



Message from Alliance for Retired Americans Leaders

Social Security and Medicare are Still in Congressional Crosshairs



Robert Roach, President, ARA

House Republicans have **multiple rival road maps** for budget cuts, just as the high-stakes battle over the nation's debt limit intensifies. Some lawmakers are still considering Social Security and Medicare cuts, including a group of approximately a dozen Senators led by Angus King (I-ME) and Bill Cassidy (R-LA), who hope to **recreate a bipartisan deal**.

Adding to the concerns was Sen. Joe Manchin's (D-WV) televised comment that there might be a "better program" to consider for future beneficiaries.

"Many members of Congress continue to insist that plans to cut Social Security and Medicare are off the table, but others are talking about plans that will slash benefits now or in the future," said **Robert Roach, Jr., President of the Alliance**. "The Alliance will continue to work to ensure the programs are safe from cuts for both today's retirees and future generations."

President Biden Goes to Bat for Retirees with His 2024 Budget



Rich Fieta, Executive Director, ARA

President Biden wrote an **op-ed** in The New York Times Tuesday to showcase his plans to protect and preserve Medicare, and he released the administration's complete budget proposal for fiscal 2024 on

Thursday.

The budget tackles two of the most pressing issues for current and future retirees: lowering prescription drug prices and adding 25 years to the solvency of the Medicare Trust Fund; it pays for it by asking those with annual income above \$400,000 to pay a little more into Medicare.

"The plan lowers out-of-pocket costs for seniors who need high-cost drugs by expanding the Medicare price negotiation that was introduced in the Inflation Reduction Act," said **Richard Fieta, Executive Director of the Alliance**. "Capping older Americans' generic drug costs for chronic conditions at \$2 will also help seniors pay for necessities like food, housing and energy."

The budget calls for a 10% increase — \$1.4 billion — over the 2023 enacted level for the Social Security Administration (SSA) to invest in staff, information technology, and other improvements. The funds would improve customer service at SSA field offices, state disability determination services, and teleservice centers.

In addition, the plan invests \$150 billion over 10 years to improve and expand Medicaid home and community-based services, such as personal care services, to allow seniors and individuals with disabilities to remain in their homes and stay active in their communities while improving the quality of jobs for home care workers. Even with those much-needed investments, the budget will reduce the deficit by nearly \$3 trillion over 10 years.

"We urge Congress to take this proposal seriously, and reject proposals that will lead to cuts to Medicare, including raising the eligibility age or further privatizing the system," Fieta added.

Thursday was National "Slam the Scam" Day



Joseph Peters ARA Sec.-Trea.

The SSA designated Thursday, March 9, as National "Slam the Scam" Day, a day to raise public awareness of Social Security and other government imposter scams.

The day was part of National Consumer Protection Week, March 5 - 11, 2023.

In 2022, the Federal Trade Commission (FTC) received over 191,000 complaints of



government imposter scams. Of those, 14.6% said they lost money to a scammer - a total of \$508.96 million. To prevent further losses, experts advise using caution when receiving calls or messages from someone claiming to be from a government agency.

Scammers often pretend to be from an agency or organization you know to gain your trust. Other tactics include saying there is a problem or a prize; pressuring you to act immediately; or telling you to

pay in a specific way.

Social Security will never threaten arrest or legal action if you do not immediately send money to resolve an overpayment you supposedly received in error. Also, SSA officials will never promise to increase benefits or resolve identity theft issues for a fee or by moving money into a protected account, require payment with a retail gift card or wire transfer, or tell you to mail cash.

"SSA has a specific **page** that allows the public to report scams involving Social Security without difficulty," advised Joseph Peters, Jr., Secretary-Treasurer of the Alliance.

A representative of the SSA led a "Slam the Scam" seminar on recognizing and preventing Social Security, government imposter, and identity theft scams for Alliance members. A recording of the seminar is available **here**.

Petition to Expand Social Security

Retirees have earned their Social Security benefits over a lifetime of hard work. Sign our petition to demand that Congress take action to protect and expand Social Security so it can continue to be there for current and future generations.

Click on each of the links below

[Learn More](#)

[Take Action](#)

ADD YOUR NAME

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

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Biden's Medicare plan: Retirement with dignity

In an op-ed for [The New York Times](#), President Joe Biden vows he will not cut Medicare. Unlike his Republican "friends," he recognizes that turning Medicare into a voucher program, does not strengthen Medicare but rather weakens and destroys it. President Biden's budget is designed to keep Medicare strong through 2050, without cutting people's health care benefits.

Medicare is an earned benefit, for which Americans pay in all their working lives. There is no cap on Medicare payroll contributions as there is with Social Security contributions. The more money you earn, the more you pay in. This money funds the Medicare Part A Hospital Trust Fund, which is currently projected to take in less than it pays out in 2028.

A voucher program would simply shift more health care costs onto older adults and people with disabilities with Medicare. President Biden appreciates that

Medicare delivers good value and could deliver better value still.

The Affordable Care Act strengthened Medicare, as did the Inflation Reduction Act, which finally gives Medicare the power to negotiate drug prices, penalizes pharmaceutical companies that raise prices faster than inflation and limits out-of-pocket drug costs if you have Medicare. All of these policies reduce the deficit by \$159 billion.

Biden's plan is to do more to lower drug prices for people with Medicare, giving more negotiating power to the federal government. He says it would save another \$200 billion, which could then go towards strengthening the Medicare Trust Fund.

Biden also wants to increase people's payroll contribution into Medicare 1.2 percent, from 3.8 percent to 5 percent, and to tax unearned income above \$400,000



at that rate as well. Biden would put that money in the Trust Fund as well. He justifies the additional contributions for wealthy Americans because today the most wealthy one percent of Americans are five times wealthier than the 50 percent who are less wealthy.

In sharp contrast, Republicans want to block Medicare from negotiating prescription drug prices. They want to remove the \$35 a month cap on the cost of insulin for people with Medicare. They want people to spend whatever it takes for their drugs or go without them, not to limit their costs to \$2,000 a year as the Inflation Reduction Act does. They want Big Pharma to win.

Curiously, Biden does not mention a massive revision to the way the government pays Medicare Advantage plans, which has cost Medicare more than \$120 billion to date and is projected to cost **\$600 billion**

dollars in overpayments over the next eight years. Probably, he fears the health insurance industry's weaponization of this proposal to scare people in Medicare Advantage. What's truly scary is that the Medicare Advantage plans have never been able to demonstrate that they deliver good care and, in the case of some complex and costly care, have been shown to deliver poorer quality, even when overpaid as much as 20 percent.

Thankfully, the Centers for Medicare and Medicaid Services, which oversees Medicare, has already proposed a revision to the way it pays Medicare Advantage plans that will rein in some, though not enough, of their massive overpayments. Since it will mean lower profits, the insurance industry's pushback, including in a Super Bowl ad, has been fierce. Let's hope the government's proposal is finalized.

