Rhode Island Alliance for Retired Americans®

RI ARA

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

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Message from Alliance *for* Retired Americans Leaders

Senator Sanders Introduces Landmark Bill to Expand Access to Dental Care

Robert Roach, Jr President, ARA

Senator Bernie Sanders (VT) has **introduced** legislation that would expand Medicare, Medicaid, and veterans' health benefits to provide dental care to more Americans. The bill would also increase the number of dentists and support staff in rural and under-served areas.

Insufficient dental care is an

issue affecting tens of millions of Americans, including seniors with Medicare. One out of every five seniors in the U.S. is missing all of their natural teeth and many of them cannot afford dentures – which can cost thousands of dollars.

"Having bad teeth or poor teeth is a badge of poverty. It becomes a personal issue, a psychological issue, an economic issue as well," **said** Sanders.

He added that spending money on dental care saves money elsewhere, since so much dental treatment is preventive. Spending on dental care frees up other funds for Medicare; for example, many people with chronic heart conditions suffer from periodontal disease, and dental care covering periodontal disease would save as much as $27.8 billion every year for Medicare patients.

"Dental care is health care," said **Robert Roach, Jr., President of the Alliance**. "Medicare should absolutely include dental benefits for all beneficiaries." Alliance Social

Alliance Mourns the Death of Barbara Franklin

Barbara Franklin, who served as president of the Illinois Alliance and AFSCME Retirees Subchapter 88, passed away on Saturday in Urbana, Illinois. She was 79.

Barbara retired from the University of Illinois in 2000 after more than 35 years of employment at the College of Education, serving as secretary to the dean of the Department of Educational

Policy Studies. During her time at the university, she was instrumental in forming the AFSCME union for clerical workers.

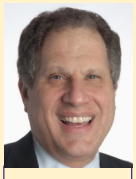
"Barbara dedicated her life to politics and social justice. She was not only a devoted state president for the Illinois Alliance, she was also a caring person who leaves behind many friends," said **Executive Director Fiesta**. "She will be missed but never forgotten."

Alliance Social Security Video Wins International Award

The Alliance **won** a 2024 Silver Telly Award for its short video, "Social Security — Our Earned Benefits." Each year the Tellys receive more than 12,000 entries from around the world.

The video explains and corrects several common misconceptions about Social Security and describes the real benefits Social Security provides to millions of Americans, such as guaranteed payments for your entire life.

"The video is a great tool to educate and persuade Americans to strengthen and expand Social



Rich Fiesta, Executive Director, ARA

Security, not cut it," said **Richard Fiesta, Executive Director of the Alliance**. "We encourage everyone to watch and share it with their friends, family, and colleagues." Watch the video **here**.

Rick Scott to Seek GOP Leadership Role

U.S. Sen. Rick Scott (FL) has **thrown his hat into the ring** to replace retiring Republican Senate Leader Mitch McConnell (KY). The first-term senator will face Senate Minority Whip John Thune (R-SD) and Sen. John Cornyn (R-TX), also a former whip.

Scott became a major factor in the 2022 election cycle with his so-called 11-point Rescue America Plan, which would have "sunset" all federal programs, including Social Security and Medicare. Sunsetting is a legal provision under which a program is automatically terminated at the end of a fixed period unless renewed by legislative action. The plan also included voter suppression proposals similar to those that several states have already enacted.

In a rare public **admonishment** of one of his top lieutenants in 2022, McConnell (KY) **rebuked** Scott's plan to sunset Social Security and Medicare within five years. Scott was then the chairman of the National Republican Senate Committee, which is in charge of developing Republican strategy and recruiting candidates to take back the Senate.

"The Rescue America Plan would have ended Social Security and Medicare as we know them," said **Joseph Peters, Jr., Secretary-Treasurer of the Alliance**. "The fact that Sen. Scott wants to be the GOP's Senate Leader should serve as a reminder about what could happen to Social Security and Medicare if the GOP retakes the Senate after November's election."

Joseph Peters, Jr. Secretary Treasurer ARA

ADD YOUR NAME

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

Medicare Rights Urges CMS to Increase Medicare Advantage Transparency and Accountability

Yesterday, the Medicare Rights Center **submitted comments** in response to a Centers for Medicare & Medicaid Services (CMS) **Request for Information (RFI)** on enhancing their Medicare Advantage (MA) data collection. According to CMS, the solicited information is intended to "support efforts for MA plans to best meet the needs of people with Medicare, for people with Medicare to have timely access to care, to ensure that MA plans appropriately use taxpayer funds, and for the market to have healthy competition."

Our response focused on opportunities to improve program transparency, plan accountability, and the MA system through data collection and reporting in several key areas: equity, provider directories and plan networks, marketing, utilization management and appeals, supplemental benefits, dually eligible individuals and dual eligible special needs plans (D-SNPs), and favorable selection and risk adjustment.

Our recommendations center beneficiary needs and are grounded in our work helping MA enrollees navigate coverage and access care. Year after year, among the **most frequent calls** to Medicare Rights Helpline are those on or behalf of MA enrollees facing care complications or coverage barriers. Based on this experience, we know that MA is increasingly affecting the lives and finances of many people with Medicare, and the program itself. **Over half** of eligible beneficiaries are now enrolled in MA, and plans draw down **billions of dollars** from Medicare each year. Despite MA's sizable and growing footprint, enrollees, advocates, researchers, families, and policymakers are often kept in the dark about important aspects of the program, including fundamentals like whether enrollees are getting the care they need and how plans are using program, beneficiary, and taxpayer funds.

These data gaps impact beneficiaries from the outset, as inadequate information undermines efforts to understand and choose optimal coverage. An increasingly cluttered MA marketplace, driven by **burgeoning profits** and **rule changes** allowing MA plans to proliferate, further hinders sound decision-making. More beneficiaries than ever before are experiencing these pitfalls. MA enrollment has more than doubled in the last decade and the share of beneficiaries enrolled in MA, **currently around 50%**, may hit **60% by 2030**.

Payments to MA plans are also climbing. As a portion of total Medicare dollars, they **ballooned** from 26% in 2010 to 45% in 2020, and could reach 54% by 2030. Per person, Medicare spending is **higher and growing faster** for MA beneficiaries than for those with Original Medicare (OM). Medicare pays MA plans an estimated **6% more** than OM for similar enrollees, translating to an extra $27 billion in 2023 alone. Higher payments per MA enrollee are expected to cost Medicare **$183 billion** in the coming years. These overpayments have **system-wide consequences**, raising taxpayer costs and Part B premiums across the board, while worsening Medicare sustainability for current and future enrollees.

These trajectories are additionally concerning because the **data are unclear** when it comes to MA quality and the beneficiary experience. Much of what we **do know suggests** room for improvement, and that plans are simply not being made to account for their use of public dollars. There is also a lack of reported demographic information, which undermines transparency and stymies equity advancement. Without these and other data points, it is impossible to know how well MA works for people with Medicare, including those from underserved communities. This, in turn, makes it difficult for beneficiaries to make fully informed enrollment choices or for policymakers to hold MA plans responsible for their spending, promises, and behaviors.

