Win the diet battle
page 17

Design tips: Small budget, big bang
page 16

China odyssey captures past, present
page 10

Find Index of Caregiving Services on page 3

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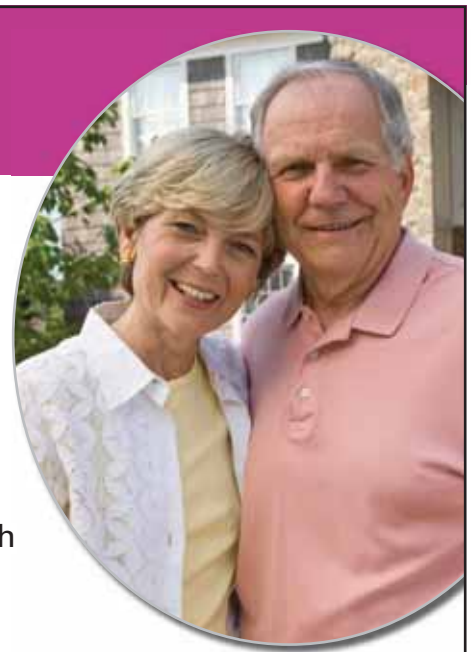

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Inside This Month

Featured Stories

Departments

Rx price hike 6

Retirement worries 6

Home sweet home 13

About The Cover

Learning how to survive the empty nest p. 4

Index of Services in this Issue

If you use any services listed above, please mention you saw their ad in the Fifty Plus Advocate.

Empty nest can be a good thing for parents

By Brian Goslow

For Elizabeth Souza, 62, of Amherst, that empty nest feeling started when her first child, Noah, began looking at perspective colleges in his junior year of high school in 1993.

"You have a foreshadowing," said Souza, who researched the empty nest phenomenon for a 2003 dissertation as part of her doctoral degree in sociology requirements while attending the University of Massachusetts at Amherst. "You recognize one stage of life is changing and morphing into the next stage, which is more tentative and uncharted."

Lisa Mikulski with sons (from l to r) David MacDonald and Kyler Mikulski

Psychology Today defines "Empty Nest Syndrome" as "feelings of depression, sadness and/or grief experienced by parents and caregivers after children come of age and leave their childhood homes." While the magazine suggests women are more likely than men to be affected, dads can also feel the pangs of children going out on their own.

When the day came to leave Noah at Franklin and Marshall College in Lancaster, Penn., Souza was jumping for joy. Not so her husband, Bill Stapleton. "They do this convocation that's a signal for parents that it's time to go, it'll be OK," she said.

"When we went to say goodbye to Noah, he was nowhere to be found. It was a shock. On our way to his dorm, Bill was putting on his sunglasses — even though it was dark — because he was really emotional about leaving Noah at college."

Souza and Stapleton's initial empty nest period came to an unexpected halt when both their children returned home after graduating college. "Noah came home after three or four years in the workforce; Phoebe right after college," Souza said. After working two years to raise the funds, her daughter enrolled in a nearby grad school, as did her brother. Their parents paid for their lodging elsewhere to cut the cord one final time.

Not all parents have the ability to assist their children to that extent and with today's challenging economy and job market, more and more adult children are moving back home after earning their college degrees.

"This causes havoc for the parents," said Dr. Marsha Vannicelli, a Cambridge-based licensed clinical psychologist. "They're neither free or not free." Often the returning adult children expect the same services provided when they were younger. "They expect to come home to hot meals waiting for them, their room picked up and laundry done for them."

They also want to be "totally independent and no longer under the jurisdiction of parental rules with a declaration of 'I'm an adult.'" This can cause agitation in the home. Vannicelli said negotiations are needed with the parents making it clear what's expected of the adult child.

When she meets with parents facing this dilemma, Vannicelli tells them the key to not letting the situation get out of hand is to not reinforce pre-college entitlement patterns.

When Frank Armstrong and Ellen S. Dunlap of West Boylston brought their daughter, Libbie, to college in Ohio in 2000, they knew that, in some ways, she wasn't ready for it.

Neither were her parents.

"I was heartbroken," Dunlap said. "I didn't see how I would live without her right there. As an only child, she was very close to both of us. Because I was afraid (of her daughter's perceived unpreparedness for college), I cried most of the way home."

When they returned from work each day — Armstrong is a lecturer in photography at Clark University; Dunlap is president of the American Antiquarian Society, both in Worcester — "we'd ask each other, 'Did you hear from Libbie?' She was, and still is, a big part of our lives," Armstrong said. Eleven years later, they haven't stopped asking.

Before Libbie left, Armstrong got a dog in anticipation of be-ing lonely without his daughter around. "That helped me considerably," he said.

Frank Armstrong and Ellen S. Dunlap with daughter Libbie (from l to r)

(photo by stephen dirado)

The events of 9/11 upset their daughter; then, after a close aunt died, Armstrong said, "she called and said, 'I need to come home and rethink things.'"

While she said it was hard knowing the difficulties their daughter was having in school, when Libbie returned home, Dunlap was proud they had given her space to make her own mistakes and grow as a person. They gave her the second floor of their home to live independently.

"We needed to give her room to grow up on her own terms; she just needed a little nudging," Dunlap said. "We told her, 'You have to get on with life,'" They encouraged her to find a volunteer position to get work experience, which eventually led to a full-time position.

That loving support paid off two-fold: Libbie recently married and is living nearby.

Armstrong and Dunlap benefited from still being fully engaged in their careers when their daughter first left home and being willing to adjust to new circumstances in her life. That's not always the case for suddenly home alone parents.

Denial of the significance of the change can lead to impulsive and dysfunctional behaviors, said Dr. David M. Reiss, Interim Medical Director at Providence Behavioral Health Hospital in Holyoke.

Weaknesses in the relationship, simmering differences or hostilities will tend to come to the surface through this life-changing event. There may be particular tension if one partner feels freed up while the other goes through a period of a significant sense of loss and grief.

Reiss said newly empty nester parents will contact him to seek help for sadness or grief or a loss of a sense of purpose — but very often, the presenting problem is marital/relationship issues that may include affairs or over-indulging and spending or complaints of depression. They have to be guided to identify and directly address the sense of grief, sadness and loneliness they're feeling, he said.

Vannicelli suggested that couples finding themselves in this dilemma try to reconnect to what brought them together in the beginning of their relationship and how they felt about each other when they wanted to make a family together. If they find there is not enough left to keep the marriage going, the couple should find an amicable way to end the marriage while keeping the family intact.

Noah Stapleton, Elizabeth Souza, Phoebe Stapleton and Bill Stapleton (from l to r)

Becoming an empty nester came unexpectedly for Lisa Mikulski, a Westbrook, Conn. single mom of two sons. She hadn't even considered the prospect until her older son, David MacDonald, 22, broke the news he was moving to Philadelphia with his best friend.

At the time, having younger son, Kyler Mikulski, 20, still at home, lessened the loss. Three months later, he suddenly announced he was moving to Boston; later that evening, a friend came over with a truck, helped him load his possessions into it, and off they went.

"That was bad," Lisa Mikulski said. "I walked back and forth between each boy's room. The following day, I had a work interview during which I realized I had nobody to go home to. That lasted about 24 hours (after which) I adjusted to that easily and realized I like being on my own."

In a single-parent family, the children leaving will generally create much more of a change or threat to the parent's sense of identity, according to Reiss.

"There can be freeing-up of motivation to be more self-focused in a positive — or negative — way. There may be a sense of loss and confusion. Most of the time there will be both," Reiss said. "Without a partner, there will be less availability for shared commiseration and comforting and there may be more loneliness and a sense of disorientation. On the positive side, if the parent has a strong ability to tolerate independence, there is less chance to be caught up in having to re-structure a marriage/partnership."

For their part, Mikulski's two sons don't feel guilty about their decision. Kyler said he visits his mom at least twice a month and sends her text messages often.

"I've spent hours with her (regarding the transition process) listening, talking, yelling, arguing, questioning, listening, lecturing, listening and listening some more," he said. "I maintain a very special relationship with her. We both know that neither of us would be in the places that we are without the other — in a positive way."

Asked what advice he would share with other offspring on helping their parents during the empty nest transition period, Kyler Mikulski said, "Do good deeds. Let mom or dad know. It'll reinforce their sanity more than you'd think."

On the other hand, his brother, David MacDonald, noted he's one of those people who isn't big on regular communication. However, that doesn't mean he isn't thinking of his mother — and doesn't love hearing from her. "Don't wait for us to call you, we appreciate the occasional check up just as much (as you do)," he said.

