Rhode Island Alliance for Retired Americans

RI ARA

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

Publication 2019 Issue 43
Published in house by the
RI ARA

October 27, 2019 E-Newsletter

Top Ten Facts about Social Security

Center on Budget and Policy Priorities

Social Security provides a foundation of income on which workers can build to plan for their retirement. It also provides valuable social insurance protection to workers who become disabled and to families whose breadwinner dies.

Eighty-four years after President Franklin Roosevelt signed the Social Security Act on August 14, 1935, Social Security remains one of the nation's most successful, effective, and popular programs.

Fact #1: Social Security is more than just a retirement program. It provides important life insurance and disability insurance protection as well.

Fact #2: Social Security provides a guaranteed, progressive benefit that keeps up with increases in the cost of living.

Fact #3: Social Security provides a foundation of retirement protection for nearly every American, and its benefits are not means-tested.

Fact #4: Social Security benefits are modest.

Fact #5: Children have an important stake in Social Security.

Fact #6: Social Security lifts millions of elderly Americans out of poverty.

Fact #7: Most elderly beneficiaries rely on Social Security for the majority of their income.

Fact #8: Social Security is particularly important for people of color.

Fact #9: Social Security is especially beneficial for women.

Fact #10: Relatively modest changes would place Social Security on sound financial footing.

Read More about these Top Ten Facts about Social Security

Social Security Lifts More Americans Above Poverty Than Any Other Program

A few changes to H. R. 3 - Lower Drug Costs Now Act of 2019

There are numerous bills in the House of Representatives that have as their purpose the lowering of prescription drug prices. The Senior Citizens League has endorsed and lobbied for passage of eight of those bills. The most recent bill with that purpose is one introduced only a few weeks ago by Speaker of the House Nancy Pelosi (D-Calif.), which we have written about in previous updates.

That bill - H.R. 3 - is the one which has the most effort behind it for passage in the House of Representatives. Pelosi's bill would direct the Health and Human Services Secretary to negotiate with drug makers to lower the price of as many as 250 of the costliest brand-name drugs lacking generic or biosimilar competitors on the market.

This week the bill was changed to include increasing over time the minimum number of medicines subject to negotiation and subjecting some newly launched, high-price drugs to negotiation.

Others changes include:

1) allowing patients with high drug costs the option to pay for their prescriptions in installments once they meet the $2,000 annual out -of- pocket deductible in a single prescription; 2) 2) expanding the prescription drug subsidy for low-income patients; and 3)
3) under certain conditions requiring drug manufacturers to submit a report to the HHS Secretary 30 days before increasing the wholesale acquisition cost of qualifying drugs.

These changes were made in order to get more Democratic members of the House to support the bill because the House leadership wants a vote of the full House on the bill the last week of this month. They also want to draw a contrast with Republicans, who widely oppose Medicare negotiation as a tool for lowering drug costs, which is the reason no Republicans have endorsed the bill.

Negotiators from the House have met with White House officials to discuss the bill and so far President Trump has been open about the possibility of working with the House to pass some kind of legislation to lower drug prices. However, Senate Majority Leader Mitch McConnell (R-Ky.) has shown no willingness to put the Medicare bill up for a vote.

U.S. House Moving Forward with Drug Pricing Bill

Lawmakers in the U.S. House of Representatives are continuing work on their drug pricing bill, **H.R. 3,** with hopes of holding a vote later this month.

Unveiled in September, H.R. 3 includes a number of provisions that would improve prescription drug access and affordability for people with Medicare. Among the bill's critical reforms are those allowing Medicare to negotiate drug prices; the imposition of inflationary rebates on certain drugs in Parts B and D; and a restructuring of the Part D benefit that would cap out-of-pocket costs, reduce the federal government's liability, and better align pricing incentives.

The bill also includes a mechanism to invest some of its savings back into the Medicare program. The reinvestments could expand and strengthen Medicare, such as by adding coverage for dental, vision, and hearing, or by easing access to programs that help low-income beneficiaries afford their health coverage and prescription drugs. The details of this provision are not yet final, and the bill's total estimated savings have not yet been released.

A **preliminary analysis** from the nonpartisan Congressional Budget Office (CBO), however, suggests lawmakers may have a significant amount of money to work with. The agency estimates H.R. 3's negotiation provisions alone would save $345 billion over seven years.

Importantly, this review also finds the examined policy changes would improve beneficiary access to needed medications. According to CBO, because the bill would lower drug prices—and therefore out-of-pocket costs—more beneficiaries would fill their prescriptions, leading to improved health and reduced spending on other Medicare-covered services, like hospital care.

The agency is analyzing the bill's other titles now, and additional savings are expected. In the interim, lawmakers are working to identify ways to allocate these funds. The possible Medicare improvements were discussed during Committee hearings today, and Medicare Rights recently **expressed support** for the reinvestment strategy. In particular, we recommended prioritizing policies that would fill longstanding gaps in coverage, ease access to low-income programs, make Medigaps more available and affordable, and better empower beneficiaries to make informed coverage choices.

We also continue to urge Congress to improve the Medicare Part D appeals process as part of any comprehensive drug pricing bill, and we need your help to make sure these important changes aren't left behind! **Take action today** and ask your representative to support the inclusion of the Streamlining Medicare Part D Appeals Process Act (**H.R. 3924**) in H.R. 3.

Looking ahead, the three committees with jurisdiction over H.R. 3— Energy & Commerce, Ways & Means, and Education & Labor—are expected to conclude their work next week, setting up a possible floor vote the week of October 28. Medicare Rights will continue to work to ensure that any final legislation is best positioned to meaningfully address the problem of high and rising drug prices within the Medicare program.

Weigh in Today! Tell Congress to fix the Medicare Part D appeals process.

Learn more about the Streamlining Part D Appeals Process Act by reading Medicare Rights' **fact sheet** and **case study**.

Read Medicare Rights' letter on H.R. 3's Medicare reinvestments.

Read the House drug pricing bill, H.R. 3..

