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December 15, 2019 E-Newsletter

Dear Mr. Pernorio From Senator Jack Reed

Dear Mr. Pernorio:

Thank you for contacting me regarding pension plans and the financial security of retirees. I appreciate hearing from you.

I recognize that parts of the multiemployer pension system, guaranteed by the Pension Benefit Guaranty Corporation (PBGC), are in financial distress. Indeed, the PBGC's own report has indicated that there is a high likelihood of plans failing over the next decade, which could jeopardize the financial security of retirees.

This is certainly a situation that merits a thoughtful and open debate about reforming the multiemployer pension system. As such, I was initially pleased that the bipartisan budget framework that passed in March 2018, which I supported, created a Joint Select Committee on Solvency of Multiemployer Pension Plans to try to help address this issue. However, the Joint Select Committee did not reach a conclusion and referred their findings back to the Senate Committee on Health, Education, Labor, and Pensions, which will continue working on this issue.

Additionally, I am a cosponsor of S. 2254, the Butch Lewis Act, which would address the looming pension crisis and reform the multiemployer pension system by establishing the Pension Rehabilitation Administration within the Treasury Department. This agency would be tasked with providing loans to troubled multiemployer plans. While S. 2254 currently awaits consideration by the Senate Committee on Finance, similar legislation was passed by the House of Representatives on July 24, 2019.

You may also be interested to know that I am committed to ensuring that Social Security and Social Security Disability Insurance (SSDI) remain strong and viable for millions of Americans. For this reason, I remain adamantly opposed to cutting Social Security as a means to reduce the deficit.

Please know that I will keep your thoughts in mind as I continue my work to ensure that individuals who work their entire lives have the financial security they deserve.

Again, thank you for contacting me, and please do not hesitate to write, call, or visit my website in the future for information regarding this or any other matter.

Sincerely,
Jack Reed
United States Senator

JACK REED
United States Senator *for* Rhode Island

Health care costs continue to rise faster than inflation

Americans want Congress to address out-of-control health care costs; these costs have been Americans' **top policy concern** for several years. Until Congress acts, costs likely will continue to rise. **Axios** reports that in 2018, Americans spent $3.65 trillion on health care, 17.7 percent of the economy.

Health care spending grew by 4.6% between 2017 and 2018. It grew even more than in the previous year, when it grew by 4.2%. Both years, **higher prices**, not an increase in utilization, fueled the increase. According to federal actuaries, corporate health insurers and corporate Medicare plans did not rein in health care prices.

Corporate health insurers have an incentive to allow provider rates to increase. The more they pay providers, the more they can charge in premiums. The **more they charge in premiums, the more they can profit**.

Higher health care costs in 2018 as well as in 2017 led to a one million person increase in the number of uninsured in each of those years. At the end of 2018, there were 30.7 million uninsured. Health insurance premiums are up, as are deductibles. In 2018, **deductibles were $500 higher** than a decade earlier, $1,400 as opposed to $900.

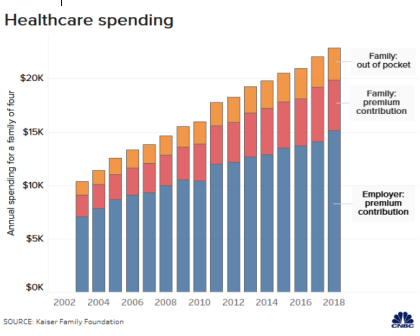
The number of people with corporate health insurance–largely employer-based coverage–dropped a bit in 2018. But, the per capita cost of private health insurance rose by 6.7 percent to $6,199 a person. Hospitals, doctors and pharmaceutical companies were able to secure significantly higher rates from insurers, leading to higher insurance premiums.

In 2018, total health care costs average around $11,000 per person. About one third of that cost was for hospital care. About one fifth of the cost was for medical care. And, about nine percent was for retail pharmacy costs.

Medicare and Medicaid, public programs, experienced much slower growth than corporate health insurance, 2 percent and 3.7 percent as compared to 6.7 percent. Corporate Medicare and Medicaid insurers were responsible for increases in these programs' spending.

The **National Business Group on Health** expects that premiums will increase 5 percent for workers and their families in 2o2o. The average cost of workplace coverage will be $15,375, up from $14,642. Employers typically pay about 70 percent of premium costs for individuals and families.

Workers will be responsible for an average of $4,500 in premiums in 2020. In 2018, the average household spent more than $5,000 on health care, double what they spent on health care 34 years earlier, in 1984.

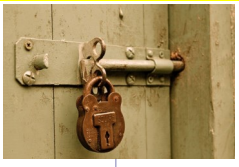


Many people find themselves locked into their Medicare Advantage plans

If you've just joined a Medicare Advantage plan this **open enrollment period**, you have until December 7, and than again **between January 1 and February 14**, to reconsider. Here's what you need to know: Once you're enrolled in a Medicare Advantage plan, you could find yourself locked in. **Medpage Today** reports that many people mistakenly think they can leave their Medicare Advantage plan.

In all but **four states,** however, switching to traditional Medicare is effectively impossible for people with a health condition. Yes, no matter where you live, you can technically switch to traditional Medicare. But, traditional Medicare has no out-of-pocket cap; you need Medicare supplemental insurance to fill coverage gaps and protect yourself financially.

Except in limited situations, you have no right to buy Medicare supplemental insurance. Without Medicare supplemental insurance, your out-of-pocket costs in traditional Medicare if you have a serious health condition could be tens of thousands, if not hundreds of thousands of dollars. With Medicare supplemental insurance, your costs are minimal.



