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RI ARA

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Drug Corporations Kick Lobbying into High Gear to Stop Medicare Drug Price Negotiation

Millions of dollars in **advertising, funded by pharmaceutical corporations and business organizations**, are being spent to block President **Biden's** Build Back Better plan, and the provision allowing Medicare to negotiate lower drug prices and expand benefits is a focus of many of those ads. Some of the campaigns are designed to reinforce the positions of Democratic elected officials who oppose drug price negotiation, including Sen. **Kyrsten Sinema** (AZ) and Reps. **Kathleen Rice** (NY) and **Kurt Schrader** (OR).

Rep. **Scott Peters** (CA), the third House Democrat to block negotiation in the House Energy and Commerce Committee, also received praise in ads funded by the pharmaceutical trade group PhRMA. Peters has accepted over $88,000 in donations from drug corporations this year alone, more than any other member of the House, and represents a district heavily-populated by pharmaceutical offices.

Both Peters and the drug industry trade group supplement their opposition to the bill with dramatically scaled-back legislation of their own, prompting White House press secretary **Andrew Bates** to say, "...for far too long, the wealthiest taxpayers and big corporations — those who can afford lobbyists — have been able to write a special set of rules for themselves."

"To say the drug corporations' lobbyists are fully engaged would be putting it mildly," said **Richard Fiesta**, Executive Director of the Alliance. "Their tactics make our grassroots opposition to their efforts, like letters from Alliance members to Capitol Hill and virtual events, more important than ever."

Alliance members have been stressing the need to allow Medicare to save hundreds of billions of dollars by negotiating lower prices and to use the savings to allow Medicare to offer dental, hearing and vision benefits.

On Wednesday, the Arizona Alliance joined allies in speaking out against Big Pharma-connected political stunts, including ads designed to mislead Arizonans about the impact of prescription drug reforms being considered in Congress. The event drew attention to one stunt in particular, executed by a Pharma-allied GOP Super PAC affiliated with key Republicans in Congress who oppose letting Medicare negotiate lower drug prices. The ploy involved shipping boxes to Arizonans disguised with the label **"MEDICAL SHIPMENT ENCLOSED," "PLEASE OPEN URGENTLY."** In the package was an empty prescription bottle with the label "prescription denied."

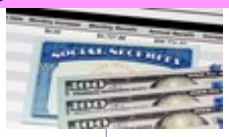
Rich Fiesta, Executive Director, ARA

The largest COLA hike in 40 years is coming to Social Security in 2022

The **cost-of-living adjustment** in 2022 will be 5.9%, according to the Department of Labor. It will be the largest increase to COLA in 40 years, and a boost to Social Security beneficiaries' checks.

For more than a decade, these adjustments have averaged below 2%, which in many cases has done little for Social Security beneficiaries – or **nothing**, in instances when their expenses have risen dramatically but their benefit checks have barely adjusted for inflation.

"For almost everybody who is retired and still alive today and receiving Social Security, this will probably be the highest COLA they have ever received," said Mary Johnson, a Social Security policy analyst for the Senior Citizens League. Johnson tracks COLA every year, and her estimates for the following year's adjustments are usually quite accurate (she expected the 2022 COLA to be between 6% and 6.1%, for example). Next year's COLA will be the highest it's been since 1982, when it was 7.4%. Anybody who began claiming Social Security at the earliest allowable age, which is 62, that year would be 102 today.



"We are talking about an inflation rate that almost all Social Security recipients have never experienced," she said.

The hike for 2022 can be attributed to inflation caused from the country's rebound since the pandemic began, such as the price in gasoline and petroleum, Johnson said.

Social Security benefits are linked to the Consumer Price Index for urban workers, which weighs the average prices of goods used by workers younger than retirement age (such as gas). There is usually a significant disconnect between that CPI and another measurement, known as CPI-E, which is tied to the spending of older Americans, such as healthcare. Because of this, benefit increases normally do not meet the needs of rising inflation for goods and services like Medicare premiums and homeowners' insurance.

The increase is still modest. The average Social Security benefit is around $1,543 a month. A 6% increase would equate to roughly $93 – a help to older Americans on fixed income, but perhaps not equal to the high expenses associated with healthcare and housing. Still, even tying benefits to CPI-E, as **Biden has proposed**, would not make a drastic change for beneficiaries' checks, Johnson said. "The CPI-E in most years yields higher COLAs, but does not reflect the cost of some of the fastest growing prices that retired and disabled Social Security beneficiaries face."

Older Americans were hit hard by the pandemic. Johnson has received emails from some Social Security beneficiaries who said they're losing their homes, or reducing their meals, in an attempt to make ends meet. They may have worsening health situations, or are taking on new obligations as a result of the pandemic.

ADD YOUR NAME

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

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Means Testing and Income Relating Undermines Medicare

Some policymakers support "means testing" or "income relating" Medicare—making higher-income people pay more or get less—by raising premiums or cutting benefits for people above a certain income level. Some approaches would even lead to people getting no benefit at all from the dollars they already paid into Medicare.

Such proposals threaten to undermine the Medicare guarantee—that those who contributed to the system will have access to high-quality health care as they get older. They also fail to recognize that older adults with higher incomes already pay more for Medicare during their working lives and/or after retirement. For example:

- Higher earners already pay more for their benefits. The **Medicare payroll tax** is 1.45% for the employer and 1.45% for the employee, or 2.9% total. Unlike the Social Security payroll tax, the Medicare tax does not have a cap. This means that higher-income earners keep paying into Medicare no matter how high their incomes go. The more someone earns, the more they pay into Medicare.
- In addition, some higher-income earners have a **0.9% payroll surcharge** during their working lives. This is on top of the above payroll tax. The threshold for this additional Medicare tax is $200,000 for single filers and $250,000 for married filing jointly.
- Those who have incomes above $88,000 per year pay more for their Medicare Part B premiums as well as any Part D (prescription drug coverage) premiums through the Income-Related Monthly Adjustment Amount (IRMAA). The **Part B IRMAA surcharges** start at $59.40/ per month, topping out at an extra $343.10 per month for the highest earners. For Part D, **the additional IRMAA premium** starts at $12.30 per month, topping out at an extra $77.10 per month for the highest earners.

Together, these policies mean that higher-income people already pay more for their Medicare benefits than lower-income people do. Further means testing would jeopardize the integrity and universality of Medicare.

It could also mean higher health care costs for the middle class. Some policymakers want to increase the IRMAA surcharge or lower the threshold from $88,000,

including in ways that would **add surcharges for incomes under $50,000**. This undeniably would increase health care costs for the middle class.