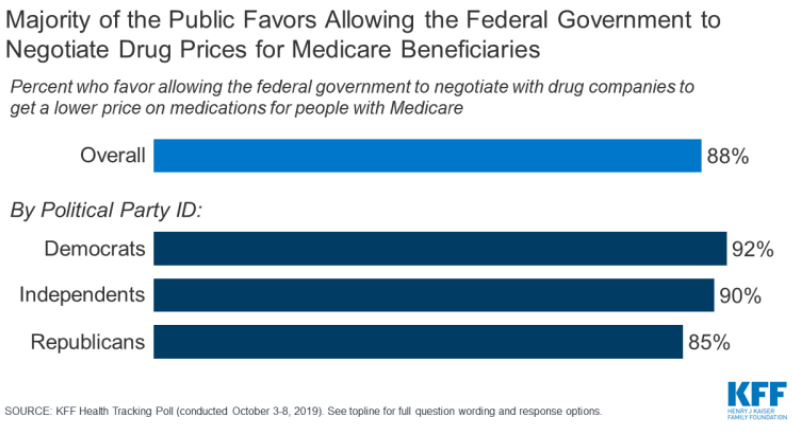
What's the Latest on Medicare Drug Price Negotiations?

Prescription drug costs are a major concern for consumers and a fiscal challenge for public and private payers. In response, lawmakers are considering a broad range of policy options, including allowing the federal government to negotiate the price of prescription drugs on behalf of people enrolled in **Medicare Part D** drug plans, a proposal which has strong and **bipartisan public support** (Figure 1).

Members of the 116th Congress have introduced bills to change the law and allow government drug price negotiation. This proposal is a key feature of the drug price legislation recently announced by Speaker Nancy Pelosi (D-CA) (H.R. 3, the Lower Drug Costs Now Act of 2019), which would require the Secretary of the Department of Health and Human Services (HHS) to negotiate the price of at least 25 (and no more than 250) brand-name drugs without generic competitors, and would make the negotiated price available to both Medicare and private payers. Several Democratic candidates in the 2020 presidential campaign have also stated their support for authorizing federal negotiation of drug prices for Medicare Part D.[1]

This issue brief begins with a brief description of the statutory prohibition on government drug price negotiations and its history and then describes several legislative proposals introduced in the current Congressional session that would give the HHS Secretary authority to negotiate Medicare drug prices. The brief also reviews analysis from the Congressional Budget Office (CBO) of the potential savings that government negotiations may generate for the Medicare program and its beneficiaries.

Figure 1



Big Changes May Be in Store for Medicare Part D

Some changes are in store for Part D in 2020 and policymakers are contemplating even more. The Kaiser Family Foundation (KFF), a nonpartisan nonprofit focused on national health issues, **recently outlined** what the program will look like next year under current law, and under recent legislative and administrative proposals.

In 2020, a provision of the Affordable Care Act (ACA) that slowed the growth rate of the catastrophic coverage threshold will expire, and the threshold will revert to its pre-ACA scheduled level. As a result, the threshold will increase more significantly in 2020 than it has in recent years.

While Part D out-of-pocket expenses are not capped, once beneficiaries pay a certain amount, their obligations are reduced. This reduction comes when they hit what is called the "catastrophic threshold." In 2019, once a beneficiary pays more than $5,100 toward their prescriptions, they enter catastrophic coverage and are on the hook for only 5% of the expenses going forward. In 2020, this threshold will jump by $1,250, to $6,350. This change could impact individuals who reach this level of spending, absent congressional action to continue the slower growth rate or otherwise restructure Part D as part of larger drug pricing reform efforts.

In the longer term, several proposed bills would change the structure of the Part D program by creating a cap on out-of-pocket expenses and reallocating responsibility for coverage expenses between insurance plans, pharmaceutical manufacturers, the Medicare program, and beneficiaries. For example, the Senate Finance Committee's drug pricing **bill** would cap beneficiary expenses at $3,100 annually, with manufacturers and Medicare each paying 20% of the costs once a beneficiary hits that limit and the insurance plan paying 60%. For comparison, the House drug pricing **bill** would set the annual out-of-pocket cap at $2,000, with plans paying 50%, manufacturers 30%, and Medicare 20% after that point. Both bills would eliminate beneficiary liability in the catastrophic phase.

By contrast, **the administration's Part D proposal** did not specify the level of the cap but would require plans to cover 80% of the costs once that threshold was reached, with the Medicare program paying 20%.

Medicare Rights strongly supports the creation of an out-of-pocket cap for beneficiary spending in Part D. The absence of a hard limit means that beneficiaries continue to be on the hook no matter how many thousands of dollars they may have already spent. While the beneficiary's responsibility in the current catastrophic coverage phase may seem low at 5%, this is often 5% of extremely expensive medications and can add up quickly. We urge Congress to advance proposals that improve beneficiary health and economic security, including by limiting beneficiary spending in Part D.

Medicare Part D Beneficiaries Who Reach the Catastrophic Coverage Limit Can Expect to Pay More Out-of-Pocket for Their Prescription Drugs Next Year

Medicare Part D enrollees with relatively high out-of-pocket expenses can expect see their costs rise in 2020, according to a **new KFF analysis**. This is mainly due to an increase in how much enrollees will pay out of pocket for their prescription drugs in the Part D benefit coverage gap phase before they qualify for catastrophic coverage.

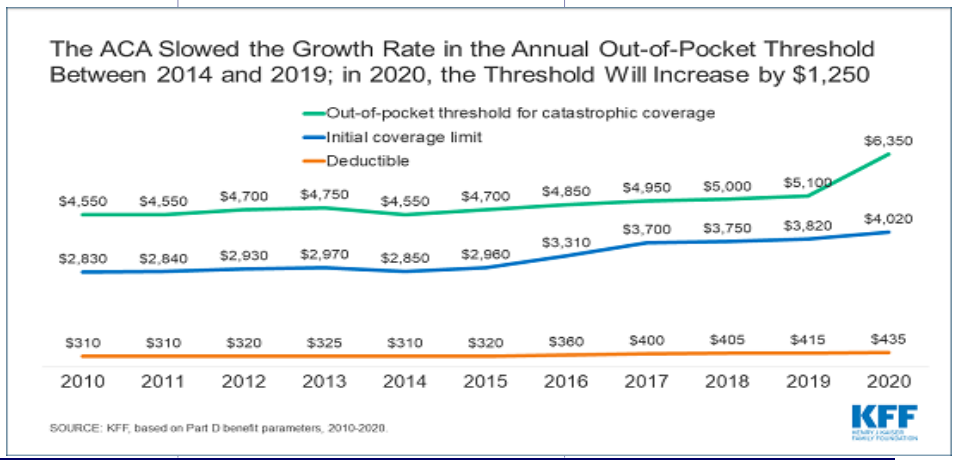
The analysis finds that out-of-pocket drug costs will increase by nearly $400 — from $2,275 in 2019 to $2,652 in 2020 — for Part D enrollees who take only brand-name drugs and have annual total drug costs that reach the catastrophic coverage threshold.

