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

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AFL-CIO Endorses USMCA After Successfully Negotiating Significant Changes

Leadership in the U.S. House has also reached an agreement with the administration to move forward next year with the White House's replacement for the North American Free Trade Agreement. AFL-CIO President **Richard Trumka stated his approval of the U.S.-Mexico-Canada Trade Agreement (USMCA),** provided that promised changes are included.

Among the changes are stronger enforcement of labor standards and the removal of giveaways to drug corporations. The original USMCA deal contained provisions that maintain lengthy patent terms for certain drugs known as "biologics." protecting them from generic competition.

AFL-CIO
AMERICA'S UNIONS

That provision has now been removed. Mexico ratified the version of USMCA that the three countries agreed to last year and is expected to approve the new agreement. **The United States and Canada are also expected to ratify the new deal**.

But there is no denying that the trade rules in America will now be fairer because of our hard work and perseverance. Working people have created a new standard for future trade negotiations.

President Trump may have opened this deal. But working people closed it. And for that, we should be very proud.

Retirees Welcome House Passage of the Lower Prescription Drug Costs Now Act

Members of the Alliance cheered the passage of the landmark "Elijah E. Cummings Lower Drug Costs Now Act" in the House of Representatives on Thursday by a vote of **230-192**. The bill, H.R. 3, will lower skyrocketing drug prices by:

- Requiring Medicare to negotiate drug prices on the 250 highest priced drugs, including insulin
- Making the lower negotiated drug prices available to ALL insured Americans, not just seniors
- Capping annual out of pocket expenses for Medicare beneficiaries at $2,000
- Using the savings to expand Medicare coverage to include hearing, dental and vision

"Americans pay the highest prices in the world for prescription drugs and seniors are bearing the brunt of this burden," said **Richard Fiesta**, Executive Director of the Alliance, in a **statement.** "Today 230 members of the House of Representatives stood up to pharmaceutical corporations and said 'enough is enough.'"

"H.R. 3 will help retirees enjoy longer, healthier lives with less financial anxiety," added Fiesta. "Negotiating drug prices will save taxpayers billions of dollars and help ensure that no retiree has to choose between filling a prescription and putting food on their table."

The Congressional Budget Office predicted that the legislation overall would lower federal spending by $456 billion over a decade. The Center for American Progress released an **analysis** of how much patients could save for certain prescription drugs under H.R. 3.

Rich Fiesta

"The savings in this bill will be used to add critical benefits to Medicare — including dental, hearing and vision — and provide more funding for crucial medical research. However, our work is not done," Fiesta continued. "We call on the Senate to pass this legislation without delay."

Lawmakers Raise Medicare Plan Finder Concerns

This week, a bipartisan group of leaders from the U.S. House of Representatives Committees on Energy & Commerce and Ways & Means **sent a letter** to the Centers for Medicare & Medicaid Services (CMS) expressing concerns with the redesigned Medicare Plan Finder (MPF). The letter points to errors that advocates and Medicare counselors experienced when using the new tool to help beneficiaries compare and select Medicare Advantage and Part D prescription drug plans during Fall Open Enrollment. In the letter, the leaders urge CMS to ensure that people with Medicare who relied on MPF information to choose a plan this year are held harmless and have the opportunity to make changes to their coverage in 2020.

This letter follows **one last week** from 15 U.S. Senators that also highlights accuracy and functionality problems with MPF and urges CMS to publicize the relief pathway available to those who may have chosen the wrong plan after using MPF.

Choosing a Medicare Advantage plan or a standalone prescription drug plan is a difficult task, and the MPF is the federal government's primary enrollment assistance tool. Millions of people rely on the information in the MPF to be accurate and useful. Making the wrong coverage decision can have severe consequences for the health and personal finances of people with Medicare. That makes it vital for CMS to ensure the MPF is providing the information people need, to catch and fix errors as quickly as possible, and to find ways to help those who relied on incorrect information when they made their coverage choices.