This conversation is particularly relevant as lawmakers debate adding dental, vision, and hearing coverage to Medicare Part B in the budget reconciliation "Build Back Better" bill. Divisions among Democrats about the package's price tag and policies mean it is likely to shrink, which may include scaling back and reworking its health care provisions. One idea under consideration is to limit some or all of the new Medicare benefits **to those with the lowest incomes**. Medicare Rights strongly opposes this strategy. It would set a terrible precedent, create additional complexity for beneficiaries and the program, and destabilize the risk pool—increasing premiums and costs.

Policymakers must keep in mind that often, the sicker a beneficiary is, the more expensive their care will be. For those with serious and chronic illnesses, middle incomes can already fall short and even higher incomes can start to become inadequate. Instead of looking to make people with Medicare pay more, the focus should be on bringing down the costs for everyone.

More means testing also undermines the universality and integrity of Medicare. By denying people the benefit they have been promised and that they've been contributing to, means testing undermines the Medicare guarantee. This chips away at the consistent, broad-based support for the program and could even cause some to drop Medicare entirely, raising costs on the middle- and lower-income beneficiaries who rely on the program.

Medicare remains an overwhelmingly popular benefit, as consistently demonstrated in public opinion polls regardless of age, income level, or political affiliation. American families are supportive of preserving Medicare because they know its value as a cornerstone of health and economic security. Further means testing would snatch some of that value away from people who are counting on Medicare to be there for them.

Take Action! Urge your lawmakers to improve—not undermine—Medicare in the budget reconciliation bill.

Democrats Still Unable to Agree on how to Lower Drug Prices

Because of unanimous Republican opposition to any current legislation being considered to lower prescription drug prices, all eyes are on the Democrats in both the House and the Senate. In particular, the two Senators receiving the most attention are Joe Manchin (D-W.Va.) and Kyrsten Sinema (D-Ariz.).

According to a report in *Politico*, last week Sinema "told the White House that she's opposed to the drug pricing proposals drafted by House Democrats, which could raise hundreds of billions of dollars to help finance Biden's party-line bill. A number of House moderates — most of whom have received substantial donations from the pharmaceutical industry and represent districts where drug companies employ thousands of people — also say they're concerned about the bill's impact on the development of new cures and therapies, echoing arguments the industry itself is pushing in ad campaigns."

Manchin has expressed support for drug pricing reform, but he has repeatedly said he'll only accept a price tag of $1.5 trillion for the bill, or $2 trillion less than the figure House and Senate Democrats have worked with for months.

Many lawmakers say they're confident they can still find a middle ground between the legislation favored by progressives that would empower Medicare to bargain directly with drug companies, and the version pushed by House centrists that would negotiate lower prices for a far narrower set of drugs. The

THE SENIOR CITIZENS LEAGUE
An Affiliate of TREA The Enlisted Association

members argue a watered-down drug negotiation bill may be the best they can hope for given Democrats' narrow voting margins and an onslaught of opposition from the pharmaceutical industry.

And with just a few weeks left to come to an agreement, the list of unresolved questions around the bill remains long. How many and what kind of drugs will be subject to negotiation? Will the government use an international or domestic benchmark for those negotiations, and how will they penalize drug companies that refuse to comply? How much can the government claw back from companies that raise their prices faster than inflation?

House Drug Price Negotiation Bill - H.R. 3

On April 22, 2021, Representatives Frank Pallone (NJ), Richard Neal (MA) and Bobby Scott (VA) introduced the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3). The bill allows the government to negotiate lower drug prices for people covered by Medicare and private insurance.

H.R. 3 repeals current law that prohibits the federal government from negotiating lower drug prices. It requires that the Secretary of Health and Human Services negotiate on up to 250 of the most expensive drugs, including insulin. The negotiated amount would be available to all payers, thus allowing workers covered by employer-sponsored plans to also benefit from the price reductions.

OIG finds Medicare Advantage continues to overcharge government

The HHS Office of the Inspector General once again **reports** on huge Medicare Advantage overcharges to the federal government. It's pretty clear at this point that Medicare Advantage plans–health plans covering people with Medicare administered by private insurers –use whatever means possible to get paid more and more money. Because the government pays them a higher rate upfront for enrollees with multiple diagnoses–"risk-adjusts" its payments–Medicare Advantage plans invest in ways to identify as many diagnoses as possible for their enrollees.

To be clear, the upfront government payments to Medicare Advantage plans intended to cover their enrollees' care is in no one's interest other than that of the insurers offering Medicare Advantage plans. The Medicare Advantage plans receive these payments regardless of the cost of the services they cover. There's no one policing them from taking taxpayer money and running, or spending as little as possible on care. The government's "capitated" payment system helps explain why the **Government Accountability Office** has found high rates of inappropriate delays and denials in Medicare Advantage.

The Medicare Advantage plans receive higher fixed payments if they can show that their enrollees have multiple diagnoses. Consequently, the MA plans often hire companies or employ doctors to assess the health of their enrollees and identify as many diagnoses as possible. This practice is called "upcoding." It is eroding the Medicare Trust Fund and driving up Part B premiums.

The **HHS Office of Inspector General** "OIG" found that several of the larger insurers offering Medicare Advantage plans are hiking up their payments significantly through upcoding. It found as much as $5 billion in potentially wrongful payments to these plans. And, lord knows the extent of the wrongful payments the OIG did not find.

The Office of the Inspector General did not name the 20 insurers it identified as responsible for the majority of overpayments. But, based upon what it did say, UnitedHealth was likely responsible for a significant amount of the upcoding and overpayments. Aetna and Humana are also engaged in upcoding that results in particularly large overpayments. It appears that Medicare Advantage plans can overcharge the government with near impunity or accountability.

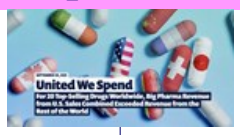
Not surprisingly, people enrolled in Medicare Advantage cost taxpayers significantly more than people in traditional Medicare. The question is why Congress allows them to continue when they cost more?

Will Congress put an end to the "risk-adjustment" gaming in Medicare Advantage? It would bring down the Part B premium for everyone with Medicare and strengthen the Medicare Trust Fund. It would also reduce the profits of insurers offering Medicare Advantage plans. The health insurers offering Medicare Advantage seem to think Congress will continue to condone this gaming. Their ranks are swelling.

US is a goldmine for pharmaceutical companies

Public Citizen released **a report** illustrating how the US is a goldmine for pharmaceutical companies. Pharmaceutical companies earn more from Americans who buy 20 best-selling prescription drugs than they do from everyone else in the world combined. No wonder that **a new Politico-Harvard poll** shows that drug price negotiation is Americans' top policy priority for Congress right now.