As a result, harmful plan practices—such as **inappropriate denials, utilization management misuse, aggressive marketing, favorable selection and other gaming**—can continue unabated, worsening health care access, outcomes, and disparities….**Read More**

Nearly 50% of American retirees underestimated their healthcare costs. Here are 3 ways to protect yourself

It's tempting — quite tempting — to look forward to your retirement through rose-colored glasses, to imagine your golden years as an endlessly happy epoch marked by relaxation, fulfillment and, crucially, good health.

But according to a new report, just about half of all American retirees underestimate their healthcare expenses. These folks are all around you. Maybe it's you.

The Schroders 2024 U.S. Retirement Survey **reveals** that 47% of all retirees report that their retirement expenses are higher than expected, while 49% believed Medicare would cover more healthcare than it did. And KFF **notes** that Medicare households spend more on health care than other households.

Schroders based its findings on interviews with 498 retired investors up to 79 years old. The survey suggests that for many, the sobering realities of senior healthcare costs don't hit home until retirement begins.

On average, retired Americans report spending 14% of their monthly income on healthcare costs such as insurance premiums, out-of-pocket expenses, prescription costs and more. No wonder a vast majority of retired Americans — 85% — listed higher-than-expected healthcare costs as a top concern. A 65-year-old retiring today can expect to **spend $157,500** in healthcare and medical expenses throughout retirement, according to the Fidelity Investment Retiree Health Care Cost Estimate for 2023. Yet 43% of those aged 55-64 and 49% of retirees 65-74 lack a retirement account, according to 2022 **figures** from the U.S. Federal Reserve. Those two figures represent a bracing discrepancy. Here's how to ensure you won't be on the wrong side of it.

The ins and outs of Medicare and average health care costs

Aside from relying on Social Security, many seniors count on Medicare to help with healthcare expenses in retirement. In a nutshell it's health insurance for people 65 or older and includes Part A (hospital insurance) and Part B (medical insurance).

Usually, Part A is premium-free if you've paid Medicare taxes for at least 10 years. You can also buy it at either **$278 or $506 a month**, depending on how long you or your spouse worked and paid Medicare taxes. Part B carries a monthly premium of $175.

Specifically, Part A covers inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery and home health care; Part B covers doctor and other health care providers' services and outpatient care, durable medical equipment, home health care, and some preventive services.

But retirees can still expect to pay healthcare costs beyond Medicare coverage. Fidelity notes that the average 65-year-old couple will spend about $12,200 on healthcare in their first year of retirement, while per-person personal healthcare spending for those 65 and older was **$22,356 in 2020**, according to the non-profit Centers for Medicare & Medicaid Services. Traditional Medicare does not cover dental, hearing, and vision services and carries deductibles along with other cost-sharing requirements...**Read More**

When 'Prior Authorization' Becomes a Medical Roadblock

Medicare Advantage plans say it reduces waste and inappropriate care. Critics say it often restricts coverage unnecessarily.

Slowly but steadily, Marlene Nathanson was recovering. She had suffered a stroke in November 2022 at her home in Minneapolis and spent a week in a hospital; afterward, when she arrived at Episcopal Homes in St. Paul for rehabilitation, she couldn't walk. Weakness in her right arm and hand left her unable to feed herself, and her speech remained somewhat garbled.

But over three weeks of physical, occupational and speech therapy, "she was making good progress," her husband, Iric Nathanson, said. "Her therapists were very encouraging." Ms. Nathanson, then 85, had begun to get around using a walker. Her arm was growing stronger and her speech had nearly returned to normal.

Then, on a Wednesday afternoon, one of her therapists told the Nathansons that their Medicare Advantage plan had refused a request to cover further treatment. "She has to leave our facility by Friday," the therapist said, apologetically.

Mr. Nathanson, then 82, felt anxious and angry. He didn't see how he could arrange for home care aides and equipment in 48 hours. Besides, he said, "it didn't seem right that the therapists and professionals couldn't determine the course of her care" and had to yield to an insurance company's dictates. "But apparently it happens a lot."

It does. Traditional Medicare rarely requires so-called prior authorization for services. But virtually all Medicare Advantage plans invoke it before agreeing to cover certain services, particularly those carrying high price tags, such as chemotherapy, hospital stays, nursing home care and home health.

"Most people come across this at some point if they stay in a Medicare Advantage plan," said Jeannie Fuglesten Biniek, associate director of the program on Medicare policy at KFF, the nonprofit health policy research organization. After years of steep growth, more than half of Medicare beneficiaries are now enrolled in Advantage plans, which are administered by private insurance companies. In 2021, those plans received more than 35 million prior authorization requests, according to a KFF analysis, and turned down about two million, or 6 percent, in whole or in part.

"The rationale plans use is they want to prevent unnecessary, ill-advised or wasteful care," said David Lipschutz, associate director of the nonprofit Center for Medicare Advocacy, which frequently hears complaints about prior authorization from both patients and health care providers. But, he added, it's also "a cost-containment measure." Insurers can save money by restricting coverage; they've also learned that few beneficiaries challenge denials, even though they are entitled to and usually win when they do.

Medicare Advantage plans are capitated, meaning they receive a fixed amount of public dollars per patient each month and can keep more of those dollars if prior authorization reduces expensive services. "Plans are making financial decisions rather than medical decisions," Mr. Lipschutz said. (Medicare Advantage **has never saved money** for the Medicare program.)

Such criticisms have circulated for years, bolstered by two reports from the Office of Inspector General in the Department of Health and Human Services. In 2018, a report found "**widespread and persistent**" problems related to denials of prior authorization and payments to providers. It noted that Advantage plans overturned 75 percent of those denials when patients or providers appealed.

In 2022, a second inspector general's report revealed that **13 percent of denied prior authorization requests met Medicare coverage rules** and probably would have been approved by traditional Medicare.

By that point, a KFF analysis found, the proportion of prior authorization denials overturned on appeal had reached 82 percent, raising the possibility that many "should not have been denied in the first place," Dr. Biniek said….**Read More**

What Is a Geriatric Care Manager?

Learn all about geriatric care managers and how they can help you provide the best care for your elder loved one.

Also known as aging life care professionals, geriatric care managers are typically licensed nurses or social workers who help seniors with medical needs overcome barriers to care.

"They can help seniors and their families schedule and manage complex care regimens and advocate for them with their insurers and health care providers," explains Whitney Stidom, vice president of sales and operations with eHealth Inc., a health insurance broker and online resource provider headquartered in Santa Clara, California.

Geriatric care managers balance seniors' physical, emotional and mental needs with quality of life. Their goal is for seniors to live independently for as long as possible

What Services Does a Geriatric Care Manager Offer?