At Medicare Rights, **we applaud CMS for its efforts to redesign the MPF**, which sorely needed an upgrade. The new site has an improved overall design and seems to lay the groundwork for future updates and enhancements. However, **some significant glitches** came to light during Fall Open Enrollment, which means we should be especially cautious before trusting the accuracy of the MPF results for all users. We strongly agree that beneficiaries who have used the new tool to choose a plan should be allowed to make changes to their coverage at any time during the upcoming plan year.

Going forward, people who made coverage decisions based on MPF results should look closely at their coverage and compare it to what they thought they had signed up for during Fall Open Enrollment. Even if there is a discrepancy, they should consider all of the circumstances of their care needs and prescriptions before making a change or seeking relief. Local **State Health Insurance Assistance Programs (SHIPs)** can help individuals learn about their options and make changes when appropriate.

Stop the Postal Sell-off: Say NO to a privatizer as the Postmaster General

The public service mission of the Postal Service has made it the most popular federal agency. However, this public good is at risk if we don't all act soon.

In June 2018 the White House announced proposals to privatize the Postal Service. Now Postmaster General Megan Brennan has announced her departure as Postmaster General in January 2020.

The Postmaster General has wide powers to shape the mission of USPS and there is a real risk that Brennan's successor could hand over parts of the service to private, profit-making corporations and prepare it for a wholesale sell-off.

The people will rightly expect a new Postmaster General who will uphold the Postal Service's public mission and will work to preserve and enhance our national treasure.

Add your voice. Protect our public Postal Service.

Sign the PETITION here

Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381

riarajap@hotmail.com • **http://www.facebook.com/groups/354516807278/**

Chart reviews boost Medicare Advantage payments by $6.7 billion, OIG finds

HHS' Office of Inspector General has raised new concerns about Medicare Advantage insurers' use of medical chart reviews to obtain higher payments from the federal government.

An analysis of 2016 Medicare Advantage data found that insurers who reported additional diagnoses **after combing patients' medical charts** were able to increase their payments from the CMS by an estimated $6.7 billion in 2017, according to the OIG's report published Thursday.

Though it is a requirement, these diagnoses reported from the medical chart reviews, which included serious illnesses like cancer, diabetes and heart disease, were not supported by records of a patient's face-of-face visit with a clinician.

While health insurers have insisted that they review patients' charts to ensure accurate Medicare Advantage payments, the analysis showed they only rarely submitted chart reviews that deleted incorrect diagnoses. Chart reviews that resulted in deleted diagnoses decreased payments by just $196.5 million.

"Chart reviews can be a tool to improve the accuracy of risk-adjusted payments by allowing (Medicare Advantage organizations) to add and delete diagnoses in the encounter data based on reviews of patients' records," the OIG wrote. "However, chart reviews—particularly those not linked to service records—may provide MAOs opportunities to circumvent the Centers for Medicare & Medicaid Services' face-to-face requirement and inflate risk-adjusted payments inappropriately."

A spokeswoman for America's Health Insurance Plans, the insurance industry's lobbying organization, said the OIG's report is based on a type of data with well-documented challenges, and noted that the OIG didn't review medical records for the analysis. AHIP has long argued that **"encounter data" is often incomplete or inaccurate** and would reduce insurers' payments.

The CMS also called into question the OIG's estimated dollar amount of risk-adjustment payments based on only chart reviews. The agency said the amount may be inaccurate because the OIG's analysis focused only on encounter data and not another type of data that is also used to calculate payments.

The way the federal government calculates payments to Medicare Advantage plans gives insurers **an incentive to make their plan members appear as sick** as possible on paper. That incentive doesn't exist in the original Medicare program.

Advantage organizations are paid a per member, per month amount to provide care. In a process known as risk-adjustment, payments are altered to pay more for sicker seniors that are expected to incur higher medical costs, based on the patients' demographic information and medical diagnoses submitted to the CMS by the Advantage insurer. Diagnoses are required to be backed up by the patient's medical record and documented from a face-to-face visit with a clinician.

