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# RI ARA

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*"Fighting for the future of our members."*
*"NOW, more than ever!!!"*

## October 23, 2017 E-Newsletter

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## What Did Trump's Health Care Executive Order Do?

President Trump **signed** an executive order on Thursday that he said would begin "saving the American people from the nightmare of Obamacare." There's a lot that's still uncertain about how the order will change the health law. Here's what we know so far.

**Is Obamacare repealed now?**

"I just keep hearing repeal-replace, repeal-replace," Mr. Trump said in the signing ceremony. "Well, we're starting that process."

If it's a start, it's largely a ceremonial one. The Affordable Care Act remains the law of the land, and none of the proposed changes would substantially alter its main provisions. The executive order could result in higher insurance premiums for some Obamacare customers and lower premiums for less regulated coverage for those who want to try new insurance options. It could cause some insurers to exit some markets in the long-term.

But the rules governing Obamacare insurance, the subsidies to help middle-income people buy it, the expansion of Medicaid to more poor adults, and Obamacare's many other provisions touching health and health insurance remain the law.

The executive order could result in real changes for some people in the insurance market. But those changes are not the same thing as eliminating the health care law.

**Did *any* laws change?**

Not yet. The executive order has no force of law itself. It instead asked three federal agencies to consider possible new regulations that could help achieve certain goals. It is not clear what those rules will say. Generally, issuing new regulations takes several months, including a period of public comment.

None of the proposed changes to regulation are specifically tied to Obamacare. But they would alter the rules for parts of the insurance system that the Affordable Care Act didn't touch, as a way of offering more Americans access to those types of insurance.

If you are insured by a large company that offers insurance, there should be few effects. But the order might make it easier for your employer to give you pretax money if you want to buy your own insurance.

If you work for a small business, the executive order could cause major changes to your plan. The order asks the Labor Department to loosen rules that permit small companies to band together to form associations and buy the kind of coverage available to larger businesses. These association health plans would be governed by federal employment law, not state insurance regulations.

That means that the plans would have far fewer rules about generosity or benefits. State insurance regulators might also have more trouble making sure that the insurers have enough money to pay their members' medical bills. Such association health plans, before 1983, when rules were looser, **were rife with fraud.**

Businesses that are unable or unwilling to join such associations might face higher premiums in the Obamacare market. The kinds of companies that are likely to fare better in an association plan are probably those with relatively healthy employees. That means that businesses that remain in the normal small business market may end up having sicker and more expensive workers, on average, increasing premiums….**Read More**

## Trump to end key ACA subsidies, a move that will threaten the law's marketplaces

President Trump is throwing a bomb into the insurance marketplaces created under the Affordable Care Act, choosing to end critical payments to health insurers that help millions of lower-income Americans afford coverage. The decision coincides with an executive order on Thursday to allow alternative health plans that skirt the law's requirements.

The White House confirmed late Thursday that it would halt federal payments for cost-sharing reductions, although a statement did not specify when. Another statement a short time later by top officials at the Health and Human Services Department said the cutoff would be immediate. The subsidies total about $7 billion this year.

Trump has threatened for months to stop the payments, which go to insurers that are required by the law to help eligible consumers afford their deductibles and other out-of-pocket expenses. But he held off while other administration officials warned him such a move would cause an implosion of the ACA marketplaces that could be blamed on Republicans, according to two individuals briefed on the decision...**Read More**

**RI Congressional Members**

**Senator Jack Reed…**

Reed Criticizes Trump's Latest Plan to Sabotage ACA.

**Senator Whitehouse**…

"This isn't a reality TV show; this is Americans' health care. Stop trying to sabotage the health care market ."

**Congressman Langevin…**

"I strongly condemn the President's reckless actions."

**Congressman Cicilline…**

"This executive order will sabotage the health care market and drive up costs for working people."

**See complete statements**

# Social Security Announces 2.0 Percent Benefit Increase for 2018

Monthly Social Security and Supplemental Security Income (SSI) benefits for more than 66 million Americans will increase 2.0 percent in 2018, the Social Security Administration announced today.