A geriatric care manager can help you work through various situations, such as:

- **Determining the level of care needed.** The care manager will take a look at your loved one's overall health picture and determine what's needed to keep them safe and supported.
- **Assessing the financial picture.** A care manager can examine your loved one's financial situation and figure out **how much care they can afford** and whether they qualify for certain programs or services.
- **Finding the right care options.** Once the geriatric care manager has completed their review of your loved one's needs and finances, they can recommend appropriate **senior care options.** They may make a recommendation for a specific senior living facility or advise you to connect with a local home care agency.
- **Creating a long-term plan.** While needs can change suddenly or unexpectedly, geriatric care managers often have the expertise to draw up a long-term care plan that considers all contingencies.
- **Liaising between family and caregivers.** A geriatric care manager often acts as a sort of foreperson on the project of caring for your loved one. For instance, they can manage and coordinate various aspects of that plan and serve as a go-between among family, care providers and other professionals, such as elder law attorneys.
- **Offering compassionate, objective advice and support.** Geriatric care managers can provide an outside perspective that may help smooth **family** disputes or other issues that sometimes crop up during this potentially difficult transition.

When Should I Hire a Geriatric Care Manager?

When it comes to hiring a geriatric care manager, look at how your loved one is managing their **activities of daily living**: Are they able to cook for themselves, keep their house tidy, manage their personal hygiene, take their medicine and pay bills on time?

If any of these are starting to falter, it may be time to contact a geriatric care manager to help you navigate senior care options.

How Much Does a Geriatric Manager Cost?

Geriatric care manager services are not covered by Medicare or Medicaid, nor are they covered by most private insurance plans….**Read More**

What Is Medicare: Coverage, Cost and Enrollment

Confused about Medicare? We'll break down all of the parts, what coverage may be best for you and how to enroll.

If you've just celebrated your 65th birthday or it's coming up in the next year, your mailbox is probably full of postcards, flyers and letters about your eligibility for Medicare.

It's important to understand the ins and outs of Medicare before you sign up to avoid unexpected costs. Even if you've been on Medicare for years, you may want to reevaluate your options annually to confirm that your plan is still the best choice for you.

In this guide, we outline everything you need to know about Medicare.

What Is Medicare?

Simply, Medicare is a federal health insurance program for those age 65 and older. Medicare also covers those under the age 65 with **disabilities**, as well as people with end-stage renal disease or **amyotrophic lateral sclerosis** (also known as Lou Gehrig's disease).

Medicare Eligibility and Enrollment

Regardless of your retirement age, you become eligible for Medicare when you turn

Medicare initial enrollment

You can sign up for Medicare three months before your 65th birthday, during your birth month or throughout the three months after. This period is known as the initial enrollment period. You may face a long-term penalty if you don't sign up during these seven months, even if you're still working.

Individuals receiving benefits four months before their 65th birthday from Social Security or the Railroad Retirement Board will be automatically enrolled in Medicare.

Medicare open enrollment

For those who aren't enrolling for the first time, the **fall open enrollment period**, also known as the annual election period, runs from October 15 through December 7. During this period, you can review or adjust your Medicare plans, or you can switch from a Medicare plan to a Medicare Advantage plan or vice versa. Coverage begins January 1 of the next year, according to **Medicare.gov**.

Another open enrollment period, known as the Medicare Advantage open enrollment period, runs from January 1 through March 31. This period is for those already enrolled in a Medicare Advantage plan who want to switch to another Medicare Advantage plan or go back to original Medicare.

Medicare general enrollment

The general enrollment period for Medicare, which lasts from January 1 through March 31, is for those who need to enroll in Medicare but missed the **initial enrollment window** and don't qualify for special enrollment (more on that below). Your insurance coverage begins the month after you enroll, and you can face penalties for not enrolling during this period.

Medicare special enrollment

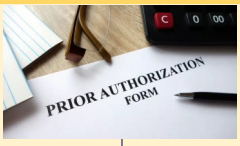
If you need to enroll or adjust your coverage outside of the regular enrollment windows, you may qualify for a special enrollment period. Some example situations include:

- You lost Medicare coverage after January 1.
- You couldn't enroll because of a natural disaster or an emergency happening after January 1.
- You're volunteering and serving in another country.
- You were recently incarcerated and couldn't sign up during your incarceration.….**Read More**

Final Rules on Medicare Advantage Prior Authorization Offer Improvements, but More Change is Needed

Prior authorization is one of the processes Medicare Advantage and other private insurance companies use to manage health care utilization and provide pre-service coverage information. While this can help plans control costs and allow patients and providers to make informed decisions, plans can over- or misuse it in ways that result in inappropriate barriers to needed care. Widespread reports detailing such enrollee and provider experiences in **Medicare Advantage, Medicaid Managed Care,** and **private insurance** indicate prior authorization abuses are happening at enormous scale.

Onerous and slow prior authorization processes, vague and confusing coverage criteria, requirements that are out of line with accepted medical practice, and unlawful denials of coverage are all broadly "prior authorization problems." These issues can result in additional burdens on overworked providers and ill patients, delay or completely bar access to needed care, result in worsening health outcomes, and contribute to the overpayment of plans as they avoid paying for care they are required by law and contract to provide.



In response to the **growth of prior authorization**, CMS recently **issued regulations** with new requirements for plans. The changes, which apply to Medicare Advantage, Medicaid Managed Care plans and Medicaid Fee for Service state administrators, Children's Health Insurance Program (CHIP) plans, and Qualified Health Plans (QHPs) on the Affordable Care Act Marketplace, require payers to make prior authorization information available through four different application programming interfaces (APIs). APIs are a set of rules and protocols that allow different software programs to talk to each other and share data. The four APIs noted in the final rule include (1) the Patient Access API, which will allow patients to access their information through health apps of their choice, (2) the Provider Access API, which will allow providers to see claims at different stages of process and payment and recent prior authorization history, (3) the Payer to Payer API, which will allow the exchange of information, including claims data and prior authorization information from one insurance to another, and (4) the Prior Authorization API, which will automate information exchange in the prior authorization process. The automated exchange will include information about whether prior authorization is required, documentation submission to meet the requirement, and status tracking.

As noted by KFF **in their analysis** of the final rule, these changes will likely result in improvements in timeliness and efficiency where the API processes are taken up by providers and patients. But their reach may be limited, as such use is voluntary. Furthermore, these changes do not improve situations where the prior authorization standards imposed by the plan, formally or in practice, are inconsistent with prevailing medical practice or with the coverage obligations of the payer under Federal and State law. Additional reform and rigorous oversight is needed to ensure plan compliance with these legal standards.