Because sicker members net higher payments, insurers often hire third-party vendors to pore over patients' medical charts to find diagnoses that clinicians failed to report to the insurer or reported in error. The OIG report showed that insurers conducted a staggering amount of chart reviews in 2016: A total 553 Medicare Advantage organizations submitted 52.6 million chart reviews for risk-adjustment purposes, for an average of more than 95,000 reviews per insurer.

The CMS allows chart reviews to be submitted as encounter data, which is information about patients documented by doctors and hospitals and is increasingly used by the CMS to determine Advantage payments. Encounter data is blended with Risk Adjustment Processing System data to calculate payments and is loathed by insurers, though the Medicare Payment Advisory Commission supports using it.

The OIG's findings add to other evidence that Medicare Advantage insurers may find ways to exaggerate their patients' illnesses to obtain higher payments. The OIG has previously audited Advantage plans and found that they were overpaid by hundreds of millions of dollars because of risk scores that weren't supported by medical diagnoses. Moreover, the U.S. Department of Justice has intervened in whistleblower lawsuits alleging that UnitedHealth Group used chart reviews to exaggerate its plan members' conditions to obtain higher payments.

According to the OIG's new report, insurers submitted 40.6 million chart reviews adding diagnoses, and for 41% of those reviews, there were no records of a patient visit, procedure, test or supplies that contained those diagnoses.

"This means that, for the entire year, these beneficiaries may not have received any other services for the medical conditions indicated by the diagnoses," the OIG wrote.

It also found that 10 Medicare Advantage parent companies that enroll 70% of Advantage members drove 79% of the risk-adjusted payments from chart reviews. Advantage insurers received payments based solely on chart reviews for 1.7 million patients. In one extreme case, a patient had diagnoses reported only on chart reviews that resulted in about $229,050 in risk-adjusted payments to the insurer.

Insurers can link a chart review to a specific service associated with the diagnosis, but the CMS does not require this, according to the OIG report. The OIG estimated that the CMS based $2.7 billion in payments on chart review diagnoses that the insurers did not link to any service provided to the beneficiary in 2016.

"For beneficiaries with unlinked chart reviews, and no records of services in all of 2016, it is not at all clear what services were used to generate diagnoses added on these chart reviews," it wrote.

The OIG recommended that the CMS provide more oversight of insurers that received payments from unlinked chart reviews and conduct audits to validate the diagnoses reported on chart reviews. It also advised the CMS to reassess the risks and benefits associated with allowing unlinked chart reviews to be used for risk adjustment. The agency agreed with the recommendations

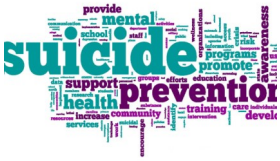
FCC moves to designate 988 a national suicide-prevention hotline number

Americans may soon be able to dial 988 to reach mental health providers if they are feeling suicidal under a new proposal approved by the Federal Communications Commission (FCC).

All five FCC commissioners on Thursday voted in favor of a proposal to designate 988 as the country's national suicide-prevention hotline number, arguing that having a 911-like option for people who are experiencing mental health crises could help combat the rising rate of suicides in the U.S.

"The need for suicide prevention services has never been greater in modern times," FCC Chairman Ajit Pai said at the FCC's open meeting on Thursday.

The proposal, which is now open to public comment, asks telecom companies to ensure users can dial 988 to reach the National Suicide Prevention Lifeline within 18 months.



The toll-free National Suicide Prevention Lifeline number is currently 1-800-273-TALK, which commissioners have argued is hard to remember. And the workers behind the hotline are facing a crunch as they handle more and more calls every year.

Last year alone, the government-backed suicide hotline answered more than 2 million calls, and the FCC is predicting that the 988 designation will lead to even more calls. That could require Congress to appropriate more funds to bolster Lifeline's work.

"Easier access to the Lifeline will mean increased calls and to greater demand for crisis services, which in turn will require increased resources," Pai said on Thursday. "As we move forward with this proceeding, we encourage interested stakeholders to work directly with Congress and our federal partners who run the Lifeline."

The suicide rate in the U.S. has been climbing for decades, spiking 33 percent between 1999 and 2017, according to the American Psychological Association. More than 47,000 Americans died by suicide in 2017, according to public data.