Between 2019 and 2020, this catastrophic threshold will increase by $1,250, or nearly 25 percent, rising from $5,100 in 2019 to $6,350 in 2020.

For enrollees who take only brand-name drugs, about a quarter of this increase will be paid out-of-pocket, with the remainder covered by drug manufacturers in the form of a price discount for brands in the coverage gap phase. Those who take only generics will pay the entire increase out-of-pocket. The relatively large increase in 2020 is due to the expiration of the Affordable Care Act (ACA) provision that slowed the growth rate in the catastrophic threshold between 2014 and 2019.

In 2017, the most recent year for which claims data is available, 4.9 million enrollees who were not eligible for low-income subsidies reached the Part D coverage gap, including 1 million who reached the catastrophic threshold. Had the threshold been higher in 2017, fewer than 1 million enrollees would have qualified for catastrophic coverage that year, meaning a larger number of enrollees would have remained in the coverage gap in 2017, where they pay a larger share of their total costs than in the catastrophic phase.

The analysis of higher out-of-pocket costs that Part D enrollees will face in 2020 comes at a time when lawmakers in Congress are considering proposals to address concerns about prescription drug costs. Proposals from the Senate Finance Committee, Speaker Pelosi, and the Trump Administration each include changes to the standard Medicare Part D benefit, including a hard cap on out-of-pocket costs for Part D enrollees and a reallocation of liability above the catastrophic threshold.



Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381
riarajap@hotmail.com • http://www.facebook.com/groups/354516807278/

Assessing Drug Price Increases in Medicare Part D and the Implications of Inflation Limits

Some recent proposals to lower prescription drug costs would require drug manufacturers to pay a rebate to the federal government if their prices for drugs covered under Medicare Part B and Part D increase by more than the rate of inflation. This proposal is included in recent legislation passed by the Senate Finance Committee (**S. 2543, Prescription Drug Pricing Reduction Act of 2019)** and introduced by Speaker Pelosi in the House of Representatives (H.R. 3, Lower Drug Costs Now Act of 2019). The Administration's **FY2020** budget includes a related proposal that applies only to drugs covered under Part B. (See Table 1 for a comparison of these proposals.) The Medicaid program currently has a similar policy in place.

This data note analyzes changes in list prices for drugs covered by Medicare Part D in recent years compared to changes in the rate of inflation. The analysis is based on data from the CMS's most recent **Medicare Part D drug spending dashboard**. Changes in list prices for Part D drugs are measured by one-year (2016-2017) and three-year (2014-2017) changes in average spending per dosage unit amounts reported in the dashboard. We compare these changes to the rate of increase in the Consumer Price Index for all urban consumers (CPI-U) over the same time periods. We analyze price changes for all drugs reported in the dashboard in 2017, along with the top 10 drugs by total Medicare Part D spending and the top 10 most commonly-used drugs in Part D in 2017 that had price increases between 2016 and 2017 above the rate of inflation. (See Methods for additional details.)

This analysis provides context for understanding the basic approach of an inflation rebate policy. It is not an analysis of any specific provision in either the House or Senate bills nor is it similar to a CBO cost estimate. Our analysis is based on unit prices that do not reflect manufacturer rebates and discounts to plans, which are considered proprietary and therefore not publicly available; the Senate Finance Committee inflation rebate proposal is also based on list prices (Wholesale Acquisition Cost), while the House proposal is based on Average Manufacturer Price, which may include some discounts to wholesalers but not rebates paid to plans and PBMs.

Key Findings

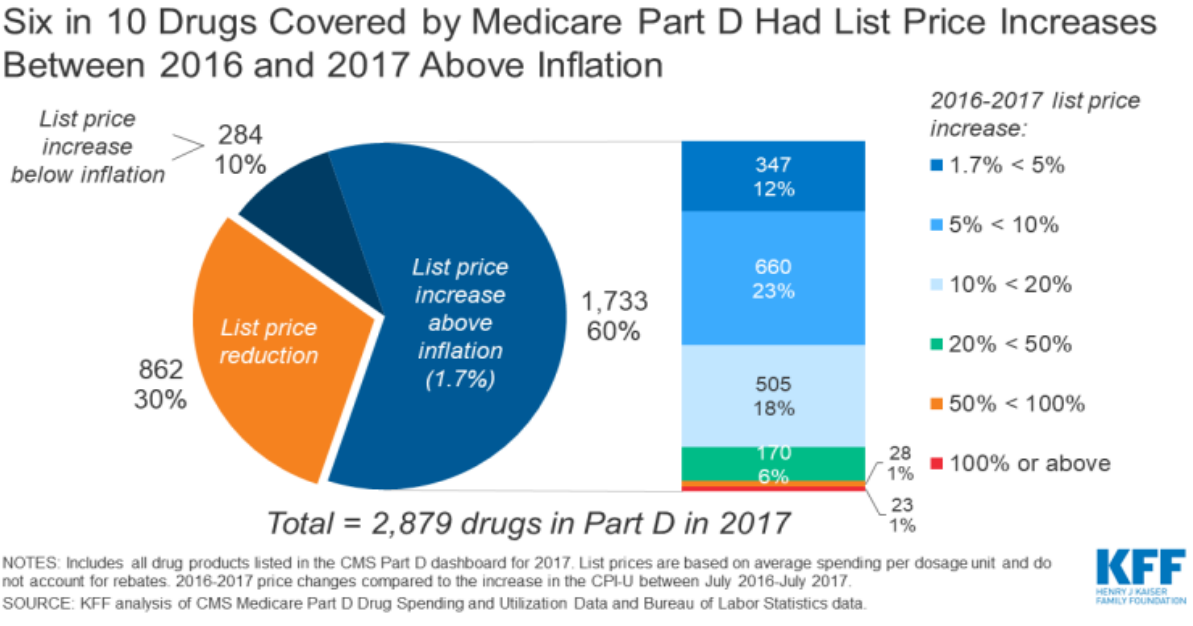
- For many drugs covered by Medicare Part D in 2017, list prices increased faster than inflation by several percentage points. Of the 2,879 drugs reported in 2017 in the Part D dashboard, including both brand-name and generic drugs, 60% (1,733 drugs) had list price increases that exceeded the inflation rate between July 2016 and July 2017, which was 1.7%.
- Among the top 25 drugs by total Medicare Part D spending in 2017, all of which were brand-name drugs, 20 had list price increases between 2016 and 2017 that exceeded the inflation rate, in some cases by several percentage points; for example, 15.7% for Lyrica, a pain medication, 15.3% for Revlimid, a cancer medication, and 13.2% for Humira Pen, for rheumatoid arthritis. For these 20 drugs, price increases ranged from 3 times to more than 9 times the rate of inflation.
- Among the 96 drugs used by more than 1 million Part D enrollees in 2017, roughly one-fifth of these drugs (22 drugs) had list price increases between 2016 and 2017 above the rate of inflation. Of the 22 most-commonly used drugs with price increases above inflation, 17 were generics (77%); half of the products (11) had list price increases below 5%, while price increases for the remaining half of products ranged from 6% to 32%–or 3 to 18 times the rate of inflation.