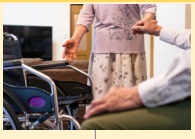
Other prior authorization changes in the final rule include a tightened timeline for standard coverage decisions in Medicare Advantage, Medicaid and CHIP, alignment of existing requirements to provide a specific reason for denial to the patient and provider, and a requirement that such reason be transmitted through the API. There is also a new public reporting guideline. Payers will now be required to report aggregate information about prior authorizations and to publish that information on their websites. However, CMS will not, at this time, be aggregating that data or incorporating it into Medicare Plan Finder or other tools available to assist beneficiaries in plan evaluation and selection. We support future changes to make this information more accessible and meaningful to all stakeholders, including consumers using CMS decision-making tools….**Read More**

New Help for Dealing With Aggression in People With Dementia

Caring for older adults with dementia is stressful, especially when they become physically or verbally aggressive, wander away from home, develop paranoia or hallucinations, engage in inappropriate or repetitive behaviors, or refuse to let caregivers help them.

Upward of 95% of patients experience these neuropsychiatric symptoms of dementia, which tend to fluctuate over time and vary in intensity. They're the primary reasons people with dementia end up in assisted living facilities or nursing homes. At some point, families and friends trying to help at home simply can't manage.

"When people think about dementia, they usually think about forgetfulness and memory impairment," said Mary Blazek, director of the geriatric psychiatry clinic at the University of Michigan. "But it's behavioral and psychological disturbances that are most disruptive to patients' and caregivers' lives." Now, help is available from a **first-of-its-kind website** created by prominent experts in this field. It offers free training in a comprehensive approach to managing neuropsychiatric symptoms of dementia — a method known as DICE — based on several decades of scientific research as well as extensive clinical practice. The website's goal is to "give people tools to better manage often-distressing situations," said Helen Kales, chair of the Department of Psychiatry and Behavioral Sciences at UC Davis Health in Sacramento, California, and one of DICE's creators. Users learn that neuropsychiatric symptoms are caused by changes in the brain that increase people's vulnerability. Nine video modules and two simulations provide comprehensive information and problem-solving techniques.



More than 16 million unpaid caregivers — primarily family members and friends — help people with dementia live at home. (An estimated 20% of patients live in institutional settings.) The most common form of dementia, Alzheimer's disease, affects nearly 7 million Americans 65 and older.

DICE is also designed to help "avoid the knee-jerk prescribing of psychoactive medications" that have potentially serious side effects, Kales said. Several medical organizations recommend that non-pharmaceutical approaches to troublesome behaviors be tried before drug therapy, but, in practice, this doesn't routinely happen.

Drugs prescribed for dementia include antipsychotic medications, such as Risperidone, which carry a black-box warning noting an increased risk of sooner-than-expected death in elderly patients; anticonvulsants, such as gabapentin, for which use has been on the rise despite concerns about safety; benzodiazepines, such as Ativan, which are associated with an increased risk of falls and, thus, fractures; and Celexa and other such antidepressants that have limited data supporting their effectiveness in easing dementia symptoms.

DICE is a mnemonic — a pattern of letters meant to serve as a memory aid — that stands for Describe, Investigate, Create, and Evaluate, the four pillars of this approach. At its core is an assumption people with dementia engage in disturbing behaviors for often-unrecognized reasons that can be addressed once they are understood.

Take an example on the website featuring Jennifer, a 55-year-old caregiver for her mother, Betty, 85, whom she tries to bathe daily in the late afternoon. When Betty resists getting into the tub, Jennifer insists, "Let's go! I have things to do." Betty responds by smacking her and shouting, "Leave me alone. It hurts."

DICE asks caregivers to step back from the heat of the moment and examine issues from three perspectives: the person with dementia, the caregiver, and the environment. All can contribute to distressing situations and all need to be considered in fashioning a response.

Examining the problem by using a "who, what, when, how, why" prompt can reveal several potential issues:

- **The patient.** Betty has arthritis and may experience pain getting in and out of the tub. She may feel tired and overwhelmed in the late afternoon.
- **The caregiver.** Jennifer may become easily frustrated when she encounters resistance — adopting a scolding and commanding tone rather than breaking down what Betty needs to do in simple steps.
- **The environment.** The bathroom tends to be cold, with overly bright lights, tepid bathwater, and no grab bars around the tub….**Read More**

UnitedHealth claims enrollees cannot challenge inappropriate care denials in court

Several months ago, Stat News exposed a common practice at UnitedHealth care and other big insurers: Large numbers of Medicare coverage denials through the use of AI. Bob Herman now reports for **StatNews** that UnitedHealth care claims a judge should dismiss a class action lawsuit against it because enrollees did not exhaust administrative remedies for appealing denials.

UnitedHealth is able to deny people coverage in Medicare Advantage with impunity and profit from its failure to comply with Medicare coverage rules. It knows that only a small fraction of people will appeal denials, so it can save money by not paying for care. It also knows that the Centers for Medicare and Medicaid Services, which oversees Medicare, does not have the resources to adequately oversee MA plans or the power to impose meaningful penalties on insurers when they violate their contracts and deny care inappropriately.

So UnitedHealth allegedly denied thousands of Medicare Advantage enrollees' rehab therapy using an algorithm, without regard to the individual needs of its enrollees. And, now it's claiming that their class action lawsuit against UnitedHealth for these denials should be dismissed because the vast majority did not exhaust their full appeal rights. (In addition, UnitedHealth claims that federal law protects insurers from these lawsuits; it argues that enrollees must sue the Department of Health and Human Services.)

UnitedHealth blames the federal government for their enrollees' plight, a novel. If the appeals process were swifter, UnitedHealth claims, plaintiffs would not be suing.

The reality, of course, is that older vulnerable patients should not have to appeal inappropriate denials of necessary care; they should not face these denials. They wouldn't have to if United considered their individual needs in making coverage determinations and put those above their shareholders' needs. But, UnitedHealth's shareholders' needs appear to come first and that means Medicare Advantage enrollees might not get the Medicare benefits to which they are entitled.

We will know soon whether the judge in the lawsuit agrees with UnitedHealth that plaintiffs claims should be dismissed because they did not exhaust their administrative remedies. Plaintiffs say that had they done so, they would have suffered irreparable harm. They needed care quickly and couldn't afford to pay for it out of pocket.

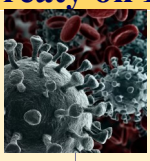
The government designed the Medicare Advantage program with a major payment system defect. It pays the insurers upfront to deliver Medicare benefits, and what the insurers don't spend on care they largely get to keep. So, they have a powerful incentive to deny care inappropriately.

RI ARA HealthLink Wellness News

Please Note: All Articles In This Section Are For Information Only And Not Medical Advice

HealthLink Wellness "Taking Control"

Nations Fail to Agree on Treaty on Preventing Next Pandemic



Following two years of tough negotiations, efforts to craft a global treaty to help countries fight future pandemics have failed, the World Health Organization has acknowledged.

"WHO Member States have ended intensive negotiations aimed at strengthening global capacities to respond to future pandemics and outbreaks in the wake of the COVID-19 pandemic, and agreed to submit outcomes of their work for consideration by the upcoming World Health Assembly, starting Monday," the WHO said in a **statement** released Friday.