"Today's [proposal] addresses a pressing need for expanded access to suicide prevention and mental health crisis services—for children, teens, and the millions of other Americans impacted by suicide," said Democratic FCC Commissioner Geoffrey Starks on Thursday. "Establishing a simple three-digit number for the National Suicide Prevention Lifeline will better connect those in need with life-saving services."

For more information on the National Suicide Prevention visit their web site below.

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK
www.suicidepreventionlifeline.org

A Closer Look at Who Benefits from SNAP: State-by-State Fact Sheets

SNAP Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) is the nation's most important anti-hunger program, reaching 42 million people nationwide in 2017 alone. These fact sheets provide state-by-state data on who participates in the SNAP program, the benefits they receive, and SNAP's role in strengthening the economy.

Read more on the State by State Data, Fact Sheets, and Resources

Tell Your Senators, Don't Tax My Retirement

Weeks ago, two Republican senators unveiled a plan that threatens to destroy the multiemployer pension system that provides retirement security to hundreds of thousands of IBEW members.

You can read more about it **here**.

Sen. Chuck Grassley of Iowa and Sen. Lamar Alexander of Tennessee want you to believe that they're trying to fix a serious problem threatening a few major troubled pensions.

"What they're really doing is threatening to undermine the entire pension system by raising taxes on your retirement benefits by 10% and placing unreasonable fees on healthy plans that could bring the entire system crumbling down," said Political and Legislative Affairs Director Austin Keyser. "They bailed out the banks and billionaires, but when it comes time to help working families, we're left out in the cold."

While the Grassley-Alexander plan is still just a proposal, International President Lonnie R. Stephenson, International Secretary-Treasurer Kenneth W. Cooper and other union leaders believe it to be one of the biggest threats to the labor movement in recent memory.

"It's not often I come to members pleading that you pick up the phone, but this is one of those times," Stephenson said. "The truth is, we don't know when this plan will turn into actual legislation – it could be next week, it could be next year – but we don't want to let it ever get to that point. It's too dangerous for IBEW members not to put on a full-court press and kill it now.

"If each and every one of our 775,000 members calls their senators, we can stop this thing dead in its tracks. Get your families to call too. This is that important," Stephenson said.

The AFL-CIO has set up a toll-free number to direct union members to their senators. Tell them to reject the Grassley-Alexander proposal and support legislation like the Butch Lewis Act that will protect the retirement benefits you worked so hard to earn.

Every IBEW retiree has paid more federal taxes on their pension than some major corporations have paid on anything, yet their plan is to take more of our money," Stephenson said. "Instead of fixing bankruptcy laws that put everybody else first and workers last, instead of fixing deregulation that cut us off at the knees, instead of freeing workers to fight for better wages and benefits, they want to come after our hard-earned pensions.

To reach your senator **Call 844-551-6921 today or visit U S Senate website here**

"Know Your Social Security"

Last week we told you about the new legislation that TSCL has endorse, called the "Know Your Social Security" bill. The bill would clarify the requirement for the Social Security Administration (SSA) to mail an annual *Social Security Statement* to all workers ages 25 and older with covered earnings but who are not receiving Social Security benefits.

Earlier this week the House Ways and Means Committee, which is the committee that has jurisdiction over Social Security issues, met to discuss the bill and on a bi-partisan basis voted the bill out of committee and sent it to the full House of Representatives to be voted on in the near future.

This is the way Congress is supposed to work and it was refreshing to see the members of the committee – both Republicans and Democrats – talk about how nice it was to work together on an issue of the common good and pass something that is so important to the welfare of so many Americans. As one of the Republican members of the committee said, while this bill may not seem like a big deal, for many Americans receiving their Social Security annual statement and seeing what their benefit will be when they retire may be the only financial planning they'll ever do.

The bill passed the committee unanimously so TSCL hopes that it will receive quick action by the full House and then sent over to the Senate for action. While there is no companion bill in the Senate, the bi-partisan nature of the House bill could be enough of an incentive to the Senators that they will want to pass it quickly. TSCL will be working on that in the coming weeks. However, because of the lateness of this year, it is likely the Senate will not deal with the bill until sometime next year.