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Temporary caregiving stint reveals a disturbing dark side

By Sondra Shapiro

Just My Opinion

I always considered myself a nurturing person. Though I don't have children, I am a classic hoverer and worrier — a regular Johnny-on-the-spot whenever friends or family require emotional or medical support. When it comes to taking care of the family cats, there's nothing I won't do for them — shots, pills, enemas, staying up all night to watch over them when they're sick.

So I was disturbed to discover I harbor a dark side. It began a couple of days into caring for my husband, who had surgery on his right foot. Since he was in a cast, on crutches and unable to drive, he required help with everything.

Before the surgery, I convinced him and myself that I was not only up for caregiving tasks, I'd be happy to perform them. "I'll take such great care of you," was a mantra I proclaimed with nauseating cheeriness. This proclamation was as much to soothe the guilty psyche of my normally active, athletic, obsessively chore-driven husband — a man of constant motion — as it was to reaffirm to myself that I was willingly embarking on a role I was born to play.

Now that I look back, my high regard for my abilities was bound to be quashed. Please do not judge me harshly — I've already done so. The purpose of my confession is to relay the new respect and empathy I have for those of you who are providing care 24/7 with no end in sight.

One of the most difficult challenges has been the struggle to keep my husband's spirit from sinking into a dark abyss — while trying to keep my own from plummeting.

We are normally an equal partnership when it comes to chores and responsibility, but during David's convalescence I naturally assumed all household responsibilities in addition to taking care of him. At the end of the day, exhaustion stole my Pollyanna demeanor, leaving behind Nurse Ratchet, who huffed and puffed her way through caregiving duties. And, believe me, David noticed and commented, adding guilt to my waning self image. "Do you know you have been constantly sighing all day?" he said about a week into our new family dynamic.

I know he expected me to perform each task with a smile, if for no other reason than because he hates thinking he is putting someone out — my occasional bad attitude was a reminder of his dependence.

I felt horrible that he felt he was inconveniencing me, because I truly wanted him to relinquish his sense of helplessness and concentrate on healing.

Friends called, insisting that I needed "me" time, offering to take me out for a few hours. I often declined because I didn't want to leave my husband alone, helpless. How selfish could I be? Instead, I stayed home, wallowing in resentment, which didn't help either of us — and which was ultimately an act of selfishness. I should have gone out for a while to recharge for both of our sakes.

Much is written about caregiver burnout, but what I learned is the care receiver suffers emotional stress, too.

For a normally active, independent person who hates being waited on, David has had an especially difficult time depending on others. My normally, even-tempered, light-hearted life-mate has been grouchy, argumentative and depressed. "I can't even carry a dish," he lamented with regularity. His dependence on me to drive him everywhere made him a nagging, back seat driver — unconscious actions, I am sure, to help him feel empowered.

His forays into independence caused us both misery. Like when he tried to help me unpack the car with his attempt to balance a bag while walking on crutches. That didn't end well and upset him and me.

He has resisted adding anything more to my daily tasks. He put off a much needed hair cut because he didn't want to ask me to take him, or a visit his sick brother because I was tired when I get home from work.

At one point, David accused me of being a bad caregiver, asking "If this is how you are now, what will you be like later if I ever need more prolonged care?" His words stung because he verbalized a fear I was beginning to harbor. One which I never would have equated with myself before I began this caregiving journey.

That comment was made during a simple request for a bowl of cereal. It was 10 p.m. on a weekend night and I had just sunk down in my La Z Boy® to vegetate in front of the TV, when he proclaimed, "I'm going down to get a bowl of cereal." To which I angrily retorted, "You know you can't do that, so I guess I will go downstairs and get it for you."

Was it wrong of me at that moment to silently paraphrase the old Henny Youngman line "Take my husband please" — and return him when he's back on his feet?

Our communication skills finally helped us get through David's convalescence. After our frustration with each other get to a boiling point, we talked things out. Even though it was tough at times, we both learned to listen. I finally was able to look objectively at my behavior and decided I didn't want to be that person.

When we recite the marriage vows, "for better or worse, in sickness and in health" it's more than rhetoric, it's a promise, one I learned should be taken seriously.

In retrospect, I ventured into my caregiving role with high, not realistic expectations. I underestimated my all-too human stamina and attitude. In fact, I believe my rose colored glasses worked against me. When I couldn't live up to my very high opinion of myself, I floundered.

David is now crutch-free, though full recovery is a long way off and he is still unable to drive. In the grand scheme of things, I should have had very little to complain about, especially since my caregiving duties were so temporary.

Now, with the luxury of more time to myself, and some perspective, I realize I am actually grateful for this experience. Had I not had the opportunity to take my caregiving skills for a test run, it might have been worse later on if I found myself

TEMPORARY page 8

Higher copays seen for Medicare brand-name drugs

WASHINGTON —

Copays for brand-name drugs are going up — sharply in some cases.

Copays for preferred brand-name drugs will increase by 40 percent on average this year, and non-preferred brands will average nearly 30 percent more, according to a study by Avalere Health. Copays are the portion of the cost of each prescription that the customer pays the pharmacy.

Avalere, a data analysis firm that serves industry and government, says its findings show that Medicare prescription plans are steadily shifting costs to chronically ill patients who need more expensive kinds of medications. At the same time, the plans are trying to keep costs in check for the majority whose conditions can be managed with less-expensive generics.

Medicare announced last summer that premiums for prescription plans would remain unchanged this year, an average of about $30 a month. But the government's numbers didn't delve into detail on copays. The Avalere study shows that the plan with the lowest monthly premium may not always be the best deal.

"Seniors need to look beyond the premium to understand their drug benefit," said Avalere CEO Dan Mendelson. "The more the cost burden gets shifted onto the patient who needs the medication, the more important it is for seniors to understand that next level."

Medicare officials took issue with the study, saying broad averages of prices charged by drug plans don't determine what an individual beneficiary will end up paying.

"Everyone's drug needs are going to be individual," said Medicare deputy administrator Jon Blum. "You can't make a general conclusion until you look at the particular plan they are in and the particular drugs they are taking."

Blum pointed out that President Barack Obama's health care overhaul law is saving money for beneficiaries with high drug costs, providing a 50 percent discount on brand-name drugs for those who fall into Medicare's "doughnut hole" coverage gap.

The administration is highly sensitive to criticism of its stewardship of Medicare. After Obama's health care law cut the program to finance coverage for the uninsured, many seniors responded by voting for Republicans in the 2010 congressional elections.

Medicare covers about 47 million seniors and disabled people, and about 9 in 10 beneficiaries have some kind of prescription drug plan. Most rely on the prescription program, also known as Part D, which is delivered through private insurance plans.

The Avalere study found that copays for preferred brand-name drugs will increase to an average of $40.60 this year, up from $29.01 currently. Preferred brands are usually drugs for which the prescription drug plan has negotiated a discount with the manufacturer.

Copays for non-preferred brand drugs will rise to $91.67 on average, from $71.52 last year.

Beneficiaries will also pay a bigger share of the cost of specialty drugs, which can exceed $1,000 or more per prescription. The share for 2012 averages about 32 percent, up from 27 percent last year. Specialty drugs include many of the newer treatments for chronic diseases such as rheumatoid arthritis and multiple sclerosis, as well as next generation anti-cancer drugs that come as pills.

By contrast, copays for preferred generics will remain stable, averaging $3.79. And copays for non-preferred generics will drop to $9.90, a 43 percent reduction from the current $17.29.

Medicare prescription plans usually have several levels of coverage — each with a different level of cost-sharing for the patient. The most common kind of plan has five levels: preferred generics, non-preferred generics, preferred brands, non-preferred brands and specialty drugs.

Since the Avalere figures are averages for the entire program, actual costs could vary markedly by medication, plan and region of the country.

The study also found big differences in the total number of drugs covered by the top 10 plans. Topping the list is the Humana Enhanced plan, which will cover nearly 80 percent of the more than 2,300 Medicare drugs. By comparison, the WellCare Classic plan will cover just under half. — AP

Workers' worries over retirement security deepen

By David Pitt

DES MOINES, Iowa —

Worker skepticism about having enough money to retire comfortably has taken a nosedive in a new national survey. Just 23 percent say they're very confident about being able to pay basic living expenses in retirement. That's down from 46 percent in 2008.

The survey by Sun Life Financial Inc., which has conducted its Unretirement Index survey since 2008, shows persistent economic uncertainty and a volatile stock market have workers increasingly doubtful they'll be able to retire when they had hoped.

The steep plunge in the index comes after three years of stability. "We think that this is a tipping point relative to what we've seen in prior years," said Wes Thompson, U.S. president of Sun Life Financial.