Findings

PRICE CHANGES AMONG ALL DRUGS COVERED BY PART D

Of the 2,879 drugs reported in 2017 in the Part D dashboard, including both brand-name and generic drugs, 60% (1,733 drugs) had list price increases that exceeded the inflation rate between July 2016 and July 2017, which was 1.7% (Figure 1). One-fourth of all Part D drugs had price increases of at least 10% between 2016 and 2017, and more than one-third (35%) had price increases above the rate of inflation but below 10%. Another 284 drugs (10%) had price increases below inflation, while for the remainder (859 drugs, or 30%), list prices decreased between 2016 and 2017….**Read More**

Figure 1



NOTES: Includes all drug products listed in the CMS Part D dashboard for 2017. List prices are based on average spending per dosage unit and do not account for rebates. 2016-2017 price changes compared to the increase in the CPI-U between July 2016-July 2017.
SOURCE: KFF analysis of CMS Medicare Part D Drug Spending and Utilization Data and Bureau of Labor Statistics data.

KFF
HENRY J KAISER FAMILY FOUNDATION

Opioid Crisis Cost U.S. Economy $631 Billion in Four Years, Study Shows

The Society of Actuaries released a **report** Tuesday examining the economic impact of non-medical opioid usage in the United States, and it concludes that from 2015 to 2018 an estimated $631 billion was spent dealing with the crisis, with more to come. The Society of Actuaries released a **report** Tuesday examining the economic impact of non-medical opioid usage in the United States, and it concludes that from 2015 to 2018 an estimated $631 billion was spent dealing with the crisis, with more to come.

The report, authored by Stoddard Davenport, MPH; Alexandra Weaver, ASA, MAAA and Matt Caverly, examines the cost of opioid misuse on a variety of areas, including health care expenditures, law enforcement and criminal justice programs and early mortality.

Opioid-related deaths increased dramatically in the period the study surveyed. According to the **Centers for Disease Control**, 33,091 opioid overdose deaths were reported in 2015, a figure that jumped to 42,249 the following year.

Early mortality represents the largest economic force in the study. The authors estimate that $253 billion of potential productivity and earnings are removed from the U.S. economy as a result of premature death as a result of opioid usage.

The second largest cost area is $205 billion in health care, which includes providing emergency services for overdoses and care for infants born with opioid withdrawal and abstinence syndromes.

The government has been saddled with a third of the total cost, primarily paid through Medicare and Medicaid, according to the report.

The authors also warn that the $631 billion figure is most likely underestimated, as they did not include any financial estimates from things they could not reliably measure including lost workplace productivity and diminished quality of life.

The study uses available data to project an estimate for 2019. The midpoint cost estimate of that data is $188 billion, indicating that the economic impacts of the opioid crisis are likely to continue to increase.

Many state and local governments are turning to the courts to address the crisis and hold the companies who made these products responsible.

The first high-profile trial of that nature begins this week, as Ohio's Cuyahoga and Summit Counties are bringing drug company Teva Pharmaceutical; distributors McKesson, Henry Schein, Cardinal Health and AmerisourceBergen; and retailer Walgreens to court. Several other defendants in that case, including Johnson & Johnson and Allergan, have already agreed to settlements with the counties.

One of the largest manufacturers of synthetic opioids, Purdue Pharmaceutical, announced in September amidst multiple lawsuits that they were filing for Chapter 11 bankruptcy. They estimate that after the proceedings the company's assets will bring $10 billion to settle lawsuits across 24 states.

Class-Action Lawsuit Seeks To Let Medicare Patients Appeal Gap in Nursing Home Coverage

Medicare paid for Betty Gordon's knee replacement surgery in March, but the 72-year-old former high school teacher needed a nursing home stay and care at home to recover.

Yet Medicare wouldn't pay for that. So Gordon is stuck with a $7,000 bill she can't afford — and, as if that were not bad enough, she can't appeal.

The reasons Medicare won't pay have frustrated the Rhode Island woman and many others trapped in the maze of regulations surrounding something called "observation care."

Patients, like Gordon, receive observation care in the hospital when their doctors think they are too sick to go home but not sick enough to be admitted. They stay overnight or longer, usually in regular hospital rooms, getting some of the same services and treatment (often for the same problems) as an admitted patient — intravenous fluids, medications and other treatment, diagnostic tests and round-the-clock care they can get only in a hospital.

But observation care is considered an outpatient service under Medicare rules, like a doctor's appointment or a lab test. Observation patients may have to **pay a larger share** of the hospital bill than if they were officially admitted to the hospital. Plus, they have to pick up the tab for any nursing home care.

Medicare's nursing home benefit is available only to those admitted to the hospital for three consecutive days. Gordon spent three days in the hospital after her surgery, but because she was getting observation care, that time didn't count.

There's another twist: Patients might want to file an appeal, as they can with many other Medicare decisions. But that is not allowed if the dispute involves observation care.