Public Citizen analyzed the financial filings of the pharmaceutical companies manufacturing 20 blockbuster drugs to arrive at its findings. It made clear that higher revenues in the US has nothing to do with the number of prescription drugs we take because **we don't take more drugs than people in other countries**. It's all about drug prices in the US.



Public Citizen's findings speak volumes as to why Pharma is so opposed to Medicare drug price negotiation. We're talking $158 billion in total revenue for just 20 drugs, nearly two-thirds (64 percent) of which comes from Americans. To date, Congress has expressly forbidden Medicare from negotiating drug prices, driving up drug costs.

Pharmaceutical company profits would fall tens of billions of dollars a year if Americans paid prices comparable to people in other wealthy countries. That's looking less and less likely as the Democrats try to pass legislation around drug prices. Perhaps, members will agree to some Medicare drug price negotiation and drug price increases capped at inflation but that's not at all a done deal.

In the meantime, Americans are forced to pay too high prices for our drugs relative to people in every other country or go without them. Pharmaceutical companies profit handsomely from their monopoly pricing power for brand-name drugs. Insurers and pharmacy benefit managers also make a lot of money off of high drug prices, but pharmaceutical companies earn more.

USPS Postal Banking Pilot Launched in Four Cities

The United States Postal Service (USPS) has begun a **paycheck-cashing service** pilot program in several locations across the East Coast, where patrons can cash paychecks for Visa gift cards up to $500. Postal customers can redeem paychecks in Washington, DC; Baltimore; Falls Church, Virginia; and the Bronx. While currently limited, the program is anticipated to expand across the country and offer additional financial services such as ATMs. It grew from an agreement with the Americans Postal Workers Union (APWU).

The Post Office's foray into banking services offers a safer alternative for underbanked and unbanked individuals, who previously relied on predatory paycheck cashing stores and payday lenders for their financial services It comes as Postmaster General **Louis DeJoy** begins to implement **plans to deliberately slow the mail** to raise revenue, with the delivery time for standard first class mail going from three days to five. These service delays are coupled with postage price increases.


Joseph Peters, Jr.

"Postal banking isn't new -- it has existed for decades before ending in 1967," said **Joseph Peters, Jr.**, Secretary-Treasurer of the Alliance. "Post Offices are essential centers of communities across the country and adding banking services makes sense for Americans and the Postal Service."

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Merck charged with blocking generic competition

Paige Minemeyer reports for **FierceHealthcare** on a lawsuit filed by two insurers against Merck for using its power to block generic competition to its cholesterol drugs, Zetia and Vytorin. A third insurer filed a separate lawsuit alleging the same. Until Congress steps in to negotiate drug prices, pharmaceutical companies will game the system every which way they can to protect and increase their profits.

What is the allegation against Merck? After many years of marketing a drug without competitors, Merck lost its exclusivity for Zetia, a cholesterol-lowering drug. As a result, Merck should have lost its monopoly pricing power for Zetia, as generic drugs like Zetia could be sold. But, to keep that power and its enormous profits, the plaintiff insurers claim that Merck paid a generic competitor not to sell a generic drug for five years. This not uncommon practice of pharmaceutical companies is called "pay for delay."

The insurers argue that, as a result of Merck's pay-for-delay agreement with the generic competitor, the insurers overpaid hundreds of millions of dollars for their enrollees' cholesterol-lowering drugs. They further argue that Merck profited from its wrongful behavior to the tune of billions of dollars.

The generic drug manufacturer also reaped significant revenue for delaying production of a generic drug like Zetia. Merck paid it handsomely to hold off. But, the insurers and their enrollees paid big time.

What is to be done? The only way to fix this problem and all the other gaming that the pharmaceutical corporations engage in to maximize profits is for the government to regulate drug prices. Regulating drug prices would also **save tens of thousands of lives** a year, enabling people who currently go without lifesaving medicines because they can't afford them to fill their prescriptions.

At this moment, the Democrats in Congress are trying to find a way to bring down drug prices. But, so many Democrats, along with Republicans, are in the pockets of the pharmaceutical companies. It's still not clear what they will be able to accomplish.

Senior citizen advocacy group tells Congress that Social Security recipients should get $1,400 stimulus payment

A senior citizens advocacy group asked Congress to send $1,400 stimulus payments to Social Security recipients who are struggling with the rising cost of living.

The Senior Citizens League said in a letter to Senate and House leaders that many seniors have seen their financial situations worsen as the "government has forgotten about us."

Social Security recipients got a **1.3% cost-of-living increase** in their payments for 2021, the slimmest increase since 2017.

"We've heard from thousands of [seniors] who have exhausted their retirement savings," the group wrote a letter sent earlier this month.

With their savings shrinking, some senior citizens have begun rationing their prescription drugs, the group said.

Others told the group they had "started eating just one meal a day." Those were just "a few of the drastic steps so many have had to take because of what inflation has done to them this year," the group said.

Next year, Social Security recipients are expected to get an about 6% bump in payments as a cost-of-living increase, **AARP** and other outlets reported. But that jump could trigger higher tax rates for some, the group said. The $1,400 stimulus "could help defray" those higher costs.

"It is unlikely Congress will take action on our proposal this year but if we can build enough support from seniors for it, we are hopeful it can become a major issue next year and that Congressional support for it will grow," the group said in **a recent blog post.**

The group has spent more than $2 million lobbying Washington lawmakers on seniors issues since 2005, according to public lobbying data compiled by **ProPublica**.

A Wrenching Farewell: Bidding Adieu to My Primary Care Doctor After Nearly 30 Years

I hadn't expected the tears.

My primary care doctor and I were saying goodbye after nearly 30 years together.

"You are a kind and a good person," he told me after the physical exam, as we wished each other good luck and good health.

"I trust you completely — and always have," I told him, my eyes overflowing.

"That means so much to me," he responded, bowing his head.

Will I ever have another relationship like the one with this physician, who took time to ask me how I was doing each time he saw me? Who knew me from my first months as a young mother, when my thyroid went haywire, and who since oversaw all my medical concerns, both large and small?

It feels like an essential lifeline is being severed. I'll miss him dearly.

This isn't my story alone; many people in their 50s, 60s and 70s are similarly undergoing this kind of wrenching transition. A decade from now, at least 40% of the physician workforce will be 65 or older, according to **data from the Association of American Medical Colleges.** If significant numbers of doctors retire, as expected, physician shortages will swell. Earlier this year, the AAMC projected an unmet need for up to 55,200 primary care physicians and 86,700 specialists by 2033, amid the rapid growth of the elderly population.