Tell Congress to Save Social Security



Even though the extremist Republicans stood during the State of the Union to supposedly show "support" for Social Security and Medicare, they are scheming to cut our earned benefits. They aren't even

keeping it a secret, going on television to promote their wacky plans and drafting legislation to cut the benefits we earned.

A growing number of anti-retiree politicians are hawking plans that **raise the retirement age to 70** (or higher!); to **privatize Social Security** (and let Wall Street gamble with our retirement); or



to reduce benefits. Those aren't just bad ideas – they are CUTS to the benefits we've earned.

"We need all hands on deck. Please, sign our petition now," said Richard Fiesta, Executive Director of the Alliance. "We must continually remind Congress that Social Security is earned, and that they need to keep the promise made

to generations of Americans."

Click [here](#). Let's make sure Congress is on notice that we won't let anyone cut Social Security.

Take Action: Sign the Alliance's Petition to Save Social Security

[Sign Our Petition](#)

Medicaid Health Plans Try to Protect Members — And Profits — During Unwinding

The federal covid-19 pandemic protections that have largely prohibited states from dropping anyone from Medicaid since 2020 helped millions of low-income Americans retain health insurance coverage — even if they no longer qualified — and brought the U.S. uninsured rate to a record low.

It also led to a windfall for the health plans that states pay to oversee care of most Medicaid enrollees. These plans — many run by insurance titans including UnitedHealthcare, Centene, and Aetna — have seen their revenue surge by billions as their

membership soared by millions.

With states poised to **start disenrolling Medicaid enrollees** in April who no longer qualify, the insurers hope to retain enrollees who are still eligible and capture those who lose coverage with the Affordable Care Act marketplace plans.

Except for the enrollees themselves, for whom losing coverage could restrict access to care and leave them vulnerable to large medical bills, no one has more at stake than these insurers. The plans have a strong financial



incentive to keep their members enrolled because states pay them per member, per month:

The more people they cover, the more money they get.

The Biden administration estimates that 15 million of the more than 91 million Medicaid enrollees will fall off the rolls, nearly half because their income exceeds program limits and the rest because they fail to complete the reenrollment paperwork.

Of the people losing eligibility, about two-thirds will enroll in a workplace health plan, health insurers predict, and the other

third will be evenly divided between ACA plans and being left uninsured.

The financial ramifications of the so-called Medicaid unwinding for health plans are huge, said Gary Taylor, a securities analyst with Cowen and Co. "It's billions of dollars for these guys," he said of the five largest Medicaid health plans: **Centene**, UnitedHealthcare, Aetna, Elevance Health (formerly Anthem), and Molina Healthcare...[Read More](#)

The choice between traditional Medicare and Medicare Advantage: It's a sham

Written by Diane Archer

If all things were equal, the choice between traditional Medicare and Medicare Advantage is easier than you think, as I wrote in a previous post. But as one reader commented, there's more to it than I could include in that post.

Here's part two, explaining why about half of all people with Medicare are now enrolled in the privatized Medicare option: Medicare Advantage.

Traditional Medicare's upfront costs are high

Traditional Medicare does not have an out-of-pocket cap. Unless people have supplemental coverage to pick up their out-of-pocket costs, their upfront costs in traditional Medicare are high. They easily could spend \$3,000 on supplemental coverage and Part D prescription drug coverage. And, that's on top of their Medicare Part B premium. Millions of people cannot afford supplemental coverage; the typical person with Medicare has an annual income of less than \$30,000. So, people with lower incomes are more likely to enroll in Medicare Advantage, which has an out-of-pocket limit and few, if any, upfront costs. Not surprisingly, wealthier individuals are more likely to enroll in traditional Medicare.

In truth: You'll spend less out of pocket in traditional Medicare with supplemental coverage than in Medicare Advantage when you need costly care and have direct access to the care you want. Cost will not be an obstacle to care as it can be in Medicare Advantage.

To save money, employers and unions steer retirees into Medicare Advantage Increasingly, companies and unions offering retiree benefits contract with Medicare Advantage plans to cover their retirees' care. The Medicare Advantage plans are willing and able to offer companies and unions special benefits to enroll their retirees, better than what they offer people in the individual market, because the Medicare Advantage plans **profit more** through these contracts than in the individual market. And companies and unions save

money on the cost of supplemental coverage.

In truth: Millions of people with retiree benefits lose their easy access to care, choice of doctors and hospitals, and coverage anywhere in the U.S. without their consent.

Medicare Advantage marketing misleads people about their benefits

Medicare Advantage plans use taxpayer dollars to promote their benefits and to claim they are better than traditional Medicare. A lot of the marketing is misleading about the benefits people will get in Medicare Advantage. The government does not use taxpayer dollars to promote traditional Medicare, let alone to explain why it is better than Medicare Advantage.

In truth: No one should trust the Medicare Advantage TV ads or mailers.

Sales agents steer Millions of people into Medicare Advantage

Sales agent commissions for enrolling people in Medicare Advantage are significantly higher than commissions for enrolling people in traditional Medicare. As a result, sales agents have a financial incentive to steer people into Medicare Advantage.

In truth: No one should trust sales agents; they should use independent, unbiased advisers, such as State Health Insurance Assistance Programs.

People aren't told that a Medicare Advantage plan might not meet their needs

The government suggests that people can pick the Medicare Advantage plan that's right for them. But, the government does not make data available about key differences among Medicare Advantage plans on Medicare Compare or anywhere else. For example, people don't know about rates of denial, disenrollment or mortality in different Medicare Advantage plans. Moreover, people do not know what their future needs will be and how the Medicare Advantage plan they choose will meet them.

The Centers for Medicare and Medicaid Services' "Medicare



& You" handbook does not warn people that some Medicare Advantage plans engage in widespread and persistent inappropriate delays and denials of care, let alone which ones.

Medicare's five-star rating system of Medicare Advantage plans is largely a farce.

In truth: People, who elect Medicare Advantage must gamble on whether they will get the care they need.

Medicare Advantage plans generally cover fewer services than traditional Medicare

While in theory, Medicare Advantage plans should cover people for the same medically reasonable and necessary services traditional Medicare covers, in practice they do not. People generally don't know about high rates of inappropriate delays and denials of benefits in some Medicare Advantage plans, let alone which plans have the highest such rates. They also do not know which Medicare Advantage plans have high voluntary disenrollment rates, particularly for people with costly conditions or high mortality rates.

In truth: Medicare Advantage plans profit from delaying and denying care, and the government does not have the tools or resources to hold them accountable when they are bad actors.