"Over the past two years, WHO Member States have dedicated enormous effort to rise to this challenge posted by COVID-19 and respond to the losses it caused, including at least 7 million lives lost," WHO Director General **Dr. Tedros Adhanom Ghebreyesus** said in the statement. "While great progress was made during these negotiations, there are challenges still to overcome. We need to use the World Health Assembly to re-energize us and finish the job at hand, which is to present the world with a generational pandemic agreement."

Back in 2021, member countries asked the WHO to oversee negotiations to figure out how the world might better share resources and stop future viruses from spreading rapidly around the globe.

On Friday, **Roland Driece**, co-chair of WHO's negotiating board for the agreement, said the World Health Assembly meeting this week will have to chart the way forward.

"We will try everything -- believing that anything is possible -- and make this happen because the world still needs a pandemic treaty," Ghebreyesus said, the *Associated Press* reported. "Because many of the challenges that caused a serious impact during COVID-19 still exist."

The co-chairs of the treaty process didn't specify what caused the collapse of the treaty, but diplomats have said vast differences remain over the sharing of information about pathogens that emerge and the sharing of technologies to fight them, the *AP* reported.

The latest draft had proposed that the WHO should get 20% of the production of pandemic-related products like tests, treatments and vaccines, and it urged countries to disclose their deals with private companies.

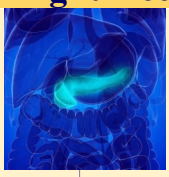
Earlier this month, U.S. Republican senators sent a letter urging President Biden not to sign off on a treaty that is essentially "supercharging the WHO."

Meanwhile, many developing countries said it's unfair that they might be expected to provide virus samples to help develop vaccines and treatments, but then be unable to afford them, the *AP* reported.

Precious Matsoso, the other co-chair of WHO's negotiating board for the treaty, told the *AP* there was still a chance to reach agreement on a treaty.

"We will make sure that this happens, because when the next pandemic hits, it will not spare us," she said.

GLP-1 Weight Loss Meds Might Keep Your Pancreas Healthy



Ozempic and Wegovy might help lower the risk of pancreatitis in patients with obesity and type 2 diabetes, a new study says.

Up to now, doctors have been cautious about prescribing semaglutide to patients with a history of pancreatitis, because they feared the drug could worsen the condition, said lead researcher **Dr. Mahmoud Nassar**, a fellow in endocrinology, diabetes, and metabolism at the University of Buffalo in New York.

In fact, the drug's prescribing information even warns about this potential side effect, Nassar noted.

"Our research highlights the safety and the potential for GLP-1 receptor agonists [like semaglutide] to reduce the risk of acute pancreatitis recurrence in individuals with obesity and type 2 diabetes, challenging previous concerns and offering new hope for effective disease management," Nassar said.

For the study, researchers analyzed data on more than 638,000 patients with a history of pancreatitis. The patients were located across 15 countries, but they were mainly from the United States.

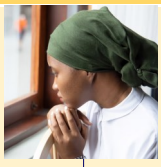
Researchers tracked how many patients developed pancreatitis again within 15 years of starting either semaglutide or other drugs for diabetes and obesity.

The other drugs included SGLT2 inhibitors, which decrease blood sugar levels by preventing glucose from being absorbed in the kidneys, and DPP4 inhibitors, which help the pancreas release insulin.

About 15% of patients taking semaglutide had wound up suffering a recurrence of pancreatitis, compared with 24% in the SGLT2 inhibitor group, 23% in the DPP4 group and nearly 52% of patients not taking any drugs at all.

The study was presented Saturday at the Endocrine Society's annual meeting in Boston. Findings presented at medical meetings are considered preliminary until published in a peer-reviewed journal….**Read More**

Lack of Insurance Keeps Many Americans From Best Cancer Meds



A cutting-edge class of drugs is saving and extending the lives of cancer patients.

But the drugs, called immune checkpoint inhibitors (ICIs), are so expensive that some uninsured Americans can't access them, a new report finds.

New policies are needed "to improve health insurance coverage options and to make new treatments more affordable," the American Cancer Society (ACS) said in a news release outlining the findings.

The study was led by ACS researcher **Dr. Jingxuan Zhao**. Her team presented the findings Saturday at the annual meeting of the American Society of Clinical Oncology in Chicago. ICIs include such blockbuster cancer medications as pembrolizumab (Keytruda), ipilimumab (Yervoy), nivolumab (**Opdivo**) and atezolizumab (**Tecentriq**).

According to the **National Cancer Institute**, the drugs focus on what are known as "immune checkpoints" -- proteins on the surface of immune T-cells that prevent the cell from binding to another cell, such as a tumor cell.

Immune checkpoints are natural mechanisms meant to keep immune reactions from running amok.

However, disengaging these checkpoints in the presence of a cancer cell is crucial to allowing immunotherapies to work.

A drug that inhibits checkpoint proteins "prevents the 'off' signal from being sent, allowing the T cells to kill cancer cells," the NCI explained.

First approved in 2011, ICI drugs have revolutionized cancer care and they are now used against a wide range of cancer types….**Read More**

Watch your feet!

Do your feet hurt? For eight in ten Americans, the answer is yes. Don't let foot aches stop you from your daily activities. Check your feet every day.

Jancee Dunn reports for the **New York Times** that your feet can alert you to issues with your overall health. For example, if your feet are swollen, it could mean you have high blood pressure, gout or kidney problems. If your feet are tingling, you might have diabetes.

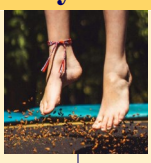
Foot pain is especially common for older adults because your skin becomes thinner and less elastic as you age. There are a wide array of treatments targeting different types of foot pain, depending when you feel pain and its location. No matter what's wrong, you can ease foot pain and feel better.

Treating foot issues is particularly important because it can decrease your risk of falling. As it is, one in three older adults fall each year. And, more than 1.5 million older adults are hospitalized each year as a result of a fall.

What to do? Study both the tips and bottoms of your feet as well as the space between your toes. If your skin is cracked, red or you have sores that won't heal, talk to your doctor.

Where's the pain? And, when do you feel it?

- Fungal infections between the toes causing redness, blisters or itching: This is typically called athlete's foot because the infection develops from sweat and moisture build-up in your feet as a result of exercise. Make sure you wash your feet, including the area between the toes, after exercise and then dry then to prevent infections. Use an over-the- counter fungal spray or cream to treat the infection. And, talk to your doctor.