Stress from the covid pandemic has made the outlook even worse, at least in the near term. When the Physicians Foundation, a nonprofit research organization, **surveyed 2,504 doctors** in May and June, 61% reported "often experiencing" burnout associated with financial and emotional strain. Two percent said they had retired because of the pandemic; another 2% had closed their practices.

Twenty-three percent of the doctors surveyed said they'd like to retire during the next year.

Baby boomers, like me, whose medical needs are intensifying even as their longtime doctors bow out of practice, are most likely to be affected.

"There's a lot of benefit to having someone who's known your medical history for a long time," especially for older adults, said Dr. Janis Orlowski, AAMC's chief health care officer. When relationships with physicians are disrupted, medical issues that need attention can be overlooked and people can become less engaged in their care, said Dr. Gary Price, president of the Physicians Foundation.

My doctor, who's survived two bouts of cancer, didn't mention the pandemic during our recent visit. Instead, he told me he's turning 75 a week before he closes the practice at the end of October. Having practiced medicine for 52 years, 40 as a solo practitioner, "it's time for me to spend more time with family," he explained….**Read More**

Pfizer COVID-19 Vaccine Boosters Covered by Medicare with No Cost-Sharing

The Centers for Medicare & Medicaid Services (CMS) recently **announced** Medicare will cover booster doses of the Pfizer COVID-19 vaccine without any cost-sharing. As with the initial vaccinations, there will be no applicable copayment, coinsurance, or deductible.

Medicare beneficiaries who are 65 and older or at **high risk** can get the shot six months after they receive their second dose of the Pfizer COVID-19 vaccine. The Pfizer boosters are **authorized** by the Food and Drug Administration (FDA) and **recommended** by the Centers for Disease Control and Prevention (CDC). The agencies expect decisions about boosters for people who received the **Moderna** or **Johnson & Johnson** vaccines will be forthcoming.

CMS also said the boosters will be covered without cost-sharing for nearly all Medicaid and Children's Health Insurance Program (CHIP) enrollees, and for eligible consumers in the commercial health insurance market.

This coverage policy comes at a critical time. As the **CDC** explained, "[w]ith the Delta variant's dominance as the circulating strain and cases of COVID-19 increasing significantly across the United States, a booster shot will help strengthen protection against severe disease" for those who are vulnerable to exposure or serious illness.

Since the start of the pandemic, older adults have been among the hardest-hit populations, **experiencing** higher rates of hospitalization and death than other age groups. While these instances declined once widespread vaccination efforts began, a new Kaiser Family Foundation (KFF) **analysis** reveals a troubling trend: COVID-19 related **deaths** among older adults are on the rise amid the Delta surge.

One reason for this could be lagging vaccinations. Recent **CDC data** show vaccines remain effective at preventing hospitalizations and death. Although older adults **have the highest vaccination rate** among all age groups (83.7%), it varies widely across states, from 95.3% in Vermont to just 71.3% in West Virginia.

The KFF report indicates there is a correlation. The authors found that during the study period (July 1 through September 25), states with the lowest vaccination rates had the highest death rates, at nearly two times the national average of 93 per 100,000 people 65 and older. Conversely, states with the highest vaccination rates experienced relatively low death rates. For example, in Massachusetts, 88.8% of older adults have been vaccinated and the death rate (28 per 100,000) was about 7 times lower than in Arkansas (198 per 100,000), which has a vaccination rate of 72.8%.

KFF notes other factors could also be at work—many older adults were among the first to receive the COVID-19 vaccine and may be among the first to experience **decreasing vaccine effectiveness** over time—which the booster shots could help address.

Older adults in US face high cost-related barriers to care

A new report from the **Commonwealth Fund** finds that cost is a large barrier to care for older adults in the US, larger than it is for older adults in 10 other wealthy countries. Consequently, many older adults in the US postpone needed care or forgo it altogether.

Congress is aware that cost is a barrier to care for people with Medicare. In response, it is looking at add vision, hearing and dental benefits to Medicare. That could be a huge help for the 63 million people with Medicare, so long as their out-of-pocket costs are minimal. Otherwise, these costs could render the additional benefits meaningless for a large cohort of people with Medicare; they would be functionally uninsured.

Today, older adults in the US spend more on healthcare than older adults in other nations. About 8.5 percent of older adults in the US skip or postpone needed care because of the cost. In sharp contrast, in Germany, the Netherlands, Norway, and Sweden, fewer than two percent of older adults report facing financial barriers to care. Even in Switzerland and Australia, which impose high out-of-pocket costs on older adults, older adults are less likely to skip or delay care than older adults in the US.

Not surprisingly, older adults in the US are also twice as likely not to fill their prescriptions and skip doses because of the cost than older adults in other countries. A recent **NBER study** found that an increase in prescription drug copays of as little as $10.40 keeps more than one in five older adults from filling life-saving prescriptions. As a result, thousands of people with Medicare die prematurely every year.

Some Democrats in Congress are saying that the government doesn't have the money to cover a larger share of health care costs for people with Medicare. In fact, right now, Medicare Advantage plans are getting government rebates of $140 per enrollee per month, along with billions a year in overpayments relative to traditional Medicare. Congress could take some or all of that money and put it towards lower out-of-pocket costs and a reasonable out-of- pocket cap in both traditional Medicare and Medicare Advantage.

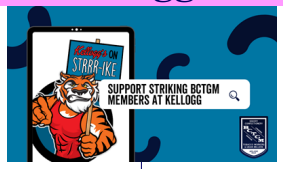
More people with Medicare would not feel the need to forgo critical care if Congress reallocated those tens of billions of additional dollars towards lower out-of-pocket costs for everyone with Medicare and an out-of-pocket cap in traditional Medicare.

The Commonwealth Fund's report compared cost-related barriers to health care in the US with those in 10 other wealthy countries.

Support BCTGM Kellogg Members on Strike

For more than a year throughout the COVID-19 pandemic, Kellogg workers around the country have been working long, hard hours, day in and day out, to produce Kellogg ready-to-eat cereals for American families.

Kellogg's response to these loyal, hardworking employees has been to demand these workers give up quality health care, retirement benefits, and holiday and vacation pay. The company continues to threaten to send additional jobs to Mexico if workers do not accept outrageous proposals that take away protections that workers have had for decades.



Kellogg is making these demands as they rake in record profits, without regard for the well-being of the hardworking men and women who make the products that have created the company's massive profits.

BCTGM members in **Battle Creek, Omaha, Lancaster** and **Memphis** produce Kellogg ready-to-eat cereals including: Rice Krispies, Raisin Bran, Froot Loops, Corn Flakes and Frosted Flakes.

Add your name and pledge your support to the striking BCTGM Members at Kellogg.

