors noted.

"As more COVID-19 patients



began receiving convalescent plasma, we started hearing physicians around the country report remarkable clinical improvements following convalescent plasma infusions in COVID-19 patients with blood cancers and antibody deficiencies, some of whom were already very ill," Henderson said.

"I have seen one of my own patients with blood cancer quickly improve after receiving convalescent plasma. Similar stories that were often very detailed suggested that a formal study would help physicians with decisions they were already making on a daily basis," he added.

In the new study, Henderson's team assessed the 30-day death

rate among 966 adults, average age 67, who had a blood cancer (such as leukemia, lymphoma or multiple myeloma) and were hospitalized due to COVID-19. Convalescent plasma was given to 143 of these patients.

Death rates were just over 13% for those who received convalescent plasma and nearly 25% among those who didn't receive it, the researchers reported.

The difference was even larger among the 338 patients admitted to intensive care due to severe COVID-19 symptoms, such as difficulty breathing or cardiac distress. In these patients, death rates were nearly 16% among those who received convalescent plasma and 47% among those who didn't receive it.

Many 'High Priority' Patients Aren't Getting Put on Kidney Transplant Lists

Many Americans who stand to benefit most from a kidney transplant may be missing a key window of opportunity, a new study finds.

The study focused on kidney failure patients who would be expected to live many years after receiving a kidney transplant. That generally includes relatively younger people without other major medical conditions.

In 2014, the U.S. kidney allocation system made changes to help ensure those patients receive a donor kidney that is

likely to function for many years — which typically means from a young, healthy donor.

A scoring system, called the estimated post-transplant survival (EPTS) score, was introduced. Once transplant candidates are placed on the waitlist, they are given an EPTS score; those in the "top 20%" get priority whenever a particularly high-quality kidney becomes available.

But the new study found that many patients who would fall into that category are not making



it onto the transplant waitlist in a timely manner.

Of more than 42,000 U.S. patients who would score in the top 20%, fewer than half were on the waitlist. And among the 34,000-plus who'd started kidney dialysis, only 37% were waitlisted for a transplant within three years.

"It's extremely discouraging," said study leader Jesse Schold, a researcher at the Cleveland Clinic in Ohio.

These are patients who are very likely to do well after a transplant, he said. But by the time they get on the transplant list, many will no longer have a top EPTS score.

In fact, Schold's team found, of dialysis patients, 61% fell out of the top 20% group within 30 months. And, as seen throughout U.S. health care, there were disparities: Black patients and those from low-income groups were less likely to be waitlisted

New Psychotherapy May Reduce Anxiety, Depression in Heart Patients

A type of psychotherapy that changes how people regulate thinking patterns may reduce anxiety and depression for people recovering from heart problems, new research shows.

The study, published Monday in the American Heart Association journal *Circulation*, found 1 in 3 people who took part in metacognitive therapy, or MCT, during cardiac rehabilitation significantly reduced their symptoms compared to those who did not receive therapy.

Roughly one-third of people with heart disease suffer from anxiety and depression, which have been associated with the progression of heart disease and other heart-related complications.

Studies show people who experience poor mental health following heart problems have a harder time recovering and a poorer quality of life than those who don't.

"This could make a big difference to patients' lives and health in the long-term," said lead study author Adrian Wells, professor of clinical and experimental psychopathology at the University of Manchester in England. Wells is the originator and developer of MCT, which aims to lower anxiety and depression by helping people regulate unhelpful thinking processes of worry and rumination. He also is founder and director of the MCT Institute



in Manchester and director of the Anxiety, Depression and Psychological Therapies Research Unit at Greater Manchester Mental Health NHS Foundation Trust.

Previous studies show cognitive behavioral therapy, or CBT, a more traditional type of psychotherapy, also can reduce anxiety and depression symptoms for people with heart disease. CBT helps people challenge the content of their negative thoughts, whereas MCT helps them reduce the amount of time they spend absorbed in negative thinking, Wells said.

In the new study, researchers compared symptoms of anxiety and depression between two

groups of heart patients enrolled in cardiac rehabilitation programs at five hospitals in England. Both groups received routine cardiac rehab services that included exercise, health education and stress management. But one group also received six sessions of group metacognitive therapy. Both groups were followed for one year.

After four months, those given MCT achieved significantly lower scores for depression and anxiety compared to those who did not receive therapy. The improvements in anxiety and depression were sustained for up to a year... [Read More](#)

Expensive brain-cancer drug no longer an option under Medicare

Brain-tumor experts and patient advocates are among those decrying a decision by the seller of a cancer drug to exit a federal discount program for Medicare patients, leaving some unable to afford a treatment that can run as much as **\$1,000 a capsule**.

The move by Miami-based NextSource Biotechnology means the drug Gleostine no longer qualifies for Medicare Part D drug assistance, meaning there is one fewer option of a handful of approved

chemotherapies.

