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# The condition of nation's healthcare is making her sick

By *Sondra L. Shapiro*

**O**n the day I turned 50 almost seven years ago, I couldn't have imagined suffering the ensuing laundry list of aches and maladies.

Stiff joints when I drag myself off the couch to grab a snack during nightly TV viewing, weight gain even though I still eat sensibly and regularly exercise, difficulty with the glare of headlights when I drive at night. The list goes on and on.

But when it comes to making me feel the harsh reality of advancing age, nothing compares with those yearly increases in my health insurance premiums.

Though I am certainly not the same spry woman I was 10 years ago, I am probably healthier and in better shape than most Americans half my age — a fact that makes little difference to my health insurer, who raised my rates by 38 percent this year.



*Just My Opinion*

Since I have worked for the same company for 30 years, and with mostly the same co-workers, we are now branded an "old" company by the insurance industry. Because I am getting so expensive to insure, my employer can no longer foot the bill entirely for my insurance. So each year I pay more and more out of pocket while getting less and less for my money. To keep my insurance premiums relatively reasonable, our company is forced to purchase policies with higher deductibles. So, I am responsible for a good chunk of change for even yearly routine medical tests.

In this or in any economy, the extra expense is tough to swallow. Yet across the country, insured working households who buy their own coverage are reporting double-digit premium increases. So those of us who are being singled out for those escalating premium costs should know what's at stake if we don't get a decent healthcare reform law, soon.

Just last month the health insurers submitted to the state the following premium request increases: Blue Cross-Blue Shield, 10 to 19 percent; Harvard Pilgrim Health Care, 8 to 12 percent; Tufts Health Plan an average 15 percent; and Fallon Community Health Plan, 18 to 32 percent. In some cases, these numbers are even higher for individuals and small business, depending on average age and other factors.

While watching the nightly news recently I saw a worker, not much younger than me, complaining that his health insurance premium has almost doubled over the last couple of years. He is a member of WellPoint Anthem Blue Cross, which raised individual insurance plans by as much as 39 percent.

Billionaire Warren Buffett, who describes healthcare costs as an "economic tape worm," and a major drain on U.S. businesses, said the nation's healthcare system needs fundamental reform to attack costs

because it's not practical to continue devoting roughly 17 percent of the U.S. gross domestic product (GDP) to healthcare.

We should be ashamed and dismayed that the rest of the world pays only 9 percent of GDP for healthcare, and has more doctors and nurses per person.

The cost inequities to individuals alone should have voters demanding reforms. One would think that aging Americans especially would be clamoring for change when you consider the following:

- Millions of seniors who signed up for Medicare Advantage, private health plans through Medicare, are facing premium increases of 14.2 percent this year, after an increase of only 5.2 percent the previous year, according to a newly released Avalere study.

Avalere, which analyzes Medicare financial data for government and private foundations, reports the upsurge in premium costs is because the feds cut payments to private plans last year.

- The average yearly cost of long-term care in the Boston area is rather steep: Home health care, \$28,600; assisted living, \$51,480; and nursing home care, \$105,485, according to 2008 federal figures.

The best way to pay for this kind of care for middle-class individuals is to purchase long-term care insurance. The premiums can be costly depending on the age you are when you jump in, the level of benefits you purchase, and the amount of time you wait to cash in on those benefits.

According to the American Association for Long-Term Care Insurance, a policy that pays out \$100 a day for three years would cost an average 55-year-old \$709 in annual premiums, and \$1,342 for a 65-year-old.

I always intended to purchase long-term-care insurance when I turned 55, but this economy combined with my larger out-of-pocket expenses for healthcare forced me to put it on the backburner.

The reticence among older Americans is a result of Republican fear mongering. The message being spread is that reform will result in cuts in the care they receive under Medicare (Advantage programs), which is negligibly accurate, since Democrats would also reinforce original Medicare by improving preventive benefits and narrowing the prescription coverage gap. And, since about three-fourths of Medicare recipients remain in the traditional program, I'd say there's more to gain under health reform for seniors.

Now let's address the back-and-forth volley of blame for the state of healthcare, which is giving me whiplash. And, I don't have the extra cash right now to visit a chiropractor.

Individuals complain about the status quo without bothering to educate themselves about the cost of care or even ways to take care of themselves.

Politicians play partisan games — each party blaming the other for the mess.

Insurers complain about the price they are forced to shell out for care and unrealistic government regulations.

Hospitals complain they don't get paid

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# Report: Can state provide assisted living to aging population?

By Brian Goslow

BOSTON —

The bad economy has dealt a double whammy to another segment of the housing market in Massachusetts. Aging boomers who will someday need supportive housing to remain living independently, may find their access limited. Not only is there less supply, but those contemplating a move may find themselves without the resources to pay for it.

A recent Harvard Medical School (HMS) study found Massachusetts has less than half the supply of assisted living units available to its elderly population than the national average.



Plumb



Stevenson



Hartstein

According to the findings of "Sizing Up the Market for Assisted Living," as of 2007, there were 163 assisted living facilities with a total of 11,364 units in Massachusetts. The report, by assistant professors of health policy at Harvard David G. Stevenson and David C. Grabowski, found that 13 out of every 1,000 state residents 65 or older live in an assisted living facility.

Massachusetts Assisted Living Facilities Association (MassALFA) president and executive director Emily Meyer said there are more than enough spaces to meet current demand, with seven new buildings having opened in 2009. "I don't think that many will be opening in the next year," Meyer said. "It's hard to predict five to 10 years from now, but they certainly are opening."

New facilities won't be coming online in dramatic numbers soon. The economic downturn, which has affected all segments of the construction business, is one reason. Another is Massachusetts was late to the table in building assisted living complexes.

"We didn't begin regulating them till 1994 when a bill (I wrote) was passed in the legislature," said Massachusetts Senior Care Association Vice President Scott Plumb. "Up until that time, no one knew how they would be regulated so they didn't build them here. They didn't know what model would be the standard here, medical or social."

Chapter 19D of the Mass. General Laws govern assisted living residences. The

Executive Office of Elder Affairs (EOEA) certifies and regulates the facilities, utilizing the assisted living statute and related regulations to provide a process for certification for assisted living units and services, as well as issuing minimum standards and guidelines. The EOEA also offers the Assisted Living Ombudsman Program to provide advocacy, information and complaint resolution to consumers.

Plumb said unlike other states that aren't as heavily regulated, Massachusetts has 40 to 50 pages of regulations and requirements that must be met to operate an assisted living facility. "Ours is not a medical model but it's not the Wild Wild West either," he said.

Assisted Living Residences (ALRs) offer a combination of housing, meals and personal care services to adults on a rental basis. Unlike licensed nursing facilities, ALRs do not provide medical or nursing services — those must be secured privately, if needed. Nor are they designed for people who need extensive medical care.

Rather, assisted living is intended for adults who need some help with activities such as housecleaning, meals, bathing, dressing and/or medication reminders and who would like the security of having assistance available on a 24-hour basis in a non-institutional environment.

"You're renting an apartment and getting your own personal care services," Meyer said. "It's a residential model with services." The average age of assisted living residents here is 84, 85 years old.

Assisted living offers qualitatively different facilities than nursing homes, Stevenson said. "They (residents) can have their own rooms, locking doors and a greater level of privacy. It's more home-like in construction. It can feel less institutional but it varies a lot from facility to facility."

These varying services are the result of its owners shaping their services to market demands. "The challenge is there's no one definition of assisted living," Stevenson said. "There can be a wider range of what assisted living facilities are across the state."

But when it comes to requiring a more uniform format, Stevenson noted, "Increased oversight and the standardization of what you see in assisted living facilities could cause the loss of flexibilities and new innovations going into place that the consumer would like to see."

The Harvard study found that Massachusetts assisted living facilities tend to be located in wealthier areas with high home values and lower minority numbers. Developers, who already have to deal with the high cost of land here, only build where they expect to operate at a profit.

The first facilities, Plumb said, were built in affluent communities, including Swansea,

Wellesley, Needham and Lexington, where clients had the resources for the private model. They were followed by a second generation of facilities further outside greater Boston in Peabody, Shrewsbury and Quincy. The latter had lower entrance deposits. With a lower number of high-income residents, Western Massachusetts has few assisted living facilities.



