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February 9, 2020 E-Newsletter

Publication 2020 Issue 06
Published in house by the
RI ARA

AP FACT CHECK: Some of Trump's claims in his State of Union address

President Donald Trump's portrayal of American renewal Tuesday night drew on falsehoods about American energy supremacy, health care and the economy as well as distortions about his predecessor's record.

DRUG PRICES

TRUMP: "For the first time in 51 years, the cost of prescription drugs actually went down."
THE FACTS: Prices for prescription drugs have edged down, but that is driven by declines for generics. Prices for brand-name medications are still going up, although more moderately.

HEALTH CARE

TRUMP: "We will always protect patients with preexisting conditions."
THE FACTS: That's a promise, not a guarantee.

The Trump administration is backing a lawsuit by conservative-led states that would overturn the entire Affordable Care Act, including its guarantees that people cannot be turned down or charged more for health insurance because of preexisting medical problems.

Trump and congressional Republicans have vowed they will protect people with preexisting conditions, but they have not specified how they would do that.

Estimates of how many people could potentially be affected if "Obamacare's" protections for preexisting conditions are eliminated range from about 54 million working-age adults, in a study last year from the Kaiser Family Foundation, to as many as 133 million people in a 2017 government study that also included children.

SOCIAL SECURITY

THE FACT: After a day of hobnobbing with billionaires in Davos, President Trump publicly revealed that cuts to earned Medicare and Social Security benefits will be on the table as soon as the end of this year. The cruel irony of this scene cannot be overstated.

BY THE NUMBERS: NEW ANALYSIS FINDS OVER 500 DRUG PRICE HIKES IN FIRST WEEK OF JANUARY

WASHINGTON, DC — A new analysis by Patients For Affordable Drugs uncovered 524 drug price spikes in the first week of 2020, spotlighting widespread pharmaceutical industry price gouging that underscores the urgent need for Congress to address the issue. The non-profit group found that 72% of those price increases were on drugs with no generic competitors. Almost 100 drug companies rang in the new year with price hikes that averaged 5.6%, more than twice the rate of inflation.

David Mitchell, a cancer patient with Medicare coverage and the founder of Patients For Affordable Drugs, paid $3,183 for his first refill of Pomalyst, a blockbuster cancer drug that Celgene/Bristol-Myers Squibb increased by more than $1,000 per month in January.

"These companies can't break their addiction to taking the maximum price increases they think they can get away with," said Mitchell. "Hundreds of price hikes make it clear why drug pricing reform is so sorely needed in America. Congress and the president will have another chance in 2020 to do right by patients and keep their promises by passing bills that stop price gouging."

Today's report, based on data from AnalySource, highlighted seven key drugs that increased in price. The snapshots demonstrate that:

Drugmakers continued historical patterns of price hikes.

Gilead raised the price of the HIV drug Truvada for the 16th time since 2005 and Pfizer raised the price of Lyrica for the 14th consecutive year.

Medicare and Medicaid are getting ripped off. The antipsychotic drugLatuda costs Medicare and Medicaid $2.4 billion annually — it increased by nearly 5% to start the year. Imbruvica, a cancer drug, costs taxpayers almost $2 billion per year and increased by 7.4% in January. Revlimid is the second most expensive drug on Medicare — it jumped in price by $907 per month in January.

The majority of drugs with price increases face no competition. AbbVie's January price hike on Humira brings the blockbuster drug's total price increase to 341% since market entry in 2006. Pfizer's Lyrica has increased 396% since 2005. Both companies have abused the regulatory system to avoid generic competition. The multiple sclerosis drug Tecfiderafaces no competition in the U.S., and Biogen increased the price again in January to $8,275 for a month's supply.

View the full data set **here**. Take a closer look at seven spotlighted drugs: **Humira**, **Imbruvica**, **Latuda**, **Lyrica**, **Revlimid**, **Tecfidera**, and **Truvada**.

How the little-known WEP provision hacks educators' retirement benefits

When educators retire, they rely on benefits they earned over their years of service in public schools to support the next chapter of their lives. However, nearly 2 million retired educators across the country are subject to the heartbreaking impacts of a program that for almost 35 years has threatened or destroyed public employees' retirement security.

The Windfall Elimination Provision (WEP) reduces the Social Security benefits of people whose work history includes both jobs covered and not covered by Social Security. That would include educators in states where public employees don't pay into Social Security who take on part-time or summer jobs to make ends meet.

WEP has done financial harm to generations of retirees. Fortunately, there are members of Congress who understand that educators should keep the retirement security they earned in jobs they held outside of education. House Ways and Means Committee Chairman Richard Neal (D-MA) introduced the Public Servants Protection and Fairness Act to lessen the impacts of WEP and protect educators. If that bill becomes law, current retirees would receive an extra $150 a month and future retirees would gain an extra $75 a month, on average.

Here are three things you need to know about H.R. 4540 and what you can do to support it:

1. How WEP might affect you

Educators are **among the people most profoundly affected** by WEP. **Fifteen states** do not pay into Social Security for public employees, who must rely solely on their pensions. But many states do not meet their pension obligations and routinely shortchange retirees (by eliminating cost of living increases, for example).

WEP harms not only retirees, but the profession at large. For example, the provision dissuades career changers from considering teaching if their previous job did pay into Social Security, because those individuals could lose up to 50 percent of the Social Security benefit they earned in their first line of work. The maximum WEP reduction for 2019 is $463 per month.

2. Educators are speaking out about retirement insecurity

When Jon-Paul Roden started teaching in 1965, he found that he needed to supplement his income. The side jobs he took on over the years made him eligible for Social Security benefits when he retired. But when he did so in 2000, he felt the impact of the WEP provision. Roden knew that he would be affected, but many of his colleagues are unaware until they are about to retire.

"It changes a person's lifestyle because they don't have the income they were expecting or were entitled to receive," Roden says. For nearly two decades, Roden has been an active NEA retired member, advocating with fellow former educators to explain the problem within their own communities and speaking with lawmakers at the U.S. Capitol.

Roden encourages other retirees to thank their members of Congress if they've signed on to legislation to address the problem. If they haven't signed on, you can join Roden in communicating regularly to members of Congress: "Email, write, and tell them your story about the negative effects of WEP," he advises. Here's an easy way to do that: **https://educationvotes.nea.org/take-action/#retirement-security**.

3. What is NEA doing and how can you help?

In the past, NEA has opposed bills that offered a partial fix to WEP, because they simply created a new set of winners and losers. But the Public Servants Protection and Fairness Act has NEA's support because it's a good incremental step toward full repeal of both the WEP and its counterpart, the Government Pension Offset (GPO). That provision reduces the Social Security spousal or survivor benefits that public employees receive. Further, under the proposed bill, no one who is currently subject to WEP would get less money.

"This bill is a great step in the right direction toward protecting the Social Security benefits that educators, firefighters, police officers, and other dedicated public employees have earned," said Marc Egan, NEA Director of Government Relations. "We fully support it even as we continue to fight for full repeal of WEP and GPO."