"There are lots of people right now who are not getting the drug," and some will likely die as a result, Henry S. Friedman, a neuro-oncologist and professor of neurosurgery at Duke University School of Medicine, told CBS MoneyWatch. "There are patients who can't afford the drug, and other drugs may not be as effective."

The Centers for Medicare & Medicaid Services, or CMS, confirmed NextSource had

NEXTSOURCE
PHARMACEUTICALS

withdrawn from the Medicaid drug rebate program, meaning states cannot receive federal funding reimbursement for Gleostine. However, states can still pay for the drug with their own funds, with each state's Medicaid program making those coverage decisions.

Used to treat a tumor known as glioblastoma and other brain cancers, Gleostine's patent has lapsed but there is no generic version.

"The decision by the company to withdraw from public health insurance programs weakens the safety net for vulnerable brain cancer patients who already have few treatment options. Lomustine, (brand name: Gleostine) is a medically-necessary part of the standard of care for patients with the most aggressive tumors and is also essential in many clinical trials," stated David Arons, CEO of the National Brain Tumor Society.

Women, Take These Key Steps to Good Urological Health

Women who try to hold their pee during the day might want to rethink that strategy.

It's time to "get up and go," according to the Urology Care Foundation, which is encouraging women to be proactive about their urological health.

That, of course, means get up and go to the bathroom if you need to. But the foundation also suggests a number of activities a woman can get up and go *do*, to get in some self-care that can benefit their urological health.

"Our goal is to help women understand what steps they can

take to improve not only their urologic health, but their overall health," Dr. Harris Nagler, president of the Urology Care Foundation --- part of the American Urological Association -- explained in a foundation news release.

Several urology-related conditions that can affect women are overactive bladder, urinary tract infections, incontinence, interstitial cystitis and bladder cancer.

There are several reasons to get up and go to the bathroom, including that holding your urine



for too long can weaken your bladder muscles over time. This can lead to problems like incontinence and not

being able to fully empty your bladder. The foundation suggests trying to urinate every three to four hours during the day.

The foundation also recommends getting up to get a drink of water often because becoming dehydrated can lead to concentrated urine, which can irritate your bladder.

Two more tips include getting up and going for a walk and setting aside time to relax.

Physical activity can help prevent bladder problems and help maintain a healthy weight. The foundation suggests walking for 30 minutes a day. To relax, the experts recommend mindful meditation, which can reduce the frequency and urgency of overactive bladder episodes and can help calm the body and mind.

More information

The U.S. National Institute on Aging offers additional [tips for a healthy bladder](#).

Too Many Older Americans Are Taking Daily Aspirin

Many older adults are still taking a daily baby aspirin to ward off first-time heart problems — despite guidelines that now discourage it, a new study finds.

Researchers found that one-half to 62% of U.S. adults aged 70 and up were using low-dose aspirin to cut their risk of heart disease or stroke. And aspirin use was common even among those with no history of cardiovascular disease — a group for whom the drug may do more harm than good.

The study authors estimated that nearly 10 million Americans who fall into that category are using aspirin.

The numbers are concerning, said senior researcher Dr. Rita Kalyani, an associate professor of medicine at Johns Hopkins University School of Medicine, in Baltimore.

Current guidelines, she said, generally discourage people aged 70 and up from routinely using aspirin to prevent a first-time heart attack or stroke.

That's, in part, because aspirin is not benign: It carries a risk of bleeding in the gastrointestinal tract or even the brain — risks that typically go up with age. And some recent trials have failed to show that low-dose aspirin really does lower the odds of first-time heart attacks or strokes.

That all may be confusing, and surprising, to people who've long believed that aspirin is a heart champion.

"It's confusing even for health care providers," said Dr. Wilson Pace, chief medical officer at the DARTNet Institute, in Aurora, Colo.

What is clear, Pace said, is that aspirin can benefit people with



known cardiovascular disease — either clogged heart arteries or a history of heart attack or stroke.

Where things get murky is in the prevention of a first-time heart attack or stroke.

Years ago, Pace said, guidelines came out "strongly in favor" of low-dose aspirin for people considered to be at high risk of developing heart disease in the next 10 years (because of risk factors like smoking, high blood pressure or diabetes).

But based on recent studies, the thinking has changed.

Now, the latest guidelines from the American College of Cardiology/American Heart Association say aspirin can be considered for "select" patients aged 40 to 70 who are not at increased risk of bleeding.

When it comes to older adults, the guidelines caution against "routine" aspirin use for primary

prevention.

That's something of a "hedge," said Pace, since there might be some cases where aspirin is a reasonable choice for an older adult at high risk of cardiovascular trouble.

But for the most part, he said, they do not need the drug for primary prevention.

"If you're 75 and have diabetes, I wouldn't start you on aspirin," Pace said. "I'd go with a statin."

He noted that statins, which lower LDL ("bad") cholesterol, "clearly help prevent primary disease."

Of course, Pace added, many older adults on aspirin actually started taking it years ago. He encouraged those patients to talk with their doctor about whether it's still necessary....[Read More](#)