"If you have daily care needs, you're not supposed to be accepted into assisted living," Plumb said.

EOEA Secy. Ann Hartstein said assisted living facilities try their best to inform people on what they do offer but people don't always hear what they're telling them.

This can include thinking they'll receive long-term care there, covered by Medicare.

That's not the case. "They can't be the primary provider of helping people with their medication," she said. "They can cue them but they can't give them their meds. They (the residents) think they'll be monitored but it's not their (the facility's) responsibility. Many assisted living facilities have outside services coming in that look like they're from inside the house (facility) but it's an outside provider hired to come in. It's why there's some confusion."

Hartstein didn't feel the huge difference in assisted living units available here in com-

parison to other states noted in the Harvard study was relevant to Massachusetts' ability to provide the services its residents will require as they age. "The number of assisted living that exists in the state is based on private market conditions and what the needs are," she said. "The developers define what they'll build based on population, market and because they see a demand for them."

Massachusetts, she said, is certainly working to keep people in their homes through a series of initiatives directly addressing the shortage of assisted living options for low-income residents. "We're trying to make assisted-living type services available to lower income residents through group adult foster care programs," Hartstein said. "SSIG (Supplemental Security Income, a joint federal and state program administered by the Massachusetts Department of Transitional Assistance) is available to help people of low income go into assisted living but it's up to the facilities to accept program participants and let lower-income people into their facility."

The Supportive House Initiative, developed by the EOEA and Department of Housing and Community Development, provides residents at 22 state-funded elderly and disabled housing facilities with the services they would get in an assisted living facility, including case management; 24-hour personal care, as needed, onsite; an on-call person for emergencies; and at least one meal per day. "These are ways to provide services to people in their own homes that they're getting in facilities so they can age-in-place in their own homes," Hartstein said.

Assisted living facilities are not cheap alternatives to nursing homes. "It's unaffordable to the majority of elders," said Plumb. Some have entrance fees of as much as a half-million dollars. Prior to the housing market crash, potential residents could sell their homes to cover the cost. With so many having trouble selling their homes, many assisted living facilities have moved to an "à la carte model" with a basic monthly charge. "The other services you need as you get frail, are add-ons," Plumb said.

According to MassALFA's Assisted Living in Massachusetts Resource and Consumer Guide, monthly assisted living fees range from about \$2,000 to more than \$7,000; the high-end fee usually covers the cost of special care units and programs for people with memory loss and/or dementia that require additional staffing and services.

While most assisted living is privately paid (in Massachusetts, the numbers are 85 to 90 percent), some long-term care insurance policies now offer coverage for some of the costs. Coverage provisions vary widely, so anyone considering this option should carefully review different policies. Some assisted living residences have financial assistance programs.

As boomers begin seeking assisted living, they probably will have different expectations of what they want from those facilities. "Boomers will have more resources and be more demanding," Plumb said. "They'll want choices: privacy, their own apartment and a kitchen. They'll demand to age-in-place. If they demand skilled care, that demand will (cause the industry to) become more medical."

This is where the line between assisted living and nursing homes becomes clearer.

For more information: [www.massalfa.org](http://www.massalfa.org); [www.mass.gov/elder](http://www.mass.gov/elder)

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# Affordable housing law under attack

BOSTON —

Opponents of the state's affordable housing zoning law (Chapter 40B) are pursuing a ballot initiative to eliminate this landmark legislation. They have gathered enough signatures to put the repeal on the November 2010 ballot.

This would immediately halt the creation of housing that is affordable to modest income families and seniors in most areas of the Commonwealth and will jeopardize the future economic prosperity of our state. This comes at a time of high unemployment, a severe recession, growing homelessness and the worst foreclosure crisis on record.

With the election seven months away, an effort is underway to defeat the repeal. A group of more than 125 civic and business leaders, academics, religious leaders, senior and disability organizations, environmentalists,



Galvin

housing and civil rights advocates, affordable housing residents and municipal officials have formed a ballot committee called the Committee Against Repealing the Housing Law. Mass Home Care has joined this effort to protect Chapter 40B. Organizers say this will be the most diverse coalition ever assembled around the issue of affordable housing in Massachusetts.

In December 2009, Secretary of State William Galvin certified that the petitioners had collected at least 66,593 registered voter signatures. The measure has been sent to the Legislature, which approves or disapproves the measure, proposes a substitute or takes no action. Unless the Legislature has enacted the measure by May 5, the proponents must gather an additional 11,099 signatures by early July. If enough signatures are gathered, the measure would be placed on the Nov. 2 ballot.

Chapter 40B, the state's affordable housing zoning law, was enacted in 1969 to address local zoning and land use restrictions that make it impossible or economically infeasible to build affordable housing under existing local zoning. Numerous studies have shown that these restrictions (large-lot zoning and the prohibition of multi-family housing) are responsible for high housing costs, low levels of housing production and increased sprawl. Today, less than 1.5 percent of land in eastern Massachusetts is zoned for multi-family.

Chapter 40B enables local Zoning Boards of Appeals (ZBAs) to approve affordable housing developments under flexible rules if at least 20-25 percent of the

units have long-term affordability restrictions. The goal is to encourage the production of affordable housing throughout Massachusetts and to help communities meet the standard of providing a minimum of 10 percent of their housing inventory as affordable.

Housing is expensive in Massachusetts for many reasons, including the fact that the housing supply has not kept pace with housing demand — particularly for working families. 40B serves households with a broad range of needs, including the elderly, people with disabilities, municipal employees, veterans and households with and without children.

The state's definition of affordable housing says that a family should not have to spend more than 30 percent of its income on housing costs. According to Chapter 40B supporters, the following facts illustrate the importance of keeping the program on the books:

- Median household income in Massachusetts: \$82,000 (October 2009).

- A family of four with annual income of \$65,000 can afford a \$180,000 home.

- The statewide median single family home sale price: \$285,000 (September 2009).

- Approximately 56,000 homes have been produced under 40B and another 10,900 homes have been approved locally, but are not under construction yet. Of these, 29,000 homes are reserved for households below 80 percent of area median income.

- 40B produces more units of affordable housing than any other housing program in the Commonwealth.

- From 2002-2006, 40B led to the creation of nearly 80 percent of all new affordable rental units in Greater Boston (outside the City of Boston).

- Chapter 40B has prompted over 89 communities to develop affordable housing plans under the 2003 "planned production" regulation.

- 51 cities and towns have met the 10 percent affordable housing threshold, more than double the number in 1997 (24).

- 40 communities are at the 8 percent or 9 percent threshold.

- 82 municipalities need 100-200 units to reach 10 percent.

- 117 municipalities need fewer than 100 units to reach 10 percent.

*Reprinted with permission from Mass Home Care.*

# Drugs at Mass. nursing homes could pose risks

BOSTON —

Federal officials say nearly 2,500 Massachusetts nursing home residents were given powerful antipsychotic drugs last year that were not intended or recommended for their medical condition.

The *Boston Globe* reported that data collected by the Centers for Medicare and Medicaid Services show that 28 percent of Massachusetts nursing home residents were given antipsychotics in 2009. Of

that group, more than one out of every five did not have a medical condition that called for such treatment.

Federal officials say the drugs are often given to patients with dementia, which puts them at risk for serious side effects, even death.

An official with the organization that represents the state's nursing homes acknowledges that the number is too high and says better training is needed.

— AP

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# Debate continues on state's driver safety reform

By Brian Goslow

When it comes to a new safe driving bill in Massachusetts, Saugus resident John Andreucci, 71, is adamantly opposed to any legislation that targets a specific age group. "It's about as discriminatory as you can get," he said. "Any part that has to do with a single group or people, I'm opposed to."

At press time, Senate and House conference committees were hammering out a final version of the bill before it's returned to the Legislature for further discussion and a vote. While the age for mandatory testing hasn't been determined, recent debate has focused on 75. Follow-up testing would be required every three years after that.

"It originally was going to be 65, but most people that age have their faculties intact," said Andreucci. He thought the age was raised to 75 after elected officials belatedly realized the proposed legislation could cost them their jobs at election time.