Additional benefits in Medicare Advantage might not be valuable

Medicare Advantage plans market their dental and vision benefits, gym memberships and other freebies not available in traditional Medicare. There's almost no data on the value of these benefits or to show who is able to use these benefits and whether out-of-pocket costs or limited access make them less beneficial than they appear.

In truth: Enrollees often can't take advantage of these additional benefits; they can come with high out-of-pocket costs and limited provider networks.

Medicare Advantage costs can be an obstacle to care

There's little information about typical out-of-pocket costs in

Medicare Advantage plans, let alone typical out-of-pocket costs for people with different health conditions, such as diabetes or cancer. The Medicare Advantage plans do not make this information available. The government's "Medicare & You" handbook does not include information on out-of-pocket limits in Medicare Advantage, which can be as high as \$8,300 for in-network care alone this year, and significantly more for out-of-network care.

In truth: Medicare Advantage plans impose financial barriers to care that lead some people – particularly those with low incomes and people of color – to skip or delay care when they get sick.

Medicare Advantage prior authorization rules and networks can be an obstacle to care

People do not know what care they will need down the road and whether their Medicare Advantage plan has specialists and specialty hospitals in its network to meet those needs. People often face obstacles such as prior authorization from their MA plans when they need critical care.

In truth: Medicare Advantage plans impose administrative barriers to care that keep some people from getting the care they need.

Traditional Medicare is not always an option once people enroll in Medicare Advantage

People are told that they can switch Medicare Advantage plans and switch to traditional Medicare each year during the Annual Open Enrollment Period. But most people don't know that, except in Maine, Massachusetts, Connecticut and New York, they have no right to buy supplemental coverage that fills gaps in traditional Medicare after they first enroll in Medicare, with limited exceptions. They also don't know that companies selling supplemental coverage generally can charge them much higher rates based on their health status if they switch out of Medicare Advantage.

In truth: People are often locked into Medicare Advantage once they enroll.

FDA is confiscating some imported life-saving prescription drugs

NBC News reports on the Food and Drug Administration's efforts to block importation of prescription drugs, to the benefit of the pharmaceutical industry and the detriment of Americans who can't afford the life-saving drugs they need in the US. Allegedly the FDA is trying to keep fentanyl and opioids from being shipped into the US. Really? The FDA found just 33 packages of these controlled substances out of 53,000 it intercepted in 2022.

The only smart solution to ensuring drug prices in the US are on a par with those in other wealthy countries, instead of two to four times higher, is to **open our borders to drug imports** from verified pharmacies abroad. **PharmacyChecker.com** reports prices from verified pharmacies in dozens of countries for a wide range of drugs. The pharmaceutical industry uses its considerable influence to prevent drug importation, claiming safety risks.

Of course, there are always risks to importing prescription drugs from abroad, just as there are risks to importing food from abroad. But, on a risk benefit analysis, the danger of being harmed from a drug imported abroad—for which there are no

reported cases—is far outweighed by the danger of preventing people from getting the drugs they need because they cannot afford them.

Moreover, if the FDA's goal is keeping opioids from entering the US, its investment in seizing packages with drugs from abroad is misplaced. The data show that few opioids are in the shipments the FDA intercepts. Almost all of the drugs were prescription drugs people had ordered from abroad at far lower cost than in the US.

But, the FDA continues its efforts, at a huge cost to the health and well-being to the Americans who need the drugs they import. The FDA has the right to confiscate drugs without US labeling or packaging. Drugs confiscated include drugs to treat asthma, diabetes, cancer and HIV, as well as a lot of drugs that treat erectile dysfunction.

While it is technically not legal to import prescription drugs from abroad, **millions of Americans do so every year**. No one has ever been prosecuted for doing so. What's particularly interesting is that both Republican and Democratic governors in Florida, Colorado, New Hampshire and New Mexico want to allow drug importation,



albeit only from Canada. Why is Congress giving the FDA \$10 million to intercept controlled

substances from abroad, when the vast majority of the drugs it intercepts are for personal use, to keep people alive? "The nation's fentanyl import crisis should not be conflated with safe personal drug importation," argues Gabe Levitt of PharmacyChecker.com.

In December, Congress told the FDA that it should focus on intercepting controlled and counterfeit drugs from abroad and drugs that pose "a significant threat to public health." That alone is not likely to help ensure that people who are importing cancer, asthma and heart drugs for personal use are able to do so. As Koontz of the FDA said, "Importing drugs from abroad simply for cost savings is not a good enough reason to expose yourself to the additional risks," he said. "The drug may be fine, but we don't know, so we assume it is not."

The FDA claims, based on Pharma-supported congressional testimony, that imported drugs have an eight to ten percent chance of being counterfeit. It's not at all clear this is accurate. And, based on the evidence, it is not at all accurate when it comes

to drugs bought from verified pharmacies around the world. Here's what's noteworthy, the U.S. Customs and Border Protection data show that it found just 365 counterfeits out of more than 30,000 drugs it inspected in 2022.

If you hear ads from the **Partnership for Safe Medicines** about the dangers of drug importation, ignore them. The Partnership for Safe Medicines is a pharmaceutical industry front group. The ads are paid for by Pharma, whose profits depend on keeping drug importation illegal.

The Biden administration has not yet approved state applications to import drugs. Pharma has tried and failed to block this Trump administration program, through a lawsuit, which was thrown out.

"We have never seen a rash of deaths or harm from prescription drugs that people bring across the border from verified pharmacies, because these are the same drugs that people buy in American pharmacies," said Alex Lawson, executive director of **Social Security Works**. "The pharmaceutical industry is using the FDA to protect their price monopoly to keep their prices high."

Congress must stop the Medigap madness

On one hand, "Medigap," health insurance coverage that supplements traditional Medicare, is an incredible product. It usually picks up all but a little of people's out-of-pocket Medicare costs. On the other hand, it forces people to choose among a sea of options they are hard-pressed to understand and to pay a lot of money upfront in order not to worry about their out-of-pocket health care costs. Congress needs to stop the Medigap madness.

Jake Johnson reports in Common Dreams on Sen. **Elizabeth Warren's** recent **report** on how insurance companies entice insurance agents with a bunch of money and prizes, with the goal of encouraging them to upsell people Medigap plans. Even though Medigap is regulated by the federal government, both

state and federal governments allow the insurers offering Medigap to run away with the store, scamming "millions of seniors ... offering agents lavish vacations to steer unknowing beneficiaries into more expensive plans," according to Senator Warren.

The insurance companies offering Medigap profited handsomely off the \$16 billion in premiums they collected last year alone. At the same time, older adults are "getting fleeced." Regulators need to step in.

People in traditional Medicare, who don't have Medicaid or retiree coverage to fill gaps in coverage, need an affordable Medigap plan. They likely assume that Traditional Medicare with Medigap is less affordable than Medicare Advantage,



corporate health insurance coverage. But, if you're looking for health insurance protection should you need costly services,

Traditional Medicare plus Medigap can be far more affordable than Medicare Advantage. Medicare Advantage often comes with out-of-pocket costs for in-network care alone of easily \$5,000 up to \$8,300 each year.