NEA also supports the Social Security Fairness Act of 2019 (S.521 and H.R.141), which would completely repeal both WEP and GPO. The measure has bipartisan support that was built in part by NEA members, who sent more than 20,000 emails to Congress in the past year alone. Add your voice! Write or call your members of Congress, and tell your stories about the negative effects of WEP and GPO.

Click here to take action »

Watch: Let's Talk About Trump's Health Care Policies

Polls say health care is consistently at the top of voters' minds in this election cycle. And President Donald Trump clearly wants to own the issue, often **talking** about the "wins" stemming from his administration's policies.

In this video explainer, KHN correspondent Shefali Luthra examines the president's talking points on a range of topics — from insurance coverage, access to care and affordability issues to preexisting condition protections and prescription drug cost.

Click n picture to view video

Preeminent Hospitals Penalized Over Rates Of Patients' Injuries

Hundreds of hospitals across the nation, including a number with sterling reputations for cutting-edge care, will be paid less by Medicare after the federal government pronounced that they had higher rates of infections and patient injuries than others.

The Centers for Medicare & Medicaid Services on Wednesday **identified 786 hospitals** that will receive lower payments for a year under the **Hospital-Acquired Conditions Reduction Program**, a creation of the Affordable Care Act. The penalties are designed to encourage better care without taking the extreme step of tossing a hospital out of the Medicare and Medicaid programs, which would drive most hospitals out of business.

Now in their sixth year, the punishments, known as HAC penalties, remain awash in criticism from all sides. Hospitals say they are arbitrary and unfair, and some patient advocates believe they are too small to make a difference. Research has shown that while hospital infections are decreasing overall, it is hard to attribute that trend to the penalties.

Look Up Your Hospital: Is It Being Penalized By Medicare?

"There is limited evidence that this is the kind of program that makes things better," said **Andrew Ryan**, a professor of health care management at the University of Michigan School of Public Health.

Under the law, Medicare is mandated each year to punish the quarter of general care hospitals that have the highest rates of patient safety issues. The government assesses the rates of infections, blood clots, sepsis cases, bedsores, hip fractures and other complications that occur in hospitals and might have been prevented. Hospitals can be punished even if they have improved from past years.

Medicare cuts every payment by 1% for those hospitals over the course of the federal fiscal year, which started in October and runs through the end of September. Since the program's onset, 1,865 of the nation's 5,276 hospitals have been penalized for at least one year, according to a Kaiser Health News analysis.

Many hospitals escaped penalties because they were automatically excluded from the program, either because they solely served children, veterans or psychiatric patients, or because they have special status as a "critical access hospital" for lack of nearby alternatives for people needing inpatient care.

This year, 145 hospitals received their first penalty, the analysis found. Conversely, 16 that had been penalized every year since the start of the program avoided punishment. Those included Novant Health Presbyterian Medical Center in Charlotte, North Carolina, and Tampa General Hospital in Florida.

Novant Health said in a statement it had lowered infection rates by being more discriminating in using urinary catheters and central lines, standardizing the steps to prevent infections in surgeries, and getting staffers to wash their hands more….**Read More**

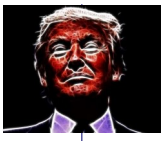
Trump Administration Unveils a Major Shift in Medicaid

States will be able to cap a portion of spending for the safety-net program, a change likely to diminish the number of people receiving health benefits through it.

WASHINGTON — The Trump administration said on Thursday **that it would allow states to cap Medicaid spending** for many poor adults, a major shift long sought by conservatives that gives states the option of reducing health benefits for millions who gained coverage through the program under the Affordable Care Act.

Seema Verma, the administrator of the Centers for Medicare and Medicaid Services, said states that sought the arrangement — an approach often referred to as block grants — would have broad flexibility to design coverage for the affected group under Medicaid, the state-federal health insurance program for the poor that was created more than 50 years ago as part of President Lyndon B. Johnson's Great Society.

The announcement by Ms. Verma, who often speaks of wanting to "transform" Medicaid, comes as her efforts to let states require adults on Medicaid to work or train for a job — which led to 17,000 people in Arkansas **losing coverage** in 2018 — are **mired in court battles.**



"Government has a solemn responsibility to provide for the most vulnerable among us," Ms. Verma said in a morning call with reporters. "Part and parcel of that responsibility is making sure the Medicaid program is sustainable."

Democrats, health care providers and consumer groups warned that capping federal funding for adults on Medicaid and giving states more freedom to decide who and what the program covers would jeopardize medical access and care for some of the poorest Americans. A legal challenge is inevitable.

"After failing to cut Medicaid in 2017 through congressional action, the Trump administration has consistently tried to achieve the same results through administrative attacks," said Emily Stewart, the executive director of Community Catalyst, a consumer group. "With fewer dollars to provide care to millions of people, let alone address current and future public health issues, C.M.S. is opening the floodgates to allow states to cut benefits and limit services."

The new funding option could possibly have the effect of increasing the number of Medicaid beneficiaries in some states — namely, the 14 that have not yet expanded Medicaid, who might see it as a more conservative way to move forward in covering poor adults. States that have already expanded Medicaid could also pursue the option, which could lead to pared-down coverage for that population, though some experts predicted most would not.

"There's no question this plan provides unprecedented flexibility to states to restrict health care under Medicaid," said Larry Levitt, executive vice president for health policy at the nonpartisan Kaiser Family Foundation. "What is less clear is how many states will want to do that and be willing to roll the dice with a cap on federal contributions."

States can use the new approach only with adult beneficiaries younger than 65 who aren't eligible for Medicaid because of pregnancy, a disability or their need for long-term care — in essence, those whom the Affordable Care Act gave states the option of covering.

Medicaid has always provided unlimited federal matching payments to states based on whatever they spend providing care to the poor.

Some of what the program covers is mandatory — emergency and hospital care ...**Read More**

5 Things To Know About Trump's Medicaid Block Grant Plan

The Trump administration **unveiled a plan** Thursday that would dramatically revamp Medicaid by allowing states to opt out of part of the current federal funding program and instead seek a fixed payment each year in exchange for gaining unprecedented flexibility over the program.

Medicaid, a federal-state health program that covers 1 in 5 Americans, has been an open-ended entitlement since its beginning in 1965. That means the amount of money provided by the federal government grows with a rise in enrollment and health costs.

The administration said the **new program** would allow states to offer patients more benefits while controlling government spending. But the plan was assailed by Democrats, consumer advocates and health providers as undermining efforts to serve the poor.

States would not be required to switch to the new model. It will be optional, and states interested in it would have to seek authority from the federal government. That makes the proposal less sweeping than efforts by Republican lawmakers to revamp Medicaid that were included in failed 2017 legislation to gut the Affordable Care Act.

The long-awaited guidance to states on turning Medicaid into a block grant allows the Trump administration to proclaim it's transforming the Medicaid program and offers a way for states that haven't expanded under the Affordable Care Act to move ahead.