The 2.0 percent cost-of-living adjustment (COLA) will begin with benefits payable to more than 61 million Social Security beneficiaries in January 2018. Increased payments to more than 8 million SSI beneficiaries will begin on December 29, 2017. (Note: some people receive both Social Security and SSI benefits) The Social Security Act ties the annual COLA to the increase in the Consumer Price Index as determined by the Department of Labor's Bureau of Labor Statistics.

Some other adjustments that take effect in January of each year are based on the increase in average wages. Based on that increase, the maximum amount of earnings subject to the Social Security tax (taxable maximum) will increase to $128,700 from $127,200. Of the estimated 175 million workers who will pay Social Security taxes in 2018, about 12 million will pay more because of the increase in the taxable maximum.

Information about Medicare changes for 2018, when announced, will be available at **www.medicare.gov**.

The Social Security Act provides for how the COLA is calculated. To read more, please visit **www.socialsecurity.gov/cola**.

# 2018 SOCIAL SECURITY CHANGES

**Cost-of-Living Adjustment (COLA):**

Based on the increase in the Consumer Price Index (CPI-W) from the third quarter of 2016 through the third quarter of 2017, Social Security and Supplemental Security Income (SSI) beneficiaries will receive a 2.0 percent COLA for 2018. Other important 2018 Social Security information is as follows:

| Tax Rate | 2017 | 2018 |
|---|---|---|
| Employee | 7.65% | 7.65% |
| Self-Employed | 15.30% | 15.30% |

**NOTE:** The 7.65% tax rate is the combined rate for Social Security and Medicare. The Social Security portion (OASDI) is 6.20% on earnings up to the applicable taxable maximum amount (see below). The Medicare portion (HI) is 1.45% on all earnings. Also, as of January 2013, individuals with earned income of more than $200,000 ($250,000 for married couples filing jointly) pay an additional 0.9 percent in Medicare taxes. The tax rates shown above do not include the 0.9 percent.

| | 2017 | 2018 |
|---|---|---|
| **Maximum Taxable Earnings** | | |
| Social Security (OASDI only) | $127,200 | $128,700 |
| Medicare (HI only) | No Limit | |
| **Quarter of Coverage** | | |
| | $1,300 | $1,320 |
| **Retirement Earnings Test Exempt Amounts** | | |
| Under full retirement age | $16,920/yr. ($1,410/mo.) | $17,040/yr. ($1,420/mo.) |
| NOTE: One dollar in benefits will be withheld for every $2 in earnings above the limit. | | |
| The year an individual reaches full retirement age | $44,880/yr. ($3,740/mo.) | $45,360/yr. ($3,780/mo.) |
| NOTE: Applies only to earnings for months prior to attaining full retirement age. One dollar in benefits will be withheld for every $3 in earnings above the limit. | | |
| Beginning the month an individual attains full retirement age. | None | |