It's also unclear who would have the final say on a driver's ability to stay on the road — and where that determination would be made. Medical offices have been the location most mentioned, but one medical group has proposed the Registry of Motor Vehicles (RMV) or another location under state jurisdiction.

"Most primary care physicians wouldn't feel comfortable being the final decision maker," said Dr. Dennis Dimitri, president of the Massachusetts Academy of Family Physicians and a family health practitioner at UMass Memorial Health Care in Worcester.

"If it's required that physicians make a report to the Registry of Motor Vehicles about patients, on a simple form, that would be easy. But if it meant making an evaluation, assessment and decision about a person's driving ability, that's very problematic for most physicians."

Dimitri said a driving ability evaluation could be a time consuming task, adding to an already overloaded appointment schedule. He called such a burden "unreasonable."

In a March 18 letter to state representatives, the Massachusetts Medical Society (MMS), noted multiple tests would be required to assess a person's physical ability, cognitive skills and vision and that a single health care provider might not be able to conduct them all, requiring a driver to go to multiple providers. The addition of thousands of such assessments to physicians' workloads could potentially delay patients seeking medical appointments and care.

Then there's the question of cost.

"It appears unlikely that either Medicare or private "medigap" health insurance would cover their cost," the



MMS letter stated. "This could create a significant burden on many applicants who would have to pay for this testing as an out-of-pocket expense."

The MMS also questioned whether health-care providers would be willing to affirmatively certify patients as fit to drive without specific protections against civil liberties.

"We need protection against liability for a physician if a patient gets into an accident and dies," said Dimitri. "That could occur if someone said a physician should have reported them."

Ultimately, he said, the onus is on the RMV to develop a process where a simple report from a physician would lead to the registry making a final decision. "A mandate to do a report would be similar to a mandate in reporting suspected cases of child and elder abuse," Dimitri said, "but it's up to the state to decide whether abuse or neglect exists."

Calls for cognitive and physical testing have been controversial. "There's wide agreement in the medical and academic communities that the kind of testing that will screen out bad drivers doesn't currently exist," said AARP Massachusetts State Director Deborah Banda. "For legislators to mandate testing that doesn't exist isn't proper."

Banda noted that the way the legislation was written when it was returned to committee in early March, anyone in the health care chain, including a dentist, could give the test. She said it has yet to be determined who would pay

for any mandatory testing, be it the person tested, the state or the person's health-care insurer.

AARP Massachusetts, which has been meeting with committee members during the legislative process, supports four provisions under consideration:

- The identification of drivers of all ages with impairments by improving the voluntary medical reporting system. AARP gives the example of a strong medical reporting system in Missouri leading to a decrease in accidents, saving lives and making roads safer.

- The implementation of a trigger system to weed out unsafe drivers of all ages; drivers who are in three accidents would automatically be reassessed. "We've been asking for in-person renewals every five years," Banda said. "It would get younger and older bad drivers off the road. This debate must focus on ability, not age." Currently, drivers can alternate every five years between in-person and remote renewals.

- Ban texting (legislation on this issue is in the House and Senate version and is likely to be included in the final version of the bill).

- Establish a commission to look at transportation alternatives for those who shouldn't be driving.

Many older drivers who are aware they shouldn't be on the road continue to do so because they have no other transportation available. "It's one of the huge issues," Banda said. "If we take away a driver's license, especially in isolated or rural areas, how are they going to get to their doctor's appointments, the grocery store, church services and remain a vital member of their communities? It's only going to grow as the population ages and their numbers increase."

Seniors can be very resistant to giving up their driving privileges. "It has a major impact on their ability to live independently," Dimitri said. "Usually, a family member is the one to tell mom and dad to stop driving and take away their keys."

Family members, friends and physicians, can be wary of taking action for fear of upsetting that person. Dimitri would like to see a system where people could anonymously report their concerns to the RMV. "That takes the onus off of them and into the authority of the objective authority," he said.

Dimitri doesn't feel any driver's safety legislation should be age specific. "There are many many older drivers who are fully capable of driving," he said. "But there are younger drivers with things that at times affect their driving safely."

DRIVER page 16



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z-3,4,10

## More insurers are paying for alternative remedies

By Marilyn Marchione

Acupuncture, not pain pills that “make me loopy,” is what Cynde Durnford-Branecki wants for her aching back, and a treatment costs her only a \$20 copayment.

“If I didn’t have insurance, there’s no way I could afford to go,” said the 51-year-old graphic designer who lives in San Diego.

After years of being lobbied for more choice, insurers and employers increasingly are covering alternative therapies. There are even alternative “HMOs” — networks of nontraditional providers that sell services to big employers and individuals.

It is one of the last frontiers for moving alternative medicine into the mainstream, fans say.

Choice may sound like a good idea, but it can lead more people to use remedies they may not realize are of unproven value. It also can mean the people who use those treatments will wind up paying for them, rather than have their insurer pay for proven remedies. Here’s how:

- Insurers only cover a narrow range of alternative services for specific conditions where there is evidence of value, such as chiropractors for some types of back pain. But these services are marketed for many other uses that lack such proof, such as chiropractic treatments for asthma or ear infections, and acupuncture for high blood pressure or insomnia. Patients can be stuck with the tab, even though the provider is in their insurer’s network.

- Most insurers do not pay for herbals and dietary supplements because they are of unproven safety and worth.

Yet some insurers, such as Aetna, let sellers advertise supplements to members, which can imply a benefit and coverage. Kaiser Permanente’s HMO carries many supplements in its pharmacies and allows its network doctors to “prescribe” ones that it then sells to members, who pay the full cost.

The result: Consumers who choose alternatives can wind up paying a greater share of their health care. Every person who chooses St. John’s wort instead of Prozac for depression, red yeast rice instead of Lipitor for lowering cholesterol, or an unproven therapy instead of a visit to a medical doctor, pays out of pocket and saves the insurer money.

Insurers insist that saving money is not their motivation for offering or promoting alternative remedies.

“In no way would it benefit Aetna to have our members using harmful things,” said Aetna spokeswoman Wendy Morphew.

Instead, these companies say they are offering the choice that consumers have long demanded, and a safer way to get supplements that people already are buying from sources of dubious quality.

“We’re not suggesting you buy this. But if you buy this, here is a place to get it safely,” said R. Douglas Metz, a chiropractor who is chief health services officer of American



Specialty Health Inc., of San Diego.

It is the largest of about half a dozen firms that provide complementary and alternative medicine services to insurers, employers and individuals. Like an HMO, it has 15,000 chiropractors, 6,000 acupuncturists, 6,000 massage therapists and others in its network.

About 13 million Americans are covered or eligible to use its services, including Durnford-Branecki, who works for the firm.

Aetna became one of its customers two years ago. A recent Aetna newsletter told members they could get at least a 15 percent discount and free shipping on more than 2,400 health

and wellness products offered through American Specialty, including vitamin and herbal supplements, aromatherapy products and homeopathic remedies.

“They offered a great program,” credentialing providers in their network and finding good supplement suppliers, said Robin Downey, head of product development for Aetna.

“We have members who come to us and ask us for these services. When we can get a discount for them, that’s something we are able to pass on,” although Aetna also recommends that members talk with their primary doctors about anything they plan to try, she said. — AP

## Bedding trends help to develop new ways to fight insomnia

If you’ve tossed all night because you were hot, restless or uncomfortable, read on.

Manufacturers are developing new ways to combat insomnia, including some technologies introduced at last fall’s Las Vegas Furniture Market and High Point Market, two of the country’s largest trade shows.

The hottest trends:

- Anti-sweat mattresses use new 3D fabrics that circulate air so you sleep cooler. Dormia and Hollandia International’s versions are priced in the \$1,500-\$2,800 range for queen size.

- Homeopathic mattresses impregnated with essential oils like lavender, chamomile, rose and calendula have long been popular in Europe; now it’s our turn. The scents are natural relaxants, and some even have anti-



bacterial properties. Nanotechnology infuses millions of lavender microcapsules into the mattress’ cover; when you lie down, some of the capsules break, releasing the fragrance. Magniflex’s Lavender Comfort queen is \$1,899.