New Law Bans Harassment at Vaccination Sites, but Free Speech Concerns Persist

It's now illegal in California to harass people on their way into a vaccination clinic, under a law signed Friday by Gov. Gavin Newsom.

But First Amendment experts continue to **raise legal questions** about the law's constitutionality, including its definition of harassment.

The new law, which takes effect immediately, makes it a misdemeanor to harass, intimidate, injure or obstruct people on their way to get a covid -19 or any other kind of vaccine, punishable by a maximum $1,000 fine and/or up to six months in jail.

Even though the measure, SB 742, was amended to remove a phrase that free speech experts said made it unconstitutional, they maintain that the new version still violates the First Amendment.

"It sweeps up broad activities that are protected by the First Amendment and defines them as harassing," said David Snyder, executive director of the First Amendment Coalition, which advocates for free speech and government transparency. "That problem hasn't changed at all."

But the law is more necessary than ever, said Catherine Flores Martin, executive director of the California Immunization Coalition, which promotes vaccines. Martin said she has advocated for pro-vaccine legislation for years, and that the atmosphere surrounding vaccination, especially covid vaccines, has grown threatening and toxic.

"Our biggest concern is when children are getting vaccinated," she said. "Some of these people feel like they need to protest, and that's scary and extremely inappropriate."

The bill was introduced by state Sen. Richard Pan (D-Sacramento), who chairs the Senate health committee and was inspired to write this new measure after protesters briefly shut down a mass covid vaccination site at **Dodger Stadium** in January. Pan is a practicing pediatrician who still administers vaccines, and has been threatened, assaulted and called out by name at protests.

Pan has been at the center of California's vaccine wars since long before the covid pandemic, and has been targeted by anti-vaccine groups for introducing laws that made it harder for parents to refuse routine vaccinations for their kids, including a **2015** law that eliminated personal belief exemptions and another approved in **2019** that made it harder to get medical ones….**Read More**

Dear Marci: *What is a Medigap?*

Dear Marci,
I am 65 years old and have Original Medicare. I receive a lot of costly care and have heard from my doctor that I should look into purchasing a Medigap policy to help lower my out-of-pocket costs. Can you tell me more about Medigaps?
-Louis (Buffalo, WY)

Dear Louis,

Medigaps are health insurance policies that offer standardized benefits to work with **Original Medicare** (not with **Medicare Advantage**). They are sold by private insurance companies and are designed to cover deductibles, coinsurance, and copayments. People may refer to these charges as the "gaps" in Original Medicare's coverage, hence the term "Medigap." If you have a Medigap, you will likely not have any out-of-pocket costs for an inpatient hospital stay or outpatient doctors' visits if your **providers accept Medicare assignment**. Medigaps may also cover health care costs that Medicare does not cover at all, like care received when travelling abroad. While you would have to pay an additional monthly premium for your Medigap, your out-of-pocket costs for the care you receive is greatly limited. This means Original Medicare and a Medigap may be a more affordable option for you if you have more health needs and receive costly medical care throughout the year. You can read more about the differences between having a Medicare Advantage Plan and having Original Medicare with a Medigap here.

Depending on where you live and when you became eligible for Medicare, you have up to 10 different Medigap policies to choose from: A, B, C, D, F, G, K, L, M, and N (policies in Wisconsin, Massachusetts, and Minnesota have different names). Each policy offers a different set of standardized benefits, meaning that policies with the same letter name offer the same benefits. However, premiums vary from company to company.

All policies must offer the following basic benefits:

- Hospital coinsurance coverage
- 365 additional days of full hospital coverage
- Full or partial coverage for the 20% coinsurance for provider charges and other Part B services
- Full or partial coverage for the first three pints of blood you need each year
- Hospice coinsurance for drugs and respite care

Beyond these basic benefits, each standardized Medigap covers a different amount of your Medicare cost-sharing. Medigap policy A is often the least expensive, but it only covers the basic benefits listed above. Policies C and F are the most comprehensive, but they generally have higher premiums. Depending on which Medigap policy you choose, you can get coverage for additional expenses, including:

- Hospital deductible
- Skilled nursing facility coinsurance
- Part B deductible*
- Emergency care outside the U.S.
- At-home recovery
- Preventive care that Medicare does not cover
- Excess physician's charges

*People newly eligible for Medicare on or after January 1, 2020, cannot purchase Medigaps that pay for the Part B deductible. This includes Plan C and Plan F. If you became Medicare-eligible before this date, you will still be able to purchase Plan C or Plan F

To learn about Medigaps in your state and your options, I recommend you contact your local State Health Insurance Assistance Program (SHIP) by calling 877-839-2675 or visiting **www.shiphelp.org**.

Note that **enrollment rules for Medigaps** differ from those for Original Medicare or Medicare Advantage Plans. We'll be covering when one can purchase a Medigap in our next newsletter, so stay tuned!

-Marci

Interpreting Emojis

Emojis are a crucial part of communication in texts and social media. You might even say they play a role in our social well-being. With thousands of individual characters, our messages to one another can now include hearts, rocket ships, or cups of coffee. But here's the problem: Do we always understand the meaning of these emojis?

Curious to see what's being interpreted by older adults who live in **55+ communities** or who enjoy other **senior living options**? Continue reading to find out.

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RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

How to Notice Signs of Functional Decline in Seniors

After a certain age, some level of decline should be expected year after year. In our forties and fifties, this decline is incremental. It happens slowly, and while it can affect our physical and mental performance, most of us are still able to live our lives comfortably. But in our sixties and beyond, decline begins to speed up. Eventually, seniors reach a point of functional decline. This is the point where elderly care is required for seniors to live comfortably and safely.

Unfortunately, it can be hard to spot functional decline. While decline accelerates in seniors, it still happens gradually enough that functional decline can go unnoticed. As a result, seniors who require elderly care in some form — either from family caregivers, **in-home elderly care professionals**, or facility living — end up without the support they need.

So how can you spot signs of functional decline in elderly adults?

Learn the Signs of Functional Decline

To determine whether or not your loved one may need elderly care or another senior service, you need to know the signs of functional decline. Keep in mind that functional decline relates to physical *and* cognitive function, so you need to be aware of the signs of decline for both.

Signs of Physical Decline
Limited mobility • Change in posture/gait • Frailty/lack of strength • Poor coordination • Difficulty breathing • Limited stamina • Exhaustion Poor balance • Pain/soreness • Signs of injury

Signs of Cognitive Decline
Memory problems • Mixed-up words • Confusion • Aggression • Irritability • Anxiety • Inexplicable behavior • Poor self-care • Poor housekeeping • Change in financial habits

Monitor Your Loved One for Signs

People sometimes miss signs of decline because they don't know what to look for. But more often, people miss them because they aren't really looking. Decline happens gradually enough that family members fail to recognize the point where elderly care may be necessary. To help prevent this from happening, family members should be making a conscious effort to monitor their elderly loved ones and track changes in their functional abilities.