The statement of support for the bill by TSCL Chairman Rick Delaney was entered into the official record of the debate on the bill by Social Security Subcommittee Chairman John Larson.

Surprising Swings In Momentum For Legislation On Surprise Medical Bills

After months of hearings and negotiations, millions of dollars in attack ads, full-court press lobbying efforts and countless rounds of negotiations, Congress appeared to be moving toward a solution to the nation's surprise medical bill problem. Sort of.

Surprise bills, the often-exorbitant medical bills that come when a patient doesn't realize they've been seen by a provider outside their insurance network, have in recent months been viewed as public enemy No. 1 on Capitol Hill.

Two committees, the Senate Health, Education, Labor and Pensions (HELP) Committee and the House Energy and Commerce Committee, have been working on plans and announced a compromise Dec. 8. Later that week, the House Ways and Means Committee followed suit by announcing its solution, though details are few.

It's been a heavy lift for lawmakers in both parties who are trying to balance the competing needs of powerful stakeholders, factions within their ranks and consumers stuck with high bills. With an election year fast approaching and polls consistently showing health care costs are a high priority for voters, the push for action has intensified.

Time Is Not Of The Essence

Despite the rushed way some committee members announced the agreement Dec. 8 — issuing a press release on a Sunday before any official bill text was released — it's now unlikely that Congress will consider the package before it wraps up work for the year.

HELP Committee Chairman Lamar Alexander (R-Tenn.) signaled as much Monday in a press release in which he promised to do everything he could to keep the surprise medical bill issue at the top of the congressional to-do list for 2020 — until it's solved. "The only people who don't want this fixed are the people who benefit from these excessive fees," he said.

Still, the recent signs of progress are significant, even if final passage happens early next year, said Loren Adler, the associate director of USC-Brookings Schaeffer Initiative for Health Policy, a research group.

Even if Congress punts it to February or March, "there's a decent shot of getting it done," Adler said. "It would be pretty darn embarrassing if Congress doesn't pass it after talking about it this long and it being such an egregious problem."

Compromise Bill

The HELP/Energy and Commerce legislative outline shows movement toward compromise on several fronts, from omitting the controversial "all-payer claims database" — a federal repository for health-pricing information — to adding more public health provisions.

It includes Senate protections against surprise bills from air ambulances, while adopting most of the House's approach to hospital bills, down to preserving the House's title for that section.

"A sign of a compromise is that nobody particularly loves it," Adler said.

Over the past few months, the biggest debate around remedies for surprise bills has centered on how to determine payment for out-of-network doctors and hospitals. One group wanted an arbitration process while the other sought a benchmark system. It seems neither side got exactly what they were seeking.

Under benchmarking, the government would set a compensation rate for providers when they see out-of-network patients. The most popular proposition was one that paid a "median in-network" rate, when doctors are paid in the middle of the range of what others in the area are paid by insurance companies for the same service.

The other idea was independent dispute resolution, or arbitration. The provider and insurer bring their best offer to a third party, who chooses between the two.

Generally, employers and consumer advocates favor benchmarking. Hospitals and doctors' groups, especially those backed by private equity firms, pushed for arbitration.

The compromise approach tracks closely with legislation advanced by the House Energy and Commerce Committee: a median in-network benchmark with an arbitration "safety valve" where either side can bring a bill to arbitration if it's more than $750. Previous versions allowed arbitration only for charges over $1,250.

"I think what we've seen come out recently is probably what a reasonable bettor would have predicted," said Benedic Ippolito, a research fellow in economic policy studies at the American Enterprise Institute….

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Analysis: In Medical Billing, Fraudulent Charges Weirdly Pass As Legal

Much of what we accept as legal in medical billing would be regarded as fraud in any other sector.

I have been circling around this conclusion for the past five years, as I've listened to patients' stories while covering health care as a journalist and author. Now, after a summer of firsthand experience — my husband was in a bike crash in July — it's time to call out this fact head-on. Many of the Democratic candidates are talking about practical fixes for our high-priced health care system, and some legislated or regulated solutions to the maddening world of medical billing would be welcome.