**Continued on next page**

# 2018 SOCIAL SECURITY CHANGES

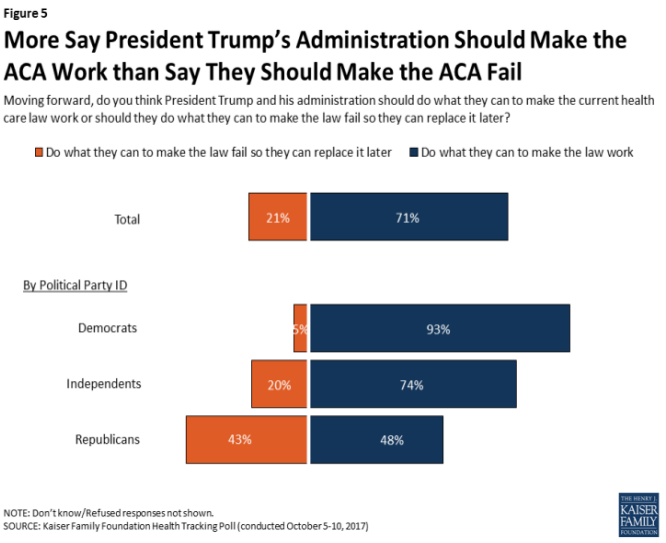
| | 2017 | 2018 |
|---|---|---|
| **Social Security Disability Thresholds** | | |
| **Substantial Gainful Activity (SGA)** | | |
| **Non-Blind** | **$1,170/mo.** | **$1,180/mo.** |
| **Blind** | **$1,950/mo.** | **$1,970/mo.** |
| **Trial Work Period (TWP)** | **$ 840/mo.** | **$ 850/mo.** |
| **Maximum Social Security Benefit: Worker Retiring at Full Retirement Age** | | |
| | **$2,687/mo.** | **$2,788/mo.** |
| **SSI Federal Payment Standard** | | |
| **Individual** | **$ 735/mo.** | **$ 750/mo.** |
| **Couple** | **$1,103/mo.** | **$1,125/mo.** |
| **SSI Resource Limits** | | |
| **Individual** | **$2,000** | **$2,000** |
| **Couple** | **$3,000** | **$3,000** |
| **SSI Student Exclusion** | | |
| **Monthly limit** | **$1,790** | **$1,820** |
| **Annual limit** | **$7,200** | **$7,350** |
| **Estimated Average Monthly Social Security Benefits Payable in January 2018** | | |
| | **Before 2.0% COLA** | **After 2.0% COLA** |
| **All Retired Workers** | **$1,377** | **$1,404** |
| **Aged Couple, Both Receiving Benefits** | **$2,294** | **$2,340** |
| **Widowed Mother and Two Children** | **$2,717** | **$2,771** |
| **Aged Widow(er) Alone** | **$1,310** | **$1,336** |
| **Disabled Worker, Spouse and One or More Children** | **$2,011** | **$2,051** |
| **All Disabled Workers** | **$1,173** | **$1,197** |

# While Trump Moves To Dismantle Health Law, Public Favors Repair

President Donald Trump has collided with a wave of public disagreement by moving to strip the Affordable Care Act of provisions intended to keep insurance prices stable.

In a **poll conducted before Trump's Thursday announcement** of unilateral changes to the law, 71 percent of the public said they preferred the administration try to make the law work rather than to hasten replacement by encouraging its failure. Even Republicans, by a small margin, favored a more conciliatory approach to the law, according to the poll from the Kaiser Family Foundation. (Kaiser Health News is an editorially independent program of the foundation.)

Trump took the opposite tact Thursday, in the wake of Congress' failure to replace the 2010 law. He announced two actions that are likely to disrupt the insurance markets for people who buy their policies on their own rather than through their employers. ..**Read More**



## Social Security Giveth, Medical Costs Taketh Away

Retirees spent on average more than a third of their Social Security benefits on out-of-pocket medical costs in 2014, **according to a recent study.** Even after factoring in other sources of income, medical spending still took a substantial 18 percent bite out of seniors' total retirement income, the study found.

In dollar terms, the typical retiree spent $4,274 per year on medical costs, not including long-term care. Insurance premiums accounted for about two-thirds of that total, according to the study, published this month by the Center for Retirement Research at Boston College.

"The premiums are huge," said Melissa McInerney, an associate professor of economics at Tufts University and a study co-author, describing their importance in overall spending by retirees.

McInerney said she was surprised at the findings, however, when the team did incorporate spending on long-term care and found little difference in spending between seniors who needed those services and those who didn't. Survey respondents who said they or their spouse lived in a long-term care facility or received home health care services spent 19.2 percent of their total income on medical care, versus 17.8 percent for those who didn't need long-term care.

For the study, researchers analyzed 2002-2014 data from the **Health and Retirement Study,** a national survey conducted every two years of 20,000 people over age 50. The sample was limited to people at least 65 years old and were receiving both Social Security and Medicare benefits. It included those who also had Medicaid, Medicare Advantage or private group retiree health insurance.

Overall, the average retiree's out-of-pocket medical spending declined 9 percent over the years studied from just under $4,700 in 2004 (in 2014 dollars) to $4,274 in 2014. That's likely due in part to the introduction of Medicare Part D prescription drug coverage in 2006 and the gradual closing of the drug coverage gap known as the "doughnut hole" that began in 2010 under the Affordable Care Act, the study found….**Read More**

## Trump Acting Solo: What You Need To Know About Changes To The Health Law

Apparently frustrated by Congress' inability to "repeal and replace" the Affordable Care Act, President Donald Trump this week decided to take matters into his own hands.