A key finding is that a growing number of workers don't see themselves as ever fully retiring. Some 20 percent say they think they will always work in some capacity. The majority of respondents, 54 percent, plan to work beyond age 65. Within that group, 11 percent plan to stop working sometime from age 66 to 69, and 16 percent are shooting for a retirement age of 70.

A year ago there was a slight glimmer of hope that the economic doldrums were easing, but workers have lost confidence again and their skepticism has deepened.

Thompson believes the sinking feeling among workers about retirement is the result of the convergence of increased personal responsibility and the fear of millions of baby boomers who are concerned about reaching retirement age without enough money.

Intensifying pressure to cut government spending makes it appear that Medicare and Social Security won't be there at current levels, pulling at least a portion of the traditional security blanket out from under millions.

Those changes came at the same time the first wave of baby boomers turned 65 last year and realized how little they've accumulated in their savings accounts.

"They realize that they can't afford to retire, which is a radical change mentally from where they were just five years ago when owning a 401(k) looked great," Thompson said.

Workers turning 65 and in good health are realizing that they could live another 20 to 30 years in retirement.

Those factors explain why the survey shows 61 percent of workers say they plan to delay retirement and work at least another three years. That's up from 43 percent who said that in 2008.

The top reason they'll keep working? Although many will choose to continue working to stay engaged socially and to stay mentally engaged in their senior years, the main reason many cited was the bare essentials. Nearly half of all workers surveyed said they'll need a job to keep earning enough money to live on. In 2008, less than a third answered with that response.

The survey questioned 1,499 workers aged 18 to 66. — AP

Feds to allow use of Medicare data to rate doctors

Picking a specialist for a delicate medical procedure like a heart bypass could get a lot easier in the not-too-distant future.

The government announced that Medicare will finally allow its extensive claims database to be used by employers, insurance companies and consumer groups to produce report cards on local doctors and hospitals.

Doctors will be individually identifiable through the Medicare files, but personal data on their patients will remain confidential.

By analyzing masses of billing records, experts can glean such critical information as how often a doctor has performed a particular procedure and get a general sense of problems such as preventable complications.

Doctors will be individually identifiable through the Medicare files, but personal data on their patients will remain confidential. Compiled in an easily understood format and released to the public, medical report cards could become a powerful tool for promoting quality care.

Medicare acting administrator Marilyn Tavenner called the new policy "a giant step forward in making our health care system more transparent and promoting increased competition, accountability, quality and lower costs."

Early efforts to rate physicians using limited private insurance data have thus far focused on primary care doctors, but Medicare's rich information could provide the numbers to start rating specialists as well. Consumers will see the first performance reports late this year, said a Medicare spokesman.

Tavenner

Medicare officials say they expect nonprofit research groups in California, Minnesota, Wisconsin, Massachusetts and other states to jump at the chance to use the data. With 47 million beneficiaries and virtually every doctor and hospital in the country participating, Medicare's database is considered the mother lode of health care information.

Tapping it has largely been forbidden because of a decades-old court ruling that releasing the information would violate the privacy of doctors. Insurance companies tried to fill the gap using their own claims data, but their files are nowhere near as comprehensive as Medicare's

Following appeals from lawmakers of both parties on Capitol Hill, President Barack Obama's health care overhaul changed federal law to explicitly authorize release of the information. Medicare followed through in regulations issued Dec. 5.

Companies will use the data analyses in their annual updates to their insurance plans. Early ratings efforts using insurance company data have lacked sufficient statistical power to rank specialists. The numbers of cases of cancer and serious heart problems in the younger, working-age population simply weren't big enough. The Medicare data could change that, since older people are more prone to chronic illnesses.

Doctors groups that fought for years to prevent release of the Medicare data, have lately shifted to putting conditions on its use.

For example, Medicare's rule gives individual providers the right to see their information before it is publicly released, and 60 days to challenge it.

The American Medical Association had previously argued that such data could be misleading to untrained consumers. For example, a surgeon who has lots of patients who develop complications may actually be a top practitioner who takes cases that others less skilled would turn away.

Medicare says it will screen the analytical methods of groups that are requesting access to the data. The organizations will have to meet other qualifications, such as having access to claims data of their own. And they will have to pay for access to the Medicare files. — AP

Let's Talk: Americans need health care and retirement security

By Deborah E. Banda

"I remember the pride I felt when I received my Social Security card at the age of 14," said Sarah, an AARP member from Natick. "I have been happy over the years to pay into this program which supported my grandparents and parents, but is now threatened by those who do not understand that we are all in this together. What happened to our country that we no longer care about each other?"

AARP and You

Over the last several months, we have heard from thousands of AARP members from across the commonwealth — and throughout the country — who have expressed their frustration, anger and even fear over the prospect of Congress cutting Social Security and Medicare benefits in order to reduce the nation's debt. More than 6.5 million signed petitions urging members of Congress not to make these cuts.

Yes, we sent a strong message to the congressional Super Committee that was working to solve the federal budget deficit. And, while they failed to act, this will not be the end of the debate.

Today, more than one million Massachusetts residents count on these lifeline programs.

In the Bay State alone, middle- and lower-income seniors rely on Social Security for 74.2 percent of their individual income. Without these Social Security benefits, nearly 300,000 of the commonwealth's older residents would face poverty. Remember, the average annual Social Security benefit is only $13,900 — while the typical Massachusetts senior on Medicare pays $6,800 a year on their out-of-pocket health care costs. And, nearly 100 percent of our older residents are enrolled in Medicare.

"Medicare is very important to my husband and me," explained Joan from Yarmouthport. "It is something we worked very hard for, for many years, and now we depend on it for our health care coverage."

We have heard from our members, and Americans 50-plus, that we as a nation need to strengthen and improve Social Security and Medicare — as opposed to treating them as a piggy bank to pay the nation's bills. Our members are extremely frustrated with the inability of Congress to address these concerns.

John of Billerica sums up this sentiment, "As young adults, we worked our entire young lives trying to keep on top of things and pay our taxes, so as we reach retirement age, we will have the help we need not to have to depend on our children. Let us not show them that there is no hope for the future."

AARP agrees. Instead, we need a national discussion to develop the tools and strategy for strengthening health care and retirement security — and for restoring prosperity to the middle class.

Many believe that Congress should be able to reduce the deficit without jeopardizing the health care and retirement security system that Americans depend on, that they have worked for and have paid into all their lives. Lawmakers could begin by cutting wasteful spending — including in our health care system — attacking fraud and eliminating tax loopholes. Their failure to date has made our members, and people 50-plus, even more cynical about the ability of government to come to grips with these issues.

They are anxious to hear solutions that address the problems faced by real people. They want to hear ideas that would lead to more jobs, bring efficiency, economy and fairness to health care and provide greater financial security.

"We have all worked hard and contributed to Social Security and Medicare for many years and we don't know how we would survive without these benefits," said Sharon of Worcester. "I think they are great plans, but need work and protection to keep them alive for future generations. We all get old and need some security in our lives."

AARP believes it is time to take the conversation about Social Security and Medicare from behind closed doors and in to the public arena. It is time to give Americans a voice.

We are about to kick off an important national conversation on finding ways to strengthen health care and retirement security, and restore prosperity to the middle class. We want to hear your ideas. And, we want to hear what you think about the options already being discussed, especially what they would mean to you and your family. We all need to understand the impact these options would have both today and tomorrow.

AARP wants to ensure that current and future generations receive the benefits they have earned over a lifetime. With your ideas, input and involvement, together, we can achieve this goal.

Deborah Banda is the state director of AARP Massachusetts, which represents more than 800,000 members age 50 and older in the Bay State. Connect with AARP Massachusetts online at www.aarp.org/ma, www.facebook.com/AARPMA and www.twitter.com/AARPMA.

Will new 'safe driver' rules make our roads safer?

By Al Norman

Last July, I wrote about a new state law that was supposed to help get unsafe drivers off the road. But will it work?

Gov. Deval Patrick signed into law Chapter 155 of the Acts of 2010, under which, if you are 75 years of age or older and applying for a renewal of a license, you will have to show up in person at a Registry of Motor Vehicles (RMV) office, where you will be given a vision test. As an option, you can produce a "vision screening certificate," signed by an optometrist or ophthalmologist to show that you meet minimum visual standards for a driver's license.

Push Back

Under the new law, you can also lose your license if you are not "physically or medically capable of safely operating" a car, or have a "cognitive or functional impairment" that will affect your ability to drive a car. Chapter 155 leaves it to "health care providers" to report to the RMV if your physical or medical condition leaves "reasonable cause to believe" that you can't operate a motor vehicle.