It could also tee up an election-year battle in which opponents will use the plan to argue that it's President Donald Trump's latest salvo in a long-running effort to unravel the health care safety net.

"The Trump administration's announcement today is a game changer," said Oklahoma Gov. Kevin Stitt, a Republican who plans to expand coverage up to ACA levels and pursue a block grant with a Medicaid work requirement and new premiums.

Here are the big things to know about how the new plan works.

1. **Millions of people might be affected by block grants.**
2. **States seeking the new authority would be able to make new cuts to benefits, including which prescription drugs are covered, and impose new out-of-pocket costs on enrollees.**
3. **The federal government will exercise less oversight over the private health insurance companies that states hire to run their programs, giving states more power to set rules on provider participation and payments.**
4. **All states could technically apply for a block grant, but most are unlikely.**
5. **The impact won't be felt anytime soon.**

Click here to read more on each of the five big things.

How Chaos at Chain Pharmacies Is Putting Patients at Risk

For Alyssa Watrous, the medication mix-up meant a pounding headache, nausea and dizziness. In September, Ms. Watrous, a 17-year-old from Connecticut, was about to take another asthma pill when she realized CVS had mistakenly given her blood pressure medication intended for someone else.

Edward Walker, 38, landed in an emergency room, his eyes swollen and burning after he put drops in them for five days in November 2018 to treat a mild irritation. A Walgreens in Illinois had accidentally supplied him with ear drops — not eye drops.

For Mary Scheuerman, 85, the error was discovered only when she was dying in a Florida hospital in December 2018. A Publix pharmacy had dispensed a powerful chemotherapy drug instead of the antidepressant her doctor had prescribed. She died about two weeks later.

The people least surprised by such mistakes are pharmacists working in some of the nation's biggest retail chains.

In letters to state regulatory boards and in interviews with The New York Times, many pharmacists at companies like CVS, Rite Aid and Walgreens described understaffed and chaotic workplaces where they said it had become difficult to perform their jobs safely, putting the public at risk of medication errors.

They struggle to fill prescriptions, give flu shots, tend the drive-through, answer phones, work the register, counsel patients and call doctors and insurance companies, they said — all the while racing to meet corporate performance metrics that they characterized as unreasonable and unsafe in an industry squeezed to do more with less.

"I am a danger to the public working for CVS," one pharmacist wrote in an anonymous letter to the Texas State Board of Pharmacy in April.

"The amount of busywork we must do while verifying prescriptions is absolutely dangerous," another wrote to the Pennsylvania board in February. "Mistakes are going to be made and the patients are going to be the ones suffering."

State boards and associations in at least two dozen states have heard from distraught pharmacists, interviews and records show, while some doctors complain that pharmacies bombard them with requests for refills that patients have not asked for and should not receive. Such refills are closely tracked by pharmacy chains and can factor into employee bonuses.

Michael Jackson, chief executive of the Florida Pharmacy Association, said the number of complaints from members related to staffing cuts and worries about patient safety had become "overwhelming" in the past year.

The American Psychiatric Association is particularly concerned about CVS, America's eighth-largest company, which it says routinely ignores doctors' explicit instructions to dispense limited amounts of medication to mental health patients. The pharmacy's practice of providing three-month supplies may inadvertently lead more patients to attempt suicide by overdosing, the association said.

"Clearly it is financially in their best interest to dispense as many pills as they can get paid for," said Dr. Bruce Schwartz, a psychiatrist in New York and the group's president.

A spokesman for CVS said it had created a system to address the issue, but Dr. Schwartz said complaints persisted.

Regulating the chains — five rank among the nation's 100 largest companies — has proved difficult for state pharmacy boards, which oversee the industry but sometimes allow company representatives to hold seats. Florida's nine-member board, for instance, includes a lawyer for CVS and a director of pharmacy affairs at Walgreens.

Aside from creating potential conflicts of interest, the industry presence can stifle complaints. "We are afraid to speak up and lose our jobs," one pharmacist wrote anonymously last year in response to a survey by the Missouri Board of Pharmacy. "PLEASE HELP." **….Read More**

Warren Is Right. Presidents Have The Power To Bypass Congress On Drug Pricing.

"The president of the United States already has the legal authority to reduce the price of many commonly used prescription drugs."

On the presidential primary campaign trail in Iowa, Sen. Elizabeth Warren (D-Mass.) brought out a favorite talking point: ways the president can bring down drug prices without waiting for Congress.

It's not the first time Warren and other candidates have referenced this alleged power. In this case, she pointed to insulin, EpiPens and HIV/AIDS drugs as possible targets.

We asked the Warren campaign for the basis of her claim and they directed us to her "Medicare for All" transition plan. It identifies two legal mechanisms — "compulsory licensing" as outlined in 28 U.S. Code Section 1498 and the so-called march-in rights provision of the 1980 Bayh-Dole Act.

We spoke to legal and pharmaceutical policy experts about whether those mechanisms could be used to bring down drug prices, as Warren described. The answer? Yes. But it's complicated and controversial.

The Legal Mechanisms

Of the two legal levers, Section 1498 is perhaps more straightforward.

The law says the government can intervene to take over patents without a company's permission if the price is too high. The government can then create competition to bring down prices by importing those products from abroad or manufacturing them. The original manufacturer can sue for damages but cannot stop Washington from breaking the patent.

"What they would do is announce they are taking other bids from other companies to supply the product" to government programs such as Medicare, said Aaron Kesselheim, a professor of medicine at Harvard Medical School, who researches drug pricing laws and has written extensively about Section 1498.

The provision has been used before — in the 1960s to procure cheap generic drugs — and was invoked as recently as 2001 as a threat to get a better price on Ciprofloxacin, a high-powered antibiotic used to treat anthrax. It also was used in 2014 in non-pharmaceutical contexts, such as by the Defense Department to acquire lead-free bullets.

Invoking this part of the U.S. code wouldn't necessarily apply to all drugs, said Jacob Sherkow, a professor at New York Law School. But products such as the ones Warren mentioned — insulin and EpiPens, for instance, which are patented in the United States and abroad and cost far less in other countries — would qualify. And that could send a message to other drug manufacturers.

"If you're a particularly aggressive president, you can find some low-hanging fruit, and use 1498 to show other pharmaceutical companies you're damn serious," Sherkow said….**Read More**

Why Home Health Care Is Suddenly Harder To Come By For Medicare Patients

The decision came out of the blue. "Your husband isn't going to get any better, so we can't continue services," an occupational therapist told Deloise "Del" Holloway in early November. "Medicare isn't going to pay for it."

The therapist handed Del a notice explaining why the home health agency she represented was terminating care within 48 hours. "All teaching complete," it concluded. "No further hands on skilled care. Wife states she knows how to perform exercises."

That came as a shock. In May 2017, at age 57, Anthony Holloway was diagnosed with ALS (amyotrophic lateral sclerosis): The Frederick, Maryland, man can't walk, get out of bed or breathe on his own (he's on a ventilator). He can't use the toilet, bathe or dress himself. Therapists had been helping Anthony maintain his strength, to the extent possible, for two years.