My husband, Andrej, flew over his bicycle's handlebars when he hit a pothole at high speed on a Sunday ride in Washington. He was unconscious and lying on the pavement when I caught up with him minutes later. The result: six broken ribs, a collapsed lung, a broken finger, a broken collarbone and a broken shoulder blade.

The treatment he got via paramedics and in the emergency room and intensive care unit were great. The troubles began, as I knew they would, when the bills started arriving.

I will not even complain here about some of the crazy-high charges: $182 for a basic blood test, $9,289 for two days in a room in intensive care, $20 for a pill that costs pennies at a pharmacy. We have great insurance, which negotiates these rates down. And at least Andrej got and benefited from those services.

What I'm talking about here were the bills for things that simply didn't happen, or only kind-of, sort-of happened, or were mislabeled as things they were not or were so nebulously defined that I couldn't figure out what we might be paying for.

To be clear, many of the charges that I would call fraudulent — maybe all of them — are technically legal (thanks sometimes to lobbying by providers), but that doesn't make them right. And no one would accept them if they appeared on bills delivered by a contractor, or a lawyer or an auto mechanic. There were so many of these charges that I came up with categories to keep track of them:

Read More on the different fraudulent categories

- **Medical Swag**
- **The Cover Charge**
- **Impostor Billing**
- **The Drive-By**
- **The Enforced Upgrade**

U.S. spending deal would raise tobacco age, deny some Trump border wall money

Congress would raise the U.S. tobacco purchasing age to 21 and permanently repeal several of the Affordable Care Act's (ACA) taxes under a massive government spending bill unveiled on Monday.

Republican and Democratic lawmakers hope to pass the $1.4 trillion spending bill before current government funding runs out on Saturday, to avoid a partial government shutdown and head off the kind of messy budget battle that resulted in a record 35-day interruption of government services late last year and early this year.

The legislation, worked out during weeks of negotiations between leading lawmakers and the Trump administration, denies President Donald Trump the full $5 billion he requested to help build his signature wall along the U.S.-Mexico border, keeping funding static at $1.37 billion for border barriers.

Most Democrats and some Republicans support a mix of improved physical barriers at the border, along with a combination of high-tech surveillance equipment and patrols by all-terrain vehicles and even horses.

They have mostly rejected Trump's calls for at least $24 billion over the long run to build his much-touted wall, which he originally said Mexico would finance. Mexico rejected that idea. The wall's price tag could escalate as the federal government is forced to acquire private lands for construction.

The crackdown on youth smoking, by changing the minimum age for cigarette and other tobacco purchases to 21 from the current 18, would give the U.S. Food and Drug Administration six months to develop regulations. The agency would then have three years to work with states on implementing the change.

The largest expenditures in the bill is for the Department of Defense, which would get a total of $738 billion for this year, $22 billion more than last year. It does not include "mandatory" programs, such as Social Security and Medicare, which are funded separately.

The legislation also includes $425 million in additional federal grants to help local governments prepare for the November 2020 presidential and congressional elections.

Some of the money would be used to harden infrastructure against cyber attacks following election meddling by Russia in 2016.

Negotiators settled on $7.6 billion for conducting next year's census, which is done once every 10 years. That would be $1.4 billion more than Trump proposed.

The bill also allocates $25 million for federal gun violence research, following a decades-long suspension of such funding.

All of the money would fund government programs through Sept. 30, 2020.

The legislation would repeal several taxes originally created to help fund the ACA, popularly known as Obamacare, that had been delayed or were only intermittently in effect.

It calls for a permanent repeal of the so-called "Cadillac tax," a 40% tax on generous health insurance plans.

It had been intended to encourage corporations to buy lower cost plans for employees but was opposed by many unions that had negotiated their health insurance plans and by businesses who said it was a benefit workers valued. The tax was delayed and never went into effect.

The spending bill would also repeal the 2.3% tax on the sale of medical devices such as catheters and pacemakers. This drew opposition from bipartisan lawmakers who said it hurt innovation at medical device companies.