Medicare Advantage plans, in contrast, have an out-of-pocket cap. Still, people are often stuck with huge out-of-pocket costs; you could end up spending as much as $6,700 a year out of pocket for in-network care alone. Many people who join and need costly health care only learn how expensive a Medicare Advantage plan can be after they have joined. Moreover, they may discover that their health plan does not cover care from the doctors and hospitals they want to use. Or, they may find that their health plan unduly **delays or inappropriately denies them access to the care** their doctors say they need.

Even if you find doctors in the Medicare Advantage plan that you like, those doctors can leave the plan at any time. Or, the plan might raise premiums and deductibles significantly. You can't rely on the plan for your health and financial well-being.

Understandably, the data show that people with **costly conditions often want to switch to traditional Medicare**. If they have **Medicaid** as well as Medicare, it's an easy switch. Medicaid picks up the out-of-pocket costs in traditional Medicare. But, if they don't, Medicare supplemental insurers who sell "Medigap" policies to fill gaps in traditional Medicare coverage are likely to refuse to sell them insurance or charge them exorbitant premiums.

You do have **limited rights to buy Medigap coverage**. You are guaranteed Medigap coverage in the first six months of enrolling in Medicare. And, if you join a Medicare Advantage plan, you are also guaranteed Medigap coverage if you switch to traditional Medicare within a year and sign up no later than 63 days after your Medicare Advantage plan coverage ends.

MedPage Today reports on one man enrolled in a Medicare Advantage plan, who, after surgery to repair a mitral valve and suffering a stroke, ended up with hundreds of dollars a month in copays for his medical services and drugs as well as $295 a day for his hospital stay. He was stunned. Neither the Medicare Advantage ads nor the insurance brokers tell people about these costs or about the difficulty of switching to traditional Medicare and buying Medicare supplemental insurance.

The American Medical Association, which is working hard to oppose Democratic health care reform proposals, knows well the risks of Medicare Advantage plans. It passed a resolution in 2018 recognizing that "seniors are lured to these advantage plans by misinformation and confusing sales techniques." The AMA also recognizes that these corporate health plans can delay access to care and can deliver poor service.

Many people understandably can't afford the cost of Medicare supplemental insurance and join a Medicare Advantage plan thinking they will save money. They might. But, you should know that you could spend a lot more in a Medicare Advantage plan if you become seriously ill and need costly care. People who get sick too often go bankrupt or forego needed care. The **Medicare Plan Finder tool** won't tell you this.

It's Not Just You: Picking Health Insurance Is Hard. Here's How To Be Smart

Science has proved, no kidding around: Picking health insurance is extremely hard.

It's open enrollment — time to pick next year's insurance — for folks who buy it on their own and for many of us in our jobs. Lots of us aren't sure we know how to pick, and research shows: We're not wrong.

A group of economists found that **most people will not make the best choice** among the plans in front of them.

And it's not just average people who have trouble. One of the economists who did that research — **George Loewenstein** of Carnegie-Mellon University — told me he was personally dreading the process of helping his adult son pick a plan.

"I have no confidence that I'm going to make the right decision," he said.

So, it's not just you.

Most of us, Loewenstein and his colleagues found, have two main problems: We don't understand all the terms, and we have a hard time doing the math.

The good news is, you can avoid some of the worst mistakes. That can mean saving thousands, or even tens of thousands of dollars.

Here's what you're aiming for.

Set Realistic Goals

You've seen the stats, like how **most bankruptcies involve medical debt,** and you've seen the horror stories, like the guy whose first month of **dialysis threatened to stick him with a half-million-dollar bill**.

The goal in my family is simple: Avoid disaster.

That may mean paying a little more every month. A health insurance payment — the monthly premium — is very annoying for most of us, especially since we often still have to shell out to see a doctor, even with insurance.

But getting that monthly payment as close to zero as possible? Probably not your best move. Not if it puts you at risk of a horror story you could avoid.

So: Be very careful with plans that don't comply with Obamacare rules. They're sometimes marketed as "Trumpcare" — **which is not actually a thing** — and although they do tend to have lower premiums, they could leave you vulnerable in unexpected ways.

Just ask the woman in Philadelphia who had her foot amputated**. Her insurance plan's response: "Nope! Not covered."….Read More**

Poll reveals that one in four older adults put off getting care for a serious medical condition

One in three adults in the US report not having been able to afford care in the past year, according to the latest **Gallup health care poll**. And, one in four adults put off getting care for a serious medical condition because of the cost. How many more people will go without care or be driven into medical debt before Congress acts?

The proportion of Americans who report not getting care for a serious medical condition this year is up 33 percent from last year, 25 percent this year, and 19 percent last year. If you add in the people who said that they put off care for a less serious condition during the last year, 8 percent, one of every three Americans put off care they needed because of the cost. That's a 50 percent increase from 2001. Not surprisingly, **Americans are looking for more than incremental change in our health care system**.

The cost of care has been prohibitive for millions of Americans for more than three decades now. And, the situation only has gotten worse. In 1991, when Gallup first started polling on this issue, more than one in five people, 22% said that they or a family member put off getting care because of the cost. Of those, half had a serious condition requiring treatment.

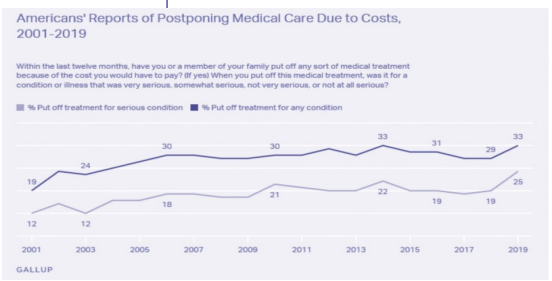
People with annual household incomes under $40,000 have the most difficulty affording care for a serious condition. Over the last year, more than one in three of them (36 percent) said they put off care for a serious condition, up from 23 percent last year. One in four people with incomes between $40,000 and $100,000 said they put off care for a serious condition this last year, about the same percentage as last year.