But here's the flaw: a doctor, a nurse or a policeman is not required to make a report. Even though the law protects health care providers from a lawsuit if they file a report in good faith — the fact that they don't have to file a report means they can just look the other way. In fact, the law also protects them from a lawsuit for not filing. A person who is allowed to report, and who strongly believes a person should not be behind the wheel, can choose to do nothing. It's hard to see how that helps keep our roads any safer.

On Nov. 9, the Department of Public Health issued proposed new regulations for Chapter 155 to give health and law enforcement officials their first look at standard definitions. "Cognitive impairment" is defined as "any condition that impairs … attention, alertness, perception, comprehension, judgment, memory or reasoning that may influence the physical action, reaction time or other responses to understand and interact with the environment." A "functional impairment" is "any symptom of a disease or medical condition that results in full or partial decrease in any or several sensory or motor functions," which includes "peripheral sensation of the extremities, strength, flexibility, motor planning and coordination."

Any cognitive or functional impairment that limits a person's attention, or the ability to understand "the immediate driver context," or to make appropriate decisions while driving, or "visuospatial processing," or impairs their "strength, flexibility, reflexes, sensory perception and physical coordination," is considered a "driving relevant" impairment. The impairment must be one that cannot be "sufficiently corrected or controlled" by medication, therapy, surgery or by some adaptive equipment or driving device.

Drivers of any age who are incapable of operating a vehicle should be off the road. The law is right to insist that whatever your impairments are, if they don't affect your ability to drive a car, they are not relevant to the RMV. This safe driver law should have mandated safety reports by doctors, because when the rubber hits the road, this law is only as good as the reports that get made, and only as helpful as the evaluations that follow. And any senior who loses his or her license should be automatically eligible for public transportation — a detail state lawmakers refused to consider.

Al Norman is the executive director of Mass Home Care. He can be reached at 413-773-5555 x 2295, and at info@masshomecare.org.

➤ Temporary

Cont. from page 5

in this role on a more long-term basis.

I may have my limits, and at times that dark side is bound to show, but that doesn't mean I'm not the caring, nurturing person I always believed myself to be. As my husband, David, might say, when I'm having those moments, "At least do it with a smile."

Fat chance!

Sondra Shapiro is the executive editor of the Fifty Plus Advocate. Email her at sshapiro.fiftypusadvocate@verizon.net or read more at www.fiftyplusadvocate.com

Gov. inspectors decry psych drug use among elderly

WASHINGTON —

Government inspectors told lawmakers recently that Medicare officials need to do more to stop doctors from prescribing powerful psychiatric drugs to nursing home patients with dementia, an unapproved practice that has flourished despite repeated government warnings.

So-called antipsychotic drugs are designed to help control hallucinations, delusions and other abnormal behavior in people suffering from schizophrenia and bipolar disorder, but they're also given to hundreds of thousands of elderly nursing home patients in the U.S. to pacify aggressive behavior related to dementia. Drugs like AstraZeneca's Seroquel and Eli Lilly's Zyprexa are known for their sedative effect, often putting patients to sleep.

But the drugs can also increase the risk of death in seniors, prompting the Food and Drug Administration to issue multiple warnings against prescribing the drugs for dementia. Antipsychotics raise blood sugar and cholesterol, often resulting in weight gain.

An inspector for the U.S. Department of Health and Human Services (HHS) told the Senate Committee on Aging that the federal government's Medicare program should begin penalizing nursing homes that inappropriately prescribe antipsychotics, according to written testimony obtained by the Associated Press.

The Centers for Medicare and Medicaid Services provides health coverage to nearly 80 million senior, poor or disabled Americans.

HHS Inspector General Daniel Levinson proposed that Medicare force nursing homes to pay for drugs that are prescribed inappropriately, and potentially bar nursing homes that don't use antipsychotics appropriately from Medicare.

A report by Levinson's office issued in May found that 83 percent of Medicare claims for antipsychotics were for residents with dementia, the condition specifically warned against in the drugs' labeling. Fourteen percent of all nursing home residents, nearly 305,000 patients, were prescribed antipsychotics.

Doctors are permitted to prescribe drugs for off-label uses, though it is illegal for drug companies to promote uses that haven't been cleared by the FDA. In recent years several pharmaceutical companies have paid huge fines to the Department of Justice in cases involving off-label marketing of antipsychotics.

In January 2009, Eli Lilly & Co. Inc. agreed to plead guilty and pay $1.4 billion for illegal promotion of Zyprexa, including marketing to nursing home doctors. The company told its sales representatives to use the slogan "5 at 5," to persuade doctors that giving 5 milligrams of the drug at 5 p.m. would make dementia patients sleep through the night.

AstraZeneca PLC has paid nearly $600 million in two separate settlements with federal and state prosecutors over alleged off-label promotion of its drug Seroquel. — AP

China revisit offers glimpse into past, present

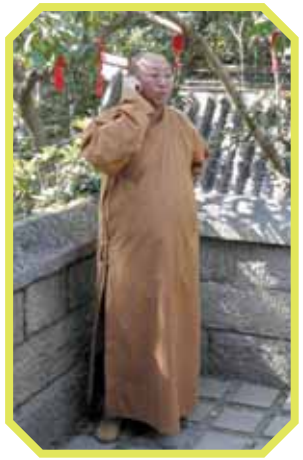
By Victor Block

CHINA — Automobiles clog city streets that were built for pedestrians and bicycles. Billboards that recently touted the benefits of socialism now advertise designer clothes and the latest electronic gadgets. Vendors sell dumplings, noodles and unidentifiable body parts of animals off wooden carts parked in front of KFC, McDonald's and other American-based fast food restaurants.

A recent return trip to China, more than 20 years after my first visit, resembled a back-to-the-future experience. Like the rest of the country, Shandong Province southeast of Beijing offers a study in contrasts. In cities, modern skyscrapers stretch as far as the eye can see. Members of the "millennial" generation sporting the latest fashions are glued to their cell phones.

Fyllis Block stands in front of a huge decorative plate at the Museum of Pottery and Porcelain

A short distance away the setting is very different. Farm fields surround small villages where tiny houses line narrow dirt streets. People strain beneath heavy shoulder yokes as their forebears did. Men and women till the soil with implements not much different from those used centuries ago.



A Taoist monk speaking on a cell phone

The natural place to begin a tour is Jinan (pronounced Dze-nahn), Shandong's capital. It is known as the "City of Springs," because more than 100 natural pools gush from the ground.

In Qufu (Chew-foo), the birthplace of Confucius, sites associated with the life of the venerated philosopher and teacher serve as a magnet for tourists. The Temple of Confucius, originally built a year before his death in 479 B.C., occupies the site of the modest three-room home where his family lived. It has been expanded over hundreds of years to include 466 rooms that sprawl over 46 acres.

The adjacent Confucian Family Mansion, begun in 1038 A.D., is almost as vast. Now comprising 152 buildings, it has served as home to senior male heirs. The third major Confucian site is the largest family cemetery in the world, where the tombs of more than 100,000 descendants of Confucius surround his simple gravesite.

Another popular destination is Mount Tai. For at least 3,000 years, it has been a place of worship in both the Taoist and Buddhist religions. Ancient emperors traveled there to offer sacrifices. Elaborate pavilions, towers and inscriptions carved on cliffs cover the 5,069-foot high mountain.

Other cities also have their unique claims to fame. Qingdao (Ching-dow) is home to the best-known Chinese beer, sold as Tsingtao in the United States and throughout the world. Qingdao also was the site of sailing events during the 2008 Olympics held in China and a museum recalls that proud moment.

Wine rather than beer is the focus of Yantai (Yan-tie), known as "the city of grape wine." Archaeological findings indicate that wine was used for sacrificial ceremonies in China 9,000 years ago. Modern production began in 1892, when the Changyu Pioneer Wine Company was established in Yantai. Today about 140 of the estimated 500 wineries in the country are located in Shandong Province.

Not far from Yantai, my wife Fyllis and I delved into village life — and the past. We strolled into the tiny hamlet of Hanqioa (Han-kwee-au), smiling at villagers who stared at us with curiosity. Men and women of all ages were preparing corn to be ground into meal, and breaking tree branches to serve as fuel during winter.

In villages like Hanqiao, life has changed little from decades ago. Introductions to intriguing historical tidbits stretching much further back in time are available at worthwhile museums in Shandong Province and throughout China.

With an 8,000-year history of pottery making, it's natural that Shandong Province is home to a Museum of Pottery and Porcelain. Displays include fine chinaware that is as much art as it is functional.

Equally appealing was a whimsical collection of over 3,000 clay pieces depicting people engaged in every aspect of pottery making a century ago.

Another museum is as interesting for its location as its contents. Workmen constructing a highway uncovered the underground burial place of a dignitary. He was laid to rest some 2,600 years ago with chariots and horses, which were buried to transport him to the next life. The carts and horse skeletons were left intact and the highway was completed overhead. The collection also includes chariots from throughout history that were used in more ways than I could have imagined.