"It's totally inhumane to do something like this," Del said. "I can't verbalize how angry it makes you."

Why the abrupt termination? **SpiriTrust Lutheran**, which provides senior services in Pennsylvania and Maryland, said it could not comment on the situation because of privacy laws. "In every client situation SpiriTrust Lutheran is committed to insuring the safety and well-being of the individual," wrote Crystal Hull, vice president of communications, in an email.

But its decision comes as home health agencies across the country are grappling with a significant change as of Jan. 1 in how Medicare pays for services. (Managed-care-style Medicare Advantage plans have their own rules and are not affected.)

Agencies are responding aggressively, according to multiple interviews. They are cutting physical, occupational and speech therapy for patients. They are firing therapists. And they are suggesting that Medicare no longer covers certain services and terminating services altogether for some longtime, severely ill patients.

Altogether, about 12,000 home care agencies (most of them for-profit) provided care to 3.4 million Medicare beneficiaries in 2017, the most recent year for which data is available.

To qualify for services, a person must be homebound and in need of intermittent skilled care (less than eight hours a day) from nurses or therapists.

Previously, Medicare's home health rates reflected the amount of therapy delivered: More visits meant higher payments. Now, therapy isn't explicitly factored into Medicare's reimbursement system, known as the **Patient-Driven Groupings Model** (PDGM).

Instead, payments are based on a patient's underlying diagnosis, the presence of other complicating medical conditions, the extent to which the patient is impaired, whether he or she is referred for services after a hospitalization or a stay in a rehabilitation center (payments are higher for people discharged from institutions) and the timing of services (payments are higher for the first 30 days and lower thereafter). Agencies now have a stronger financial incentive to serve patients who need short-term therapy after a stay in the hospital or a rehabilitation facility, said Kathleen Holt, associate director of the Center for Medicare Advocacy. Also attractive will be patients who need nursing care for complex conditions such as post-surgical wounds.

At the same time, there are fewer incentives to serve patients who need extensive physical, occupational and speech therapy.

"We are very concerned about that potential," said Kara Gainer, director of regulatory affairs for the American Physical Therapy Association. ...**Read More**

KFF Health Tracking Poll – January 2020: Medicare-for-all, Public Option, Health Care Legislation And Court Actions

Key Findings:

The Democratic presidential primary campaign featured extensive discussions of different health care reform proposals. As Democratic primary voters in early primary states begin casting their ballots to select their nominee, the latest KFF tracking poll finds that a majority of Americans favor a national Medicare-for-all health plan (56%) but a larger share favors a government-administered "public option" (68%). Notably, nearly half of adults (48%) favor both of these proposals. Among the 17% who favor a public option but oppose Medicare-for-all, when asked to explain their reasoning in their own words, the most common responses indicate that they prefer a public option because it allows choice (32% of those who were asked, or 5% of the total public).

Eight in ten Americans think taxes for most people would increase both under a Medicare-for-all plan (83%) or a public option health plan available to all (81%). However, more adults think that all Americans would have health insurance coverage under a Medicare-for -all system (62%) than under a public option (53%).

At the start of this election year, lowering prescription drug costs (22%) and continuing the ACA's protections for people with pre-existing conditions (19%) lead the public's health care priorities for Congress. Additionally, eight in ten or more say it is at least very important that Congress work on lowering prescription drug costs (87%), ensuring the ACA's pre-existing condition protections continue (83%), and protecting people from surprise high out-of-network medical bills (80%) during the next year.

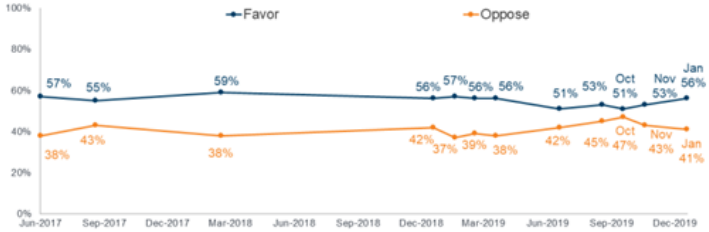
President Trump has an overall negative approval rating among the public when it comes to his handling of various health issues, with his most negative ratings for his handling of the Affordable Care Act (35% approve and 56% disapprove, for a net approval of -21 percentage points) and his handling of the costs of prescription drugs (30% approve, 54% disapprove, net approval -24 percentage points). On the other hand, majorities of Republicans approve of his handling of all the health care issues asked about in this month's poll, especially his handling of Medicare (+68 percentage points net approval). Among all adults, President Trump's net approval rating for his handling of Medicare is -10 percentage points.

In a December ruling, the U.S. Court of Appeals for the 5th Circuit in Texas agreed with a lower court judge that the provision of the Affordable Care Act's individual mandate is unconstitutional since Congress eliminated the tax penalty established to enforce it, and sent the case back to the lower court to decide how much of the ACA should be allowed to stand. A majority of adults say they are worried that they or someone in their family will lose health insurance coverage in the future if the Supreme Court overturns either the ACA's protections for people with pre-existing conditions (57%) or the entire health care law (58%). ...**Read More**

Figure 1

Public More Likely To Favor Than To Oppose A National Medicare-for-all Health Plan

Do you favor or oppose having a national health plan, sometimes called **Medicare-for-all**, in which all Americans would get their insurance from a single government plan?

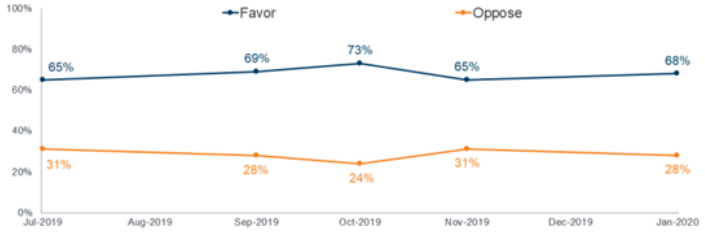


SOURCE: KFF Health Tracking Polls. See topline for full question wording and response options.

Figure 2

About Two-Thirds Of The Public Favor A Public Option

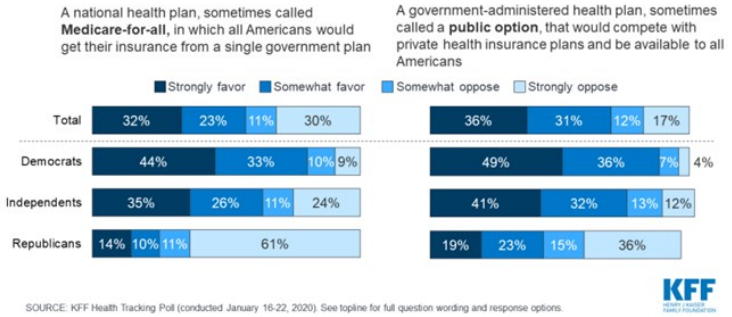
Do you favor or oppose having a government-administered health plan, sometimes called a **public option**, that would compete with private health insurance plans and be available to all Americans?