But, people can't trust their insurance agents to steer them to the Medigap plan they need. In fact, these agents often steer them to Medicare Advantage plans, where they make the biggest commissions. People are far better off turning to their State Health Insurance Assistance Program (SHIP) for free unbiased assistance choosing

a plan.

Warren wants the Centers for Medicare and Medicaid Services, which oversees Medicare, to step in. The only truly non-predatory solution would be for the government to sell people a gap-filling policy or, better still, reduce or eliminate out-of-pocket costs in Medicare.

Congress could also add an out-of-pocket cap to traditional Medicare, reducing people's need for Medigap coverage altogether. In fact, the **Congressional Budget Office** recently found that a high out-of-pocket cap—\$8,500—would reduce Medicare spending. It would also give people the choice of traditional Medicare without having to buy Medigap supplemental coverage.

What to Know Before the Public Health Emergency Ends in May

The COVID-19 public health emergency (PHE) will end in May. This will mean several changes in health programs like Medicare and Medicaid and for providers, including hospitals, nursing homes, and certain specialists.

While there are still significant numbers of COVID-19 cases in many communities, the end of the PHE will **end guaranteed access to free at-home diagnostic tests through Medicare**. Some Medicare Advantage plans may choose to continue to cover such tests. Laboratory-conducted COVID-19 tests ordered by a provider will still be covered at no charge, and coverage for COVID treatments and vaccines will not change. For Medicaid, current coverage of at-home testing, treatment, and vaccines will stay in place until September

2024. After that, states may make coverage changes.

Many Medicare telehealth services will remain in place until the end of 2024, allowing people to use telehealth no matter where they are, instead of just from rural areas; to access telehealth visits from home rather than traveling to a health care facility; and to use a telephone for certain telehealth visits like mental health care instead of using both audio and video. Medicaid telehealth coverage was not PHE-related, so it will be left to states to decide how and when to cover it.

To help protect public health, some states and territories have provided COVID-19 vaccinations, testing, and treatment for uninsured individuals using Medicaid



funds. **This coverage will end with the PHE. Medicaid's enrollment changes are extremely important.** As Medicare

Rights has outlined before, Congress put continuous enrollment requirements onto state Medicaid programs at the start of the pandemic, and these requirements are set to expire in April. People who no longer qualify for Medicaid will lose coverage, and enrollees who have difficulties navigating burdensome administrative processes are also at risk. As part of this shift, **Medicaid enrollees who first became eligible for Medicare during the pandemic** but did not sign up will have to do so.

Certain providers have also had greater flexibility during the PHE, including waivers that

allow greater autonomy for certain specialties, reduced or delayed paperwork, and initiatives like Acute Hospital Care at Home, which allowed hospitals to provide hospital-like care to people in their own homes. Each of these flexibilities is on a different timeline for expiration.

As **Medicare** and **Medicaid** finances take center stage, take this opportunity to check your health coverage and see what is in store for you as the PHE ends. If you think you will still qualify for Medicaid, be sure to check in with your state to see what you need to do to ensure your coverage is uninterrupted. Think you might no longer qualify? You might still be eligible for **help covering your Medicare costs.**

Feds Move to Rein In Prior Authorization, a System That Harms and Frustrates Patients

When Paula Chestnut needed hip replacement surgery last year, a pre-operative X-ray found irregularities in her chest.

As a smoker for 40 years, Chestnut was at high risk for lung cancer. A specialist in Los Angeles recommended the 67-year-old undergo an MRI, a high-resolution image that could help spot the disease.

But her MRI appointment kept getting canceled, Chestnut's son, Jaron Roux, told KHN. First, it was scheduled at the wrong hospital. Next, the provider wasn't available. The ultimate roadblock she faced, Roux said, arrived when Chestnut's health insurer deemed the MRI medically unnecessary and would not authorize the visit.

"On at least four or five occasions, she called me up, hysterical," Roux said.

Months later, Chestnut, struggling to breathe, was rushed to the emergency room. A tumor in her chest had become so large that it was pressing against her windpipe. Doctors started a regimen of chemotherapy, but it was too late. Despite treatment, she died in the hospital within six weeks of being admitted.

Though Roux doesn't fully blame the health insurer for his mother's death, "it was a contributing factor," he said. "It

limited her options."

Few things about the American health care system infuriate patients and doctors more than prior authorization, a common tool whose use by insurers has exploded in recent years.

Prior authorization, or pre-certification, was designed decades ago to prevent doctors from ordering expensive tests or procedures that are not indicated or needed, with the aim of delivering cost-effective care.

Originally focused on the costliest types of care, such as cancer treatment, insurers now commonly require prior authorization for many mundane medical encounters, including basic imaging and prescription refills. In a **2021 survey** conducted by the American Medical Association, 40% of physicians said they have staffers who work exclusively on prior authorization.

So today, instead of providing a guardrail against useless, expensive treatment, pre-authorization prevents patients from getting the vital care they need, researchers and doctors say.

"The prior authorization system should be completely done away with in physicians' offices," said **Dr. Shikha Jain**, a Chicago hematologist-oncologist. "It's



really devastating, these unnecessary delays."

In December, the federal government **proposed several changes** that would force health plans, including Medicaid, Medicare Advantage, and federal Affordable Care Act marketplace plans, to speed up prior authorization decisions and provide more information about the reasons for denials. Starting in 2026, it would require plans to respond to a standard prior authorization request within seven days, typically, instead of the current 14, and within 72 hours for urgent requests. The proposed rule was scheduled to be **open for public comment** through March 13.

Although groups like AHIP, an industry trade group formerly called America's Health Insurance Plans, and the American Medical Association, which represents more than 250,000 physicians in the United States, have expressed support for the proposed changes, some doctors feel they don't go far enough.

"Seven days is still way too long," said **Dr. Julie Kanter**, a hematologist in Birmingham, Alabama, whose sickle cell patients can't delay care when they arrive at the hospital showing signs of stroke. "We

need to move very quickly. We have to make decisions." Meanwhile, some states have passed their own laws governing the process. In Oregon, for example, health insurers must respond to nonemergency prior authorization requests **within two business days**. In Michigan, insurers must **report annual prior authorization data**, including the number of requests denied and appeals received. Other states have adopted or are **considering similar legislation**, while in many places insurers regularly take four to six weeks for non-urgent appeals.

Waiting for health insurers to authorize care comes with consequences for patients, various studies show. It has led to **delays in cancer care** in Pennsylvania, meant sick **children in Colorado** were more likely to be hospitalized, and blocked **low-income patients across the country** from getting treatment for opioid addiction.