Given the increased popularity of wine in China, the Changyu Wine Culture Museum in Yantai is another popular stop. Never before had Fyllis and I visited a wine cellar over 100 years old, or seen such an extensive display of primitive vessels used in ancient wine making.

A couple in Hanqiao village take time out from their work to pose for a photograph

Wine production in China, spanning some 9,000 years, is but one of countless activities and attractions that serve as bridges between the past and present. Exploring that country's history and experiencing current developments provides a fascinating contrast. Shandong Province offers much that the country has to offer in a compact area.

If you go

The best way to visit China is on a group or individual guided tour that includes travel, English-speaking guides, accommodations and other arrangements. For more information or help planning a trip, go to travelshandong.com or call Night Hawk Travel, which specializes in tourism to Shandong Province, at 800-420-8858.

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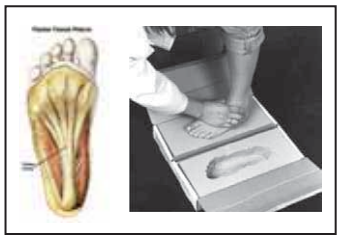

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Studies find new drugs boost skin cancer survival

CHICAGO —

They're not cures, but two novel drugs produced unprecedented gains in survival in separate studies of people with melanoma, the deadliest form of skin cancer, doctors recently reported.

In one study, an experimental drug showed so much benefit so quickly in people with advanced disease that those getting a comparison drug were allowed to switch after just a few months.

The drug, vemurafenib, targets a gene mutation found in about half of all melanomas. The drug is being developed by Genentech, part of Swiss-based Roche, and Plexxikon Inc., part of the Daiichi Sankyo Group of Japan.

The second study tested Bristol-Myers Squibb Co.'s Yervoy, a just-approved medicine for newly diagnosed melanoma patients, and found it nearly doubled the number who survived at least three years.

Only two drugs had been approved to treat melanoma, with limited effectiveness, until Yervoy, an immune-system therapy, won approval in March.

The experimental drug, vemurafenib, (vem-yoo-RAF-eh-nib), is aimed at a specific gene mutation, making it the first so-called targeted therapy for the disease. The drug got attention when a whopping 70 percent of those with the mutation responded to it in early safety testing.

The new study, led by Dr. Paul Chapman of Memorial Sloan-Kettering Cancer Center in New York, was the key test of its safety and effectiveness. It involved 675 patients around the world with inoperable, advanced melanoma and the gene mutation. They received vemurafenib pills twice a day or infusions every three weeks of the chemotherapy drug dacarbazine.

After six months, 84 percent of people on vemurafenib were alive versus 64 percent of the others.

Less than 10 percent on the drug suffered serious side effects — mostly skin rashes, joint pain, fatigue, diarrhea and hair loss. About 18 percent of patients developed a less serious form of skin cancer. More than a third needed their dose adjusted because of side effects.

The study is continuing, and many remain on the drug.

The study was sponsored by the drug's makers, and many of the researchers consult or work for them. The companies are seeking approval to sell the drug and a companion test for the gene mutation in the U.S. and Europe. A Genentech spokeswoman said the price has not yet been determined.

The other new drug, Yervoy, is not chemotherapy but a treatment to stimulate the immune system to fight cancer. Dr. Jedd Wolchok of Memorial Sloan-Kettering led the first test of it in newly diagnosed melanoma patients.

About 502 of them received dacarbazine and half also got Yervoy. After one year, 47 percent of those on Yervoy were alive versus 36 percent of the others. At three years, survival was 21 percent with Yervoy versus 12 percent for chemotherapy alone.

Side effects included diarrhea, rash and fatigue. More than half on the new drug had major side effects versus one quarter of those on chemotherapy alone.

Bristol-Myers Squibb paid for the study and many researchers consult or work for the company. — AP

Aging in place: A little help can go a long way

By David Crary

VERONA, N.J. —

Retirement communities may have their perks, but Beryl O'Connor said it would be tough to match the birthday surprise she got in her own backyard when she turned 80 last year.

She was tending her garden when two little girls from next door — "my buddies," she calls them — brought her a strawberry shortcake. It underscored why she wants to stay put in the house that she and her husband, who died 18 years ago, purchased in the late 1970s.

"I couldn't just be around old people — that's not my lifestyle," she said. "I'd go out of my mind."

Physically spry and socially active, O'Connor in many respects is the embodiment of "aging in place," growing old in one's own longtime home and remaining engaged in the community rather than moving to a retirement facility.

According to surveys, aging in place is the overwhelming preference of Americans over 50. But doing it successfully requires both good fortune and support services — things that O'Connor's pleasant hometown of Verona has become increasingly capable of providing.

About 10 miles northwest of Newark, Verona has roughly 13,300 residents nestled into less than 3 square miles. There's a transportation network that takes older people on shopping trips and to medical appointments, and the town is benefiting from a $100,000 federal grant to put an aging-in-place program called Verona LIVE in place.

Administrated by United Jewish Communities of MetroWest New Jersey, the program strives to educate older people about available services to help them address problems and stay active in the community. Its partners include the health and police departments, the rescue squad, the public and public schools, and religious groups.

Among the support services are a home maintenance program with free safety checks and minor home repairs, access to a social worker and job counselor, a walking club and other social activities. In one program, a group of middle-school girls provided one-on-one computer training to about 20 older adults.

Social worker Connie Pifher, Verona's health coordinator, said a crucial part of the overall initiative is educating older people to plan ahead realistically and constantly reassess their prospects for successfully aging in place.

"There are some people who just can do it, especially if they have family support," said Pifher, "And then you run into people who think they can do it, yet really can't. You need to start educating people before a crisis hits."

There's no question that aging in place has broad appeal. According to an Associated Press-LifeGoesStrong.com poll conducted in October, 52 percent of baby boomers said they were unlikely to move someplace new in retirement. In a 2005 survey by AARP, 89 percent of people age 50 and older said they would prefer to remain in their home indefinitely as they age.

That yearning, coupled with a widespread dread of going to a nursing home, has led to a nationwide surge of programs aimed at helping people stay in their neighborhoods longer.

Verona LIVE is a version of one such concept: the Naturally Occurring Retirement Community, or NORC. That can be either a specific housing complex or a larger neighborhood in which many of the residents have aged in place over a long period of time and need a range of support services in order to continue living in their homes.

Verona is an apt setting. Roughly 20 percent of its residents are over 65, compared with 13 percent for New Jersey as a whole.

Another notable initiative is the "village" concept. Members of these nonprofit entities can access specialized programs and services, such as transportation to stores, home health care or help with household chores, as well as a network of social activities with other members.

About 65 village organizations have formed in the U.S. in recent years, offering varying services and charging membership fees that generally range between $500 and $700 a year.

One of the potential problems for people hoping to age in place is that their homes may not be senior-friendly.

"It becomes a challenge because we live in Peter Pan houses, designed for people who never grow old," said Susan Bosak, a social scientist who is overseeing a program to boost intergenerational engagement in Tulsa, Okla.

Many older people live in homes that are 40 or more years old, abounding with narrow interior doorways, hard-to-reach kitchen cupboards and potentially hazardous bathroom fixtures.

"If you're a boomer person, with money to remodel, think about making your house more user-friendly, not just more beautiful, for when you have your knee replacement or a chronic condition," said Nancy Thompson of AARP. "We're talking smart, convenient. It doesn't have to look institutional or utilitarian."

To promote this outlook, AARP has teamed up with the National Association of Home Builders to create a designation for certified aging in place specialists trained in designing and modifying residences for the elderly. Several thousand builders, contractors, remodelers and architects have been certified. Building or remodeling homes can include such details as touchless faucets, trim kitchen drawers instead of cupboards, grab bars and nonslip floors in the bathrooms.

Arizona's Pima County, along with a few other local governments, has gone a step further, passing an ordinance requiring that all new homes in the unincorporated areas around Tucson offer a basic level of accessibility. They must have at least one entrance with no steps. Minimum heights and widths are set so that light switches can be easily reached and doorways are passable in a wheelchair.

For now, Beryl O'Connor's two-story, four-bedroom Cape Cod house, built in the 1940s, poses no physical challenges for her. Her own bedroom is on the ground floor, and she recently had a safety bar installed in her bathtub, so she thinks prospects are good for staying put over the long term.

Plus, she's got company at home — a 26-year-old granddaughter lives upstairs and commutes to a job in New York — and many friends around town, where she has a busy schedule of club meetings, group lunches, card games and occasional bus trips to casinos.