The data speaks for itself. The US is rationing care based on ability to pay. Corporate health insurers do not provide coverage that adequately protects people from financial risk. About 12 percent of people with pre-existing conditions reported not getting care because of the cost. Even people with annual incomes over $100,000 are foregoing care. About one in eight of them, 13 percent, reported delaying care for a serious or somewhat serious condition because of the cost.

This year's increase in the proportion of people delaying care does not appear related to the type of coverage they have. The increase was the same for people with private insurance, Medicare and the uninsured.

The Gallup report notes that there appears to be a partisan element to the polling data. The recent increase in the proportion of people reporting that they delayed getter care is significantly greater among Democrats, up 12 percent, than Independents and Republicans, up three to five percent respectively.

Delayed care not only can hurt Americans, it can hurt the economy. It can mean lower productivity on the job. And, it can mean greater health care spending over time.



US household spending on health care tops $1 trillion in 2018 for first time

American households spent more than $1 trillion on **health care** in 2018, reaching a pricey milestone, according to federal data released Thursday.

That includes out-of-pocket expenses for medical services and premiums for employer coverage, individual policies and Medicare, as well as Medicare payroll taxes. The figure grew by 4.4% from a year earlier.

The data -- part of the **National Health Expenditure report** -- comes as Americans, elected officials and presidential candidates try to tame the rising cost of health care. The issue is a top priority for **President Donald Trump** and has split the **Democrats primary contenders**.

Progressive candidates such as Sens. Bernie Sanders of Vermont and Elizabeth Warren of Massachusetts argue that the best way to reduce costs is to have the federal government take over the health insurance industry, while moderates such as former Vice President Joe Biden and South Bend, Indiana, Mayor Pete Buttigieg advocate less radical steps, such as a government-run health insurance option.

Overall, US health care spending rose 4.6% to $3.6 trillion last year, faster than in 2017 but the same as 2016, according to the report, issued by the Centers for Medicare and Medicaid Services. It accounted for 17.7% of the economy, slightly less than a year earlier.

Notably, the prices for prescription drugs at retail pharmacies fell 1% in 2018 -- the first time since 1973 -- due to a drop in generic drug prices and relatively low growth in brand-name drug prices. The data is based on the consumer price index for prescription drugs, which Trump often cites to show his progress in lowering health care spending. Some experts, however, say this index does not truly reflect the rising cost of drugs, in part because it excludes the pricey medications administered in hospitals and doctors' offices.

Private businesses, meanwhile, shelled out nearly $727 billion on health care, an increase of 6.2% -- the fastest growth rate since 2003. More than three-quarters of that spending is on employer contributions for insurance premiums, which rose at a quicker pace than in 2017.

Spending by Medicare, Medicaid and private health insurance grew faster in 2018 partly because of the reinstatement of the health insurance tax, an Affordable Care Act provision that Congress suspended for 2017. The tax was expected to raise $14.3 billion in 2018, according to the Internal Revenue Service.

While the growth in health care usage slowed last year, larger hikes in prices more than offset it. Hospital prices rose 2.4% last year, somewhat faster than the year before. Hospital spending accounts for one-third of health care expenditures.

The number of uninsured people rose by 1 million for the second year in a row, to 30.7 million in 2018. The uninsured rate remained roughly steady at less than 10%. Democrats have slammed Trump for undermining the Affordable Care act, which helped reduce the uninsured rate after the health insurance exchanges opened and states expanded Medicaid in 2014….**Read More**

Trump administration proposes Social Security rule changes that could cut off thousands of disabled recipients

The Trump administration is proposing changes to Social Security that could terminate disability payments to hundreds of thousands of Americans, particularly older people and children.

The new rule would change aspects of disability reviews — the methods by which the Social Security Administration determines whether a person continues to qualify for benefits. Few recipients are aware of the proposal, which is open for public comment through January.

Critics of the plan liken it to the administration's efforts to cut food stamps, among other entitlement programs, with insufficient information offered to explain curtailing benefits.

Social Security officials declined to comment. For years, Republicans have argued that Social Security benefits need to be reined in to save money.

The new rule, advocates for low-income Americans say, is just a way to push people off the disability rolls.

"I have serious concerns about this proposed rule," said U.S. Sen. Bob Casey (D., Pa.), adding that it "appears to be yet another attempt by the Trump administration to make it more difficult for people with disabilities to receive benefits."

In a similar vein, U.S. Rep. Brendan Boyle, a Northeast Philadelphia Democrat, said, "These changes seem arbitrary, concocted with no evidence or data to justify such consequential modifications. This seems like the next iteration of the Trump administration's continued efforts to gut Social Security benefits."

Typically, Americans who are too physically and/or mentally impaired to work may be eligible for one of **two kinds of benefits**: Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI).

While SSDI is for people who have worked at least 10 years, SSI is for low-income recipients who have seldom, if ever, been employed..

More than 16 million Americans receive either SSDI (8.5 million) or SSI (8 million). SSI benefits can run to $770 a month; SSDI payments, which are based on lifetime earnings, can range from $800 to $1,800 monthly, government figures show….**Read More**

How can I file a grievance?

Dear Marci,

I like the coverage that I get from my Medicare Advantage Plan, but I have had several problems with the plan in the past, including getting poor customer service when talking with plan representatives and having trouble finding in-network providers. What can I do about these issues?
-Grace (New Orleans, LA)

Dear Grace,

If you are dissatisfied with your Medicare Advantage or Part D prescription drug plan for any reason, you can choose to file a grievance. A **grievance is a formal complaint** that you file with your plan. A grievance is not **an appeal**, which is a request for your plan to cover a service or item that it has denied.