Monday, a trial begins in federal court in Hartford, Conn., where patients who were denied Medicare's nursing home benefit are hoping to force the government to eliminate that exception. A victory would clear the way for appeals from hundreds of thousands of people.

The class-action lawsuit was filed in 2011 by seven Medicare observation patients and their families against the Department of Health and Human Services. Seven more plaintiffs later joined the case.

"This is about whether the government can take away health care coverage you may be entitled to and leave you no opportunity to fight for it," said Alice Bers, litigation director at the Center for Medicare Advocacy, one of the groups representing the plaintiffs.

If they win, people with traditional Medicare who received observation care services for three days or longer since Jan. 1, 2009, could file appeals seeking reimbursement for bills Medicare would have paid had they been admitted to the hospital. More than 1.3 million observation claims meet these criteria for the 10-year period through 2017, according to the most recently available government data...**Read More**

Joseph Peters, Jr.

Joseph Peters, Jr., Secretary-Treasurer of the Alliance, said, "If the patients win this lawsuit, hundreds of thousands more could finally receive the benefits they should have had in the first place. Instead of creating bureaucratic loopholes, the federal government should be focused on providing comprehensive coverage so that no Americans go bankrupt in order to get the care they need."

RI ARA HealthLink Wellness News

AHA News: Lowering Blood Pressure May Prevent New Brain Lesions in Older People

(American Heart Association News) -- Many people know treating high blood pressure reduces the odds of a heart attack, stroke or heart failure. Now, a new study suggests another added benefit: a lower risk of lesions in the brain that increase the chances of dementia, stroke and falls in older adults.

The study, published this week in the American Heart Association journal *Circulation,* included 199 women and men age 75 and older. They all had systolic blood pressure (the top number) of 150 or higher and brain MRIs showing lesions known as white matter hyperintensity lesions that are common in older adults.

Half of the participants were given medication to lower their systolic blood pressure to 145. The other half were given medication to decrease it to 130 or lower. After three years, MRIs showed fewer new lesions had developed in the white matter of participants whose systolic blood pressure was 130 or lower than in those whose blood pressure target was 145.

"People who initially reviewed our study were worried 130 would be too low for these older adults," said Dr. William White, the study's lead investigator and a professor of medicine at the University of Connecticut School of Medicine's Calhoun Cardiology Center in Farmington. "But we found that both treatments were equally safe. In fact, fewer patients had major heart events when their systolic blood pressure was 130 or less. And the patients whose blood pressure was 130 or lower had significantly less damage to their brain."

Under the American College of Cardiology and AHA guidelines for managing blood pressure, people with a systolic blood pressure of 130 or higher are considered to have high blood pressure. Previously, the cutoff was 140 for adults under age 65 and 150 for those 65 and older.

White and his colleagues started their study in 2011, six years before the guidelines were updated. Today, nearly half of U.S. adults have high blood pressure and only about half of them take medication or make lifestyle changes necessary to bring their blood pressure down to a healthy level, according to AHA statistics.

By age 60, between 10% and 20% of people have white matter hyperintensity lesions, also known as white matter disease. They are seen in most adults over age 90.

Some areas of the brain look gray on imaging scans; other areas look white. The gray matter is found on the brain's outer layer, which controls memory, thought and movement. The white matter contains nerve fibers that send signals from one part of the brain to another.

Studies have shown people with white matter lesions are at increased risk for stroke or developing problems with thinking and memory. The lesions can also prevent the nerve fibers from relaying the messages that help people walk and move safely.

Dr. Jeff Williamson, a gerontologist at Wake Forest Baptist Medical Center in Winston-Salem, N.C., who was not involved in the study, called the research "an excellent approach for studying how high blood pressure affects day-to-day life."

"We've known for many years the development of white matter disease is associated with cognitive decline and even dementia," said Williamson, a co-author of the 2017 blood pressure guidelines. "This study shows reducing blood pressure can reduce or prevent accumulation of white matter disease."

White hopes the findings encourage doctors to keep their older patients' blood pressure at 130 or lower.

"If you are 80 and don't have a terminal disease," said White, "your life span could be for another 10 to 15 years, and over those years, brain functioning is of major importance for the quality of life of older people. If we can stop white matter lesion growth in its tracks, function could be improved."

17 Questions to Ask About Your New Doctor

Basics

- Is the doctor taking new patients?
- Is the doctor covered by my insurance plan?
- Does the doctor accept Medicare?

Qualifications and Characteristics

- **Is the doctor board certified? In what field?**
- Is the age, sex, race, or religion of the doctor important to me?
- Will language be an obstacle to communication? Is there someone in the office who **speaks my language?**
- Do I prefer a group practice or an individual doctor?
- Does it matter which hospital the doctor admits patients to?

Logistics

- Is the location of the doctor's office important? How far am I willing to travel to see the doctor?
- Is there parking? What does it cost? Is the office on a bus or subway line?
- Does the building have an elevator? What about ramps for a wheelchair or walker?

Office Policies

- What days/hours does the doctor see patients?
- Are there times set aside for the doctor to take phone calls? Does the doctor accept emailed questions? Is there a charge for this service?
- Does the doctor ever make house calls?
- How far in advance do I have to make appointments?
- What's the process for urgent care? How do I reach the doctor in an emergency?
- Who takes care of patients after hours or when the doctor is away?

Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381

riarajap@hotmail.com • **http://www.facebook.com/groups/354516807278/**

With severe flu season potentially on horizon, doctors are urging patients to get flu shots now

Contrary to popular belief, you should not wait until November or December to get your flu shot. The time is now, experts say.

"With the flu season starting earlier in Australia, and us already seeing cases of confirmed flu even in September, it's worth getting your flu shot now and ideally before Halloween," Dr. Ali Raja, the Executive Vice Chairman of the Department of Emergency Medicine at Massachusetts General Hospital, told Fox News.

Doctors often look at Australia and the Southern Hemisphere's flu activity for clues about what our flu season may look like since their winter--their prime flu season--is our summer. According to reports, Australia's flu season began in April, about two months earlier than usual.

Dr. Dyan Hes, a pediatrician at Gramercy Pediatrics in New York, said she has already had two positive flu cases so far this fall, and one over the summer. All three children had not received their flu vaccine yet.

"We encourage children to get their flu vaccine early in the fall. Children have strong immune systems and the vaccine should offer protection throughout the flu season," Hess told Fox News.