In some cases, care has been denied and never obtained. In others, prior authorization proved a potent but indirect deterrent, as few patients have the fortitude, time, or resources to navigate what can be a labyrinthine process of denials and appeal.... **Read More**

RI ARA HealthLink Wellness News

Pharmacies, Hospitals Facing Shortage of Asthma Drug Albuterol

Ongoing shortages of a medication that hospitals and emergency rooms rely upon to treat breathing problems are likely to worsen in coming days and weeks, experts warn.

That's because one of the two major U.S. suppliers of liquid albuterol, Akorn Pharmaceuticals, abruptly laid off its entire workforce and closed plants in New Jersey, New York and Illinois in late February.

"We're down to just one plant that's supplying liquid albuterol to all patients in the United States," said **Dr. Juanita Mora**, a Chicago allergist/immunologist and volunteer spokesperson for the American Lung Association.

That remaining supplier of liquid albuterol, Nephron Pharmaceuticals, has had manufacturing issues of its own, exacerbating the situation even more, said **Bayli Larson**, a strategic initiatives associate with the American Society of Health-System Pharmacists (ASHP).

"Another phenomenon that could be at play is institutions, anticipating the shortage, may have increased their orders to ensure they had enough on hand," Larson added. "ASHP discourages hoarding as a countermeasure to medication supply disruptions; however, some institutions feel they have to do it to avoid jeopardizing patient care."

The shortage comes at an extremely inopportune time, Mora said.

"We are about to enter allergic asthma season, where pollen levels are going to begin to rise all throughout the United States," Mora said. "And we know so many kids and adults suffer from allergic asthma symptoms and are already starting to see it now, even here in Chicago, because we've had such a mild winter. I have a second asthmatic person of the day today coming in wheezing."



Albuterol acts upon the airways, helping them dilate to improve breathing. It's used for a variety of breathing disorders, most commonly asthma and COPD, Mora said.

"It's used by 25 million asthmatics in the United States -- that includes 20 million adults and 5 million kids -- and 24 million people with COPD or emphysema, plus anyone who suffers from any respiratory disease," Mora said. "So this shortage is definitely concerning to the medical community."

Liquid albuterol is typically used by emergency rooms to help people who are having a dire breathing problem. The medication is administered from a nebulizer via a mouthpiece or face mask.

Some families with asthmatic children also use liquid albuterol in home nebulizers to help the kids breathe easier, Mora said. She's already heard from parents

who are unable to find liquid albuterol or refill it in pharmacies.

However, albuterol inhalers are in stock and readily available, Mora and Larson said.

Mora is recommending that all her patients have their albuterol inhaler up to date and current.

"Usually each of the canisters has 200 doses. That should carry them for a long time. It works just as well as the albuterol liquid," Mora said.

If people rely on inhalers at home, that will help ease shortages among hospitals and emergency rooms, Mora said.

"I'm telling people not to go ahead and try to fill liquid albuterol and hoard it," Mora said. "Let the albuterol liquid that's currently available hit the hospitals and emergency departments where kids and adults are going in with asthma exacerbations or COPD exacerbations or emphysema." ...[Read More](#)

Should I Take Melatonin for Sleep? An Expert Has Answers

There's nothing worse than having trouble falling asleep or staying asleep. Watching the time go from minutes to hours only stresses you out and decreases the chance of a good night's rest.

Is it time to try melatonin supplements, a popular sleep aid?

Plenty of folks might want to know: In a recent study from the **U.S. Centers for Disease Control and Prevention** (CDC), 14.5% of American adults said they struggled to fall asleep while nearly 18% had trouble staying

asleep during the 30 days before the study.

The human body secretes melatonin on its own to help with sleep. But when might you need more than your body produces?

First, what is melatonin?

"Melatonin is a natural hormone that's mainly produced in your pineal gland," according to the **Cleveland Clinic**. Located in the brain, this gland responds to daylight and darkness by secreting melatonin. It secretes



more melatonin at night and less during the day.

"When it gets dark in the evening, melatonin starts being secreted. It peaks around 3 o'clock in the morning and then it starts decreasing, and by 7 a.m. it's suppressed," explained **Dr. Sanjeev Kothare**, co-director of the Pediatric Sleep Program at Cohen Children's Medical Center in New Hyde Park, N.Y.

But when the melatonin you produce doesn't seem to be doing the job, you want relief.

That's when melatonin supplements and natural sources of melatonin from the food you eat can be worth considering.

Is melatonin safe to take?

Melatonin supplements are manufactured and sold as dietary supplements. The U.S. Food and Drug Administration regulates dietary supplements under a different set of rules than prescription drugs and over-the-counter medications. ...[Read More](#)

Losing Weight After 60: Healthy Diet and Exercise Tips for Seniors

We'll start with the good news: Losing weight after 60 is a realistic goal. And maintaining a healthy weight can help you **live an active and engaged life as a senior**. However, many older people have to adjust their prior weight-loss strategies to lose extra pounds safely. That's because what works for younger people when it comes to weight loss doesn't necessarily work for seniors.

But that doesn't mean you can't achieve your healthiest weight. You can lose weight as you get older by recognizing how your body changes with age and creating a safe, effective weight-loss plan.

For many seniors, that process starts with determining their ideal weight. And because body composition changes with age, you may find that your goal



weight and health priorities shift as you grow older. That's just one reason why it's essential to work closely with your healthcare team if you think that you need to lose weight.

This article will help you discover how to stay healthy while safely losing those extra pounds. So keep reading to learn more about how to create a sound plan for senior weight loss.

- ◆ [Do I need to lose weight? Why weight charts can be misleading for seniors](#)
- ◆ [Why is losing weight over 60 more difficult? How your body changes with age](#)
- ◆ [How can I improve my metabolism? Outsmarting the aging process](#)
- ◆ [What's the best diet for seniors? Tips for safe weight loss](#)

Two Healthy Diets May Reduce Brain 'Plaques' Tied to Alzheimer's Risk

Elderly adults who eat plenty of leafy green vegetables, fish and other healthy fare may take years off their "brain age," a new study suggests.

Researchers found that seniors with either of two healthy eating patterns -- the Mediterranean and MIND diets -- showed fewer brain "plaques," abnormal protein clumps that are a hallmark of Alzheimer's disease.

In fact, people with the highest Mediterranean or MIND scores had brains that were up to 18 years younger than their counterparts with more of a burger-and-fries diet.

Experts said the findings do not prove that spinach and fish will ward off dementia. But they do add to a growing body of evidence linking healthy eating to

slower brain aging.

Lead researcher **Puja Agarwal** called the results "exciting," because they suggest that even a simple dietary change could make a substantial difference.

Based on the findings, older people who eat, say, a cup of leafy greens a day could have a brain that's four years younger, versus their peers who shun the likes of kale and spinach.