Times when you may wish to file a grievance include if your plan has poor customer service or you face administrative problems. Some examples of issues that might lead you to file a grievance include:

- Your plan fails to return a coverage determination or appeal decision on time
- ¨ Your plan fails to expedite a coverage determination or appeal
- ¨ You experience poor quality of care from an in-network provider
- ¨ You experience poor customer service from a plan representative
- ¨ You are asked to pay an incorrect copayment amount
- ¨ You are involuntarily disenrolled from your plan
- ¨ There is a change in premiums or cost-sharing
- ¨ You receive inadequate written communications from your plan
- ¨ You experience marketing abuse

In some cases, you may want to file both an appeal and a grievance.

To file a grievance, send a letter to your plan's Grievance and Appeals department. Visit your plan's website or contact them by phone for the address. You can also file a grievance with your plan over the phone, but it is recommended to send your complaints in writing. Be sure to send your grievance to your plan within 60 days of the event that led to the grievance.

Your plan must investigate your grievance and get back to you within 30 days. If you made your grievance in writing, the plan must respond to you in writing. If you make your request over the phone, your plan may respond verbally or in writing, unless you specifically request that the response be in writing. If your request is urgent, your plan must get back to you within 24 hours. If you have not heard back from your plan within this time, you can check the status of your grievance by calling your plan or 1-800-MEDICARE.

In some cases, if you have an issue with your plan that has not been resolved through the grievance process, or if you want to make Medicare aware of other issues, you can file a complaint at 1-800-MEDICARE. Medicare uses a system called the Complaint Tracking Module (CTM) to handle beneficiary concerns with Medicare health and drug plans. You might want to call Medicare to make a formal complaint in order to escalate an issue to Medicare's attention. For example, if a plan fails to respond to appeals according to Medicare's specified deadlines, and you cannot access needed care, you can call 1-800-MEDICARE to make a complaint.

Medicare uses information from the complaint tracking module in setting Medicare Advantage and Part D star ratings each year. Star ratings measure how well Medicare Advantage and Part D plans perform. Medicare scores how well plans perform in several categories, including quality of care and customer service. Ratings range from one to five stars, with five being the highest and one being the lowest. Making a complaint to Medicare about a problem with a private plan is a way to make sure that plan is held accountable.
-Marci

The I.R.S. Sent a Letter to 3.9 Million People. It Saved Some of Their Lives

The Upshot|The I.R.S. Sent a Letter to 3.9 Million People. It Saved Some of Their Lives.

a working paper finding that these notices increased health insurance sign-ups. Obtaining insurance, they say, reduced premature deaths by an amount that exceeded any of their expectations. Americans between 45 and 64 benefited the most: For every 1,648 who received a letter, one fewer death occurred than among those who hadn't received a letter.

In all, the researchers estimated that the letters may have wound up saving 700 lives.

The experiment, made possible by an accident of budgeting, is the first rigorous experiment to find that health coverage leads to fewer deaths, a claim that politicians and economists have fiercely debated in recent years as they assess the effects of the Affordable Care Act's coverage expansion. The results also provide belated vindication for the much-despised individual mandate that was part of Obamacare until December 2018, when Congress did away with the fine for people who don't carry health insurance.

"There has been a lot of skepticism, especially in economics, that health insurance has a mortality impact," said Sarah Miller, an assistant professor at the University of Michigan who researches the topic and was not involved with the Treasury research. "It's really important that this is a randomized controlled trial. It's a really high standard of evidence that you can't just dismiss."

The uninsured rate for Americans is rising for the first time in a decade, as states tighten eligibility rules for Medicaid, and as the Trump administration cuts back on health care outreach.

"It's an innovation to know that just sending a letter to people with information about what it means to be insured versus uninsured can substantially change coverage rates," said Katherine Baicker, dean of the University of Chicago Harris School of Public Policy. "That is really important, new information."

Previous research has found a link between expanded health insurance access and fewer deaths. Multiple studies showed a decline in mortality rates after states expanded Medicaid, but none could tie the outcome directly to the policy change, since states typically cannot randomly pick which residents do and don't receive Medicaid. That makes the Treasury experiment, an unintended result of a budget shortfall, distinctively useful.

The most prominent similar study, the Oregon Health Experiment, was much smaller and more equivocal. There, Oregon ran a lottery for slots in a Medicaid expansion in 2008. Those who gained health coverage in the lottery reported feeling better and having fewer unpaid medical bills. They were more likely to fill their medication prescriptions for conditions like diabetes and cardiovascular disease.

But researchers did not produce evidence that Medicaid enrollees in Oregon had a lower risk of death, something they attribute to the fact death is a rare event (especially so for the under-65 population typically enrolled in Medicaid). Finding any change requires a very large sample to study.

"What we ended up producing had such wide confidence intervals, they were not really useful for policymaking," said Ms. Baicker, one of the economists who closely studied the Oregon Health Experiment.

Some economists had cast doubt on the connection between health coverage and mortality, noting that even an uninsured person is not completely excluded from the health care system. Federal law requires emergency rooms to treat all patients regardless of their ability to pay. One recent study showed that hospitals spend an additional $900 on free care for each extra uninsured patient they treat. It describes hospitals as "the insurers of last resort."

"It's not clear that every person who gets new health insurance will cut their probability of dying by a large amount," said Kosali Simon, a health economist at Indiana University.

The Obama administration had planned to send letters to all 4.5 million Americans paying tax fines for not carrying health coverage, only to learn the budget was not quite big enough. About 600,000 uninsured taxpayers were randomly left out of the mailing.

This created a randomized controlled trial, which researchers generally view as the gold standard for studying the results of a specific policy intervention — in this case, the effects of being nudged to get health coverage.

"I was definitely torn about it," said Jacob Goldin, a co-author of the paper who worked as an economist at the Treasury Department and is now an associate professor at Stanford. "We were hoping the letters would be beneficial, and wanted them to go to everybody. But it was also an exciting research opportunity."