SOURCE: KFF Health Tracking Polls. See topline for full question wording and response options.

Figure 3

Larger Shares Favor A Public Option Than A Medicare-for-all Plan

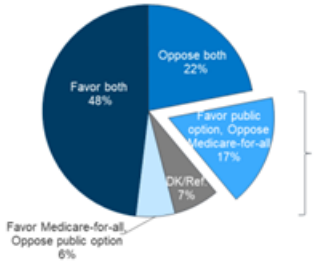


SOURCE: KFF Health Tracking Poll (conducted January 16-22, 2020). See topline for full question wording and response options.

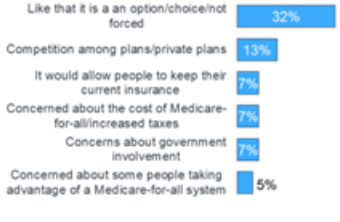
Figure 4

About Half Of Adults Favor Both Medicare-for-all And A Public Option

Do you favor or oppose having a national health plan, sometimes called Medicare-for-all / government-administered health plan, sometimes called a public option?



AMONG THE 17% WHO FAVOR PUBLIC OPTION, OPPOSE MEDICARE-FOR-ALL:
What is the main reason that you favor a public option but oppose a Medicare-for-all plan?



SOURCE: KFF Health Tracking Poll (conducted January 16-22, 2020). See topline for full question wording and response options.

How to Protect Your Social Security from Identity Theft

It takes seconds for your life to be destroyed by identity theft. When one dishonest person finds your lost wallet, or steals a few pieces of trash from your curb, they can cause a ripple effect of financial, legal and emotional problems that follow you for years.

Identity theft is becoming more and more common. The Bureau of Justice Statistics **estimated** that about three percent of U.S. households experienced identity theft in 2004. That number more than doubled in one decade: in 2014, an **estimated** seven percent of households were victims of identity theft. Protect yourself and your future by safeguarding your Social Security number from thieves.

How Identity Theft Theft Happens

Often, identity theft starts with someone getting hold of your ***Social Security*** number. That can happen in many ways. A thief can get your information by:

- Stealing your purse or wallet and finding your Social Security card, or a copy of it, inside.
- Intercepting your incoming mail or outgoing garbage and finding documents that include your SSN or account numbers.
- Baiting you into revealing your SSN by posing as a representative of the government, a bank or other business.
- Taking it from employment records that aren't properly protected.
- Using online hacking schemes to do things like record your keystrokes or intercept communication between you and your bank.

But these are just a few of the ways identity theft can start. And identity thieves come up with new scams all the time, so it's important to be vigilant….**Read More**

Life Expectancy in U.S. Increases for First Time in 4 Years

After four years of declines, life expectancy in the United States increased in 2018, health officials reported Thursday.

The jump in longevity comes as deaths from opioid overdoses dropped for the first time in 28 years, as did deaths from six of the 10 leading causes.

The new data could be a glimmer of good news for Americans' health, with recent declines in average lifespans initially casting doubt on progress made over the past decades.

The three-year trend in life expectancy for the total population either decreasing or remaining steady has stopped, with the increase in life expectancy in 2018," said lead researcher Kenneth Kochanek, from the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS).

"The decrease in mortality from unintentional injuries in 2018 is a reverse from the 2014-to-2017 trend," he added.

"From 2014 to 2017, the increase in deaths from unintentional injuries contributed the most to the decrease in life expectancy, with decreases in cancer mortality offsetting this change in life expectancy," Kochanek said.

Between 2010 and 2014, life expectancy increased from 78.7 years to 78.9 years, then fell between 2014 and 2017 from 78.9 years to 78.6 years.

But in 2018, it went back to 78.7 years, which is still below the peak of 78.9 years in 2014, Kochanek said.

The 10 leading causes of death in the United States are heart disease, stroke, chronic respiratory disease, Alzheimer's disease, diabetes, flu, kidney disease, suicide, cancer and accidents. Between 2017 and 2018, decreases in deaths from cancer and unintentional injuries contributed the most to the increase in life expectancy, with increases in mortality from influenza and pneumonia offsetting the change in life expectancy, Kochanek added.

The increase in life expectancy between 2017 and 2018 is statistically significant, but time will tell whether it holds, he added. A similar increase occurred between 2013 and 2014 before falling the following year.

Other findings in the report include:

- Among the 10 leading causes of death, only deaths from suicide and flu-related pneumonia rose.
- More than half the increase in life expectancy in 2018 was from fewer deaths from cancer and accidents.
- Drug overdose deaths dropped 4% from 2017 to 2018, from about 70,200 in 2017 to nearly 67,400 in 2018. The majority of drug overdose deaths (90%) were unintentional.
- Drug overdose deaths in 2018 dropped in 14 states and the District of Columbia. Across the country, the overdose death rate was 20.7 per 100,000 in 2018 and 21.7 in 2017.
- The rate of drug overdose deaths from drugs such as fentanyl, fentanyl analogs and tramadol rose 10% from 2017 to 2018.
- Between 2012 and 2018, the rate of drug overdose deaths from cocaine more than tripled, and from drugs such as methamphetamine increased five times…..**Read More**

Republican's TRUST Act is designed to gut Social Security and Medicare

Alex Lawson writes for **The Hill** about Senator Mitt Romney's ongoing quest to gut Social Security. In October 2019, Romney introduced the TRUST Act, which would create a secret fast track for cutting Medicare and Social Security benefits. It's a bill that flies in the face of the needs of Americans, the overwhelming majority of whom support **strengthening Social Security**.

The **TRUST Act** is designed to enable Congress to quickly starve Medicare and Social Security of funds, weakening these programs. Romney's vision for shoring up Social Security for future generations is to reduce people's benefits. You might call it the DISTRUST Romney Act.

The TRUST Act would appoint "bi-partisan" commissions to look at Medicare and Social Security Trust funds and recommend actions to Congress on how to "simplify" them. Romney and other co-sponsors would like to make changes to them in ways that would cut benefits.

As Lawson explains, 'Republicans don't want to "save" Social Security. They want to, in **Norquist's famous words**, "drown it in the bathtub."'

In sharp contrast, the **Social Security 2100 Act** would increase Social Security benefits while strengthening the program for future generations. It provides greater benefits to the most low-income people receiving benefits. And, we can easily afford it.

To promote equity in the Social Security program, it lifts the cap on Social Security contributions so that wealthy Americans pay their fair share. Right now, wealthy Americans only contribute to Social Security on the first $137,700 of their income.

RI ARA HealthLink Wellness News

What to know about white matter disease

White matter disease, or leukoaraiosis, involves the degeneration of white matter in the brain. White matter is tissue that includes nerve fibers (axons), which connect nerve cells.

A fatty tissue called myelin covers the axons. These axons connect the neurons of the brain and spinal cord and signal nerve cells to communicate with one another.