- Organic bedding can help people with allergies and those susceptible to chemicals emitted by synthetic materials. Eco-friendly wool, cotton, solid wood and natural rubber latex is produced by companies like Northern California’s OMI, which was co-founded by author Walter Bader, who suffers from chemical sensitivity himself. Their OrganicPedic Sierra is \$1,995, while Ecomfort’s plant-based foam mattress and Aireloom’s certified organic cotton version are in the \$1,000 to \$3,000 range,

depending on size.

- Lightweight futons are also new, replacing the bulky traditional standby. Futons are finding favor with those unwilling to spend on pricey, space-gobbling sofa beds. The new versions use refined foam engineering to make a plush, versatile, durable sleep surface.

According to Michael Nermon, vice president of the Specialty Sleep Association, other trends include customized mattresses with one firm side and one soft one. Advancements in the American bedding industry in recent years mean consumers can shop for more domestic products, too.

Experts say you need to calm your brain with a book, quiet conversation or solitary reverie to get a good sleep.

Some tips from the National Sleep Foundation:

1. A supple, comforting mattress is better than a too-firm one, especially if you have

back pain.

2. Sleeping with Rover? Not a good idea. It’s comforting for many to have pets close by, but animals don’t understand space sharing. Provide them a spot near your bed, instead.

3. Go with the glow. Our biological clocks are strongly influenced by light; the more bright light we’re exposed to during the day, the better we’ll sleep. Keep the bedroom dark, and use a low-illumination night light in the bathroom.

4. Sleep cool. In general, temperatures above 75 and below 54 disrupt sleep. Our internal temps drop at night, so most of us sleep better in a cool room.

5. Drip, drop, tick, tock. Banish annoying noises if they disrupt your rest. Conversely, city dwellers may toss and turn if it’s too quiet; travel with a white-noise maker or favorite travel clock. — AP

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# Travel with mom yanks out boomer lesson

By Maria Sudekum Fisher

**DOMINICAL, Costa Rica** —

My 20-year-old daughter Emma has been following me on strange trips all her life — Beijing on a bike, rural Romania, the frozen Boundary Waters in January and campouts at 10,000 feet that left her sick and dazed because of the altitude.

Now that she's in college and her own wanderlust has kicked in, it's my turn to traipse after her.

But my trip to visit her while she spent a semester abroad in Costa Rica turned into a three-generation adventure when her grandmother and aunt decided to join us. And it was there, on a jungle beach, that I learned a lesson about backing off. But I didn't learn it from Emma; it was my mother handing out that lesson — her and her unlaced tennis shoes.

After one year on campus Emma couldn't wait until the typical junior year to study abroad. So as a first-semester sophomore she left for Costa Rica in August to study ecology and Spanish.

Her college doesn't encourage family and friends to visit the students in Costa Rica. But how do you resist the lure of traveling with your child in a tropical setting? In December. Did I mention she was on the Pacific coast near great beaches?

I found reasonably-priced airfare. Emma found me really reasonable lodging in a wildlife refuge a short bus ride from the home of the family she was living with near the grungy surf haven of Dominical.

I mentioned the weeklong itinerary to my sister, Cecelia, and my mother, Mary, and presto, another strange trip took shape; three generations together in the rainforest. No one, except Emma, speaks Spanish. But we're all pretty hardy. In fact, when Mom read about Hacienda Baru, where we would be staying, she said she'd forgo the canopy zip line over the jungle. But not out of fear.

"I just did one a few months ago in Mexico," she said. Sure she's 78, but, so is Clint Eastwood.

All sorts of neurotic mayhem ensued from the moment we landed. There was the usual bickering that happens

when people with too much shared DNA spend a lot of time together in a hot place with unreliable transportation.

But things didn't get ugly until one morning — I think it was Day Three — when we took the public bus from Hacienda Baru to Marino Ballena — a national park with a beautiful, deserted stretch of beach.

Mom hadn't slept well the night before, and her energy seemed to be sagging. We had stocked up at a tiny store on sardines, crackers and water, which revived her some. But by noon, we needed real food.

Mom stood up, seemed a little shaky, and pulled on her pink and white tennis shoes. She looked like she was struggling with the laces.

"Here," I said. "I'll tie them."

Note to self and any other people with go-get-'em aging parents: Don't

offer to tie their shoelaces. Ever.

"You are not tying my shoes!" she said. "Some day, your children may be tying YOUR shoes. But you are NOT tying my shoes!"

I don't remember what we had for lunch at the little restaurant about a five-minute walk from the beach. But I know there were red table cloths, and the food came with beer and a side of loathing from me to her and back.

Things got worse when Mom said she wanted to take the early bus back to Hacienda Baru rather than wait for the 4 p.m. bus the rest of us were taking.

You'd think I would have learned, but I offered to go with her. I don't know what possessed me. Chalk it up to the sun. I thought she was tired. Blah. Blah. Blah. Wrong again.

"You have GOT to be kidding!"

Mom got on her 1 p.m. bus alone. Emma, Cecelia and I walked back to the beach. I spent the rest of the day in awe of the beach, its emptiness and perfect waves, and of the confusion mothers and daughters can summon.

I had wanted to help. But instead I insulted. How I

missed the cues to give my mother room, to wait until asked, I will never know.

I doubt Clint's kids offer to tie his shoes. Of course, I don't know this for sure, but it's a safe bet, right? If you're traveling the world, zipping around the park on your bike, studying French and basically yanking as much out of life at 78 as you ever were, you can probably tie your own laces and might even bristle at someone with half your energy offering to do it for you.

Figuring this stuff out may be part of aging and watching people you love age. But it's not the easy part.

The rest of the trip was a delight. A thigh-sized green iguana fell from a tree, landing next to Emma with a splat. We played Hearts before dinner. When Hacienda Baru ran out of vodka, Mom took up tequila. Capuchin monkeys navigated the canopy above us. Toucans flew from our backyard trees.

On the last afternoon in Dominical, after leaving Emma at a spot where she could catch a bus back to her home, I joined Mom and Cecelia on a shuttle bus crammed with young people and surfboards for the four-hour ride to San Jose. Our flight home was the next day.

But just as the shuttle was leaving, Emma came walking up the road.

"I missed the bus," she said, clearly exhausted. "And, I can't find a taxi."

Dominical is a fun place. But it's not somewhere you want your daughter to be stuck at night without a ride home. Emma — like her grandmother — is very independent and asks for little. Every now and then she wants her back rubbed or some cash. But not often. And here she was tired, a little worn out — most likely from too much time with her mom, aunt and grandmother.

The shuttle driver said he wasn't going her way. I got out and unloaded my luggage.

"We'll figure something out," I said.

We were both relieved, I think. Emma wasn't asking me to tie her shoelaces, but I could still help — even if it meant just standing by as she trolled for transportation.

And Mom could happily find her own way home. — AP



Hacienda Baru



Marino Ballena

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# Love can overcome life's obstacles no matter what

By Kim Kimzey

SPARTANBURG, S.C. —

**M**arlu Taylor looks into her husband's face. His expression has an almost childlike innocence to it. "What did you tell me this morning? You remember?" Marlu asks Buddy.

Buddy tries to remember.

"If you were on an island? Do you remember?" Marlu gently prods.

But he cannot recollect the conversation they had as Marlu drove him to an adult day care.

"One good thing about Alzheimer's, I can tell him he said anything and that he's done things, and he doesn't remember," she jokes.

They share a laugh.

"You told me this morning that if you could be on an island with anybody, it would be me," Marlu said.

"Yes," he replies.

"And I told him that I can't cook."

Marlu doesn't take herself very seriously.

Faced with a disease that has ravaged her best friend and husband, many women might crumble under the gradual loss of the man they first fell in love with.

The Taylors have decided to handle Buddy's "death sentence" with humor and honesty.

Marlu — who in school never raised her hand in class — has become an advocate for Alzheimer's awareness.

Marlu and Buddy had been married 13 years when she first noticed signs something was wrong.

Buddy, then a real estate appraiser, owned a business. In an uncharacteristic mistake, he forgot to pay a bill. There were some other errors, too. He had difficulty conversing with her and drove his lawn mower into a ditch.