The letters went out in two batches, in December 2016 and January 2017, in one of the Obama administration's final efforts to increase awareness of the Affordable Care Act's coverage options.

The subsequent research, published by Mr. Goldin with the Treasury economists Ithai Lurie and Janet McCubbin, found that gaining coverage was associated with a 12 percent decline in mortality over the two -year study period (the first months of coverage seemed to be most important, presumably because people could get caught up on various appointments and treatments they might have been missing).

Months later, in August 2017, the Trump administration cut the health law's outreach budget by 72 percent.

And at the end of 2017, Congress passed legislation eliminating the health law's fines for not carrying health insurance, a change that probably guarantees that the I.R.S. letters will remain a one-time experiment.

Now's the Time to Tell Congress to Vote Yes on H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act
Click Here to tell Congress

More on Legislation to reduce the cost of prescription drugs.

Both parties in Congress are also working on legislation to reduce the cost of prescription drugs. However, that's not going quite so well. As we've reported in the past, House Speaker Nancy Pelosi has a bill (H.R.3) that would allow Medicare to negotiate some drug prices and use fees to pressure drug companies to offer lower prices to private insurers. Republican members of the House all oppose the bill as does President Trump.

However, there are also differences in opinion on this legislation among Democratic members of the House. Some members want to add language to the bill that would direct the federal government to study how to require drug makers to refund money to employer-sponsored health plans when the companies raised prices above the rate of inflation. The government would then have to issue regulations based on its study. But the latest reports are that the final bill will drop the mandate that the government impose new regulations — and instead only require it to only conduct a study. And, another provision some Democrats want added would make the prices that the government does negotiate under the legislation available to the uninsured.

Expectations are that the bill will be voted on by the full House next week. It is likely to pass without any Republican votes in favor of it.

Republicans in the Senate are having the same sorts of problems as the Democrats are in the House. As we've reported in the past, Sen. Chuck Grassley (R-Iowa), Chairman of the Senate Finance Committee, and Sen. Ron Wyden (D-Ore.), Ranking Members of the Finance Committee, introduced a bill in July meant to lower prescription drug prices, a bill which President Trump has since decided to support. However, that bill is now stalled in the Senate because of objections from Republican Senators. Senate Majority Leader Mitch McConnell (R-Ky.), has said the bill is bad policy.

Other Republican Senators object to a key provision in the bill that would require drug companies pay money back to Medicare if their prices rise faster than the rate of inflation. They argue that constitutes a "price control" that violates traditional GOP free-market thinking. The bill also contains a provision that would cap seniors' out-of-pocket costs for Medicare drugs. However, that provision is less controversial.

When the measure came up for a vote in the Finance Committee over the summer, nine Republicans voted against it, compared with just six who backed it.

Senator Grassley is determined to keep pushing for support of the bi-partisan bill and is hopeful of winning support from more Republican Senators next year.

'Food Pharmacies' In Clinics: When The Diagnosis Is Chronic Hunger

There's a new question that anti-hunger advocates want doctors and nurses to ask patients: Do you have enough food?

Public health officials say the answer often is "not really." So clinics and hospitals have begun stocking their own food pantries in recent years.

One of the latest additions is Connectus Health, a federally qualified health clinic in Nashville, Tenn. This month, part of LaShika Taylor's office transformed into a community cupboard.

"It's a lot of nonperishables right now, just because we're just starting out," she said, but the clinic is working on refrigeration so it can also stock fresh food.

It's not that patients are starving, Connectus co-director Suzanne Hurley said. It's that they may have a lot of food one day and none the next. That's no way to manage a disease like diabetes, she said.

"I can prescribe medications all day, but if they can't do the other piece — which is a decent diet and just knowing they're not going to have to miss meals," she said, "medications have to be managed around all of those things."

Trudy Hoffman receives monthly infusions at Nashville General Hospital and now goes home with a bag of nutritious food to help stretch her budget and keep her fed.

Second Harvest Food Bank of Middle Tennessee, a local food bank, is encouraging more health care providers to consider on-site pantries. The food bank also wants every patient — not just those suspected of being low income — to be asked about their food situation.

"We're really pushing for universal screening, so you're not picking who you're asking that question to. The doctor already asks you really personal questions, and we don't think twice about it," said Caroline Pullen, Second Harvest's nutrition manager. "I think people have always been scared to ask this question because they didn't really have the resources of where to send them."

"Food insecurity," as it's known, has become a **particular concern among seniors**. The anti-hunger group Feeding America found that more than 5 million older Americans don't have enough food to lead a healthy life — a figure that has doubled in the last two decades.

In response, food banks are increasingly meeting seniors where they get their health care. Hospitals from **Utah** to **Massachusetts** are sending patients home with food.

Trudy Hoffman now gets free groceries at her monthly visits to Nashville General Hospital.

"They just asked me, did I want a bag of food to carry home?" she recalled. "And I said, 'Yeah.'"

The city-funded hospital started its pantry just for cancer patients in recent years but opened it to all patients this year and **received a $100,000 grant** in October to fund its expansion.

Organizers call it a "food pharmacy," following the lead of places like **Children's Hospital of Philadelphia**, with patients getting a "prescription" for what to pick up. Some shelves have high-calorie superfoods for cancer patients to keep their weight up. Others have low-sugar staples for people with diabetes and low-sodium items for patients with hypertension…

Vernon Rose, who oversees the Nashville General Hospital Foundation, said no one is surprised to see dozens of patients using the pantry each day.

"Because when you're in a place like ours, where 40% of the folks can't even afford their health care, you can imagine the choices they're making," she said — such as deciding whether to pay for food, utilities or medicine.

The pantry operates mostly with grant funding.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Further evidence that controlling high blood pressure can reduce dementia, Alzheimer's risk

Treating high blood pressure with medication not only improves older adults' cardiovascular health, but also can reduce their risk of dementia and Alzheimer's disease, according to a thorough examination of long-term data from four countries.