Late Thursday evening, the White House announced it would cease key payments to insurers. Earlier on Thursday, Trump signed an **executive order** aimed at giving people who buy their own insurance easier access to different types of health plans that were limited under the ACA rules set by the Obama administration.

"This is promoting health care choice and competition all across the United States," Trump said at the signing ceremony. "This is going to be something that millions and millions of people will be signing up for, and they're going to be very happy."

The subsidy payments, known as "cost-sharing reductions," are payments to insurers to reimburse them for discounts they give policyholders with incomes under 250 percent of the federal poverty line, **or about $30,000 in income a year** for an individual. Those discounts shield these lower-income customers from out-of-pocket expenses, such as deductibles or copayments. These subsidies have been the subject of a lawsuit that is ongoing.

The cost-sharing reductions are separate from the tax credit subsidies that help millions of people pay their premiums. Those are not affected by Trump's decision.

Some of Trump's actions could have an immediate effect on the enrollment for 2018 ACA coverage that starts Nov. 1. Here are five things you should know….**Read More**

## Medicare Rights Center Identifies Enrollment Gaps for People Transitioning to Medicare from Expansion Medicaid


After the Affordable Care Act (ACA) gave states the option to expand their Medicaid programs to cover certain low-income adults who are not eligible for Medicare, 32 states decided to cover this population. The report—developed with support from the **National Council on Aging** (NCOA) through a cooperative agreement from the Administration for Community Living—covers the promising practices used in some states that other states might adopt. The report also examines hurdles that states will work through in their own ways, seeking the most seamless coverage possible for millions of lower-income older adults and people with disabilities.

Whenever individuals must transition from one system to another, challenges inevitably arise. That so many states are finding promising ways to aid people in transitioning seamlessly to Medicare from expansion Medicaid is cause for optimism, but it is clear that there is much to do to improve these transitions.

Drawing on months of interviews with targeted states, Medicare Rights identified three key parts of the transition process for those moving from expansion Medicaid to Medicare, each with its own state-specific promising practices and challenges:

1. Identification of expansion Medicaid beneficiaries transitioning to Medicare
2. Beneficiary communications
3. Determinations and redeterminations for Original Medicaid and Medicare Savings Program eligibility

...**Read More**

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# A Few Pointers To Help Save Money And Avoid The Strain Of Medicare Enrollment


Older or disabled Americans with Medicare coverage have probably noticed an uptick in mail solicitations from health insurance companies, which can mean only one thing: It's time for the annual Medicare open enrollment.

Most beneficiaries have from Oct. 15 through Dec. 7 to decide which of dozens of private plans offer the best drug coverage for 2018 or whether it's better to leave traditional Medicare and get a drug and medical combo policy called Medicare Advantage.

Some tips for the novice and reminders for those who have been here before can make the process a little easier.

**Pay Attention To The Mail**

If you are already enrolled in a Medicare Advantage or drug plan, carefully read the "annual notice of change" or "evidence of benefits" letter from the insurer. It is not another sales pitch or more insurance mumbo-jumbo. That required letter highlights the cost and benefit changes in store for next year. Ask the insurer for another copy if you can't find it.

"Some people just tend to get that mail and throw it all in the trash, but it's really important that they read it," said Francine Chuchanis, director of entitlement rights at Direction Home Akron Canton Area Agency on Aging & Disabilities, an Ohio group that assists older adults and people with disabilities.

**Choosing Between Traditional Medicare and Medicare Advantage**

The open enrollment period is your opportunity to switch plans, including moving between the government-run traditional Medicare program and Medicare Advantage.

Medicare Advantage plans are offered by private insurers, which receive payments from the federal government to help cover the costs of beneficiaries. They restrict members to their network of doctors and hospitals and a list or formulary of covered drugs. With some rare exceptions, you cannot leave the plans midyear — even if the plans drop drugs from the formulary or your hospitals, physician specialists or medical equipment suppliers leave the plan.