Marlu suspected Buddy had suffered a mini stroke. At Buddy's age — then 57 years old — she did not think he would receive the "nasty diagnosis" a neurologist gave him six years ago.

As they left the neurologist's office, Marlu said she told the receptionist, "They just gave him a death sentence. They just told me he has Alzheimer's. What do we do?"

It took Buddy a year to accept the diagnosis, Marlu said. She immediately set out to take care of financial issues. Buddy's business was sold. It took two years to sell their home.

The couple now live in a town house.

Marlu still works full time. A caregiver stays home with Buddy twice a week. Buddy goes to adult day care three days a week.

Buddy said he and Marlu are a team.

"I believe in honesty," she said.

That openness builds trust. It makes them feel like a team in grappling with a fatal disease someone in the United States is diagnosed with every 72 seconds, according to a 2007 report from the Alzheimer's Association.

Buddy has a more advanced case of Alzheimer's. They've discussed end-of-life issues and the possibility Buddy might one day go to a nursing home if she's unable to provide the care that he needs.

"I like to talk to him about anything that may be coming down the pike," she said.

She said she assures Buddy she will keep him at home as long as she can. She doesn't want to admit him to an assisted care facility. It would be the final resort if she's unable to do any more to help him.

"He needs to feel secure in that I'm just not going to give up on him. I think that's real important to him," Marlu said.

She has found ways to keep Buddy active. He did volunteer work until it became increasingly difficult to accomplish certain tasks.

Buddy now paints rocks. He enjoys the activity and it helps with his hand/eye coordination, which has diminished as a result of Alzheimer's. Buddy gives the rocks away. "We call them his memory rocks," Marlu said.

"I just want the best I can do for Buddy because I know he would do that for me, and the only way you can get that is to knock on doors and ask a lot of questions, because Alzheimer's has been such a quiet thing," Marlu said.

Her love for Buddy keeps her going.

"He still has the sense of humor and the kindness and all that kind of good stuff that he's always had," she said.

She said she's gotten to know him on a different level and is now more wife than caregiver.

"But we love each other ... the love is different. It becomes more of respect and preserving dignity, you know. That's very important to me."

She is consumed with day-to-day demands and doing the best job she can while they contend with a disease some describe as the "long goodbye."

"You say goodbye many times. You're



LOVE page 13

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# Massachusetts hospital costs on the rise again

BOSTON —

Hospital costs in Massachusetts have increased steadily over the past decade and show little sign of slowing, according to a new report.

By 2007, the most recent year studied in the report, hospital costs had climbed to more than 55 percent above the U.S. average.

**Related column page 2**

That translated into per-person hospital costs in Massachusetts of \$3,015 a year, compared to the U.S. average of \$1,941, said Alan Sager, professor of health care finance at Boston University's School of Public Health and one of the report's authors.

Catherine Bromberg, spokeswoman for the Massachusetts Hospital Association, a group of more than 100 hospitals and health system members,



Coakley

said the report "inaccurately utilizes data that, while useful for establishing national statistics and trends, is unreliable for drawing conclusions at the state level."

She said other studies have put Massachusetts hospital rates much lower.

Sager said it's difficult to pin down a single cause for the increase, although he

said his study rules out the state's sweeping 2006 health care law as a factor.

He pointed to other factors including a heavy reliance on teaching hospitals, an "elaborate and expensive pattern of clinical services" and a decline in manufacturing companies, which he said added pressure to keeping health costs low so they could compete with companies in other states.

He also pointed to what he called a lack of political will.

"We've seen it possible to squeeze costs, but we've also seen, when pressure relaxes, for costs to explode again," he said.

That may be changing. Officials overseeing the 2006 law have conceded it put a premium on insuring as many people as possible while postponing tough decisions on controlling costs.

The administration of Gov. Deval Patrick held three hearings on ways to ease rising health care spending. Attorney General Martha Coakley unveiled a final report on her office's investigation into what is driving up the cost of health care in the state.

**The administration of Gov.**

**Deval Patrick held three hearings on ways to ease rising health care spending.**

A preliminary report released in January detailed what Coakley's office called "serious systemwide failings in our commercial health care marketplace that threaten access to affordable, quality health care."

The report found that prices paid by health insurance companies to hospitals and physician groups vary significantly within the same geographic area and that price variations can't be explained by the quality of care or the sickness of the population being served.

Sager said one way to tackle the cost issue is to work more closely with doctors to discourage the overuse of expensive tests, procedures or hospitalizations.

Doctors say they sometimes order the extra work in part to protect themselves from malpractice lawsuits. — AP

► **Love**

Cont. from page 12

losing that person as you go along. Parts that you used to know are not the same. You don't communicate the same way," Marlu said.

Marlu said if one is willing to accept and not be afraid of the diagnosis, it's not "easy, but it doesn't have to be terrible."

Caregivers need to know they're not alone, she said. Others understand and "can help you through all of this. You don't just have to do it all alone."

Joyce Finkle, program director of the Spartanburg Area Office of the state Chapter of the Alzheimer's Association and Jill Smith, the chapter's program associate, are often inspired by the level of commitment and love they see caregivers display.

Smith said in her two years with the organization, the couples she has met have overwhelmingly maintained "solid marriages" despite one spouse's devastating disease.

"I can think of one case where the fiancé walked," Smith said.

"They just have made a commitment. Love takes work. It's not always just natural

and automatic so you make a choice, you know, to be loving and to hang in there and I think they've made those commitments," Finkle said. "I think humor gets a lot of our people through it. Their spirituality gets a lot of people through it," she added.

"At a time when people will walk away from a marriage for anything, these people are in it for the long haul," Smith said. "Any sickness causes trauma in a marriage, you know. But they hate the Alzheimer's, but they love the person. They love that relationship and have the wonderful memories and they still make good memories." — AP

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## Five tips for singles to plan a secure retirement

By Dave Carpenter

CHICAGO —

Single people get left out of the picture a lot when it comes to retirement. Typically it's smiling couples who are shown contemplating their sunset years in ads, brochures and magazines.

The big picture is about to change, however. Financially ready or not, a wave of single baby boomers is poised to alter the face of retirement, bringing a new set of planning priorities into focus.

Single people are now 96 million strong and make up 43 percent of the adult population, up from 28 percent four decades ago. Nearly half are over age 40, including 13 million who have never married. Those figures have swelled as people divorce more often, live longer or simply choose not to marry.

That means single people are commanding more attention from financial planners and companies looking to cater to their needs — and even the occasional magazine cover.

"It's still mostly couples who seek retirement planning, but more singles are starting to come forward," said Eleanor Blayney, consumer advocate for the non-

profit Certified Financial Planner Board of Standards.

With no spouse to rely on, extra precautions are needed in order to be well-positioned for retirement. That holds especially true for women because they live longer. Three of every four single people age 65 or older are women.



Blayney

Klea Theoharis, a 54-year-old investor relations consultant from Queens, N.Y., has been a diligent saver ever since her mother told her as a young child about the need to be self-sufficient. She reckons she has saved an average 30 percent of her pay each year and now has a comfortable cushion for retirement.

But she is surrounded by single women in her condo development who are struggling because they didn't plan well. One has burned through her money, another had to go back to work after retiring early, a widowed neighbor doesn't know what to do with her money, and still another is divorced and doesn't understand investing.

Theoharis doesn't blame the women for their lack of financial acumen. Rather, she said, it's all the retirement articles and planning models based on couples.

Single people need to pay more attention to concerns that may not be as

urgent for traditional families, said Jacob Herschler, vice president of business strategy at Prudential Financial Inc.

Here are some retirement planning priorities that single people in particular should focus on:

1. Save or pay a price — The cost of living for single retirees is about 40 percent higher than for couples, according to the American Academy of Actuaries. That's because couples can share housing and other expenses.

Still, planners say single people tend to wait longer than married people to take retirement saving seriously. That can lead to big problems.

Roughly half of all people age 55 and over — single and married alike — have saved less than \$50,000, according to the Employee Benefit Research Institute. That's an alarmingly small sum in light of rising health care costs and growing length of retirement, which now lasts 15 to 20 years on average.

The focus on savings should include building a large emergency fund since single people don't usually have a second income to fall back on when something goes wrong, as couples do, said Jean Setfand, AARP director for financial security.