A global team of scientists cross-referenced data from six large, longitudinal studies that tracked the health of over 31,000 adults over age 55 across several years of follow-up. They found that treating high blood pressure — no matter with which type of antihypertensive drug — reduced dementia risk by 12% and the risk of developing Alzheimer's disease by 16%. The findings, coordinated by investigators in the Laboratory of Epidemiology and Population Science of the NIA Intramural Research Program, were published in *Lancet Neurology*.

This comprehensive look extends the evidence from the recent **SPRINT MIND trial** that showed lowering blood pressure levels reduced the risk for a combination of dementia and mild cognitive impairment. The scientists teamed up to analyze data from six comprehensive, community-based health studies conducted between 1987 and 2008 in the United States, France, Iceland and the Netherlands. They examined all five major types of blood pressure medications — ACE inhibitors, angiotensin II receptor blockers, beta-blockers, calcium channel blockers and diuretics — and found that the type of medication did not make a difference.

Participant data was divided into two groups — 15,537 people with high blood pressure and 15,553 people with normal blood pressure. In all, 1,741 diagnoses of Alzheimer's disease and 3,728 cases of other dementias developed over time. People who controlled their blood pressure with medicine were found to have the same risk for developing dementia as individuals with normal blood pressure who did not require medication.

The investigators were pleased to work with a deeper data pool than previous studies, allowing them to look at specific medication types used to keep blood pressure at safe levels. The expanded study also gave them much longer-term follow-up data, which were helpful to observe the gradual onset of dementia and Alzheimer's symptoms. The large group of people studied also factored in additional health conditions common to older adults, giving them a clearer picture of the multiple issues that come with aging that are typically seen by general physicians.

Still to be investigated is how long-term changes in blood pressure impacts dementia risk, and further research with more detailed information is needed on specific antihypertensive medications.

Together with the SPRINT MIND trial, this latest data adds to the evidence base that treating and reducing high blood pressure can also help reduce the risk of dementia. The researchers hope their findings add urgency to the need for better hypertension awareness among the rapidly growing global population of older adults, many of whom are at risk for developing high blood pressure or already have it but are not managing it properly.

This study was supported by the Alzheimer's Drug Discovery Foundation and the NIA Intramural Research Program.

Special Handling Needed for Seniors in Cardiac ICU

Seniors in cardiac intensive care units may suffer delirium and other problems if doctors only focus on their heart, a new American Heart Association (AHA) scientific statement says.

Older adults in the cardiac ICU require different care from younger patients, according to the statement. They're likely to be frail, have other medical conditions and use multiple medications.

"Treating the whole patient -- considering their entire health profile, rather than focusing only on their acute cardiovascular event -- is essential for achieving the best possible outcomes among geriatric patients with acute cardiovascular disease," statement writing group chair Dr. Abdulla Damluji said in an AHA news release.

Damluji, a cardiologist, is an assistant professor of medicine at Johns Hopkins University School of Medicine in Baltimore.

Seniors in a cardiac ICU often struggle emotionally and physically due to bright lights, noise, new medications, urinary catheters, dietary changes and sleep disruptions.

"For vulnerable older adults who may already be experiencing cognitive decline, the environment in the cardiac intensive care unit may deplete already limited coping skills and could lead to delirium," Damluji said.

Delirium is common in critically ill patients and increases the risk of dying in the hospital. "Reducing the level of sedation used in older patients may help mitigate delirium. However, more research needs to be done to fully understand how best to treat this condition in the context of acute cardiovascular illness," Damluji said.

Many older patients are frail when admitted to the cardiac ICU, and extended bedrest can worsen their frailty. This can lead to poor medication tolerance, an increased risk of falling, weakened heart function and bedsores.

Getting older heart patients out of bed as soon as appropriate and encouraging movement may preserve strength, improve ability to walk and result in less time in the cardiac intensive care unit, according to the AHA.

Another potential problem for older cardiac ICU patients is that they take an average of 12 prescription medications. This increases the risk of harmful side effects and detrimental interactions. Older patients may benefit by being taken off some of their medications if appropriate, according to the statement.

"Strategies to achieve a holistic care approach for each patient remains an important goal to improve care of older patients in the cardiac intensive care unit," Damluji said.

Lower handgrip strength associated with cognitive impairment

Older adults with a weaker handgrip were more likely to be cognitively impaired than those with a stronger grip, according to an NIA-funded study in the *Journal of Alzheimer's Disease*. The findings suggest that handgrip strength may be a potential low-cost, easy way to help detect cognitive impairment and, in combination with other measures, to identify people who may benefit from early interventions.

A team led by researchers from North Dakota State University looked at data over an eight-year period from almost 14,000 people, age 50 or older, in the NIA-supported Health and Retirement Study. A handheld instrument called a dynamometer was used to assess handgrip strength, and a modified screening tool from the Mini-Mental State Examination was used to measure cognitive function every two years. Of the 13,828 participants who were assessed, 1,309 had some degree of cognitive impairment.

Results showed that each 5-kilogram decrease in handgrip strength — roughly 11 pounds — was linked to 10% greater odds of having any cognitive impairment. For the 264 participants with severe cognitive impairment, the odds of a lower grip strength were 18% greater than for all other participants. As people age, they lose muscle mass, resulting in a weaker grip. Grip strength also can weaken due to age-related changes in parts of the brain that coordinate movement. These same areas of the brain also correspond to cognition, the researchers note. The neural and motor functions needed for the grip strength test may become compromised when cognitive impairment starts, they explain.

Previous studies investigating the relationship between cognitive function and grip strength have shown mixed results, likely due to smaller numbers of participants and varied assessments across studies making it difficult to combine data. Future research is needed to further explore the connection between grip strength and cognition, for example, investigating any associations with structural changes in the brain.