This year, Australia was hit with nearly **300,000 confirmed cases** with the predominant flu strain being the H3N2 virus, which is known to cause more severe illness and hospitalizations.

According to the **World Health Organization (WHO)**, seasonal influenza is an acute respiratory infection caused by influenza viruses that circulate in all parts of the world.

"Influenza strains tend to follow migration patterns from the Southern hemisphere to the Northern hemisphere such that this A strain, H3N2, in Australia would be expected to be the predominant strain we see here this winter, but this is not absolute," Dr. Leonard R. Krilov, Chief of the Division of Pediatric Infectious Diseases at NYU Winthrop Hospital, told Fox News.

The effectiveness of the flu vaccine has seen its ups and downs over the years.

The Centers for Disease Control and Prevention (CDC) says recent studies estimate the influenza vaccine helps reduce the risk of coming down with the flu by between 40 to 60 percent among the overall population during the flu season (winter months).

On their website, the CDC states, "in general, current flu vaccines tend to work better against influenza B and influenza A(H1N1) viruses and offer lower protection against influenza A(H3N2) viruses."

U.S. scientists look at the last few years of the flu to develop a vaccine that will counter what they think the flu is going to look like this year, Raja said.

"In order for them to produce the vaccine a couple of months before a flu season actually starts, they really are making very educated guesses about this [formula] because if they waited until the flu was actually out and had those samples to work with they'd never get enough flu vaccine made in time to be effective," said Raja, who is also an associate professor at Harvard Medical School.

Although the efficacy of the vaccine may seem worse in some years (the 2017 vaccine was only 40 percent effective, according to the CDC), experts say that even if the flu vaccine doesn't exactly match the strains that circulate, it's still worth getting.

"Even if not fully protective, the flu vaccine has been shown to modify the severity of a flu infection," Krilov said.

Many scientists and experts know the vaccine is not perfect, but especially for those who are at high risk for flu complications -- like pregnant women, young children, adults over the age of 65 and those with chronic health problems like asthma and heart disease--getting vaccinated could be lifesaving.

One study that looked at patients hospitalized with the H1N1 strain found patients that were vaccinated had a 36 percent lower risk of dying and a 19 percent lower risk of ICU admission than patients who were unvaccinated.

Krilov also said the vaccine helps create a herd immunity by protecting those around you.

Why Being Able to Talk with Your Doctor Matters

In the past, the doctor typically took the lead and the patient followed. Today, a good patient-doctor relationship is more of a partnership. You and your doctor can work as a team, along with nurses, physician assistants, pharmacists, and other healthcare providers, to manage your medical problems and keep you healthy.

How well you and your doctor talk to each other is one of the most important parts of getting good health care. But, talking to your doctor isn't always easy. It takes time and effort on your part as well as your doctor's.

This means asking questions if the doctor's explanations or instructions are unclear, bringing up problems even if the doctor doesn't ask, and letting the doctor know if you have concerns about a particular treatment or change in your daily life. Taking an active role in **your health care** puts the responsibility for good communication on both you and your doctor.

All of this is true at any age. But, when you're older, it becomes even more important to talk often and comfortably with your doctor. That's partly because you may have more **health conditions and treatments** to discuss. It's also because your health has a big impact on other parts of your life, and that needs to be talked about, too

Good doctor-patient communication is important for good health care, but it can be challenging. Share this infographic to spread the word about ways older adults can get the most out of their medical visits.

Click on picture for more information about talking to your doctor.

Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381

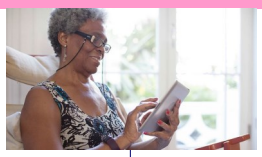
riarajap@hotmail.com • **http://www.facebook.com/groups/354516807278/**

How to Keep Your Brain Sharp and Healthy as You Age

So you've noticed some changes in your thinking. Perhaps you often misplace your keys or have trouble coming up with the right word in conversations. But how do you know if these changes are a normal part of getting older, or if they might be pointing to a health problem such as **dementia?**

How Your Brain Changes as You Get Older

Your brain's volume gradually shrinks as you get older. When this occurs, some of the nerve cells in your brain can shrink or lose connections with other nerve cells. Blood flow within your brain slows somewhat as you age, too. These age-related changes are thought to be behind the differences in cognitive function many people notice as they age. Everyone has lapses in memory from time to time, but significant **memory loss** is not a normal part of getting older. It's important to talk with your doctor if you or a loved one is experiencing memory loss and other cognitive symptoms that interfere with normal activities and relationships.



How Dementia Can Affect Cognitive Skills

Dementia occurs when nerve cells in the brain stop working, lose connections with other brain cells, and die. The **National Institute on Aging** defines dementia as having two or more core functions that are impaired, including memory, language skills, visual perception, and the ability to focus and pay attention. Cognitive skills, such as the ability to reason and solve problems, may also be impaired.

There are several different causes of dementia, including:

- **Alzheimer's disease** The most common cause of dementia, **Alzheimer's disease** occurs when nerve cells in the brain become damaged or die. The disease affects the parts of the brain that are involved in thinking, remembering, problem-solving, using language, and other cognitive skills.
- **Vascular dementia** The second leading cause of dementia, vascular dementia is a decline in thinking skills caused by cerebrovascular disease, a condition in which blood vessels in the brain are damaged and brain tissue injured, depriving brain cells of vital oxygen and nutrients, according to the **Alzheimer's Association**. Individuals at highest risk include those who have had a stroke or a **transient ischemic attack** (TIA, also known as a "ministroke").
- **Lewy body dementia** The third most common form of dementia, **Lewy body dementia** is caused by abnormal protein deposits that accumulate inside nerve cells, forming clumps called Lewy bodies. As a result, nerve cells no longer function adequately and begin to die. This impacts thinking, memory, behavior, sleep, mood, and movement.
- **Frontotemporal dementia** Frontotemporal dementia is the most common form of dementia for people under age 60, and it's caused by degeneration of the frontal and/or temporal lobes of the brain. FTD leads to a gradual, progressive decline in behavior, language, or movement, with memory usually relatively preserved, according to **The Association for Frontotemporal Degeneration.**
- **Other types of dementia** Human immunodeficiency virus (HIV) infection, Huntington's disease, head trauma, and other health conditions can affect nerve cells in the brain, leading to symptoms of dementia….**Read More**

I Got a Fever After the Flu Shot—Here's Why That's Totally Normal

So, when it's **flu season**, you better believe I'm **getting my flu shot.** I know that getting the vaccine doesn't mean I'm completely protected against the flu (I mean, who am I kidding with my luck?) but as a health reporter, I've done enough stories on otherwise healthy people who have died from the flu to make me want to get any protection I can—even if it just means I'll get a more minor case of the illness.