- Toenail fungus is very common among older adults. It results from brittle and dry nails and reduced circulation to the feet as you age. Your toenail becomes discolored and thick. If it doesn't hurt, you don't really have to worry about it. But, it could spread to other toes.
- Ingrown toenails: To prevent them, cut toenails straight across. Do not round them at the edges.
- Blisters: You can pop a blister with a clean tool. But don't take the top off. Simply put an antiseptic cream on with a bandaid until it heals.
- Bunions, hammertoes, corns or calluses. More than one in three older adults have bunions. They appear on the inside of your feet at the base of the big toe. Hammertoes are protrusions on the top of your toe that keep your toe from sitting straight and flat. With calluses and corns, there's a thickening of your skin. Corns might also have some fluid.
- Plantar fasciitis: One in ten adults over 50 suffer from plantar fasciitis. It causes a pain on the bottom of your feet, which can be debilitating. It is an inflammation of the tissue on the bottom of your feet and across its full length. It might not be possible to prevent plantar fasciitis. It often results from exercise, when the muscles in your legs and feet are tight. And, you don't want to stop exercising!!!!! But, you should be sure to take time to stretch your muscles, particularly your calves, before and after exercising.

Good foot hygiene:

- Do not wear shoes that are tight. But, avoid wearing flip flops, which can aggravate foot issues, including arch pain and plantar fasciitis.
- Do not polish your toenails if they are discolored. Do not get callus shavers or foot peels. Avoid high heels!!!
- Do exercise your feet. You can roll a tennis ball underneath them. Get a foot massage and do legs up the wall exercises. Soak your feet in water with vinegar. Wash and moisturize your feet every day.
- Do use suntan lotion on your feet to avoid sunburn and skin cancer on the tops and soles of your feet.

Warding off bunions, hammertoes, corns and calluses and easing pain:

- Keep your toenails clipped.
- Wear shoes that support your feet and do not pinch your feet
- Do foot exercises to develop the muscles in your feet.
- Wear padded bandaids or moleskins over the affected areas of your feet
- Soak your feet regularly and then moisturize them with a lotion containing urea.
- If the pain is preventing you from doing what you want to do, talk to a doctor about the costs and benefits of surgery. Use a pumice stone on calluses.

Treating plantar fasciitis and osteoarthritis:

- Ice your foot where it hurts early and often!
- Wear shoes that do not bend.
- Walk a little, even if it hurts.
- Stick to bicycling, swimming and other exercises that are not high-impact; take a break from activity that's hard on your feet.
- See a physical therapist.
- Get a shoe insert tailored to your feet

1 in 8 Older Americans Are Stricken With Traumatic Head Injury

About one in eight U.S. seniors will be treated for a traumatic brain injury, typically during a fall, a new study finds.

Medicare data shows that about 13% of seniors suffered a severe concussion during an average follow-up period of 18 years, researchers report.

Although these injuries can be treated, they increase the risk of serious conditions like dementia, Parkinson's disease, seizures, heart disease, depression and anxiety, they added.

"The number of people 65 and older with TBI is shockingly high," said senior researcher **Dr. Raquel Gardner**, a neurologist with the Sheba Medical Center in Israel.

For the study, researchers tracked about 9,200 Medicare enrollees with an average age of 75.

Women, white people, the healthier and the well-off appear at higher risk of concussion, according to the data -- a finding that runs counter to prior research.

For example, about 64% of people who had a traumatic brain injury were female, even though women represented 58% of the total group studied, researchers said.

Likewise, about 84% of people in the total group were white, but whites represented 89% of concussions, results show.

About 31% of those with traumatic brain injury were in the top 25% of wealth, while 22% were in the lowest quarter, researchers said.

Seniors with concussion also were less likely to have lung disease or to struggle with activities of daily living like bathing, walking and getting out of bed. They also were less likely to have dementia.

The new study was published May 29 in the journal *JAMA Network Open*.

"It's possible that our findings reflect that adults who are healthier, wealthier and more active are more able or likely to engage in activities that carry risk for TBI," said lead researcher **Erica Kornblith**, an assistant professor of psychiatry with the University of California, San Francisco.

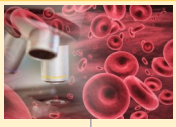
"While most TBIs in older people occur from falls at ground level, if you are in a wheelchair or bed-bound, you don't have as many opportunities for traumatic injuries," Kornblith added. "It's also possible that participants with cognitive impairment are more limited in their activity and have less opportunity to fall."...**Read More**

Strategy Could Expand Stem Cell Donor Pool for People Battling Blood Cancers

An older drug used in a new way could open the path for more patients with potentially deadly blood cancers to receive a lifesaving stem cell transplant, a new study finds.

The drug, cyclophosphamide, could help patients receive a stem cell transplant even if the donor isn't a relative and only partially matches their blood type, researchers report.

Blood cancer patients had a high survival rate of 79% at one year after receiving a stem cell transplant from a stranger followed up by treatment with cyclophosphamide, researchers found.



"The outcomes seem to be very comparable to those of a fully matched donor," said researcher **Dr. Antonio Jimenez Jimenez**, a physician-scientist with the University of Miami Miller School of Medicine.

Administering cyclophosphamide several days after transplantation can help patients avoid graft-versus-host disease (GvHD), a deadly side effect in which the transplant mounts an immune attack on the patient.

GvHD typically occurs in 60% to 80% of transplants in which the donor and recipient aren't related, according to the National Institutes of Health.

But after one year, about half (51%) patients in the new study had not developed GvHD and had not suffered a cancer relapse, results show.

Finding a matched donor is a major hurdle for patients with blood cancer, researchers said.

The National Marrow Donor Program contains more than 40 million potential donors, but there are disparities in the program.

Only half of Hispanic and a quarter of Black patients can find a fully matched donor, compared with more than 70% of white patients, researchers noted.

Cyclophosphamide has been increasingly used over the past decade or so to help patients accept partial donor matches from relatives, researchers said. The chance of a full match from a sibling is only 25%, and the chance of a partial match is 50% ….**Read More**

Suicide Rates Among Cancer Patients Are Falling

Even as suicide rates have risen among Americans generally, one group appears to be bucking that trend: People diagnosed with cancer.

Experts are crediting improved access to counseling and other "psychosocial care" with easing the emotional toll of cancer and keeping more patients from making tragic decisions.

Nevertheless, cancer patients still face elevated risks for suicide, noted a team led by **Dr. Qiang Liu** of the National Cancer Center at the Chinese Academy of Medical Sciences in Beijing.

"The cancer-related suicide rate is estimated to be double that of the general population in the United States," Liu's group noted in the study. "Notably, the risk of suicide in men is significantly higher compared to women. This heightened cancer-related suicide risk remains elevated for up to 15 years following their diagnosis."

The new report was published May 27 in the journal ***Translational Psychiatry***.

In the study, Liu's team looked at data on over 5 million Americans who'd been diagnosed with cancer between 1975 and 2017.

Of the more than 8,000 who died by suicide, most (82%) were male, white (93%) and older (73% were ages 50 to 79).

However, there was some good news: The rate at which suicide claimed the lives of people with cancer has declined steadily over the decades. These deaths first started to decline gradually between 1989 and 2013, the numbers showed, and then dropped much more sharply -- by about 27% each year -- between 2013 and 2017.

Liu's team credited a combination of factors behind these promising trends, not the least of which is the fact that many tumors are no longer the death sentences as they were a generation or two ago.