If validated, grip strength could be an easy test used by doctors to help distinguish cognitive dysfunction from normal age-related decline, the researchers noted. It also may have the potential to be used during clinical trials to gauge the effectiveness of interventions meant to prevent or delay cognitive impairment.

Demand on the Rise for Home Healthcare

An aging population means more need for at-home services, but insurance reimbursement rates pose a challenge for agencies and caregivers.

When illness, injury, or age-related health issues strike, home healthcare can provide an effective and less-costly alternative to hospitalization or admission to an assisted living facility.

A positioning statement on the state of the home care industry from the Joint Commission, an independent nonprofit health services oversight group, confirms that care can be provided less expensively in the home, and home care is a key step toward achieving optimal health outcomes for many patients. Also, findings in the statement conclude that home care interventions can improve quality of care and reduce hospitalizations due to chronic conditions or adverse events. As America's elderly population continues to grow, so does demand for health-related services that can be provided in the comfort of a patient's home.

Ninety percent of Americans ages 65 and older want to stay at home for as long as possible, and this age group is growing rapidly, reports the Home Care Association of America and the Global Coalition on Aging.

The United States Census Bureau predicts that by 2020, 56 million Americans will be 65 and older; by 2050, that number will reach 84 million. The frail elderly population — those 85 and older — will triple by 2040. And nearly 70 percent of Americans who reach 65 will be unable to care for themselves at some point without assistance.

It's not just the elderly who can benefit from at-home care. About 5.6 million children in the United States receive at least 5.1 hours of medical care at home, which costs families (including those providing care themselves) a combined total of $36 billion each year.

What Is Home Healthcare?

Home healthcare companies allow people who require extra care no matter what their age to remain in their homes, reducing the burden otherwise shouldered by healthcare facilities, hospitals, assisted living or rehabilitation centers, and nursing homes.

Most home healthcare companies offer a wide range of medical and personal services, including nursing care, physical and occupational therapy, and social work. Medical professionals, therapists, and aides can assist with postoperative care and disease management.

Home health services can be performed by a licensed nurse (registered or licensed practical nurse) on a full-time, part-time, or intermittent basis.

Full- or part-time home health aides do not have a nursing license but are highly trained to help patients with basic activities and needs such as bathing, toileting, dressing, eating, mobility assistance, and companionship. Such services are commonly referred to as home care, as opposed to home healthcare services provided by licensed nurses and medical professionals.

"Our certified nurse's aides (CNAs) can help with anything in the rehabilitation process, whether activities of daily living, medication management, exercise and being active, getting to doctor's appointments on time and more," says Sam Cross, administrator at Broad Street Home Care in Chicago.

"CNAs report to supervising nurses and let physicians know if there are changes in symptoms and whether action needs to be taken," he adds.

"Without feeling like a hospital, you have effective support in the home."

Trisha Lasher, RN, a field nurse with Bayada Home Health Care in Sinking Spring, Pennsylvania, makes as many as 22 home visits a week. "[We] do the same thing as in a hospital, assisted living or nursing home," Lasher explains. "We are the eyes and ears of the doctor and the voice of the client to the doctor and agency."...**Read More**

Good news for anyone looking for help losing weight

Many of us are overweight, struggling to figure out how to shake off some pounds. And, it's never easy. The good news is that Medicare pays the full cost of weight-loss counseling for people needing help losing weight. **The bad news is that only a very small percentage of the people who might benefit from weight counseling are taking advantage of it.**

The **Centers for Disease Control** reports that more than three in 10 people with Medicare are obese. And, obesity contributes to chronic health conditions, including **heart disease**, some types of cancer and **diabetes**. Studies show that counseling can help people take steps to lose significant weight.

Medicare covers weight-loss counseling for **everyone with a body mass index of 30 or more, under Part B.** To be covered, only primary care doctors or the nurse practitioners and physicians' assistants who practice in their offices can provide the benefit.

The Medicare obesity-counseling benefit includes a weekly session for the first month and a session every two weeks for the next five months. Another six months of counseling, one visit each month, is covered for people who lose at least 6.6 pounds during the first six months of counseling.

Medicare covers weight-loss counseling at no cost to you if you see a doctor who accepts "assignment," accepts Medicare's approved rate as payment in full. Medicare sometimes covers **gastric bypass surgery or laparoscopic banding surgery** for people who are morbidly obese.

For reasons that are unclear, only a very small percentage of people with Medicare have taken advantage of the obesity-counseling benefit. They may not be aware of the obesity-counseling benefit or they may not be able to find doctors who will provide the counseling services. In sharp contrast, 250,000 people with Medicare have taken advantage of **smoking-cessation counseling**, which Medicare also covers

Study reveals how diabetes drug promotes healthy aging

Doctors commonly prescribe metformin to help people with type 2 diabetes lower their blood sugar levels. The drug increases insulin sensitivity through its effects on glucose metabolism.

However, although there is clear evidence of metformin's effectiveness, scientists do not fully understand how it interacts with cells and tissues at the molecular level.

Now, a new ***Cell Reports*** study has mapped metformin activity in the liver and yielded some surprising results.

Using cell cultures and mice, the researchers identified numerous biochemical switches for turning various cell and molecular processes on and off.

The findings shed light not only on metformin's mechanism of glucose control, but also on a surprising number of other reactions and pathways.

The researchers suggest, for instance, that the new findings could help explain recent revelations about metformin's apparent ability to promote healthy aging.

Large-scale clinical trials of metformin are already under way to test the drug's effectiveness in extending life span and health span — that is, the proportion of a person's life span that they spend in good health. However, the underlying biochemistry has been unclear.

Teams from three research centers worked on the study: the Salk Institute for Biological Studies, the Scripps Research Institute — both in La Jolla, CA — and Weill Cornell Medical College in New York.