But unlike traditional Medicare, Medicare Advantage plans often cover dental, hearing and vision care, and they cap your out-of-pocket expenses. Once you reach that limit, the insurer pays for covered services, and you pay nothing. But details of these plans — such as the caps on member spending, the premium prices and service areas — can change from year to year.

On the other hand, with traditional Medicare, patients can go to any provider who participates in the program, and most providers do. Because there is no limit on the share of medical expenses beneficiaries pay, most purchase "Medigap" supplemental policies or have other insurance to lower those costs.

**Check Your Plan's Network**

If you choose Medicare Advantage, contact your doctors, hospital and other providers directly to find out if they are in the plan's network. Be sure to give the office the plan's full name, not just the name of the insurance company since insurers offer multiple plans that may have similar names, said Gina Upchurch, executive director of Senior PharmAssist in Durham, N.C. If you have the plan's code numbers, she said, those can help the doctor's office check.

**Confirm Where Your Drugs Are Available**

When choosing a drug plan, also known as Medicare Part D, the total costs are most important. Consider factors beyond the premiums. You may pay different amounts when the plan first begins each year than when you're in the coverage gap called the **doughnut hole** and after you get out of that hole. Find out whether the lowest price is available at your favorite pharmacy or if you must travel elsewhere to get that price. Most plans offer their lowest prices only at their preferred, in-network pharmacies.

Also, ask what other restrictions apply. For example, do you need prior authorization or have to try another drug first before you can get the one your doctor prescribed? Also, will the price vary depending on the frequency or the quantity of your prescription?

"You can save thousands of dollars just by switching pharmacies," said Christina Dimas-Kahn, director of the San Mateo County office of the California Department of Aging's Health Insurance Counseling and Advocacy Program. That's because drug plan prices can depend on whether a drugstore is a preferred pharmacy within the plan's network. She helped a senior reduce his drug bill last year from $119,000 to $18,000 after changing pharmacies.

**Do You Qualify For A Subsidy?**

Low-income people can qualify for the "extra help" subsidy that pays for the premiums of certain drug plans and other costs. They may also be eligible for assistance to reduce their share of medical costs in traditional Medicare. Premiums and subsidy amounts **can change each year,** so if you already have the subsidy confirm that it is enough to cover the plan's premium next year. Otherwise, you can be billed for the difference.

**Check The Calendar**

There's a lot to consider and only seven weeks to do it. And remember, this enrollment period is different from the Affordable Care Act's marketplace enrollment, which begins Nov. 1 and lasts through Dec. 15.

Federal officials have granted seniors who **live in areas affected by this year's hurricane damage** — Alabama, Florida, Georgia, Louisiana, Mississippi, South Carolina, Texas, Puerto Rico and the U.S. Virgin Islands — or depend on caregivers in those areas until the end of December to make their choices.

**Getting Help**

Individual assistance is free from the federally funded Senior Health Insurance Information Program (**www.shiptacenter.org),** the Medicare Rights Center (800-333-4114 and its website Medicare Interactive (**www.medicareinteractive.org**) as well as from Medicare's plan finder website and helpline (**www.medicare.gov**, 800-633-4227) .

Still, studies have shown that most Medicare beneficiaries don't switch plans.

"They are likely to stay with whatever plan they're in because they are afraid to make a change," said Bonnie Burns, a consultant for California Health Advocates.

# RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

## Rheumatoid arthritis could be treated with a novel hydrogel

A simple yet effective new treatment for rheumatoid arthritis may be in sight; researchers have now created a hydrogel that could absorb the excess joint fluid that arises with disease, as well as deliver medications to affected joints.

Created by researchers from the Institute for Basic Science (IBS) in the Republic of Korea, the gel works by responding to nitric oxide, which is a gas that has been **linked** to the development of **rheumatoid arthritis**.

The team recently **reported** the details of their novel hydrogel in the journal *Advanced Materials*.