The study, published March 8 in *Neurology*, builds on past research into diet and dementia.

Both the Mediterranean and MIND diets have already been linked to slower mental decline and a lower risk of Alzheimer's disease, the researchers said in background notes. Now the new



findings connect the diets to fewer objective signs of Alzheimer's -- the plaques that begin to form in the brain years before dementia symptoms appear.

That strengthens the case that the eating patterns are truly associated with lower Alzheimer's risk, according to Agarwal, an assistant professor at Rush University Medical College in Chicago.

"It also gives us a first view into the mechanisms," she said.

That is, less accumulation of brain plaques may be one way the diets protect against Alzheimer's - though, Agarwal said, it's not yet clear how they might accomplish that.

The traditional Mediterranean

diet -- famously linked to lower risks of heart disease and stroke - is generally high in fish, olive oil, vegetables, beans, nuts and fiber-rich grains.

The MIND diet is very similar, but emphasizes leafy green vegetables and berries over other vegetables and fruit. That's based on research tying those foods to better brain health.

Both diets, according to the Rush University researchers, are high in plant foods that have various nutrients and chemicals that can ease inflammation in the body and protect cells from damage.

Both diets are also notable for what they leave out: red meat, sugar and heavily processed foods....[Read More](#)

Depression Ups Odds for a Stroke

In yet another example of the mind-body connection, people with depression symptoms may face an increased risk of having a stroke, as well as a worse recovery afterwards.

A new international study, published online March 8 in the journal *Neurology*, found about 18% of those who had a stroke had symptoms of depression, compared to 14% of those who did not have a stroke.

After adjusting for other contributing factors, researchers determined that people with symptoms of depression before stroke had an overall 46% increased risk of stroke compared to those with no symptoms of depression.

As the symptoms increased, so did the higher risk of stroke.

"Depression affects people around the world and can have a wide range of impacts across a

person's life," said study author **Dr. Robert Murphy**, of the University of Galway in Ireland.

"Our study provides a broad picture of depression and its link to risk of stroke by looking at a number of factors including participants' symptoms, life choices and antidepressant use," Murphy said in a journal news release. "Our results show depressive symptoms were linked to increased stroke risk and the risk was similar across different age groups and around the world."

The researchers used data from more than 26,000 adults in the INTERSTROKE study, which included 32 countries across Europe, Asia, North and South America, the Middle East and Africa.

More than 13,000 of the participants had a stroke. They



were matched with more than 13,000 people who had not had a stroke but were similar in their age, sex, racial or ethnic identity.

Information was collected about depression symptoms in the year prior to the study, including whether participants had felt sad, blue or depressed for two or more consecutive weeks in the previous 12 months.

Participants also answered questions at the beginning of the study about cardiovascular risk factors, including high blood pressure and diabetes.

Researchers found that people who reported five or more symptoms of depression had a 54% higher risk of stroke than those with no symptoms. Those who reported three to four symptoms of depression had 58% higher risk and those who

reported one or two symptoms of depression had a 35% higher risk.

The people who had depression symptoms weren't more likely to have severe strokes. They were, however, more likely to have worse outcomes a month after the stroke.

A study limitation is that depression symptoms were assessed only at the start of the study and not over time.

"In this study, we gained deeper insights into how depressive symptoms can contribute to stroke," Murphy said. "Our results show that symptoms of depression can have an impact on mental health, but also increase the risk of stroke. Physicians should be looking for these symptoms of depression and can use this information to help guide health initiatives focused on stroke prevention."

Do Old People Smell Different? The Facts About Changing Body Odor for Seniors and Caregivers

Does an "old people smell" really exist? Or is that term just another untrue stereotype about seniors? The answer isn't entirely straightforward. Although scientists have discovered that older people experience physiological changes that can lead to a distinct scent, that smell isn't necessarily as unpleasant as

the term often implies. And it's usually not the result of poor hygiene or housekeeping.

Fortunately, there are many things you can do to minimize its causes if the smell bothers you.

This article will teach you why people's natural scent can change



with age. You'll also learn tips for preventing the distinctive odor. And you'll find out why you shouldn't panic if you notice that your body smells different than it used to. Plus, you'll discover other factors that can influence a senior's scent and get tips on how to talk to a loved

one about body odor.

- ◆ [Why do people smell different as they get older?](#)
- ◆ [Is nonenal a bad thing?](#)
- ◆ [How can I prevent nonenal odor?](#)
- ◆ [When to worry: Tips for seniors and caregivers](#)

FDA mammography update raises cost questions

The FDA is **updating mammography guidelines** in a move that could protect people at higher risk of developing breast cancer but also drive up demand for more tests and screenings.

Why it matters: The agency's **new rule** requires mammogram providers to notify patients about breast density, which can make it harder to detect cancer and as a result, puts some at increased risk of the disease. 38 states already have such reporting requirements.

◆ Under the **Affordable Care Act**, health plans are required to pay for an annual mammogram at no cost for women 40 and older.

State of play: The FDA's update takes effect in September 2024 and differs from guidance from the **U.S. Preventive Services Task Force**, which says that there's "insufficient" evidence to suggest that there are benefits in additional screenings for women with dense breasts.

◆ It's difficult to tell the

difference between a tumor and dense breast tissue because they both appear white on a mammogram, so "a small tumor may be missed," according to the **Centers for Disease Control and Prevention**.

◆ The FDA recommends that patients meet with health care providers if they're found to be at higher risk.

◆ The FDA will begin evaluating facilities to ensure that they comply with the disclosure requirements, per **the New York Times**.

Don't forget: The CDC estimates that approximately half of women aged 40 and over have dense breasts.

Between the lines: The agency says that while some follow-up tests may be able to find cancers that are missed on a mammogram, they are also more likely to show a "false positive result."

◆ These false positives could



lead to "unnecessary tests, like a biopsy," whose costs may fall on the patient, per the CDC.

◆ The FDA said health care costs are outside of the scope of its decision-making authority.

Zoom out: The language of the state disclosure laws varies, and some mammography providers aren't told what they should communicate, according to an **analysis** from Dense Breast-Info, an educational website.

◆ "A lot of people have received notifications over the last several years" about their breast density but "aren't really sure what to do with that information," said Usha Ranji, associate director for women's health policy at the Kaiser Family Foundation.

◆ The FDA's guidance sets a national standard around screenings and "[reiterates] the importance of provider communication," Ranji added.

What also happened: The

FDA said that it was looking to ensure that mammogram facilities were using devices "of high quality" that can accurately show the results.

◆ In particular, the agency says that images of mammogram results should not be "copied or digitized from hard copy original images" because it can "adversely affect the accuracy of interpretation."

◆ The agency disagreed with some public comments saying that 3D mammogram should be the standard for people seeking breast cancer screenings, only saying facilities use "only more expensive technology" would significantly increase costs for facilities and negatively impact their ability to operate.