2. Calculate retirement income: The traditional three-legged stool approach to retirement security — employer pension,

Social Security and personal savings — is a bit lopsided for single people because of their heavy reliance on Social Security.

Social Security benefits account for 90 percent of income for four of every 10 unmarried retirees and two of every 10 married couples, according to the Social Security Administration.

That underscores the added urgency for single people to carefully assess their sources of retirement income. They may want to also consider buying an annuity to provide an additional stream of regular income.

Go to the Social Security site ([www.ssa.gov](http://www.ssa.gov)) to estimate how much you will receive from the government at various retirement dates. It's a good idea financially to wait at least until full retirement age — 66 or 67, depending on your birth year — before starting your benefits.

Singles who are divorced or widowed should look into whatever assets they might be entitled to — from a former spouse's Social Security benefits to his or her pension, 401(k) or group life insurance.

3. Get disability insurance — Who's going to pay for your retirement if you have a serious accident or prolonged illness that prevents you from working?

Single people generally don't have the ready solution that married couples do.

RETIREMENT page 15

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# Which comes first, pension to buy services, or services to qualify?

By Tracey Ingle

Which came first, the chicken or the egg? This is the quintessential issue in VA nonservice connected disability pensions. We talked last month about the VA calculating a veteran's income for determining qualification for Aid and Attendance benefits by subtracting unreimbursed medical expenses from the total household income. If there are insufficient expenses to decrease the income below the benefit level, then the veteran receives no pension benefit. Huh? What?



## Veterans Information

The example we used last month was Sally, our single veteran with total monthly income of \$1,900. Sally also pays \$98.40 for Medicare, \$175 for health insurance and \$48.60 for Medicare Part D. If that were the end of the story, Sally would only qualify for \$66.67 a month of the Aid and Attendance pension benefit. But in our example, at the recommendation of her doctor, Sally was also paying \$1,500 a month for a home health aide to help her with some of her daily, personal chores like getting washed up and dressed in the morning, and meals. This meant that Sally actually received \$1,566.67 a month as an Aid and Attendance pension.

The question becomes then, did Sally need to hire the home health aide in order to qualify for the pension, or could she have applied, gotten the benefit and then hired the home health aide? In other words, which comes first, receiving the pension benefit to be able to afford the home health aide, or hiring the home health aide in order to qualify for the pension benefit?

For many social service benefits, we apply, find out if we qualify, and then once the benefit is approved, receive the services. The VA's nonservice connected disability pensions (aka Aid and Attendance) works the other way around though. The veteran needs to already be paying for the services before the VA will approve and pay the benefit. This means that there is a certain amount of financial risk to the veteran. The veteran could purchase the services only to find later that for some other unrelated reason, they do not qualify.

The moral to this story is that you have two choices: you can purchase the services and risk losing the cost of them if you are later denied the benefit for other reasons, or you can not purchase the services and not apply for the benefit. With the first, you can always cancel the services later, and only have lost the cost of them while the application was pending. With the second, you are guaranteed to receive neither services nor benefits.

The good news is that there are attorneys accredited by the VA to guide veterans in determining their eligibility for the Aid and Attendance benefit. Unfortunately, the VA

does not make it easy to find a local accredited attorney. Go to the VA website: [www.va.gov](http://www.va.gov). In their search window (upper right corner of the screen), select "Search all VA web pages," type in "accredited attorneys" and click search. Scroll through the search results looking for "OGC — Accreditation Search." (It was the ninth listing in my

search.) From that window, you will be able to search for attorneys, claims agents and veterans service organization representatives.

*Tracey Ingle is the Probate Puzzle Person and Principal of Ingle Law. She can be reached at 508-281-7900 or [tracey@inglelaw.com](mailto:tracey@inglelaw.com).*

## ► Retirement

Cont. from page 14

That makes long-term disability insurance all the more important so their retirement security isn't ruined by a medical issue.

Employer-paid disability insurance is required in most states. But confirm that your employer offers long-term disability coverage — not just short-term, also known as sick leave. The typical long-term disability group plan covers up to 60 percent of salary.

If your employer doesn't offer long-term coverage or if you're self-employed, strongly consider an individual plan. The cost varies widely depending on age and health but can easily approach \$100 a month. It might be worth it.

4. Make long-term care insurance a priority — Long-term care insurance is a critical part of single people's retirement plans because there's likely no one else to take care of them. As opposed to long-term disability insurance, long-term care coverage helps pay for professional care when you can no longer perform the regular activities

of daily living, such as bathing, dressing and eating.

It can run \$2,000 a year or more if you wait until your 60s to get it, less if you get it earlier.

On the bright side, life insurance is an insurance you can probably forego if you have no partner or children.

5. Do thorough estate planning — Single people should take extra pains to ensure that someone has the legal right to manage their assets or make medical decisions for them.

Consider meeting with an estate planning lawyer to get the proper documentation in place. You'll need a will to state how you want your assets distributed after your death, a health care proxy and living will should you become incapacitated and unable to make medical decisions, and a durable power of attorney for finances to allow someone to handle your money matters in an emergency.

Despite the need for extra planning, the outlook for single retirees certainly isn't bad. They can enjoy greater flexibility and financial autonomy than their married counterparts if they prepare well. — AP

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## Mixing old and new is a great money-savings idea

By Melissa Rayworth

You probably didn't realize, when you put an ornate old picture frame next to the sleek Pottery Barn sofa in your living room, that you had your finger on the pulse of America's design culture.

But you did.

What some interior designers call "transitional" decorating, artfully mixing contemporary pieces with vintage ones, is "the No. 1 featured style in magazines like *House Beautiful*, and in *Elle Decor* on a fine level," said interior designer Mallory Mathison.

It works in any room, and helps you get style mileage out of things you already own or buy second-hand. It's also environmentally friendly and practical to use older items in otherwise contemporary rooms.

"There is something to be said about a well-made, 50-year-old piece still doing its job in your present home," said designer Brian Patrick Flynn. "A lot of older things were just made better. But mixing those quality older pieces with something new gives them a fresh look."

Another money-saver: The look can be easily tweaked and ages beautifully, unlike all-modern or all-traditional rooms.

Designer Janine Carendi agrees: "Interiors that do not age well," she said, "are those that are designed without any reference to other styles."

Mixing old and new has its challenges, of course. But it can be done just as easily and more affordably than sticking with one style. "Contemporary is hard to pull off without looking cheap if you don't have very fine things," Mathison said. "And traditional can get old and staid if you don't have very fine pieces also."

Another bonus: This approach is all about personal expression.

"I have never come across a client who is one-dimensional," Carendi said. "And interiors should reflect their experiences, tastes, travels and personalities. Mixing old and new is a way to achieve this."

Sounds appealing. But how do you create an eye-catching combination of old and new, rather than a jumbled hodgepodge



Mathison of conflicting styles?

### Texture, scale and shape

"It doesn't matter how many old or new pieces are mixed together, but rather how it's done," said Flynn, whose trademark style is creatively combining the two. "A muted, traditional sitting room can be totally updated with one piece of bold modern art. On the flip side, a super-minimalist modern space can be given that unexpected touch of traditional with a crystal chandelier hanging above a sleek dining table."

One good tactic is using contrasting textures, like smooth and rough or shiny and matte. "If your new pieces and old pieces all have the same or similar textures, the room will fall flat," Flynn said. "If your new sofa has the same type of upholstery as an old ottoman, break it up by introducing a new texture with throw pillows."

"I would not mix more than a few styles," said Carendi, but the percentage of old versus new is up to you.

Apparently, size matters. "Ensure that the proportions of the furniture do not fight and that the size of one does not overwhelm the other," she said. "Look at the individual shape of each piece."

### Where to do it

Mixing old and new can work in any room.

For bedrooms, said Flynn, "I like to go new with the actual bed and bedding, but pair those with old side tables and acces-

sories. The sleek, tailored look of a new bed with aged furniture and accessories makes a beautiful combination."

For dining rooms, he said, try "rustic farm tables paired with clean modern seating."

### Style strategies

One easy approach, said Mathison, is grouping several of the same items from different eras. "Hang five mirrors on a wall," she said, "maybe an old one from your grandmother, an old one from a flea market, a new one from Pottery Barn. It looks like a lot of thought and design went into it." You can do the same with pieces of china or other types of items.