Rheumatoid arthritis is an autoimmune disorder estimated to affect around **1.5 million people** in the United States. According to the Arthritis Foundation, rheumatoid arthritis is almost **three times more common** among women than men, and women are likely to develop the condition at an earlier age.

In rheumatoid arthritis, the immune system mistakingly attacks healthy joint tissue, primarily in the joints of the hands, wrists, elbows, knees, ankles, and feet.

This can lead to a buildup of synovial fluid. While synovial fluid normally helps to lubricate the joints and make it easier for us to move, an excess of this fluid can cause swelling and pain.

Previous **studies** have suggested that nitric oxide is a key player in rheumatoid arthritis.

"Nitric oxide is like a double-edge sword," explains study leader Won Jong Kim, of the Center for Self-Assembly and Complexity at IBS. "It regulates **inflammation** and protects our body by killing external pathogens.

"However," he adds, "when in excess, it is toxic and may cause RA [rheumatoid arthritis], as well as other autoimmune diseases, cardiovascular diseases, and cancer."...**Read More**

## How a green tea compound could prevent Alzheimer's

Studies have tied green tea to a reduced risk of Alzheimer's, but the mechanisms underlying this link have been unclear. Now, a new study reveals how a compound in the popular beverage disrupts the formation of toxic plaques that contribute to the disease.

Researchers found that the green tea polyphenol epigallocatechin gallate (EGCG) stops the formation of beta-amyloid plaques — a hallmark of **Alzheimer's disease** — by interfering with the function of beta-amyloid oligomers.

Lead study author Giuseppe Melacini, of the Departments of Chemistry and Chemical Biology at McMaster University in Canada, and colleagues recently reported their **findings** in the *Journal of the American Chemical Society*.

Alzheimer's disease is a progressive neurodegenerative condition characterized by a decline in memory and thinking, as well as behavioral problems.

It is estimated that almost **50 million people** worldwide are living with the disease. By 2050, this number is expected to rise to 131.5 million.

The precise causes of Alzheimer's disease remain unclear, but it is believed that beta-amyloid plays a key role. This "sticky" protein can clump **together, forming plaques that** disrupt communication between nerve cells.

The new study from Melacini and his team sheds light on how EGCG could help to prevent beta-amyloid plaque formation, bringing us closer to much-needed prevention strategies for Alzheimer's disease. ...**Read More**

## Cascade of Costs Could Push New Gene Therapy Above $1 Million Per Patient

Outrage over the high cost of cancer care has focused on skyrocketing drug prices, including the $475,000 price tag for the country's first gene therapy, **Novartis' Kymriah**, a leukemia treatment **approved in August**.

But the total costs of Kymriah and the **21 similar drugs** in development — known as CAR T-cell therapies — will be far higher than many have imagined, reaching $1 million or more per patient, according to leading cancer experts. The next CAR T-cell drug could be approved as soon as November.

Although Kymriah's price tag has "shattered oncology drug pricing norms," said Leonard Saltz, chief of gastrointestinal oncology at Memorial Sloan Kettering Cancer Center in New York, "the sticker price is just the starting point."

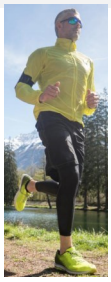
These therapies lead to a cascade of costs, propelled by serious side effects that require sophisticated management, Saltz said. For this class of drugs, Saltz advised consumers to "think of the $475,000 as parts, not labor."

Dr. Hagop Kantarjian, a leukemia specialist and professor at the University of Texas MD Anderson Cancer Center, estimates Kymriah's total cost could reach $1.5 million.

CAR T-cell therapy is expensive because of the unique way that it works. Doctors harvest patients' immune cells, genetically alter them to rev up their ability to fight cancer, then reinfuse them into patients.

Taking the brakes off the immune system, Kantarjian said, can lead to life-threatening complications that require lengthy hospitalizations and expensive medications, which are prescribed in addition to conventional cancer therapy, rather than in place of it….**Read More**

## Exercise does not prevent blocked arteries, study finds



A long-term study including more than 3,000 participants made an unexpected find: white men who spend more than 7 hours exercising each week are most at risk of developing coronary artery calcification.