There have also been "promising advances in **medical treatments** for malignancies," the Chinese researchers noted.

However, beyond those advances, "this period witnessed an evolving role of psycho-oncology care, palliative care and hospice care, leading to the promotion and increased utilization of these services by patients with cancer, enhancing their overall quality of life," Liu's group wrote.

"Furthermore, the development of integrated care models, including collaborative care models, has provided a more comprehensive and coordinated approach to cancer care," they added.

If you or a loved one is struggling with suicidal thoughts and feelings, the **988 Suicide & Crisis Lifeline** can help.

Binge-Eating Disorder Could Be Tougher to Kick Than Thought

Prior studies have suggested that binge eating disorder may not last long, but a more rigorous look at the illness finds that just isn't so.

"The big takeaway is that binge-eating disorder does improve with time, but for many people it lasts years," said study first author **Kristin Javaras**, assistant psychologist in the Division of Women's Mental Health at McLean Hospital in Boston.

"As a clinician, oftentimes the clients I work with report many, many years of binge-eating disorder, which felt very discordant with studies that suggested that it was a transient disorder," she said in a hospital news release. "It's very important to understand how long binge-eating disorder lasts and how likely people are to relapse so that we can better provide better care."

In binge eating disorder, which typically arises around a person's mid-20s, people feel their eating is out of their control. Anywhere from 1 to 3 percent of American adults are thought to have the disorder.

According to Javaras' team, prior studies looking at binge eating disorder were either retrospective (meaning they often relied on people's memory of their disorder).

If they were prospective (following patients through time) they were often very small (less than 50 people) or didn't include people tackling severe obesity.

In the new study, Javaras' team tracked outcomes for 137 adults diagnosed with binge-eating disorder for five years. People ranged in age from 19 to 74 and they had an average BMI of 36 (the threshold for obesity is a BMI of 30).

The people in the study were independently living within their communities and weren't in treatment programs, better reflecting "real-world" experiences with binge-eating disorders.

At the 2.5-year mark, 61% of people in the study still met all the criteria for a binge-eating disorder, and another 23% still had "clinically significant symptoms" although they fell shy of an actual binge eating disorder diagnosis, the researchers said.

By the five-year mark, most of the study participants still met the criteria for have a binge-eating disorder, although some had made improvements, the study authors said.

Even among those who were in remission at 2.5 years, 35% went on to have a full-blown binge-eating disorder by five years, Javaras' team said.

At the five-year mark, most people still had binge-eating episodes, although many had improved.

The findings were published May 28 in the journal *Psychological Medicine.*

Javaras notes that prior studies have suggested that treatment programs do help curb eating disorders, but not everyone has access to such programs.

Even a Small Urban Garden Can Boost Your Microbiome

A small urban garden can contribute to your health, especially if the garden contains rich soil, a new study shows.

A one-month indoor gardening period increased the bacterial diversity of participants' skin and appeared to improve their response to inflammation, researchers found.

Growing, harvesting and consuming food produced in an urban garden every day could help city dwellers fend off disease, researchers suggested.

"The findings are significant, as urbanization has led to a considerable increase in immune-mediated diseases, such as allergies, asthma and autoimmune diseases, generating high healthcare costs. We live too 'cleanly' in cities," said lead study author **Mika Saarenpaa**, a doctoral researcher with the University of Helsinki in Finland.

"We know that urbanization leads to reduction of microbial exposure, changes in the human microbiota and an increase in the risk of immune-mediated diseases," Saarenpaa added in a university news release. "This is the first time we can demonstrate that meaningful and natural human activity can increase the diversity of the microbiota of healthy adults and, at the same time, contribute to the regulation of the immune system."

For this study, participants gardened using regular flower boxes, using plants bought off a store shelf. The crops included peas, beans, mustards and salads.

A group of 15 people gardened using naturally derived and microbially rich soil, while another control group of 13 gardened with microbially poor peat-based soil.

Peat is the most widely used growing medium in the world, researchers said.

However, the people in the control group had no improvements in inflammatory response or skin bacteria, indicating that peat-based gardening does not bring the health benefits of gardening in diverse forest soil.

The improvements among the people toiling with rich soil could theoretically lead to better health by improving immune response to illness, researchers said.

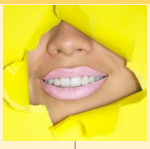
The new study was published recently in the journal ***Environment International***.

"If gardening turns into a hobby, it can be assumed that the regulation of the immune system becomes increasingly continuous," Saarenpaa said.

Based on these findings, Saarenpaa said schools and parents should consider having children garden with rich soil, since the development of the immune system is most active in childhood.

"My research emphasizes the dependence of our health on the diversity of nature and that of soil in particular," Saarenpaa said. "We are one species among others, and our health depends on the range of other species. Ideally, urban areas would also have such a diverse natural environment that microbial exposure beneficial to health would not have to be sought from specifically designed products."

Dental crisis in the US: 20 percent of Americans have lost their teeth



One in five older adults in the US have lost their teeth. There is a crisis in dental care. Jessica Glenza interviews Bernie Sanders for her piece in the **Guardian** on the need to improve dental care as part of fixing our broken health care system.

Senator Sanders has introduced a bill in the Senate to expand Medicare dental benefits and improve them in Medicaid. The bill also gives dental benefits to veterans through the Veterans Administration.

Traditional Medicare does not cover dental care. Medicare Advantage plans sometimes offer limited dental benefits, but they are so limited that people in Medicare Advantage face the same dental issues as people in Traditional Medicare.

Half of adults in the US have gum disease. Sixty nine million adults have no dental insurance and those who do often have limited coverage. The out-of-pocket costs with insurance are high. People can't afford dental bills that are several thousand dollars.

Two million Americans went to the hospital because of tooth pain in 2019. Nearly half a million other people went abroad for lower-cost dental care. Dental care is much less costly in Mexico. Having bad teeth can cause serious health issues, including malnutrition. It can be emotionally and psychologically destructive.

Senator Sanders says that expanding dental coverage in the US is a political winner. The overwhelming majority of Americans support it. He has tried to persuade President Biden to include dental benefits in Medicare as part of his re-election platform.

For his part, President Biden has taken small steps to improve dental coverage in Medicare. For example, some cancer patients with Medicare are now covered.

Republicans continue to oppose extra Medicare benefits. They claim they are unaffordable. But, it's all a question of government priorities. Republicans are happy to approve $900 billion in military spending and tax cuts for the wealthiest Americans.

The American Dental Association opposes a dental benefit in Medicare. It fears a large administrative burden on dentists.

For Minor Health Issues, Pharmacist Care May Be the Low-Cost Option

Allowing pharmacists to treat minor illnesses could potentially expand health care access to more people and save millions of dollars, a new study suggests.

Care for a range of minor health issues -- urinary tract infections, shingles, animal bites and headaches -- would cost an average of about $278 less when treated in pharmacies rather than in a doctor's office or urgent care clinic, researchers estimated.