"You've got to socialize," she said. "There are things out there to do — you've got to look for them."

Ira and Roseanne Bornstein, who live a few blocks from O'Connor, also think their longtime home can accommodate them suitably for many years to come. There's a room on the ground floor they could convert to a bedroom, and space upstairs to house a live-in aide if one were needed.

"It's a modest home, but it's always worked for us," said Rosanne Bornstein, 63, who was a school counselor and teacher for 25 years. "We're very strong in wanting to stay here."

Her 69-year-old husband, a retired pharmacist, said they worry that the economics of relocating might result in a smaller residence, and crimp their ability to entertain and host out-of-town guests.

"People are younger and healthier when they retire," he said. "If you plan right, you can have a lot of time to enjoy it."

Connie Pifher, the town social worker, engages with aging-in-place issues as part of her job, and also on a personal level as she nears retirement at 64.

Divorced, with two grown sons, she used to be determined to stay on in her four-bedroom house as a retiree. Now she's planning to move out, to a co-op or townhouse. She said the ordeal of a recent three-day power outage after a surprise snowstorm hammered home the point that "it's time to move out of Dodge."

"Do I want to worry about the sump pump or getting the car out of the garage when the door doesn't work?" she asked.

One former option, moving to an upscale retirement community, is off the table for financial reasons. She said the value of her house has dropped too far for her to afford that switch.

That's a relatively common problem, with many continuing-care retirement communities charging entry fees of several hundred thousand dollars, followed by ongoing monthly fees.

In several states, there's debate about whether to promote aging in place by shifting more Medicaid dollars to community-based programs and away from traditional nursing facilities. But budget problems may complicate such efforts as some financially struggling states cut back on home health services that help keep some elderly people out of nursing homes.

Susan Bosak, the social scientist who is advising Tulsa on its Across the Generations initiative, said building positive intergenerational relations throughout a community is vital to enhancing life for its elderly.

"Aging in place fosters the illusion we can do it by ourselves, but we can't," she said. "A high quality of life requires support from the entire community."

It's worth the effort, she said, if it means that more older people are aging where they feel most comfortable.

"Home is more than just meeting our need for shelter," she said. "It's in our memories. It's where we can be ourselves."

Online: AARP fact sheet: tinyurl.com/3jxoso3; National Association of Home Builders: tinyurl.com/6cwbdn.

Plan would lift wages of home care workers

WASHINGTON —

President Barack Obama says it's inexcusable that home health care workers who care for the elderly and disabled can be paid less than minimum wage, and he's going to change it.

The president has announced new Labor Department rules that will require those workers to be paid minimum wage, plus overtime. Currently 29 states don't require minimum wage and overtime for home health care workers.

There are nearly 2 million such workers nationwide, and the president says that number will only grow as the population ages.

Obama made the announcement at the White House, surrounded by home health care workers. He said they "work their tails off" and deserve to be paid fairly.

It was the latest executive action announcement by Obama aimed at pressuring lawmakers or moving forward without their help. — AP

Longevity insurance: Old-age money protection

By Dave Carpenter

CHICAGO —

Odds are growing that you'll live past 85. But will your money last that long? And what if you make it to 95 or 100?

With lifespans lengthening, those nearing retirement may want to consider financial protection to guard against the possibility of outliving their money.

It's now increasingly available in the form of longevity insurance, which usually involves giving a sum of money to an insurer in your 60s in exchange for monthly payments that start at 80 or 85 and continue for the rest of your life.

The little-known financial product is gaining new attention at a time when few have pensions and Congress is discussing changes to Social Security that could reduce future benefits. New York Life Insurance Co. began offering a policy in July, joining a handful of others including MetLife, Symetra Financial and The Hartford.

But it's not just about insurance companies looking to make money off aging baby boomers. Retirement experts and some financial advisers say it can make a lot of sense for those who have enough savings to be able to spare a small portion in exchange for future monthly income that they can't outlive.

"This is something that people ought to be thinking about as they approach retirement," said Anthony Webb, research economist for the Center for Retirement Research at Boston College.

Longevity insurance is the relatively new term for an annuity designed to cover the latter years of retirement. An annuity is an investment product in which you typically pay an insurance company a lump sum and get back a stream of payments for life.

Certain annuities have sullied the category name for being complex and loaded with fees — mostly variable annuities, where the value can sink with stock market declines. But more financial advisers are touting annuities as a way to receive the guaranteed lifetime income that pensions once provided.

With the longevity annuity, income is fixed and starts at a specified future age, frequently 85.

Under MetLife's "maximum income" version, for example, a woman who buys longevity insurance with a $100,000 lump sum at age 65 could receive annual income of $59,010 starting at 85. That wouldn't be enough to cover a year of nursing home care, but as supplementary income it would go a long way toward covering living expenses.

Payouts are higher for men because of shorter average lifespans. A 65-year-old man purchasing $100,000 of insurance would get $73,580 annually from MetLife starting at 85.

If you die before payments start, the money you gave the insurance company is gone.

The insurers do offer alternate versions that guarantee death benefits to heirs, allow clients to start collecting income whenever they need it, even let them out of the contract. But those conditions can double the price paid.

Buying this protection serves dual purposes. It ensures a predictable stream of income for your later years, removing worries about having to depend on family members for financial assistance. And defining the exact time period that savings have to cover — say, from age 65 to 85 — allows retirees to spend more confidently and invest more aggressively without fear of running out later.

"If you have one of these that kicks in at 85, it becomes a much simpler problem of how to spend down one's wealth," said Webb.

The big downside, of course, is giving a pile of money to an insurer and hoping you and the company both are around in 20 years or whenever the benefits start flowing. Your best bet is to find a company with the best ratings by A.M. Best, Fitch, Moody's and Standard & Poor's.

Demand for this insurance is low so far. But rising life expectancy should help it grow. After all, for a reasonably healthy 65-year-old couple's chances are 63 percent that one of them will live until 90, 36 percent that one will make it to 95 and 14 percent that one will reach 100, according to the Society of Actuaries.

The key is to remember it's an insurance policy and not an investment.

Jason Scott, managing director of the Financial Engines Retiree Research Center, calls longevity insurance an efficient way of handling the risk of living a long time. "It's really expensive for an individual to plan for a life that might last to 100," he said.

Dallas Salisbury, 62, had no qualms about buying longevity insurance three years ago that won't pay him a cent until his 85th birthday in 2034.

His health and family history both suggest that Salisbury, who is president of the Employee Benefit Research Institute in Washington, D.C., has an excellent chance of cashing in. Both parents lived past 93, and an aunt reached 104. He said he'll recoup his original cost, not counting inflation, after a year of payments. And if he makes to 90, he'll have reaped a 10 percent annual return on his money.

But even more important in his decision, he said, was the chance to lock in long-term financial certainty at a modest cost. He and

INSURANCE page 15

Another important chapter in state's probate code

By Linda T. Cammuso

The new Massachusetts Uniform Probate Code (MUPC) was signed into law several years ago and several important and significant changes took effect on Jan. 2. The new legislation is designed to simplify, streamline and clarify the probate process. In certain cases it will require less court supervision and estate resolution will be quicker and be less costly, at least in theory.

Legal Briefs

Among the many changes, terminology has been streamlined and modernized. Previously, probate forms and terminology were different for those who died with a will (testate) and for those who passed without one (intestate). There will no longer be a confusing distinction between executor and administrator; the term now used to identify the person assigned by the court to manage the estate is personal representative.

The laws of intestate distribution, which apply when someone dies without a will, have also changed and will particularly impact the blended family — i.e., marriages in which the spouses have children from prior unions and may have children together.

Under the former law, if a person died intestate (without a will) and was survived by a spouse:

•If the decedent had descendants (children or grandchildren), the surviving spouse took only half the estate and the descendants took the remaining half.

•If the decedent had no descendants, the surviving spouse took the first $200,000, and then split the remainder with the decedent's heirs at law (blood relatives).

Under the new law, for intestate estates with surviving spouses:

•If the decedent is not survived by parents or descendents, the surviving spouse takes the entire estate. There is an exception, though: If the surviving spouse has descendants from a prior relationship (i.e. not of the decedent), the surviving spouse takes the first $100,000 plus half the remaining estate, and the other half goes to the decedent's nearest heirs at law (blood relatives).

•If the decedent is survived by descendents, the surviving spouse takes the entire estate. The exception to this rule is: If any of the descendants are not common to the decedent and the surviving spouse (i.e. either the decedent of the surviving spouse has descendants from a prior relationship), the surviving spouse takes the first $100,000 plus half the remaining estate, and the decedent's descendants take the other half.