One strategy is to take stock of the things your loved one has difficulty with over the course of a typical week or month. You can do this mentally, or you might consider taking private notes. This will allow you to compare how your loved one is functioning now compared to the past. Gradual changes become much more stark if you can compare how well they're doing now to six months or a year ago.

You may also wish to have conversations with family members. Sometimes, individual family members each notice different signs of decline, but nobody notices all of them. Conversations with your loved one will also give you a better sense of the areas where they feel they're having the most trouble. These conversations can also give insight into signs of decline that occur in private.

Should you determine that your loved one is suffering from functional decline, you may wish to explore elderly care options. If you are considering in-home elderly care, we invite you to **contact your local Visiting Angels**. Th care coordinators at our local offices will be happy to provide guidance about coping with decline, speak with you about your care options, and schedule your loved one for a free, in-home elderly care assessment.

Expert Panel Backs Off Recommendation for Aspirin to Prevent Heart Trouble

(HealthDay News) Most people shouldn't bother taking daily low-dose aspirin to reduce their risk of a first heart attack or stroke, the nation's leading panel of preventive medicine experts announced Tuesday.

The U.S. Preventive Services Task Force (USPSTF) issued a draft recommendation that essentially backs off its previous advice urging many folks to consider taking low-dose aspirin to prevent heart disease.

If the proposal is adopted, the task force would recommend against low-dose aspirin use to prevent heart problems for people 60 and older.

The choice for people between 40 and 59 would be between themselves and their doctor, but the task force warns that the "net benefit of aspirin use in this group is small."

"Persons who are not at increased risk for bleeding and are willing to take low-dose aspirin daily are more likely to benefit," the draft recommendation says.

The change reflects new data showing that daily aspirin does little to prevent a first heart attack or stroke, but greatly increases the risk of potentially serious side effects like bleeding.

The proposal would not change guidelines for people taking aspirin to prevent a second heart attack.

"There's no longer a blanket statement that everybody who's at increased risk for heart disease, even though they never had a heart attack, should be on aspirin," task force member Dr. Chien-Wen Tseng told *The New York Times*. "We need to be smarter at matching primary prevention to the people who will benefit the most and have the least risk of harms." Tseng is research director of family medicine and community health at the University of Hawaii.

While aspirin is a very effective blood thinner that can prevent blood clots from clogging arteries and causing a heart attack or stroke, heart experts have constantly weighed that benefit against the risk of internal bleeding.

New data suggest that "the increased risk of bleeding associated with aspirin use occurs relatively quickly after initiating aspirin," with the absolute risk of bleeding increasing with age, the USPSTF says in its draft recommendation.

A low dose is between 81 milligrams and 100 milligrams.

One of the main goals of the proposed recommendations, Tseng told the *Washington Post*, is "to get people to talk with their clinicians instead of just buying a bottle off the shelf and saying, 'I should be on aspirin.' "

The USPSTF's current advice regarding aspirin use in preventing heart disease was issued in 2016.

At that time, it recommended low-dose aspirin for 50- to 59-year-olds who had a 10% or greater risk of a heart attack or stroke over the next decade. These folks should also have no increased risk for bleeding, a life expectancy of at least 10 years, and be willing to keep up with their daily aspirin regimen. The current recommendations say people between the ages of 60 and 69 have an individual choice to take aspirin if they have a 10% or higher risk of a potentially fatal heart-related event within the next decade….**Read More**

CDC Urges Flu Shots as Survey Shows Half of Americans Don't Plan on It

(HealthDay News) -- A new survey showing that nearly half of U.S. adults are not likely to get a flu shot this season has prompted federal health officials to urge all Americans to get the flu vaccines.

Even more troubling is that the poll of 1,110 respondents aged 18 and older also found that nearly 1 in 4 of those at high risk for flu-related complications said they don't intend to get a flu shot, *The New York Times* reported.

Overall, 61% of respondents agreed that vaccination provides the best protection against the flu, but 44% said they either didn't intend to get a shot or were unsure whether they would get one.

The survey was commissioned by the National Foundation for Infectious Diseases.

Overall vulnerability to flu could be higher in the United States this year due to "relaxed COVID-19 mitigation strategies, increased travel and the reopening of schools," the foundation's medical director, Dr. William Schaffner, told the *Times*.

The severity of the upcoming flu season is unclear, but other respiratory infections have already returned, Dr. Rochelle Walensky, head of the U.S. Centers for Disease Control and Prevention, said during a Thursday news briefing to release the survey data.

She noted that because last year's flu season was so mild, people don't have the natural immunity to the flu they might have gained if they'd gotten sick, the *Times* reported.

Everyone age 6 months and older should get a flu shot, Walensky advised.

"The COVID-19 pandemic is not over, and the risk of both flu and COVID-19 circulating could put additional strain on hospitals and frontline health care professionals," she warned.

Walensky also raised alarms about a decline in the flu vaccination rates among young children, to 59 percent from 64 percent the year before. In the 2019-2020 season, she said, 199 children died from the flu, about 80 percent of whom were not vaccinated.

This year's overall U.S. flu vaccination rate of about 52% is similar to last year's, but there's a "disparity gap" between whites (56%) and Blacks (43%), Walensky noted.

The survey did suggest that the COVID-19 pandemic has had a positive effect on behaviors that could help reduce the spread of the flu. Nearly half of the respondents said the pandemic has made them more likely to stay home from work or school if they're sick, and 54% said they would wear a mask at least sometimes during the flu season, the *Times* reported.

Many Older Americans Who Should Be Checking Blood Pressure at Home Aren't

If you are over 50 and you have high blood pressure or a health condition for which blood pressure control is essential, at-home blood pressure checks can avert medical emergencies.

The trouble is that too few of these people actually perform them, a new survey reveals.

"This poll shows that we have more work to do to encourage older adults with certain chronic health conditions to monitor their blood pressure," said Alison Bryant, senior vice president of research for AARP. "We know that the risk of high blood pressure increases with age, so this is an important topic for older adults to discuss with a health provider."

The National Poll on Healthy Aging from the University of Michigan Institute for Healthcare Policy and Innovation surveyed more than 2,000 adults aged 50 to 80. It found that 60% said they were either taking medication to control their blood pressure or had a chronic health condition that requires blood pressure control, such as a history of stroke, heart disease, heart failure, diabetes or chronic kidney disease.