Coronary artery calcification (CAC) is a condition characterized by a buildup of plaque in the main vessels that supply blood to the heart.

This condition can lead to a wealth of **cardiovascular problems**, including the poor circulation of blood to and from the heart, depending on the severity of plaque buildup in the arteries.

According to **available data**, CAC is more common in men than it is in women, and it usually develops late in life. Some populations considered to be "at risk" of developing CAC are individuals with a higher body mass index (BMI), those with **hypertension**, and people with **chronic kidney disease**.

A new study conducted by researchers from the University of Illinois at Chicago (UIC) and the Kaiser Permanente in Oakland, CA, has now looked at the impact of physical exercise on the likelihood of developing CAC.

Dr. Deepika Laddu, from the UIC, and her colleagues made some surprising **findings**, which were reported earlier this week in the journal *Mayo Clinic Proceedings*.

The team recruited 5,115 participants through the **Coronary Artery Risk Development in Young Adults** study between March 1985 and June 1986. The baseline cohort included both black and white men and women, all of whom were aged between 18 and 30. ...**Read More**

## Under 2 hours of walking per week may considerably prolong life

A new study published in the *American Journal of Preventive Medicine* suggests that even a little walking can significantly reduce mortality risk, compared with inactivity.

The Physical Activity Guidelines for Americans **recommend** that adults engage in at least 150 minutes of moderate physical activity, or 75 minutes of intense physical activity, each week to reap "substantial" health benefits.

Some of these **benefits** include a reduced risk of premature death, cardiovascular diseases such as **coronary heart disease** and **stroke, cancer**, **type 2 diabetes**, and **osteoporosis**.

**Mental health** is also believed to benefit from a more active lifestyle, as exercise improves cognitive function and reduces the likelihood of having **depression.**

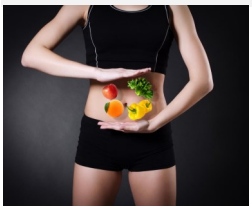
The Guidelines also emphasize the fact that "some physical activity is better than none" — and a **new study** further strengthens this message.

The research, led by Alpa V. Patel, Ph.D., strategic director of the Cancer Prevention Study-3 for the American Cancer Society (ACS), focuses on the most common and accessible form of physical activity: walking.

The study found that even levels of walking that do not meet the national recommendations still lower the risk of premature death by a considerable amount.

Dr. Patel and her research team examined data from almost 140,000 people who took part in the Cancer Prevention Study II Nutrition Cohort. Of the participants, 6–7 percent said that they did not take part in any moderate or vigorous physical activity at the beginning of the study. ...**Read More**

## A healthy gut means healthy aging



Extremely healthy seniors appear to have the same bacterial composition in their guts as healthy 30-year-olds, shows new research.

The **new study** was carried out by researchers at the Lawson Health Research Institute of Western University in Ontario, Canada, in collaboration with those at the Tianyi Health Science Institute in Zhenjiang, China.

The scientists analyzed the gut microbiota of more than 1,000 very healthy individuals aged between 3 and 100 years, and the findings were published in the journal *mSphere*.

Greg Gloor, a professor at Western University's Schulich School of Medicine & Dentistry, is the senior investigator of the study. The first author of the paper is Gaorui Bian, of the Tianyi Health Science Institute.

### Gut bacteria in the young and the elderly

Bian and colleagues used **16S Ribosomal RNA sequencing** to analyze the microbial composition of the participants' guts.

The participants were selected based on criteria of "extreme health." These included no reported disease, either in themselves or in their family.

Participants did not smoke, did not consume any alcohol, had no reported moodiness, and had not been prescribed any drugs or **antibiotics** in the 3 months leading up to the study.

They also had no family history of major cardiometabolic, gastrointestinal, or neurological diseases.

**The study yielded several main findings. Firstly, the microbial composition of the extremely healthy seniors resembled that of those who were also healthy but decades younger.** ...**Read More**

**Petition Subject: Elimination of the Unfair GPO and WEP Provisions of the Social Security Act**

ADD YOUR NAME

**Get The Message Out: SIGN THE PETITION!!!!!**

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