◆ A mammogram on average costs **between \$90 and \$250 without insurance** and the price could potentially be higher depending on the technology that is used.

Poll Finds More Americans Worried About Health Care Understaffing

A growing number of Americans are feeling the effects of the health care staffing crisis in the United States, a new *HealthDay/Harris Poll* has revealed.

Health care has witnessed the greatest recent increase in consumers affected by staffing shortages, more so than retail, hospitality, education, customer support and manufacturing, poll results show.

More than a third (35%) of people noticed or had been

affected by health care staffing shortages at the time of the February poll, up from 25% last November, noted **Kathy Steinberg**, vice president of media and communications research at the Harris Poll.

By comparison, 24% had been affected by staffing shortages in education in February, up from 17% in November.

Retail had the greatest staffing woes, with 36% of consumers noticing or being affected by not



enough workers in February. But that number barely budged from November, when 35% said they'd seen staffing problems in stores.

"Quite concerningly, the data reveal an even more pronounced impact on women, who are more likely than men to have experienced shortages in health care now [41% vs. 28%], and also more likely to have noticed such shortages now than just a few months ago [41% in

February vs. 31% in November]," Steinberg added.

These shortages have hampered people's ability to receive medical care.

More than 4 out of 5 U.S. adults (84%) have tried to get health care in the past six months, and of those nearly 3 in 4 (73%) experienced delays or challenges in getting the care they need, the poll shows....**Read More**

Reducing Home Hazards Cuts Seniors' Risk of Falling

Nearly one-third of older people fall each year, most of them in their own homes. But it's possible to reduce those numbers by a quarter, according to a new study.

Five steps can cut the risk of falls by 26%, the researchers reported in the March 10 issue of the *Cochrane Database of Systematic Reviews*. Those steps are: decluttering; reducing tripping hazards; improving lighting; and adding hand rails and non-slip strips to stairs.

"Falls are very common among

older people. They can cause serious injury or even death, but they are preventable. In this review, we wanted to examine which measures could have the biggest impact on reducing falls among older people living at home," lead author **Lindy Clemson**, professor emeritus at the University of Sydney, Australia, said in a journal news release.

The review found that people most at risk of falls, such as those recently hospitalized for a fall or



those needing support for daily activities, such as dressing, would benefit the most from decluttering.

Other measures — such as having the correct prescription glasses or special footwear — didn't make a difference. Neither did education about falls.

For the study, the researchers analyzed 22 studies that included data on more than 8,400 people living at home.

Taking measures to reduce falls around the house reduced

falls by 38% in people who were at a higher risk.

The reviewers estimated that if 1,000 people who had previously fallen had followed these measures for a year, there would have been 1,145 falls instead of 1,847.

"Having had a fall or starting to need help with everyday activities are markers of underlying risk factors, such as being unsteady on your feet, having poor judgment or weak muscles," Clemson said....**Read More**

FDA-Mandated Tweak to Common Rx Painkillers May Have Saved Lives

Acetaminophen, a popular over-the-counter medication for millions struggling with pain and fever, can also be found in prescription painkillers that combine acetaminophen and an opioid into one pill.

The problem? The U.S. Food and Drug Administration has long known that high dosages of acetaminophen (Tylenol) can harm the liver. So, in 2011 the FDA set new safety limits on exactly how much acetaminophen could be packed into any prescription painkiller.

Now, a new study shows the move likely saved lives.

Ever since the FDA announced the regulatory change, which slashed the limits on acetaminophen from up to 750 milligrams (mg) to up to 325 mg, there has been an 11% to 16% annual drop in the number of

hospitalizations and acute liver failure cases involving the combo painkiller. One such combo is Vicodin, which contains hydrocodone and acetaminophen.

"This suggests that the mandate was likely the largest driver in the decreases in acute liver failure cases and hospitalizations in combination acetaminophen-opioid products," said study author **Dr. Jayme Locke**, director of the University of Alabama at Birmingham's Comprehensive Transplant Institute.

The report was published in the March 7 issue of the *Journal of the American Medical Association*. Locke and her colleagues stressed that their investigation does not definitively prove that the FDA



mandate directly caused acetaminophen-opioid drug complications to plummet.

"Certainly, other factors could have played a role," Locke noted. "For example, the mandate may have brought the issue of acetaminophen toxicity to the forefront for both providers and patients," presumably leading some to cut down on acetaminophen dosages on their own.

At the same time, she pointed out that the FDA mandate did *not* place any new limits on over-the-counter acetaminophen dosing. Not surprisingly, "similar [downward risk] trends were not observed in acetaminophen alone," Locke said.

According to the study authors, the intended purpose of combining acetaminophen with

an opioid was to enable doctors to expose patients to lower doses of each of the two drugs. Given the burgeoning opioid addiction crisis, that approach made sense.

But researchers started to warn that at such high doses acetaminophen was proving toxic to the liver.

In fact, the new report highlights one 2005 study that found more than 4 in 10 of all acute liver failure cases linked to acetaminophen use ended up being traced back to acetaminophen-opioid painkillers.

In 2009, such red flags prompted an FDA advisory panel to recommend an outright ban on such combo drugs. In the end, the FDA chose the dosage limit route... [Read More](#)

Blood Pressure Measurements in the Clinic May Vary Widely Between Doctor's Visits

Blood pressure measurements taken in a medical office can vary widely between visits, new research finds, offering further support for guidelines that call for supplemental home monitoring.

"These large variations in blood pressure measurements pose a great challenge to determine whether hypertension treatment is actually working," said lead study author Yuan Lu, an assistant professor at the Yale School of Medicine in New Haven, Connecticut. "It makes clinical decisions very difficult."

The study, published

Wednesday in *Circulation: Cardiovascular Quality and Outcomes*, was designed to show how ineffective it can be to rely solely on office-based measurements, she said.

Nearly half of U.S. adults have high blood pressure, also called hypertension, and just 1 in 4 have the condition under control. High blood pressure is defined as having a systolic blood pressure – the top number – of 130 mmHg or higher or a diastolic reading – the bottom number – of 80 mmHg or more.

Research shows uncontrolled



hypertension can lead to heart attacks, strokes, heart failure, kidney disease, vision loss and other health conditions. High blood pressure in midlife and beyond also has been linked to cognitive decline and dementia.

Guidelines from the American Heart Association and American College of Cardiology recognize that readings vary between medical office visits and recommend out-of-office measurements, using home or ambulatory devices, to supplement those taken by health

care professionals.

However, the use of out-of-office monitoring devices remains limited, Lu said. "The majority of patients treated for hypertension are treated based on office-based measurements."