With that in mind, I got my flu shot on Wednesday. And by Wednesday night**, I came down with a fever**. I had chills, sweating, and all the other fun stuff that comes with a fever. So, I bundled up in bed, took some acetaminophen, and tried to sleep it off. The next morning, it was back. I took some acetaminophen again, and went about my day. And, by that evening, I had a low-grade fever again. WTH?

Wait, can the flu shot really cause a fever?

Turns out, you *can* get a fever after the flu shot. And, while it's not super common, I got it. Because of course I did.

It's important to make this clear up front: **You can't get the actual flu from the flu vaccine**. "What's in the vaccine is only part of the flu virus," explains **William Schaffner, MD**, an infectious disease specialist and professor at the Vanderbilt University School of Medicine. "It can't in any way reconstitute and make you sick."

When you get the flu vaccine, it stimulates your immune system to develop antibodies to protect you against the flu, explains infectious disease expert **Amesh A. Adalja, MD,** senior scholar at the Johns Hopkins Center for Health Security. "Your immune system is turning on and reacting to the vaccine, and that can cause a fever," he says.

It can also **cause other side effects associated with the flu shot**, muscle aches, headaches, fatigue, and pain or swelling at the injection site.

How long does this fever usually last?

It shouldn't be more than a day or two, Dr. Adalja says. "It's not usually something that interferes with your life," he adds.

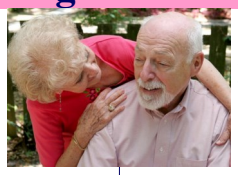
What can you do if you get a fever after the flu shot?

If it's bothering you, you can take **acetaminophen,** Dr. Schaffner says—that should bring the fever down. But, if it's a minor fever and you otherwise feel okay, he says you're fine to just let it ride.

It's important to point out that **your fever with a flu shot should be pretty minor, like a degree or two above your usual**. (Mine was 100.5 at its worst.) "If it's really high, prolonged, or you feel badly, call your healthcare provider," Dr. Schaffner says. "Something else might be going on at the same time." Translation: If your fever is high and not going away, it's possible you already caught the flu—or another circulating virus—before the vaccine had time to go into full effect (which often takes about two weeks).

Sure enough, I feel pretty okay today so, fingers crossed, I'm healthy again.

What Helps Calm Agitated Dementia Patients?



Dealing with the agitation, anxiety and aggression that often come with dementia is one of the most challenging aspects of caring for someone with this brain disorder. But new research suggests that massage and other non-drug treatments may be more effective than medications.

Even just taking people with dementia outdoors can help, said study author Dr. Jennifer Watt, a geriatrician and clinical scientist at the Li Ka Shing Knowledge Institute at St. Michael's Hospital-Unity Health in Toronto.

"The bottom line from our study is that non-medication based therapy and multidimensional care seem to be better than medications for treating the symptoms of aggression and agitation in persons with dementia," she said.

Dementia, a progressive loss of thinking and memory skills, affects 50 million people worldwide. Up to three-quarters have behavioral and psychological symptoms. People with such symptoms often need institutionalized care sooner.

Health care professionals rely on several medications to lessen symptoms of agitation and aggression, but these medications carry significant risks. One, ironically, is worsening memory and thinking, the researchers said.

Some medications -- such as anti-psychotics -- may do little to control symptoms, according to the American Board of Internal Medicine Foundation. Plus, they carry the U.S. Food and Drug Administration's most serious warning, because they increase the risk of stroke and death in people with dementia.

Given the challenges of using medications, researchers wanted to know more about alternatives, Watt said.

They included 163 studies in their analysis, with a total of more than 23,000 people. Studies included drug and non-drug interventions. In most of the studies, the patients' average age was 75 or older. There were a variety of dementias, such as Alzheimer's disease and vascular dementia, in stages from mild to severe.

Medications studied included antidepressants, antipsychotics, dementia-specific medications, cannabinoids and a combination medication, dextromethorphan-quinidine (Nuedexta), to treat uncontrollable laughing or crying.

Non-drug interventions included changes in environment, outdoor activities, recreational therapy, exercise, massage, music therapy and cognitive stimulation as well as caregiver education and support.

Researchers found that outdoor activities were the most effective for reducing agitation and aggression. Outdoor activities, massage and touch therapy ranked highest for treating verbal aggression. Exercise and modifying daily activities seemed best for dealing physical aggression, the study reported.

Nuedexta and medications from cannabis were more effective than a placebo in reducing agitation and aggression. But Watt said these drugs aren't prescribed much, and there may be side effects.

"It's important to prioritize the use of non-medication based treatment as much as possible," she said.

Watt acknowledged that it's not possible to implement all or even some of these non-drug treatments.

"Caregiving is hard," Watt said. "People are doing the best they can with the time and resources they have. We need to raise awareness and advocate for more financial resources to support these types of interventions."...**Read More**

Your Personality as a Teen May Predict Your Risk of Dementia

Could your personality as a teen forecast your risk for dementia a half-century later?

Very possibly, say researchers, who found that dementia risk is lower among seniors who were calm, mature and energetic high schoolers.

"Being calm and mature as teen were each associated with roughly a 10% reduction in adult dementia risk," said study co-author Kelly Peters, principal researcher at the American Institutes for Research in Washington, D.C. "And vigor was associated with a 7% reduction."

The finding has its origins in the 1960s, when more than 82,000 students in roughly 1,200 U.S. high schools took a personality test. More than 50 years later, their personality traits were compared to dementia diagnoses.

While Peters said there's plenty of evidence that personality changes near the time of a dementia diagnosis, the lingering question has been whether personality or some aspects of it actually *causes* dementia.

"That's the big question," she said. "Is it only that personality can be affected by dementia? Is it just an expression of the disease?" By focusing on teens who didn't later develop dementia, Peters said, "this study really starts to tease that out."