Old lighting fixtures or lamps from flea

markets (or your attic) can bring cool contrast to an otherwise modern room. "Just have them painted, rewired or get new lampshades," Mathison said.

You can even do a mix of old and new within a single item: Take a traditional piece of furniture, perhaps something Queen Anne or Chippendale, and have it reupholstered in a bold geometric print or brightly colored solid.

How do you know when you've struck the right balance?

"The best way to keep it looking good is to plan from the beginning," Mathison said. "If you're hitting antique malls, it's good to go with an idea in mind, rather than just buying what you see." — AP

## ► Driver

Cont. from page 6

For example, physicians aren't required to report a person who suffers a seizure disorder to the RMV. However, it's expected they would tell them to wait six months before returning to the road. "That's a disease specific situation," Dimitri said. Suffering a stroke doesn't necessarily forbid a return to driving either, he said, but it's difficult to decide whether someone who's had a stroke should drive. "Most physicians aren't set up to do that evaluation in their office," he noted.

Then there's the slow onset of dementia, where it's a matter of deciding when there's a problem and action is needed. "What often happens is the family has to make the difficult decision of taking the keys away from an impaired family member for the safety of the family and those on the road," Dimitri said. Because they see a person on a much regular basis than a doctor, a family member or friend of someone suffering with dementia may be more capable of evaluating physical and cognitive abilities. "We need a better way of dealing with that," said Dimitri.

Until there is a better way of judging a person's ability to continue driving, Andreucci is skeptical about what the legislature will finally put into place. "You could shoot foul shots," he suggested cyni-

cally. "If I get seven out of 10, I keep my license."

He doesn't feel it's fair to put any person, let alone seniors with their way of life on the line, under the pressure of a single test to determine whether they keep their license. He compares it to a professional athlete playing in a major sporting event. "They can make every shot in practice but in a championship situation, they'll miss the last two shots that could have won the game and end up with nothing," he said. "With a mandatory driving test, if you don't pass, you won't be able to get around anymore. Talk about pressure."

Andreucci is a sports official for volleyball and track and field events throughout the North Shore and up into New Hampshire. "I couldn't do it, absolutely 100 percent couldn't do what I'm doing, if I couldn't drive," he said.

Ironically, in sports, he's judging those at the other end of the driving curve, where teenagers taking their driver's test are given endless attempts to pass. "If you fail your driver's test at 16 1/2, you can take it again," Andreucci said. "You won't be able to do that if you fail at 75."

"Of all the people I know that are driving, I'd rather be driving with them now than when they were teenagers. All the nutty things they did, I don't know how we made it. I know there's some of them I wouldn't ride with them then, but 50, 60 years later, I'd drive with them now."



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# Brand-new sitcoms prep to join TV Land classics

By Frazier Moore

NEW YORK — When TV Land was launched in 1996, it was more than just another cable channel. It was a refuge where viewers could revisit old friends like Beaver Cleaver, the Clampetts and Sheriff Andy Taylor. It was a portal into a video past, a carefully tended landscape of idealized TV.

TV Land hasn't trampled on that landscape in the meantime. But, even so, the neighborhood has been spruced up through the years.

Consider *Hot in Cleveland*, a comedy series set for a June premiere. For the first time, TV Land is producing its own original sitcom. But "Hot" should fit right into the neighborhood. It's funny, comfy and a true-blue reflection of the shows that surround it.

Filmed in the trusty multicamera style, it stars a bevy of grand dames of classic comedies: Valerie Bertinelli (*One Day at a Time*), Jane Leeves (*Frasier*), Wendie Malick (*Just Shoot Me*) and the incomparable Betty White (*The Golden Girls*).

The premise is evergreen: Fabulous friends make an abrupt life change, cutting their Los Angeles roots to relocate in, of all places, Cleveland. Then laughs ensue (at least judging from a sneak peek at the pilot that will kick off the series' 10-episode season).

"All the other networks are looking to reinvent the comedy," said Keith Cox, TV Land's executive vice president of development and original programming. "How do you step away from the traditional? What's the new thing?" But we're embracing the good old traditional comedy — it just needs to feel contemporary, be really funny and have really great actors."

TV Land has another sitcom in gestation. *Retired at 35* hasn't gotten an official go-ahead, but don't bet against



*Hot in Cleveland* will star Leeves, White, Bertinelli and Malick (from l to r) (photo courtesy tv land)

such an announcement soon, with a premiere sometime after October. Based on its pilot, *Retired* has its own easy feel, comfort factor and familiar faces (George Segal and Jessica Walter among them), and its own reservoir of laughs.

Meanwhile, TV Land has more scripts in development, with the goal of building a slate of original sitcoms in the seasons ahead.

"We're already out there in a very big way looking for the next one," said TV Land President Larry W. Jones, though he added, "Our agenda isn't just getting into original sitcoms."

TV Land, which began as a "classic TV" spinoff of Nickelodeon's *Nick at Nite* franchise, has already been airing original programming. Since 2008, several unscripted series like *High School Reunion* and *Make My Day* have found their place on the schedule amid scripted oldies. Unscripted reality shows may seem out of place, but

TV Land execs insist that, conceptually, they're part of a unified whole, with the total package aimed at the audience TV Land has always courted: baby boomers.

"We always kept a certain life-stage age in mind: the 40- and 50-something demographic," said Jones, 49 (colleague Cox is 45), noting that TV Land's audience can be a good one for advertisers: higher income, fewer responsibilities and maybe a mid-life urge to pamper themselves.

TV Land is available in 90 million homes, where average viewership during the day is 550,000 total viewers. In an average week, more than 30 million people tune in.

What do those people tune in to watch? Research found the overarching theme for shows that fit on TV Land deals with life changes, second chances and self-reinvention. The theme is aspirational, or at least liberating. And it transcends program genres.


It applies to reality shows like *First Love Second Chance* (what if you could give your very first love a second chance?) and *She's Got the Look* (which aims to discover the next supermodel over the age of 35).

And it dovetails with both of TV Land's new comedies: creating a new life, whether it's middle-aged women starting over in Cleveland, or a young career guy chucking it all and retiring to Florida to join his wacky parents.

Such a theme, said Jones, "provides an environment that allows you to create a new sitcom — a modern sitcom with familiar touch points."




Familiar, that is, without calling a lot of attention to themselves.

"You don't really come to TV Land to learn anything," Jones said with a chuckle. "We're pure escape, here to give you a laugh. That's what our heritage is." — AP



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# Stop the cuts: Slashing safety net programs hurts seniors

By Deborah E. Banda

Sometimes I think: I'm beginning to sound like a broken record. Stop cutting programs for older residents. Please stop now. But, today I say: It's time to turn up the volume.

The state legislature is hard at work, with the House and Senate each in the process of developing their budget proposals for fiscal year 2011, which will begin on July 1. Although tax revenue is expected to grow slightly, the state still faces challenges with rising health care costs, high unemployment — and an increased reliance on safety net programs.



## Editorial

Gov. Patrick has already released his \$28.2 billion version of the state budget for FY11. While sparing some big-ticket items like tax incentives for the biotech and film industries, the governor makes more cuts to Prescription Advantage, the state's pharmacy assistance program for seniors that works in tandem with Medicare Part D.

AARP's message to legislators: It's time to step up to the plate, stop the cuts, and protect your older constituents.

Yes, the commonwealth — like businesses and families everywhere — is trying to manage during tough economic times. AARP believes, however, that budgeting to the bottom line means more than taking out the ax. It means making every penny count, and looking at every single line item to trim the fat. It means shared sacrifice — perhaps reducing some

of those incentives for the film industry — and not hitting our most vulnerable residents over and over again.

Right now, the safety net for seniors is in tatters. Over the past three years, vital programs that vulnerable seniors in this commonwealth count on have been victim to budget cut, after cut, after cut. Programs such as Prescription Advantage, home care and protective services are now operating at bare-bones levels. And, let's be very clear: The real victims aren't the programs; they are the people. Too many older residents are hurting because of misplaced budget priorities.