And just about everyone treated by a pharmacist had their medical problem resolved, results showed.

"Pharmacists, especially in the outpatient community setting, are a viable solution to part of our patient access to care problem in our state and country," said lead study author Julie Akers, an associate professor of pharmacotherapy at Washington State University.

"Pharmacists are trained and qualified to do this work, and unfortunately in many settings, highly underutilized," Akers added in a university news release. "And they could have a huge impact on how fast patients access care, which can minimize the complexity and the progression of their condition."

The study focused on the state of Washington, where since 1979 pharmacists have had the legal right to treat patients if they've received a doctor's authorization to prescribe and administer certain drugs.

Pharmacists are trained in clinical evaluation of common illnesses as part of their education, and already make recommendations for conditions that can be treated with over-the-counter medications, Akers noted.

The right to treat patients -- called "prescribing authority" -- takes that practice to the next level by allowing them to prescribe medications if OTC drugs aren't enough.

For the study, researchers analyzed data from nearly 500 patients who received care from 175 pharmacists at 46 pharmacies in Washington state between 2016 and 2019.

The team followed up with patients 30 days after their pharmacy visit to assess treatment effectiveness, then compared those cases with insurance data from people with similar ailments who sought care at a doctor's office, urgent care clinic or ER….**Read More**

Study Confirms Effectiveness of 'Watch-and-Wait' Approach to Prostate Cancer

For a large percentage of men with prostate cancer, the tumor may be so slow-growing that doctors advise a "watch-and-wait" approach instead of active treatment.

Now, a study of almost 2,200 patients followed for up to a decade finds that, for most, that decision may be a wise one.

"In this study, 10 years after diagnosis, 49% of men remained free of progression or treatment, less than 2% developed metastatic disease and less than 1% died of their disease," reported a team led by **Lisa Newcomb**. She's a cancer prevention researcher at the Fred Hutchinson Cancer Center in Seattle.

According to Newcomb, "our study showed that using active surveillance that includes regular PSA exams and prostate biopsies is a safe and effective management strategy for favorable-risk prostate cancer."

The findings were published May 30 in the ***Journal of the American Medical Association***.

A few decades ago many, if not most, men newly diagnosed with **prostate cancer** were quickly sent to treatment -- typically either surgery (prostatectomy) and/or hormone-suppressing treatments.

Both of these interventions can come with side effects such as impotence or urinary issues, which can seriously affect a man's quality of life.

However, over the past two decades, new insights into the varied nature of prostate tumors have changed all that.

Based on certain tests, doctors are now able to spot aggressive, fast-moving tumors that could pose an imminent threat, versus so-called "indolent" tumors, which progress very slowly.

In cases involving older men, especially, indolent tumors may not be as serious a threat to health as other conditions, such as heart disease.

All of this has led to many prostate cancer patients being offered what's clinically known as an "active surveillance" approach to their care.

In this scenario, no treatment is given. Instead, patients are asked to routinely undergo tests to check if a suspected "indolent" tumor has progressed to something more dangerous.

But how well does this strategy work to keep men living long, high-quality lives?

In their study, Newcomb's group looked at the latest data from a study launched in 2008 to track prostate cancer outcomes.

Included in the study were 2,155 men "with favorable-risk prostate cancer and no prior treatment" being cared for at one of 10 centers throughout North America.

The men's health was tracked for up to 10 years (average follow-up was 7.2 years). They averaged 63 years of age at the time the data was collected, and 83% were white. Almost all (90%) had been diagnosed with a less serious grade 1 prostate tumor when they entered the study.

Within 10 years of diagnosis, 43% of the men did see a change in their tumor status, based on biopsy results, and were then referred to some form of treatment, the researchers reported. Among this group, 11% experienced a recurrence of their tumor.

However, the original "watch-and-wait" strategy seemed to have paid off: Among the original cohort, almost half never needed to resort to active treatment, and only a small fraction ever developed metastatic cancer (2%) or died of it (1%), the Seattle group concluded.

“An important finding was that adverse outcomes such as recurrence or metastasis do not seem worse in people treated after several years of surveillance versus one year of surveillance, alleviating concern about losing a window of curability," Newcomb said in a journal news release.

“We hope that this study encourages the national acceptance of active surveillance instead of immediate treatment for prostate cancer," she added.

Mediterranean Diet Cuts Women's Risk of Early Death by 23%

Experts have long extolled the benefits of the Mediterranean diet and a new study adds to that evidence, finding it cuts the odds for an early death in women by 23%.

“For women who want to live longer, our study says watch your diet!" said study senior author **Dr. Samia Mora**, of Brigham and Women’s Hospital in Boston.

"The good news is that following a Mediterranean dietary pattern could result in about one quarter reduction in risk of death over more than 25 years with benefit for both cancer and cardiovascular mortality, the top causes of death in women [and men] in the US and globally,” said Mora, a cardiologist and director of the Center for Lipid Metabolomics at the hospital.

The findings were published May 31 in the journal ***JAMA Network Open***.

The **Mediterranean diet** has long ranked high on nutritionists' healthiest-diets list.

It relies heavily on plants (nuts, seeds, fruits, vegetables, whole grains, legumes) and its main source of fat is olive oil.

People on the diet eat moderate amounts of fish, poultry, dairy, eggs and alcohol, and tend to avoid red meat, sugary fare and processed foods.

The new study tracked health outcomes for more than 25 years among a group of more than 25,000 participants in the ongoing Women's Health Study.

All of the women in the study were deemed to be healthy when they enrolled.

Besides finding that risks of dying within the study period fell by almost a quarter for women closely following the Mediterranean diet, the study also found reductions in deaths linked to heart disease or cancer….**Read More**

Nerve Surgery May Help Some Battling Severe Migraine

Nerve surgery can reduce the number of headache days for people who suffer frequent **migraines**, a new review finds.

The procedure also can decrease the frequency and intensity of migraine attacks, according to results published in the June issue of the journal ***Plastic and Reconstructive Surgery***.

“Our study adds new evidence that headache surgery improves both sets of measures, providing a more comprehensive assessment of the results of headache surgery," said researcher **Dr. Jeffrey Janis**, a professor of plastic surgery, surgery, neurosurgery and neurology at the Ohio State University Wexner Medical Center.

Migraine surgery seeks to relieve nerve compression at trigger sites in the head and neck, researchers explained. This pressure is thought to contribute to headaches.

Neurologists assessing migraine treatments tend to focus on whether they reduce the number of days a person has a headache, Janis said.

On the other hand, plastic surgeons performing headache surgery typically use an index that evaluates the frequency, intensity and duration of migraines, Janis added.

"This discrepancy is one reason why some headache specialists have been slow to recognize the growing body of evidence showing the effectiveness of headache surgery,” Janis noted in a journal news release.

For this review, researchers decided to consider both ways of assessing the effectiveness of migraine surgery, so that both groups of professionals could find common ground regarding the procedure….**Read More**