Of those patients, the 74% who said they had a home blood pressure monitor were more likely to check their blood pressure at home than those without a monitor.

But fewer than half of survey respondents with both a blood pressure-related health condition and a home blood pressure monitor said they checked their blood pressure at least once a week, and 19% said they never used their monitor.

Only about two-thirds of those who had blood pressure-related health conditions who said their health providers encouraged them to check their blood pressure regularly did, according to the poll.

Of the older adults who said they check their blood pressure at home regularly, only 50% share the readings with a health provider

Of those with blood pressure-related health conditions who didn't have a home blood pressure monitor, 54% said it was because they didn't think they needed it or had never considered it. …..**Read More**

Which vaccines do older adults need?

As you get older, your doctor may recommend more vaccinations, also known as shots or immunizations, to help prevent certain illnesses.

Talk with your doctor about which of the following vaccines you need. Make sure to protect yourself as much as possible by keeping your vaccinations up to date.

- **COVID-19 vaccines**
  Coronavirus (COVID-19) is a respiratory disease that causes symptoms such as fever, cough, and shortness of breath. It can lead to serious illness and death. Studies show that COVID-19 vaccines are effective at keeping people from getting COVID-19. Getting a COVID-19 vaccine will also help keep you from getting seriously ill even if you do get COVID-19. We are still learning how effective COVID-19 vaccines are against new variants of the virus. **Read more about COVID-10 vaccine effectiveness.**

- **Flu vaccines for older adults**
  Flu — short for influenza — is a virus that can cause fever, chills, sore throat, stuffy nose, headache, and muscle aches. Flu is very serious when it gets in your lungs. Older adults are at a higher risk for developing serious complications from the flu, such as **pneumonia**.
- **Vaccines to help prevent pneumonia**
  Pneumococcal disease is a serious infection that spreads from person to person by air. It often causes **pneumonia in the lungs** and it can affect other parts of the body.
- Tetanus, diphtheria, and pertussis (whooping cough) vaccines
  Tetanus, diphtheria, and pertussis are serious diseases that can lead to death.
- **Shingles vaccine for older adults**
  Shingles is caused by the same virus as chickenpox. If you had chickenpox, the virus is still in your body. The virus could become active again and cause shingles.

What are some side effects of getting a vaccine?

Common side effects for all these vaccines are mild and may include pain, swelling, or redness where the vaccine was given.

Before getting any vaccine, talk with your doctor about your health history, including past illnesses and treatments, as well as any allergies….**Read More on each of these vaccines**

As You Age, Your 'Microbiome' Changes

The key to eternal youth may lie in our guts.

Advancing age seems to change the makeup of the microbiome in the small intestine, and in the future, it may be possible to tweak this bacterial milieu and boost longevity, new research suggests.

The gut microbiome is made up of trillions of microorganisms and their genetic material. The diversity of these organisms is believed to play a role in promoting health and well-being.

With normal aging, the bacteria in the small intestine shift from microbes that prefer oxygen (aerobic bacteria) to those that can survive with less oxygen (anaerobic bacteria). There is also an increase in coliform bacteria in relation to other organisms with advancing age, the study showed.

The new study is observational and not designed to say how, or even if, these changes affect aging. "We don't have correlations here in terms of cause and effect," said study co-author Dr. Ruchi Mathur. She is an endocrinologist and director of the Cedars-Sinai Diabetes Outpatient Treatment & Education Center in Los Angeles.

For this study, the researchers looked at microbial changes that occur in the small intestine with chronological age, medication use, and diseases in people aged 18 to 80.

The small intestine is located further up the digestive tract and is about 20 feet long. "It is where really cool stuff happens. It's more metabolically active and may play a greater role in human health and diseases than the large bowel," Mathur said.

Previously, the same team mapped the microbiome of the entire gastrointestinal system and noted pronounced differences along the digestive tract.

When researchers compared bacterial populations in the small intestines based on age alone, the oldest individuals in the study had a more significant shift from aerobic to anaerobic bacteria and a greater proportion of coliform bacteria compared with their younger counterparts.

Coliforms can become too abundant in the small bowel with age and exert a negative influence on the rest of the microbial population. "They are like weeds in a garden," Mathur said.

The number of medications a person took and the number of diseases they had were associated with other changes in bacterial diversity in the small intestine. "Certain microbial populations are influenced more by medications, while others are more affected by certain diseases," she said. "We have identified specific microbes that appear to be only influenced by the chronological age of the person."

If future studies validate these findings, treatments targeting the bacterial changes linked to aging alone may help prolong life. "If we can tease out the organisms that increase with chronological age, we can develop specific targets to manipulate them and see if we can make changes in longevity," Mathur said.

The next step is to see if the findings hold in people aged 80 to 100, she said….**Read More**

Could Too Little Iron Boost Your Risk for Heart Disease?

Iron is vital to health, and too little in your diet might lead to heart disease, European researchers report.

They said about 1 in 10 new cases of heart disease in middle-aged people might be prevented if they had sufficient levels of iron in their diets.

"Our findings are based on an observational study and can therefore only report on associations, not on causality," said lead researcher Dr. Benedikt Schrage.

"This being said, our findings indicate that iron deficiency might be a suitable target for preventive measures in the general population and support the conduction of trials which explore the efficacy of iron supplementation in individuals with functional iron deficiency," said Schrage, of the general and interventional cardiology department at University Medical Center in Hamburg, Germany.

The connection between iron deficiency and heart disease isn't clear. But iron is essential for equilibrium in the body and energy metabolism, which might be a potential link, Schrage said.

People who are deficient in iron usually don't consume enough of the mineral in their diet or can't process the iron they do get, he said. Iron-rich foods include meat; poultry; eggs; seafood, including tuna, scallops and shrimp; vegetables such as spinach and sweet potatoes, and beans, according to the American Red Cross. Other good dietary sources include enriched breads and pasta, and fruits like strawberries and watermelon.

"Iron supplementation per se plays a minor role, as long as the overall uptake is sufficient," Schrage said. "However, some individuals might not be able to absorb enough iron via the intestines. For these individuals, intravenous iron therapy might be an option."...**Read More**

Another Barrier for Black and Hispanic People: Good Mental Health Care

Living with a mental health disorder isn't easy. It can carry the weight of stigma, making you feel different. For people who face racial and ethnic discrimination, experts say the added "otherness" of mental illnesses may prove one hurdle too many in reaching the help they need.

"They might not want to share that they are having a problem with members of their family or community, for fear of being discriminated against or treated differently," said Alice Villatoro, an assistant professor in the public health program at Santa Clara University in California. "They are already treated as an 'other' as a minority, and don't want to add to that."