Degeneration of the white matter — specifically, the myelin sheaths — can affect a person's mood, focus, muscle strength, vision, and balance.

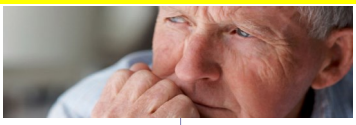
White matter disease may develop with conditions associated with aging, such as stroke, but it can also affect young people due to conditions such as cerebral adrenoleukodystrophy and multiple sclerosis (MS).

Prognosis and life expectancy

White matter disease includes many different conditions. It can be progressive, and people who develop this form of white matter disease will notice their symptoms become more pronounced as time goes on.

The life expectancy of a person with white matter disease depends on many factors, including the specific type, the rate at which it progresses, and the complications it causes.

Research has suggested a link between white matter disease of an unknown cause and the risk of stroke and dementia. According to a review of six large prospective studies, people with white matter damage have a higher risk of stoke than those without the condition.



Symptoms

White matter plays an essential role in communication within the brain and between the brain and spinal cord. As a result, damage to this tissue can lead to issues with:

- ♦ problem-solving
- ♦ memory and focus
- ♦ mood
- ♦ balance walking

In the beginning stages of progressive white matter disease, the symptoms may be mild. As time passes, however, the symptoms may get worse.

Causes

Research suggests that the risk of white matter disease increases with age and the presence of cardiovascular disease. Medical, lifestyle, and other risk factors that play a role in white matter disease include:

- chronic hypertension
- diabetes
- genetics
- high cholesterol
- history of stroke
- inflammation of the blood vessels
- Parkinson's disease
- ♦ smoking

One 2014 study suggests that unexplained white matter disease may be the result of damage due to small silent strokes.

A silent stroke is so small that it occurs without any symptoms. This means that the person does not usually know that they have had a stroke.

This study suggests that repeated silent strokes could lead to white matter disease…..**Read More**

As VA Tests Keto Diet To Help Diabetic Patients, Skeptics Raise Red Flags

A partnership between the Department of Veterans Affairs and Silicon Valley startup Virta Health Corp. is focusing attention on the company's claim that it provides treatment "**clinically-proven to safely and sustainably reverse type 2 diabetes**" without medication or surgery.

The assertion is at the heart of an ongoing debate about the keto diet's effect on diabetes. Some diabetes experts are skeptical of Virta's promise and are expressing concerns that the company's partnership with the federal government is giving the diet too much credence.

The agreement has helped raise the national profile of **Virta**, a fledgling health company that has developed a proprietary system of remote coaching and monitoring for people with Type 2 diabetes to help them follow the keto diet, which is high in fat and low in carbohydrates.

Despite its strict requirements, the keto diet has gained popularity in recent years with consumers and studies noting it helps shed pounds and can lead to improved health. But the company's claim about reversing diabetes is unusual. Type 2 diabetes is often linked to excess weight, and the company said its studies suggest that significant weight loss through keto can lower patients' blood sugar and need for diabetic medications.

The diet has won support among some diabetes researchers and patient groups. But other public health advocates are concerned that the science of treating diabetes with a keto diet is not well studied. They worry about keto's effect on the heart and the paucity of vegetables and fruits generally in the diet.

In a **press release** announcing the collaboration, VA Secretary Robert Wilkie said Virta's regimen would help the department create "a more comprehensive approach to care."

Under the accord, Virta is providing its services free to about 400 VA patients for a year while federal officials evaluate the service and their health.

In November, Virta **announced** in a news release that the initial 90-day results were promising. It said veterans reported weight loss, reduced blood sugar and lower reliance on diabetes medication.

But Virta declined to provide KHN with underlying data, citing the need to protect patient information. It did arrange an interview with its then-chief counsel and vice president of finance, Anand Parikh. He said he expected the partnership with the VA to soon expand. Parikh, who left the company in December, said that future government collaboration will likely involve payment to Virta but that it was too early to estimate a price. The treatment currently costs other patients $370 per month, plus a one-time $500 initiation fee.

A VA spokesperson did not respond to detailed written questions concerning the partnership.

The VA runs the country's largest integrated health care system and is considered **a leader in diabetes care. Roughly 25%** of its patients have the disease, which is twice the national average. Inside the VA, diabetes is the leading cause of blindness, renal disease and amputations.

Virta offers diet coaching, monitoring and support through a smartphone application. Patients can use the services around the clock and regularly upload their blood sugar readings and other medical details, such as weight and blood pressure.

"One of the most important things about our approach is that we individualize for each person," Parikh said.

The VA's work with Virta has raised alarm bells, including on Capitol Hill….**Read More**

New Study Supports Lowering Age of First Colonoscopy

The rate of colon cancer among Americans spikes sharply between the ages of 49 and 50, a new study finds -- supporting the case for earlier screening for the disease.

Researchers say the uptick between those two ages does not reflect an actual increase in the occurrence of colon cancer but the fact that screening for the disease has traditionally begun at age 50. So "latent" cancers that had been present for some time are caught at that age.

Experts said the findings could have implications for colon cancer screening recommendations, which at the moment are conflicting.

For years, guidelines from various groups said that people at average risk of colon cancer should begin screening at age 50. Earlier screening was reserved for people at increased risk.

But in 2018, the American Cancer Society lowered its recommended threshold to age 45, largely due to a rising incidence of colon cancer among younger Americans.

But the U.S. Preventive Services Task Force -- which sets federal screening standards -- still recommends a starting age of 50 for people at average risk.

Given the debate, Dr. Jordan Karlitz said his team wanted to take a closer look at how Americans' colon cancer rates change by yearly increments in age. Past studies, he explained, have looked at age blocks, like 45 to 49 and 50 to 54.

A year-by-year look, Karlitz said, could give a clearer picture of what's going on among people in their 40s. It has long been suspected that incidence of colon cancer in that age range is higher than statistics show, because most people in their 40s are not screened.

The researchers expected to see an increase in colon cancer between age 49 and 50. What they found was a 46% rise.

"It was a steep uptick," said Karlitz, an associate clinical professor at Tulane University School of Medicine in New Orleans. "We expected we'd see something, but not to that extent."

The pattern probably reflects cancers that started before age 50 -- even years before -- but weren't caught until screening started, according to Dr. Umut Sarpel.

Sarpel, who was not involved in the study, is an associate professor of surgical oncology at Mount Sinai's Icahn School of Medicine in New York City.

"The results of this study support efforts to lower the screening age to less than 50 years," Sarpel said.

The findings, published online Jan. 31 in *JAMA Network Open*, are based on government cancer data for 2000 through 2015. Karlitz's team focused on colon and rectal cancer rates among 30- to 60-year-olds.

During that period, the rate among 49-year-old Americans was just under 35 cases per 100,000 people. That jumped to 51 cases per 100,000 among 50-year-olds, the investigators found.

The vast majority of cases caught at age 50 -- nearly 93% -- were invasive, which means they would probably require more extensive treatment and had likely been there for some time.