More than 40,000 seniors have lost crucial coverage from Prescription Advantage. They no longer get assistance with premiums or help making co-payments for the medicine that keeps them healthy and out of more expensive care. As the old saying goes: penny-wise and pound-foolish.

Meanwhile, nearly 3,000 older residents across the state who are eligible for home care still wait for services — for assistance to bathe, walk, eat, go to the bathroom, manage their health conditions. How are they getting by day-to-day? Many are just an accident away from acute care. Or, even worse, they face losing their independence if they must leave their homes for institutional care. It's like Russian roulette. And, it's wrong.

As they develop the FY11 state budget, AARP calls on legislators to hold harmless the programs and services on which seniors rely — and provide funding at FY10 levels for Prescription Advantage, home care and protective services, as well as Councils on Aging and Senior Centers, the place in each community that provides the services that local seniors need.

But, we also urge our state leaders to seize an opportunity to provide help now. In February, Massachusetts received an almost \$133 million budget windfall because the Obama administration cancelled scheduled payments related to Medicare prescription drug coverage for low-income seniors. In turn, we believe seniors should see some benefit from this relief.

AARP continues to call on the Patrick administration and the legislature to use a small portion of the windfall to immediately restore \$5.6 million in funding to Prescription Advantage. This infusion will reverse last year's emergency "9C" cuts, bring the program back to its original FY 2010 level of \$40 million, and most importantly, allow benefits — specifically premium assistance — to be reinstated for more than 40,000 Massachusetts residents.

While I believe this request is nothing but reasonable, at press time, three months later, still no action had been taken.

Furthermore, as the economy continues to inch towards recovery and revenues tick upwards, AARP calls for funding to be restored to all safety net programs that have been decimated over the past few years, so that these programs can again provide the assistance on which so many of our most vulnerable residents rely — no matter what their age. Yes, difficult decisions must be made. But let's do so with compassion, not just with a calculator.

*Deborah E. Banda is the state director of AARP Massachusetts, serving more than 800,000 members age 50 and older in Massachusetts. Learn more at [www.aarp.org/ma](http://www.aarp.org/ma), and connect at [www.facebook.com/AARPMMA](http://www.facebook.com/AARPMMA) and [www.twitter.com/AARPMMA](http://www.twitter.com/AARPMMA).*

## President Obama should expand Medicare For All

By Al Norman

A group called "Health Care Now" has been urging President Barack Obama to look backwards for the solution to health care reform.

They want Medicare For All, and they argue that all the president's goals can be accomplished by extending Medicare coverage to every American. In his State of the Union speech, the President challenged anyone who "has a better approach that will bring down premiums, bring down the deficit, cover the uninsured, strengthen Medicare for seniors, and stop insurance company abuses, let me know."

Health Care Now is letting the President know. They say that "improved" Medicare For All will:

- Provide comprehensive medical, men-



## Editorial

tal, dental, vision and prescription coverage to all people from birth to death without gaps.

• End the profit-driven practices of insurance companies denying and restricting coverage.

• Be the only solution with built-in cost controls, with immediate savings of \$400 billion per year by removing the high administrative and marketing costs from 1,300 private insurance plans.

• Put the brakes on our health care costs which are spiraling out of control, and relieve businesses of the financial burden of paying for health benefits.

• Relieve the financial stress placed on Medicare from providing coverage for just the elderly and individuals with disabilities. Everybody, healthy and ill, will contribute to the Medicare fund throughout their lives,

and Medicare will be there for them when they need it.

The Medicare For All solution is so simple it's elegant. But the insurance industry is entrenched, wealthy and not ready to give up their profits. The big business community is also out to gut healthcare reform. The U.S. Chamber of Commerce is the largest lobbyist in America today.

I hate to think what would have happened in 1965 if the current cast of characters in Washington had been around when Medicare was being debated. The same voices today were present then. Ronald Reagan was denouncing Medicare as socialist medicine — and that rhetoric is still with us 45 years later.

No one is saying that Medicare today is a perfect model. If you have something wrong with your eyes, teeth or feet, forget about Medicare. And if you need long-term care, don't run to Medicare. That's why

Health Care Now talks about "improved" Medicare For All. The administrative costs are low — and even with the deductibles and copayments — most seniors would not trade Medicare away for the uncertainty of a private insurance policy. A Medicare For All would include all Americans, and would have the best chance of keeping costs constrained, because it would have the largest risk pool of people paying in, and the negotiating clout to get acceptable rates out of providers.

Medicare is a way that we, the consumers, can get organized and be a potent lobbying force for affordable health care.

That sounds a lot better than what they are jousting about in the halls of Congress these days.

*Al Norman is the Executive Director of Mass Home Care. He can be reached at 413-773-5555 x 2295, or at [info@masshomecare.org](mailto:info@masshomecare.org).*

## ► Healthcare

Cont. from page 2

enough by insurers while at the same time charging ridiculous amounts for services and materials. I was enlightened and dismayed by a recent CNN report by Dr. Sanjay Gupta, the network's chief medical correspondent. Gupta took viewers through a typical hospital operating room where he singled out individual items: a standard IV bag, \$280; a stapler used for surgery, \$1,200; a suture, \$200; and a needle used for biopsies, a whopping \$800. Holding up the needle, he said, "If you ask the manufacturer why it's so much money for a device like this, they

will say it took years to develop something like this, and research and development costs are so significant. Also they are guaranteeing a certain level of effectiveness of the needle."

But when you look at a hospital bill, it is not just the cost of the supplies, Gupta said, there are administrative costs built in and the expense of covering individuals who don't have insurance and who cannot pay the bill.

He pointed out that most people never know what their care is costing because they have insurance so they never ask. So we should read those insurance statements and insurers should have to provide them. We should question the costs. We need to

take responsibility and be more educated about our care. Gupta suggested calling the hospital and requesting a breakdown of charges. He said if the price seems high, you might be able to negotiate some of them down.

As an aging baby boomer, I find it difficult to accept that my healthcare expenses could be, quite literally, the death of me. This, despite being an educated consumer, who has religiously put money away for old age. I keep thinking, how much is it really going to take?

It is wrong that I am forced to pay more for my insurance because of my age or that others are denied insurance because of pre-existing conditions.

It is wrong that the government programs on which we have depended and that have helped previous generations are being allowed to crumble because of the lack of guts among our political representatives to fix them.

It is wrong that the cost of long-term care is out of reach for so many Americans.

So, while I'm not overly enamored with the health care tome that has come out of Washington — what truly makes me sick is the alternative of living with the status quo.

*Sondra Shapiro is the executive editor of The Fifty Plus Advocate. She can be reached at [sshapiro.fiftyplusadvocate@verizon.net](mailto:sshapiro.fiftyplusadvocate@verizon.net).*

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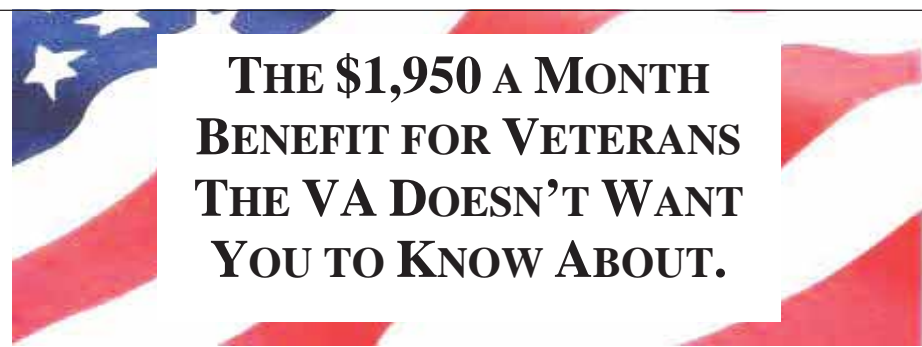
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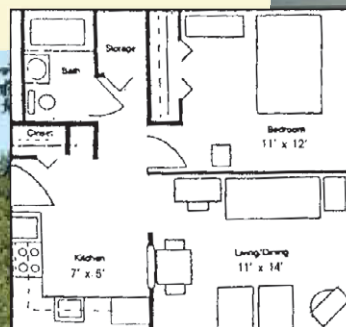
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