The new Massachusetts Uniform Probate Code expands the rights of a surviving spouse and at the same time acknowledges the reality of blended families. These changes highlight the facts that 1) estate planning is not a one-size-fits-all process and 2) creating a customized estate plan with a skilled estate-planning attorney is more important than ever.

The next question: have these changes made your will obsolete or ineffective? Although the new law does not invalidate old wills, your will may rely on default provisions in the law (e.g. definitions of who is defined as a kindred, descendant, heir at law, etc.) that are now different. The short answer is, if you're not certain of the law's effect on your will, you should have it reviewed by a qualified estate planning attorney.

Linda T. Cammuso, a founding partner at Estate Preservation Law Offices and an estate planning professional, has extensive experience in estate planning, elder law and long-term care planning. Linda may be reached at www.estatepreservationlaw.com or by calling 508-751-5010. Archives of articles from previous issues may be read at www.fiftyplusadvocate.com.

➤ Insurance

Cont. from page 14

his wife bought longevity policies with different insurers, spending 10 percent of their investment portfolio at the time. That means they can decide what to do with 90 percent of their assets between now and age 85 without worrying about holding back money for an indefinite number of years beyond life expectancy.

"Paying 10 percent for that type of certainty to me is worth it," he said. "If you want to protect yourself against living a long time and running out of money, the only way of doing it is where someone else takes on that longevity risk."

Longevity insurance should interest those of somewhat above-average income — roughly the 60th through 95th percentiles of the population, according to Webb, who also suggests buying some form of inflation protection with the policy.

Those from families with a history of longevity, are particularly good candidates for it. Even those who find it a good fit for their finances, however, aren't advised to spend any more than 15 to 20 percent of their assets. And while the price is lower if you buy it younger, most experts don't recommend getting coverage until you're in your 60s. — AP

Small home renovations buy time

By Melissa Rayworth

It's a reality of our fragile economy: Many homeowners who dream of the perfect kitchen or master bath are putting full-scale renovation on hold in favor of more limited changes.

"What's on everyone's minds is making the space feel a little better and function a little better until you can reach the ultimate kitchen or bath that you want," said Danny Lipford, host of the nationally syndicated home-improvement radio show *Homefront with Danny Lipford*. He said he often hears from listeners planning smaller redecorating projects to tide them over until real renovation fits in their budgets.

But which small projects are worth it if you're going to remodel the space within just a few years?

Choose projects that offer big change at little cost, or that serve as first steps toward eventual full-scale renovation, said Sabrina Soto, designer and host of HGTV's series *The High Low Project*.

Lipford suggests making changes to the biggest surfaces in a room, such as countertops or floors. Old laminate countertops can now be painted for less than $50, he said, and the results look surprisingly good. Using a type of paint sold in a kit (Lipford recommends one found at Gianigranite.com), homeowners can paint over the old countertop and then seal it with a coating that mimics the look and solid feel of laminate.

Tanya Memme, host of A&E's *Sell This House*, agrees that big surfaces are a good place to start. "Any room will look bad if the floors aren't in decent shape," she said.

Cover a soon-to-be-replaced wood or tile floor with a colorful new rug, or put down peel-and-stick vinyl tiles. Good quality vinyl tiles resembling granite can cost several hundred dollars if you're covering a full kitchen floor. But the change is dramatic, so it may be worthwhile even for just a few years of use.

Old ceramic tile floors and tile walls can get a facelift for just a few dollars if you use grout stain, Lipford said. You can make dingy grout a pristine white again or change it to a new color that contrasts with your old tile.

Memme suggests adding a tile backsplash to a kitchen wall for a burst of new style. Do it yourself to save money. "It might seem difficult to put up tile," she said, "but actually it's very easy to do." Small tiles come on a mesh sheet, so you're not placing each one.

Another way to bring big change to walls: Michael Hydeck, president of the National Association of the Remodeling Industry, suggests painting with different textures. Try a faux finish like granite or marble, or buy the same shade of paint in two different finishes — one shiny and one matte — and paint alternating stripes in each.

Installing under-cabinet or over-cabinet lighting probably isn't wise if you'll be removing the cabinets in a year or two, Hydeck noted. But a new ceiling light can be installed now and still be used when kitchens or bathrooms are renovated.

Changing window treatments also can change a room's lighting and bring in fresh color. "Everybody gets used to what's up on their windows," Memme said, "because they've been living with it. They don't see the wear and tear." Remove old blinds or shades and replace them with inexpensive curtains.

Soto suggests phasing in new major appliances ahead of a full kitchen renovation. If need be, they can be relocated elsewhere in the room once the remodeling is done. She also suggests buying new countertop appliances, such as microwaves or toaster ovens, now, with the anticipated redesign of the kitchen in mind.

If you can't replace appliances now but are craving change, Lipford said appliance paint is available from Rustoleum and other companies. It can give new life to an old refrigerator or dishwasher, and is easy to apply yourself.

Small items such as drawer pulls, electrical switch plates and doorknobs can easily be changed. Swap out old knobs for new door handles, switch from brass to nickel, or bring in jeweled or glass or ceramic pieces for added style.

Faucets also can be changed now and then re-used when you eventually replace the entire sink.

Old glass shower doors can be removed relatively easily and replaced by a stylish fabric shower curtain. Swap out old kitchen chairs with cool, flea-market finds, or recover chair cushions yourself with a few yards of new fabric.

Replace a dated bathroom mirror with an inexpensive framed one, or build your own frame with strips of molding. — AP

Losing weight, keeping it off, two different things

A new study indicates that the practices that help people to lose weight and the practices that help them keep it off do not overlap much.

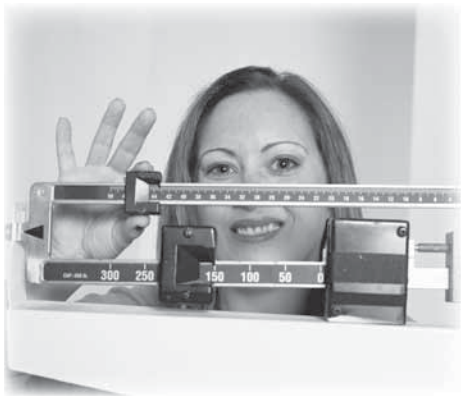
"No one announces to a dieter, 'You're moving into the weight-maintenance stage. You'll have to do things differently,' said lead author Dr. Christopher Sciamanna. His group investigated whether two distinct sets of behaviors and thought patterns were involved in weight loss and its maintenance.

Practices associated with successful weight loss only were:

- Participate in a weight–loss program;
- Look for information about weight loss, nutrition or exercise;
- Eat healthy snacks;
- Limit the amount of sugar you eat or drink;
- Plan what you'll eat ahead of time;
- Avoid skipping a meal, including breakfast;
- Do different kinds of exercise;
- Do exercise that you enjoy;
- Think about how much better you feel when you are thinner.

Practices significantly associated with successful maintenance only were:

- Eat plenty of low-fat sources of protein;
- Follow a consistent exercise routine;
- Reward yourself for sticking to your diet or exercise plan;
- Remind yourself why you need to control your weight.



If the two stages do demand different practices, then weight loss programs might need to guide people about key strategies for each phase explicitly, said Sciamanna, a professor of medicine and public health sciences at the Penn State College of Medicine.

Dr. Lawrence Cheskin, director of the Weight Management Center at Johns Hopkins Bloomberg School of Public Health, said, "We do often tell patients about the different skills that are needed and the different approaches to take to achieve weight loss and weight maintenance. This work adds substance to that general statement." Cheskin has no affiliation with the study.

Sciamanna's group surveyed a random sample of 1,165 adults by telephone. Some had been successful at losing weight; some had also maintained a weight loss. They asked them about 36 things they might do and think about to lose weight and keep it off. The researchers defined long-term success as losing at least 30 pounds and keeping if off for a year.

Fourteen practices were associated with either successful loss or successful weight loss maintenance, but not both. The overlap between practices associated with weight loss and those associated with weight loss maintenance was 61 percent, not much higher than that expected by chance.

"Some people are 'black and white,' " Cheskin said. "They'll diet strictly, eating nothing they're not meant to eat, or they won't be careful at all. Maintenance requires something in between. This research could have implications for what we should emphasize when we are trying to help people lose versus maintain their weight." — NEWSWISE

Heart disease, No. 1 killer, can sneak up on women

By Lauran Neergaard

WASHINGTON —

Heart disease can sneak up on women in ways that standard cardiac tests can miss.

It's part of a puzzling gender gap: Women tend to have different heart attack symptoms than men. They're more likely to die in the year after a first heart attack.

In fact, more than 40 percent of women still don't realize that heart disease is the No. 1 female killer. One in 30 women's deaths in 2007 was from breast cancer, compared to about 1 in 3 from cardiovascular disease, according to the American Heart Association.