Statistics show that most colon cancers are diagnosed after age 50. However, the rate among younger Americans has been on the rise, for reasons that remain unclear.

An American Cancer Society study found that since the mid-1990s, colon cancer rates among Americans aged 20 to 54 have been steadily inching up -- by between 0.5% and 2% each year. Rectal cancer has risen faster, by 2% to 3% per year.

"It has been known for approximately 15 years that rates of colon and rectal cancers are rising among young patients," said Dr. Joshua Meyer, a radiation oncologist at Fox Chase Cancer Center in Philadelphia. "This appears to be true both under age 40 and between age 40 and 50."

What has been unclear, Meyer said, is how long colon tumors may be growing when they are finally caught through screening.

"This study makes it clear that these have been growing for a number of years," said Meyer, who was not involved in the research.

The increase between ages 49 and 50 was seen not only for cancers confined to the colon and rectum, but also for regional cancers -- meaning the disease has spread into nearby lymph nodes. There was also a small increase (just under 16%) in the most-advanced cancers -- those that have spread to distant sites in the body.

Meyer said it's concerning to see a rise in more-advanced cancers. The findings support "consideration of lowering of the screening age for colorectal cancer," he said.

Researcher Karlitz said he hopes the results "shed light" on the fact that colon cancer is more common among people in their 40s than the statistics suggest.

For now, he said that people should discuss the best screening strategy, including starting age, with their doctor. And everyone -- no matter how young they are -- should act on potential cancer symptoms, Karlitz stressed.

Some potential red flags include a persistent change in bowel habits; abdominal pain or cramping; stool that is dark or has visible blood; and unintended weight loss.

How to make your own will

If you do not already have a will or would like to revise your will, you should consider making your own will. It's actually pretty easy to do. **Paul Sullivan** reports for The New York Times on tools available on the web to make your own will.

Some online tools for creating a will are simple to use. It can take less than an hour. The companies offering online tools are for-profit, but they provide services for free or at little cost. You can check out FreeWill, Rocket Lawyer and LegalZoom.

If you have family, friends or charities to whom you would like to leave some or all of your property, you should have a will. That said, almost six in ten Americans die without wills, including a lot of celebrities. Aretha Franklin, for example, did not have a will. So, do not think of yourself as an outlier if you do not have one.

FreeWill allows you to create a will and leave money to charity at no cost. You can change your mind about which charities to leave money to, as many people do, over time.

Rocket Lawyer costs $40 a month and will link you with a lawyer. You can get help with legal documents online.You are billed separately for time you spend speaking with a lawyer.

LegalZoom gives you access to a lawyer and help with your **power of attorney** and **health care proxy** in addition to the will. The cost for a year is between $149 and $349. The cost includes the lawyer's time.

Online tools to help you create a will may not serve you as a well as a lawyer. If you can afford a lawyer whom you trust, you may want to invest in one, especially if you have a lot of assets. That way, you will be sure you dot all your i's and cross your t's when you create your will.

You should have a durable power of attorney and a health care proxy document in addition to a will. The **durable power of attorney** gives someone you trust control over your finances–to the extent you desire–if you are not able to act on your own behalf. The **health care proxy** document identifies someone you trust to act on your behalf and express your wishes in a medical crisis, if you cannot speak for yourself.

Ageism Affects People Around the Globe

Ageism, (prejudice or discrimination on the grounds of a person's age.)

Discrimination based on age -- ageism -- is widespread throughout the world, and it takes a toll, new research reveals.

The study of more than 7 million people aged 50 and older in 45 countries found that age affected whether or not they got medical treatment and, whether the treatment, its length and frequency were appropriate.

The investigators reviewed 422 published studies, and found that 96% of older people experienced ageism.

According to the new report, ageism led to poor outcomes in depression and physical health, including shorter life expectancy.

"The injurious reach of ageism that our team documented demonstrates the need for initiatives to overcome ageism," said senior author Becca Levy, a professor of psychology at Yale School of Public Health in New Haven, Conn.

In 85% of the studies, her team found that health care was denied to older people, and in 92%, ageism affected medical decisions.

Ageism affects people regardless of age, sex, or race and ethnicity, the researchers noted in a Yale news release.

Study first author E-Shien Chang, a doctoral student in the Yale School of Public Health, said, "Our research highlights the importance of recognizing the influence of ageism on health. Policies to improve older persons' health must take ageism into account."

What to know about chronic dehydration

Chronic dehydration can be mild or severe. In some cases, it can even require a visit to the hospital. Certain groups, such as older adults and athletes, may be more at risk.

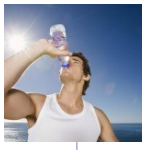
Dehydration can occur when a person loses excessive water and does not take enough in to replace it. Causes include acute vomiting and **diarrhea**, heat exposure, prolonged vigorous exercise, and some conditions and medications.

Chronic dehydration occurs over a longer period of time. It can be mild or, in serious cases, lead to complications.

This article looks at chronic dehydration, including its signs and symptoms, effects, causes, treatments, and prevention.

How much water do we need?

How much water a person needs each day is difficult to assess and can vary from person to person. A person's water needs are based on their metabolism, environmental conditions, and activity levels.



The **Third National Health and Nutrition Examination Survey** based its **adequate intake** for total water intake on a combination of drinking water, beverages, and food.

For males aged 19–30 years, it recommends 3.7 liters (l) per day. For females aged 19–30 years, it recommends 2.7 l per day.

However, there is no scientific or clinical consensus for precise values of daily water requirements, according to one **2012 review**.

Someone can become dehydrated if they lose as little as **3%** of their **body weight** from lack of water intake.

Signs and symptoms

The signs and symptoms of dehydration depend on how dehydrated a person is. Thirst is one of the first symptoms to indicate that the person needs to drink.

Some other **signs and symptoms** of chronic dehydration include:

- **headaches**
- being unable to focus or concentrate
- passing darker urine than usual
- **tiredness** or fatigue
- muscle weakness and cramps
- **constipation**
- dry, flaky skin
- altered kidney, heart, or digestive function.

Effects of chronic dehydration

The effects will depend on how severe the dehydration is. Low daily water intake can cause constipation, lack of focus, and tiredness. These symptoms can negatively impact a person's daily life.

One 2012 review reports that the only condition consistently linked with chronic low daily water intake is urolithiasis, which occurs when stones form in the kidney, bladder, or urinary tract.

Some research has suggested that increasing water intake may help with weight management. However, there is not enough evidence to explain how this happens.

The 2012 review also cites some evidence to suggest that increased fluid intake is linked with a lower risk of some **cancers,** though this evidence is inconclusive…..**Read More**

What to do about constipation?

The **National Institute on Aging** (NIA) offers advice on what to do about constipation, a condition virtually all of us face at one time or another. Generally, it's not serious. Here's what the NIA recommends doing.

Constipation is not a disease. Rather, it is a symptom. Often people are constipated when they have fewer bowel movements than normal or it takes a lot of time to pass stools, and the stools are hard. Older people are more prone to constipation than younger people.