Lu and her colleagues analyzed more than 7.7 million blood pressure measurements for 537,218 adults, who were an average 53 years old and treated in the Yale New Haven Health System. Patients had an average of 13 outpatient visits each during a roughly 2.4-year period... [Read More](#)

Long-Term Study Supports 'Watch and Wait' for Most Prostate Cancers

A man with prostate cancer who takes the "watch-and-wait" approach has the same long-term survival odds as those who undergo radiation therapy or surgery, according to a new large-scale study.

Patients had the same 97% survival rate after a decade and a half whether doctors treated their tumor or simply put it under observation, British researchers found.

"Survival from prostate cancer was high after 15 years of follow-up, whether patients received radiotherapy, prostatectomy [prostate removal] or active monitoring," said study co-

author **Jenny Donovan**, a professor of social medicine with the University of Bristol.

"Only 3% of patients in the study died from prostate cancer."

Researchers presented the findings last weekend at the European Association of Urology's annual meeting, in Milan, and the results were published simultaneously in the *New England Journal of Medicine*.

For the study, researchers evaluated nearly 82,500 men in the United Kingdom who underwent a prostate-specific antigen (PSA) test between 1999



and 2009.

The study recruited just over 1,600 men diagnosed with localized prostate cancer as a result of their screening and randomly assigned them to one of three groups -- an active monitoring group, a group that underwent surgery to remove their prostate, and a group that received radiation therapy for their cancer.

After 15 years, only 45 had died -- 17 in the active monitoring group, 12 in the surgery group and 16 in the radiation therapy group.

Men on active monitoring were more likely to see their cancer

progress or spread, but this didn't reduce their chances of long-term survival.

As a result, the researchers concluded that men diagnosed with low- or moderate-risk prostate cancer don't need to panic and rush their treatment decisions.

"Many patients with prostate cancer contained to the prostate could delay or forgo radical treatment without compromising quality of life or longevity," Donovan said. "All men with low-risk and many with moderate-risk prostate cancer could safely choose surveillance over surgery or radiation." [Read More](#)

New Ablation Treatment Could Improve A-Fib Care

A quicker, safer option for treating an irregular heartbeat called atrial fibrillation might be just months away.

Atrial fibrillation is currently treated with drugs or a procedure known as thermal ablation. Thermal ablation uses extreme temperatures to disable areas of the heart causing the abnormal heart rhythm. The new system -- called pulsed field ablation -- uses electricity instead of extreme heat or cold to disarm critical heart muscle cells.

"This technology will probably take over thermal ablation," said lead researcher **Dr. Atul Verma**, a cardiologist at McGill University Health Center in

Montreal.

"Keep in mind, this is just the first generation of this technology. I think as time goes on over the next five to 10 years, we're going to see further iterations that are going to make this better," he added.

Atrial fibrillation, or a-fib, is the most common abnormal heart rhythm. According to the U.S. Centers for Disease Control and Prevention, 12 million people in the United States will have a-fib by 2030. While it can cause fatigue and chest pain, the biggest danger is a heightened risk of stroke.

With traditional ablation, doctors snake tiny instruments to



the heart through a vein or artery. Thermal ablation usually takes two hours or more and can damage surrounding tissue.

The advantage of pulsed field ablation is it can be done in under an hour with pulses that last no longer than 30 seconds and with no damage to surrounding tissue, the researchers said.

The trial was funded by Medtronic, the technology's maker, and used its system called PulseSelect.

Verma noted that the Medtronic system is one of several systems undergoing testing but may be the first to be approved by the U.S. Food and

Drug Administration.

"It's probably going to be about six months or so before we see approval and then release into the wider market in the U.S.," he said.

The study pitting pulsed field ablation against thermal ablation was done in nine countries: the United States, Canada, Australia, Austria, Belgium, France, Japan, the Netherlands and Spain. It enrolled people who continued to have a-fib even while taking medication. In the first phase, doctors treated 60 patients to get a feel for the procedure. They then enrolled more patients and did up to 300 procedures....**Read More**

Falls Can Be More Dangerous for Older Men Than for Women

While older women are treated for falls more often than elderly males, men are more likely to sustain skull fractures when they topple over, new research suggests.

This is a serious concern because more than 3 million people aged 65 and older are treated in U.S. emergency departments each year for falls.

"The high incidence of head injury and subsequent skull fractures due to falls is a cause for concern as our aging population continues living active lifestyles," study co-author **Dr. Scott Alter**, an associate professor of emergency medicine at Florida Atlantic University

College of Medicine, said in a university news release.

Head trauma is the leading cause of serious injury, and skull fractures are a serious head trauma outcome, the study authors noted.

About 58% of these falls happen to women, according to the 2016 National Trauma Database annual report.

To study this further, Alter and his colleagues evaluated all patients seen with head trauma at two level-one trauma centers in southeast Florida.

The researchers examined skull fractures due to acute trauma, comparing them by gender,



patient race/ethnicity and how the injury happened.

About 56% of the more than 5,400 patients were women. About 85% of the head injuries sustained happened in falls. The women and men had a mean age of about 83 and 81 years, respectively.

Men had a significantly increased incidence of skull fracture secondary to head trauma, due mostly to falls. The researchers noted that the outcome was unexpected because previous research has indicated women were more susceptible to facial fractures.

Although this trend also was seen across races and different

ethnic groups, the results were only statistically significant for white people, the investigators found.

"As falls caused the greatest number of head injuries and subsequent skull fractures, fall prevention may be an important intervention to consider" in reducing illness and injury, Alter said.

"Although fall prevention education can be addressed in the primary care setting or at assisted living facilities, the emergency department could also represent an opportunity to educate patients and to prevent future death and disability from falls in this population," he added.

HealthLink Wellness "Taking Control" Science for the Individual

Some of the Highlights:

- ◆ Revolution in Personal Control of Health Based on Science

There is a revolution taking place in personal health and wellness. This book is the results of 20 years of a community-based wellness program "HealthLink Wellness". As you open the book you will see that it is the culmination of the cooperation and funding of many groups, both labor and non-labor. A true community partnership.

Scientifically Derived Health Outcome Measures:

- ◆ HealthLink Risk Profile Index

Ten-year probability estimates of coronary heart disease, originally developed by the

Framingham Heart Study. It has the endorsement of both the American College of Cardiology and American Heart Association. A Risk Profile calculator was developed so that individuals can monitor their own personal progress.

- ◆ Wellness-Comorbidity Matrix.

It is designed to outline for the individual the dynamics of wellness and comorbidity interaction. Its use, in conjunction with the Risk Profile Index, is to make it

easier for individuals to set reasonable incremental goals.

Some of Our Results with Retiree Health:

- ◆ Reduce the number of individuals with hypertension from 61% to 37%
- ◆ Increase the number of individuals with normal blood glucose from 51% to 71%
- ◆ Increase the number of individuals with normal Total Cholesterol from 48% to 70%
- ◆ In addition to the science of wellness, this book also covers how HealthLink

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