Fear of discrimination and stigma is just one of the many complex barriers contributing to disparities in who gets mental health care, a gap that research shows widens as severity of mental illnesses grows. It can carry long-term consequences. A recent scientific statement from the American Heart Association analyzed a large body of research showing a strong link between mental and physical well-being and the impact of psychological stress on heart and brain health.

While the rates of mental health disorders, conditions ranging from mild to moderate depression and anxiety to more severe and pervasive conditions such as schizophrenia, are similar across races and ethnicities, research shows white adults are nearly twice as likely to receive mental health services as Black or Hispanic adults.

When they do receive care, research shows they are treated differently than their white peers. Black adults are less likely to be offered medication or behavioral therapy and are more likely to be incarcerated than any other racial or ethnic group as a result of a mental illness, according to the American Psychiatric Association. Black, Hispanic, Asian, American Indian and Alaskan Native adults with serious mental illnesses also are more likely to be overdiagnosed with conditions such as schizophrenia and to be involuntarily hospitalized when they seek care….**Read More**

Studies Show Power of Pfizer Vaccine Starts to Wane After Two Months

(HealthDay News) -- Two new studies confirm that the immunity offered by two doses of Pfizer's coronavirus vaccine drops off after about two months, although protection against severe disease, hospitalization and death holds strong.

The reports, from Israel and Qatar, add to evidence that suggests even fully vaccinated people need to continue to guard against COVID-19 infection.

In one **study**, Israeli researchers found that antibody levels among 4,800 health care workers fell rapidly within months after two doses of the Pfizer vaccine, "especially among men, among persons 65 years of age or older, and among persons with immunosuppression."

That study also found that that immunity lasts longer in people who are vaccinated after natural COVID-19 infection.

In the other **study** of Pfizer's vaccine, researchers in Qatar found that "protection against infection builds rapidly after the first dose, peaks in the first month after the second dose, and then gradually wanes in subsequent months," Laith Abu-Raddad, of Weill Cornell Medicine-Qatar, and colleagues wrote.

"The waning appears to accelerate after the fourth month, to reach a low level of approximately 20% in subsequent months," they added.

However, the researchers also found that protection against hospitalization and death remained above 90%.

The vaccine's weakening protection may be due to people's behavior, the study authors noted.

"Vaccinated persons presumably have a higher rate of social contact than unvaccinated persons and may also have lower adherence to safety measures," they wrote. "This behavior could reduce real-world effectiveness of the vaccine as compared with its biologic effectiveness, possibly explaining the waning of protection."

The studies were published Wednesday in the *New England Journal of Medicine*.

Pfizer has been saying that immunity from the first two doses of its vaccine begins to wear off after a few months, *CNN* reported. Last month, the U.S. Food and Drug Administration approved emergency use of booster doses of Pfizer's vaccine six months after high-risk people finish their first two doses.

Meanwhile, the U.S. Centers for Disease Control and Prevention has recommended booster shots for people over 65, people with medical conditions that raise their risk of severe COVID-19, and people at high risk of coronavirus infection because of their jobs.

In the United States, more than 6 million people have already received a third dose of vaccine. On average, the CDC says, the pace of booster shots is now higher than the rate of people getting vaccinated for the first time, *CNN* reported.

3 studies link hearing loss with less physical activity among older adults

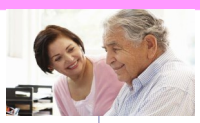
Older adults with **hearing loss** may be more sedentary and more likely to experience worsening physical function than those without hearing loss, according to three recent NIA-supported studies. The findings, which were reported in *JAMA Network Open* and the *Journals of Gerontology, Series A*, suggest that treating hearing loss may be a way to promote healthy aging among older adults.

Hearing loss is common among older adults. About two-thirds of Americans older than 70 have difficulty hearing. In addition to aging, hearing loss can be caused by exposure to loud noises, certain drugs, disease, and heredity. Treatment options include wearing hearing aids, using assistive-listening devices, or having surgery to implant a small electronic device near the ear.

Measuring patterns of physical activity

A team of investigators at NIA and Johns Hopkins University set out to learn whether hearing loss is associated with certain physical activity patterns among adults between the ages of 60 and 69. Using the results from hearing exams that had been conducted on a subgroup of **National Health and Nutrition Examination Survey (NHANES)** participants, the team examined data from 221 people with normal hearing, 48 with mild hearing loss, and 22 with moderate to severe hearing loss. All these 291 participants had worn motion-based monitors on their hip for a week to capture how long they were engaged in sedentary behavior, light physical activity, and moderate or vigorous activity….**Read More**

Why Skin Cancer Checks Are Even More Important for Hispanic People



(HealthDay News) – When Hispanic people get a skin cancer diagnosis, their tumors are about 17% larger than those of white people, researchers say.

According to the American Academy of Dermatology (AAD), skin cancer is often diagnosed at a more advanced stage in people with black and brown skin, leading to worse results. This makes it especially important to know the signs of skin cancer.

"Patients and the medical community need to be cognizant that skin cancer can develop in patients regardless of their race and ethnicity," said study co-author Dr. Laura Blumenthal, a dermatologist in Thousand Oaks, Calif., and colleagues.

Their research found that Mohs micrographic surgery defect sizes -- an approximation of tumor size -- were larger in Hispanic patients than in white patients and noted disparities in all skin cancer types.

Defect sizes of squamous cell carcinomas were 80% larger than defect sizes of basal cell carcinomas in Hispanic patients. By comparison, in white patients, defect sizes of squamous cell carcinomas were only 25% larger than defect sizes of basal cell carcinomas.

The findings were published Oct. 5 in the *Journal of the American Academy of Dermatology*.

To find cancer early, the AAD said everyone should do regular skin self-exams and look for the warning signs of melanoma, easily remembered as ABCDE.

A is for asymmetry, when one half of the spot is unlike the other half.

B is for border, when the spot has an irregular, scalloped or poorly defined border.

C is for color. The spot has varying colors from one area to the next, such as shades of tan, brown or black, or areas of white, red or blue.

D is for diameter. Melanomas -- the deadliest skin cancer -- are usually greater than 6 millimeters, about the size of a pencil eraser when they're diagnosed, though they can be smaller.

E is for evolving because the spot looks different from the rest or is changing in size, shape or color.

If you notice any new or suspicious spots on your skin, or any spots that are changing, itching or bleeding, see a board-certified dermatologist.

The most preventable risk factor for skin cancer is unprotected UV exposure, so always seek shade, wear sun-protective clothing and apply a broad-spectrum, water-resistant sunscreen with an SPF of 30 or higher, the academy recommends.