At an average age of 16, the students were assessed for 10 traits: calmness, vigor, organization, self-confidence, maturity/responsibility, leadership, impulsivity, desire for social interaction, social sensitivity, and artistic and intellectual refinement.

By 2011-2013, when they were almost 70 years old, more than 2,500 had developed dementia.

Enter lead author Benjamin Chapman, an associate professor of psychiatry at the University of Rochester in New York.

After stacking 50-year-old personality profiles up against current medical records, he and his team found that the risk of dementia was notably lower among seniors who were calm, vigorous and mature as teens.

Calmness was defined as being stress-free and not neurotic; vigor as being energetic and outgoing; and maturity as being responsible, reliable and conscientious.

Peters said the findings could guide policy thinkers to develop improved social support systems "to help kids build up protective qualities." But she highlighted some reservations.

For one thing, the team "only looked at traits that were protective," she said. And money seemed to matter: Calmness, vigor and maturity did not appear to protect against adult dementia among teens who grew up in relatively poor households.

Chapman's study also tracked dementia only around age 70. That, said his Rochester colleague Dr. Anton Porsteinsson, means "there's a lot more work to do." He was not involved in the study….**Read More**

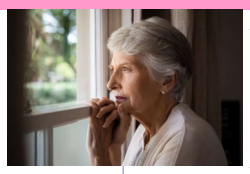
Dementia poses threat to health similar to HIV and AIDS, summit told

Dementia poses a threat to global health on the same scale as HIV and AIDS, the Dutch government has said, warning that the number of people with the condition will not be far off the population of Germany by 2030.

In a **speech t**o the World Dementia Council summit in Japan on Friday, Hugo de Jonge, the Dutch health minister, said dementia was underfunded, misunderstood and overlooked, as HIV and AIDS were in their **early days.**

"Only when it became clear how quickly the epidemic of HIV/AIDS was taking hold … taking millions of lives around the globe, did a global awareness emerge," De Jonge said. "A huge sense of urgency arose … and around 15 years after the epidemic first took hold, an effective treatment had been found.

"Today, we are on the verge of another epidemic; not a disease that attacks our immune systems, but our brain, our memory, our personality, ourselves. Like HIV/AIDS in its early days, dementia is a globally underfunded area of medicine."



He pointed out that if all people believed to **have dementia** lived in one country, it would be roughly the size of Spain, and cited predictions that by 2030, this hypothetical nation would contain nearly 75 million people. "By then, it should become a member of the G7," De Jonge said.

"The costs of dementia care by that time are estimated at a **staggering $2tn** (£1.6tn). No one should be in any doubt: dementia is one of the biggest medical and social challenges we'll face in the years ahead. In some countries, it already is the **main cause** of death."

The challenge is particularly relevant in the Netherlands, which has an ageing population of just over **17 million** people, **280,000 of whom** have some form of neurological impairment such as dementia or Alzheimer's disease.

Prof Philip Scheltens, the director of the Alzheimer Centre at UMC teaching hospital in Amsterdam, has lobbied the Dutch government for serious investment in research.

"The comparison with AIDS is often made," he said. "The urgency is unbelievably huge, as it was at the time, although it might be better to compare it with cancer. There is still no medicine and we need to go back to the drawing board to understand dementia. The worldwide budget must go up."

The Netherlands will also call for other countries at the G20 health ministers' meeting this weekend in Okayama, Japan, to participate in **a joint research programme**. In July next year, Amsterdam will host a **strategy summit** for 6,000 researchers.

Lenny Shallcross, the executive director of the World Dementia Council, who was at the Japan summit, said: "Dementia is the biggest health challenge of the 21st century."

Hilary Evans, the chief executive of Alzheimer's Research UK, said the AIDS comparison was appropriate.

"One in three people born today will develop this devastating condition in their lifetime, unless we find new ways to prevent and treat the diseases," she said.

"We've seen what can successfully be achieved in other areas of health by a movement of people coming together to call for change, tackle stigma and drive radical and sustained increases in research funding.

"Thanks to this research investment, today HIV is no longer a terminal condition in many countries, and research has changed so many lives. We want to see the same for dementia and the 50 million people worldwide affected by the condition."

Does an apple a day really keep the doctor away?

There are plenty of common cliches that we use in our everyday conversations, but "an apple a day keeps the doctor away" is a lesson that has been passed down for generations. It's a saying that seems to come with little to no explanation as to how eating an apple a day keeps the doctor away other than it just does. Apples are packed with nutrients perfect for maintaining a healthy diet, but does adding one apple to your meal plan every day truly curb doctor visits? Yes and no.

The **first known example** of the use of the saying comes from a 19th-century magazine published in Wales. It was originally phrased, "Eat an apple on going to bed, and you'll keep the doctor from earning his bread." Over the next century, it evolved to "an apple a day, no doctor pay" and "an apple a day sends the doctor away." It wasn't until 1922 that the saying we know and love today was first documented. "An apple a day keeps the doctor away" is a good proverb, but only when not taken literally.

Apples have a substantial amount of **health benefits**. They contain pectin, a prebiotic that feeds **probiotics**, the healthy bacteria in your stomach that breaks down food and kills threatening organisms. During pesky flu season when it feels like a cold or worse is always on the brink of hitting you, an apple is a great snack because it contains **vitamin C,** an immune system booster. And, according to the **American Institute for Cancer Research**, the **phytochemicals** found in each bite of an apple help in the fight against cancer. So, while eating an apple a day shouldn't stop you from visiting your doctor for check-ups, its nutrients do help prevent medical conditions, such as high blood pressure and diabetes, and contribute to a healthy diet. A healthy diet likely means fewer trips to the doc.

Researchers at the University of Michigan and Dartmouth actually put the question to the test. After surveying adults who eat an apple a day compared to those who don't, they **found** that people who consume more apples had other healthy habits, however, there's no significant relationship between eating an apple and fewer doctor visits. Instead, researchers concluded that eating an apple a day "keeps the pharmacist away:" Apple eaters use fewer medical prescriptions.

Apples are a great snack for the entire family. And when you're tired at the job or looking for crunchy food to munch on, they are a nutritious replacement for **junk food**. An apple a day might not keep the doctor away, but its nutrients will help improve your overall health. Just don't let being an apple eater prevent you from neglecting other aspects of your health, like ignoring the **early signs you might be getting sick.**