You should not worry too much if you do not have a bowel movement every day. Some people have bowel movements twice a day and others have bowel movements three times a week. Everyone is different. For some, it can mean bowel movements twice a day.

To determine whether you are constipated, doctors might have you answer these questions:

- Do you often have fewer than three bowel movements a week?
- Is it usually difficult for you to pass stools?
- Are your stools generally lumpy or hard?
- Do you feel blocked or as if your bowels are full?

If the answer is no to all of these questions, you likely do not have a constipation issue. If your answer is "yes" to at least one of these questions, you may have a constipation issue. You should talk to your doctor. The doctor can check the cause. You should also talk to your doctor if there is blood in your stool.

Constipation can have a range of causes, including diet, exercise, and use of laxatives. Inactivity can cause of constipation. So can eating a lot of high-fat meats, dairy products and sweet desserts as well as prepared and processed foods that are low-fiber. Excess use of laxatives and enemas also can cause constipation because they can confuse your body.

And, some prescription drugs used for depression and high blood pressure, allergy medicines, antacids and some painkillers can cause constipation. An **SSRI**, such as **Prozac** or amitriptyline might be the cause, as might an **opioid**, such as oxycodone or hydrocodone.

People with stroke, diabetes and irritable bowel syndrome are prone to constipation. Their conditions affect muscles and nerves used for bowel movements. If your doctor finds this is the cause, it may be treatable….**Read More**

What's the Difference Between Osteoporosis and Osteoarthritis?

These two totally different conditions are sometimes confused. Here's what you should know about each.

WHAT'S IN A NAME? WELL,

Ifit's **osteoporosis** and **osteoarthritis**, for starters, a shared prefix. "Osteo" means bone, and that matching descriptor also spells confusion for many seniors, who are disproportionately affected by both conditions.

"This kind of confusion is something that we see almost daily," says Dr. Gianluca Toraldo, an endocrinologist and the director of the Bone Health Clinic at **Lahey Hospital & Medical Center** in Burlington, Massachusetts. That's because besides sounding similar, a major shared risk factor for the development of both chronic conditions is aging.

But from symptoms – or a lack thereof – to how each impacts the body and the ways in which they're managed, the two conditions are totally different.

Osteoporosis refers to "porous bone," or a thinning of bone, where the quality and density of bone is decreased, so that it becomes weak and brittle. This puts a person is at higher risk for sustaining a fracture. However, there are typically no other noticeable symptoms before a bone break. "So it's a silent disease until a fracture occurs," says Dr. Meryl LeBoff, chief of the calcium and bone section and director of the Skeletal Health and Osteoporosis Center and Bone Density Unit at **Brigham and Women's Hospital** in Boston. Apart from that, there are generally no outward signs that a person may have osteoporosis, which affects about 10 million in the U.S., predominantly women.

By contrast, osteoarthritis is an inflammatory condition that affects the joints – like the hips, knees, spine and joints in the hands. Unlike with osteoporosis, this most common form of arthritis can cause a range of symptoms. Those include joint stiffness, declining flexibility, bone spurs and, perhaps most noticeably, pain.

Despite these obvious and significant differences, osteoporosis and osteoarthritis mix-ups persist. Many people have only a faint idea that they're at risk or are just learning about one or both conditions. Toraldo mainly sees patients with osteoporosis, but he says sometimes patients with osteoarthritis symptoms come to him, confusing the two. In fact, sometimes patients come in and say simply, "I'm here because I have 'osteo,'" he notes. "It doesn't tell you anything."

Are the Conditions Linked?

The short answer is not really, experts say. But some people have both osteoarthritis and osteoporosis. So while they're not directly associated, they share certain risk factors, such as age and gender. "Both conditions are more common in women than they are in men – although clearly they both can affect men as well," says Dr. Andrea Singer, chief medical officer at the National Osteoporosis Foundation and director of women's primary care at **MedStar Georgetown University Hospital** in Washington.

Genetics may also put a person at higher risk of developing each condition as well. "Both conditions tend to run in families," Singer points out.

But one condition doesn't directly cause or raise a person's risk of developing the other, clinicians say. That said, having one doesn't protect you against developing the other, either. It was once thought that having OA might protect a person against osteoporosis. In fact, osteoporosis – which is typically diagnosed by scanning bone density – may be obscured by bone growth around joints affected by osteoarthritis. So, osteoporosis can sometimes be obscured during a bone scan test by the presence of OA.

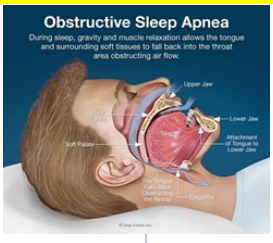
Past research LeBoff was involved in found that 25% of patients studied with advanced osteoarthritis, who came in to Brigham and Women's Hospital for joint replacement, also had osteoporosis, according to bone density criteria. "So it really changed the concept that the osteoarthritis patients did not get osteoporosis, when in fact a subset of them do get osteoporosis," LeBoff says. "It's important to consider that in some patients."

For those undergoing joint replacement surgery for OA – like knee or **hip replacement** – having osteoporosis as well can significantly affect how successful the procedure is. Because a replacement joint must be placed in bone, it makes a difference whether that bone is strong or the quality is diminished and the bone mineral density decreased. If you have a bone with osteoporosis, it's quite possible that the hardware won't stay in the bone, requiring another operation on the joint. The chance that the replacement doesn't work properly is very high, Toraldo says. "In my opinion, a person with osteoarthritis must be evaluated for osteoporosis."...**Read More**

The hidden costs of sleep apnea

You may have read about insurers charging their members **higher copays for some drugs** than their retail price. You also may have read about medical device companies **collecting and selling people's data** without their knowledge. Marshall Allen reports for **Pro Publica** on the hidden costs of having sleep apnea.

Sleep apnea interrupts your sleep throughout the night. It can cause loud snoring. It keeps you from functioning well during the day. Without treatment, you have an increased likelihood of heart disease, diabetes and cancer.



If you are among the millions of Americans with sleep apnea, a CPAP machine may help you sleep through the night. Continuous Positive Airway Pressure (CPAP) machines are one of a limited number of ways to address sleep apnea, and they work for many patients. So, insurers tend to cover them.

But, CPAP machines turn out to be a hidden profit center for insurers. Some insurers charge you copays to rent a CPAP machine and for needed supplies– filters, hoses and masks–that are more than it would cost to buy them outright.

Moreover, insurers can monitor your sleep through these machines, compromising your privacy. And, if you're not using the CPAP machine, insurers may deny coverage and require you to pay for them in full. They also may require you to pay out of pocket for all supplies that come with the machine.The machines relay data that allows the insurers to know whether patients are using them as prescribed.

Medicare covers the CPAP but requires you to use the CPAP a minimum of four hours a night for at least 21 nights a month (7 out of ten nights). Doctors must let Medicare know if their patients are complying and whether the machine is working. But, the machine is loud, requires you to use a mask, and takes getting used to, so it is not always easy to comply from the get-go.