"These results," says Reuben J. Shaw, one of the study's corresponding authors, "provide us with new avenues to explore in order to understand how metformin works as **a diabetes** drug, along with its health-span-extending effects."

"These are pathways that neither we, nor anyone else, would have imagined," he adds.

Shaw is a professor of molecular and cell biology at the Salk Institute and director of the Salk Cancer Center.

An old drug with many potential uses

Other recent research has also suggested that metformin may have anti-aging effectsTrusted Source and an ability to protect bone, especially during the early phases of rheumatoid arthritis.

Until the new study, scientists' understanding of the biochemical effects of metformin was limited to knowing that the drug activates a signaling pathway called AMPK. This pathway plays a key role in balancing energy levels in cells.

Prof. Shaw had also discovered that when nutrients levels are low, the AMPK pathway holds back cell growth and alters metabolism. Researchers have seen this effect in cancer. Knowing this led Prof. Shaw and colleagues to wonder if metformin might also work through oth

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Humans first **started using** metformin as a glucose-lowering drug more than 60 years ago. **Researchers have shownTrusted Source** that the treatment reduces premature deaths among people with **type 2 diabetes.**

More recently, scientists have found that metformin may be effective in a number of other conditions, including **obesity, cancer**, metabolic syndrome, polycystic ovary syndrome, and nonalcoholic fatty live disease.

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An 'Epidemic of Loneliness' in America? Maybe Not

Despite media stories about a "loneliness epidemic" plaguing the elderly, two new studies find that they feel no more lonely than their peers from past generations.

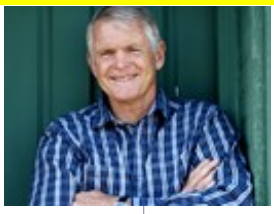
The studies -- one in the United States, one in the Netherlands -- reached the same basic conclusion: Yes, people tend to feel more lonely after age 75 or so. But today's older adults are no more likely to feel isolated or lacking in companionship than previous generations.

In fact, the Dutch study found, older people may now be somewhat less lonely because they tend to have more self-confidence and feelings of control over their lives.

Both studies were published in the Dec. 10 issue of the journal *Psychology and Aging*.

According to the U.S. Census Bureau, 28% of older Americans now live alone. Some researchers, and media stories, have suggested that older adults are facing a loneliness "epidemic" due to societal changes like shrinking family sizes, divorce, and less involvement in religious and civic groups.

But those societal shifts do not necessarily mean that people actually feel more lonely, said Louise Hawkley, a senior scientist with the University of Chicago's National Opinion Research Center.



In the new U.S. study, her team found that baby boomers (born between 1948 and 1965) appear similar to the previous generation (born between 1920 and 1947) when it comes to feeling lonely.

"Among older adults, we found no evidence of an 'epidemic,'" Hawkley said.

The findings come from an ongoing health and aging study. Back in 2005, it surveyed over 3,000 Americans born between 1920 and 1947. A decade later, close to 2,400 baby boomers were recruited.

All answered questions about their health and social circles; they also completed a standard "loneliness scale" that asks people how often they feel "left out," isolated or lacking in companionship.

Overall, Hawkley's team found no evidence that boomers were more lonely than the previous generation was at their age.

That does not, of course, mean that loneliness isn't a problem. In this study, people did tend to report more isolation after age 75 -- and it was more common among those with health problems and those living alone.

"Loneliness matters," Hawkley stressed. "It can have serious consequences for a person's well-being." And, she added, as the large baby boomer generation ages, the ranks of lonely older Americans may grow. But the study found no proof that loneliness is a particularly acute problem for today's older people.

The Dutch study uncovered a similar pattern, using data from a long-term study of nearly 4,900 adults born between 1908 and 1957. In fact, the researchers found, people born in more recent times were slightly less likely to report loneliness than their similarly aged counterparts from earlier generations.

James Maddux is a senior scholar with the Center for the Advancement of Well-Being at George Mason University, in Fairfax, Va. He said, "I like the fact that two studies in two different countries both found basically the same thing." Maddux was not involved in either study.

"There's a big difference between being alone, and actually feeling lonely," Maddux pointed out. So it can't be assumed, he said, that social trends -- like divorce or less church-going -- translate into lonelier people.

Maddux said the Dutch study is particularly interesting because it points to specific factors that may buffer older adults against loneliness: self-efficacy and "mastery" -- which, together, refer to a sense of competency and control over your life.

People who scored higher in those traits were less likely to report loneliness. And that, in part, explained why older adults in recent years were somewhat less lonely than those of past generations.

"As you get older, it's important to maintain a sense of control over your life," Maddux said.

Sometimes, he explained, well-intentioned family members can "undermine" elderly adults' sense of control by trying to do everything for them.

Technology could be one way to help older people retain more autonomy, especially if they can't drive or have difficulty getting around, Maddux noted. The simple ability to go online and buy something can make a difference, he said.

It's also possible, Hawkley said, that social media and video chatting platforms could help older people stay more connected with the world. Even though some traditional institutions aren't as prominent as they used to be, she noted, other societal changes might allow new ways to connect.

All About the Flu and How to Prevent It

Each winter, millions of people suffer from seasonal flu. Flu—the short name for influenza—is caused by viruses. Viruses are very small germs. Some viruses can spread easily from one person to another. They cause illnesses or infections like the flu.

Flu is a mild illness for some people. For older people, especially those who have health problems like diabetes or heart disease, the flu can be very serious, even life-threatening.

Click on each link below for more information

- How Serious Is Flu?
- How Does Flu Spread?
- Is It the Flu or a Cold?
- Can Flu Be Prevented?
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- When Should I Get My Flu Shot?
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For More Information About the Flu

Centers for Disease Control and Prevention (CDC)
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