A new report said there's been too little progress in tackling the sex differences in heart disease. It outlines the top questions scientists must answer to find the best ways to treat women's hearts — and protect them in the first place.

"A woman's heart is her major health threat, and everyone who takes care of a woman has to realize that," said Emory University cardiologist Dr. Nanette Wenger, who co-authored the report.

HEART page 18

Help is available for tinnitus sufferers, part 1

By Robert Mario

Hearing Health

Suffering from a "ringing in the ears" sounds benign enough on the scale of medical problems, but tinnitus and related hearing disorders that affect millions of Americans can become so severe that they lead to decreased life quality, anxiety, panic, depression and social isolation.

Ringing in the ears, or tinnitus, is a common hearing disorder that is generated internally. Hyperacusis is a condition that amplifies sounds from the environment, causing distraction and pain.

Tinnitus and hyperacusis can vary in degree from mild symptoms that can be easily controlled, to symptoms that cause extreme pain and discomfort. Both afflict people of all ages.

Symptoms can occur alone or simultaneously. The longer the symptoms go untreated, the more intrusive they can become. As many as 40 million Americans experience symptoms all the time, and it is believed those symptoms are significant enough to affect quality of life in one to two million of them. There is no cure for tinnitus, but many sufferers may be interested to know that there is a treatment approach that was developed and tested throughout the 1980s and finally put into clinical practice in the early 1990s. "Even though tinnitus and hyperacusis are each classified as a symptom and not a disease, they do require treatment," said Pawel Jastreboff, PhD, ScD, professor in the Department of Otolaryngology at Emory University School of Medicine, and director of the Emory Tinnitus and Hyperacusis Center.

According to Jastreboff, "both tinnitus and hyperacusis may affect attention, work, sleep and sociability. These disorders can cause serious psychological as well as physical dysfunction that can devastate a patient's life. Jastreboff and Dr. Jonathan Hazell developed tinnitus Retraining Therapy (TRT) in the 1980s. Jastreboff is a neurophysiologist who has conducted research at universities such as Yale, University of Maryland. He is now at Emory University in Atlanta, Georgia. More than two decades ago, Jastreboff and his wife Margaret, an associate professor of otolaryngology, combined their backgrounds in neurophysiology, neuroscience, electro acoustics, biophysics, biochemistry and pharmacology to study how the brain processes information within the auditory pathways.

Tinnitus therapy and information will be discussed further in next month's column.

Dr. Robert Mario, PhD, BC-HIS, is the director of Mario Hearing and Tinnitus Clinics, with locations in West Roxbury, Cambridge, Mansfield and Melrose. He can be reached at 781-979-0800 or visit www.mariohearingclinics.com. Archives of articles from previous issues can be read at www.fiftyplusadvocate.com

➤ Heart

Cont. from page 17

Make no mistake: Heart disease is the leading killer of men, too. The illness is more prevalent in men, and tends to hit them about a decade earlier than is usual for women.

But while overall deaths have been dropping in recent years, that improvement has been slower for women who face some unique issues, said the report from the nonprofit Society for Women's Health Research and WomenHeart: The National Coalition for Women with Heart Disease.

Sure, being a couch potato and eating a lot of junk food is bad for a woman's heart just like a man's. High cholesterol will clog arteries. High blood pressure can cause a stroke.

But here's one problem: Even if a test of major heart arteries finds no blockages, at-risk women still can have a serious problem — something called coronary microvascular disease that's less common in men. Small blood vessels that feed the heart become damaged so that they spasm or squeeze shut, Wenger explained.

Specialists who suspect microvascular disease prescribe medications designed to make blood vessels relax and blood flow a bit better, while also intensively treating the woman's other cardiac risk factors. But Wenger said it's not clear what the best treatments are.

The report said part of the lack of understanding about such gender issues is because heart-related studies still don't focus enough on women, especially minority women. Only a third of cardiovascular treatment studies include information on how each gender responds even though federal policy said they should. The report urged direct comparisons of which treatments work best in women, and improved diagnostic tests.

Then there are the questions of how best to tell which women are at high risk. Nearly two-thirds of women who die suddenly of heart disease report no previous symptoms, for example, compared with half of men. As for heart attacks, chest pain is the most common symptom but women are more likely than men to experience other symptoms such as shortness of breath, nausea and pain in the back or jaw.

Online: Women and heart disease info: www.womenheart.org.

Meet Ginny

Ginny lives in her own apartment and enjoys going out to dinner often with friends. A true social butterfly, her wheelchair doesn't hold her back, she is an active member of the Red Hat Society, Handicapped Commission and the Multiple Sclerosis Society.

Ginny has been attending a PACE day center for five years. Knowing the PACE team is there to support her as her needs change, she says **"I am able to focus on enjoying and living my life."**

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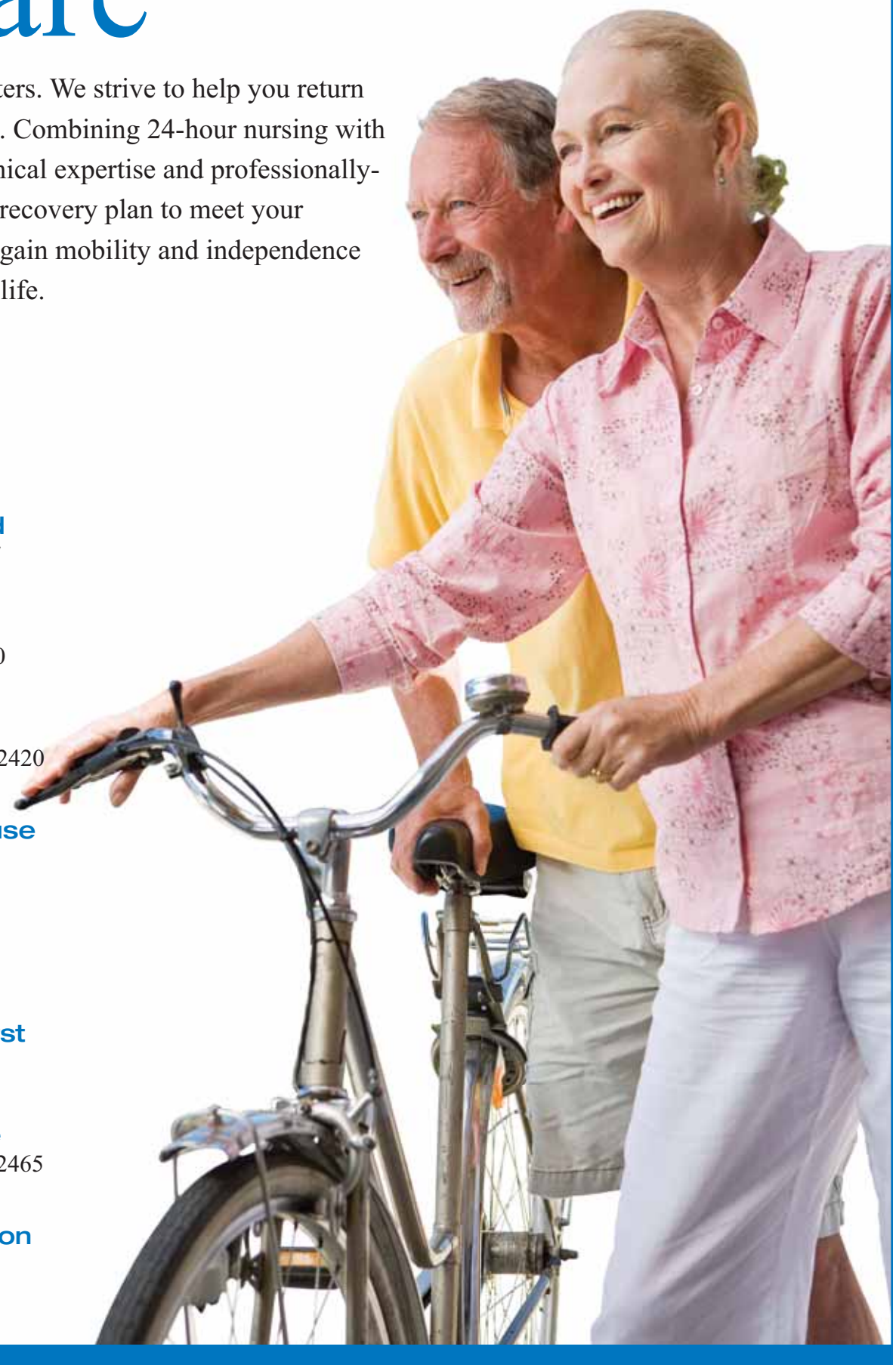

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