Another tax to be repealed is an industry-wide health insurance fee of about 2.5% to 3% of premiums collected.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

'Prehab' Before Surgery Helps Speed Seniors' Recovery

"Training" for surgery can improve seniors' outcomes and reduce insurance costs, a new study says.

It included 523 Medicare patients in Michigan, average age 70, who exercised, ate a healthy diet and practiced stress reduction techniques for at least one week before a major operation. It's a process the researchers called prehabilitation, or prehab for short.

These patients were compared to a control group of 1,046 Medicare patients who had the same operations at the same hospitals but did not do prehab.

Patients studied had different types of chest/heart and abdominal operations at 21 hospitals in Michigan.

Compared to the control group, prehab patients had shorter hospital stays (a median six days versus seven days). Two-thirds went straight home from the hospital, compared to 57% of the control group.

Medicare paid nearly $3,200 less for hospital and post-hospital care for the prehab group than for controls: $31,641 versus $34,837.

Insurance payments were lower among prehab patients for post-hospital care -- including skilled nursing facilities ($941 versus $1,566 for controls) and home health care ($829 versus $960 for controls), according to the study published online Dec. 5 in the *Journal of the American College of Surgeons*.

"Prehabilitation is good for patients, providers, and payers," said study co-author Dr. Michael Englesbe, a transplant surgeon at the University of Michigan. "We believe every patient should train for a major operation. It's like running a 5K race: You have to prepare."

Prehab makes the most of a patient's well-being and ability to withstand the stress of surgery, Englesbe said in a journal news release.

Previous research found prehab provides a number of benefits, including a lower rate of postoperative complications and speedier return to normal functioning.

"Prehab has been gaining momentum over the past 10 years. More surgeons and other clinicians are appreciating its benefits," Englesbe said. "However, the feasibility and value of broad implementation of prehabilitation outside the research environment were unknown."

He said every patient scheduled for major surgery -- not just those at high risk -- should ask their doctor for a prehab program.

Purdue Pharma's Foreign Affiliate Now Selling Overdose Cure

The gleaming white booth towered over the medical conference in Italy in October, advertising a new brand of antidote for opioid overdoses. "Be prepared. Get naloxone. Save a life," the slogan on its walls said.

Some conference attendees were stunned when they saw the company logo: Mundipharma, the international affiliate of Purdue Pharma — the maker of the blockbuster opioid, OxyContin, widely blamed for unleashing the American overdose epidemic.

Here they were cashing in on a cure.

"You're in the business of selling medicine that causes addiction and overdoses, and now you're in the business of selling medicine that treats addiction and overdoses?" asked Dr. Andrew Kolodny, an outspoken critic of Purdue who has testified against the company in court. "That's pretty clever, isn't it?"

As Purdue Pharma buckles under a mountain of litigation and public protest in the United States, its foreign affiliate, Mundipharma, has expanded abroad, using some of the same tactics to sell the addictive opioids that made its owners, the Sackler family, among the richest in the world. Mundipharma is also pushing another strategy globally: From Europe to Australia, it is working to dominate the market for opioid overdose treatment.

"The way that they've pushed their opioids initially and now coming up with the expensive kind of antidote -- it's something that just strikes me as deeply, deeply cynical," said Ross Bell, executive director of the New Zealand Drug Foundation and a longtime advocate of greater naloxone availability. "You've got families devastated by this, and a company who sees dollar signs flashing."

Mundipharma's antidote, a naloxone nasal spray called Nyxoid, was recently approved in New Zealand, Europe and Australia. Mundipharma defended it as a tool to help those whose lives are at risk, and even experts who criticize the company say that antidotes to opioid overdoses are badly needed. Patrice Grand, a spokesman for Mundipharma Europe, said in a statement that heroin is the leading cause of overdose death in European countries and nasal naloxone is an important treatment option.

Injectable naloxone has long been available; it is generic and cheap. But Mundipharma's Nyxoid is the first in many countries that comes pre-packaged as a nasal spray — an easier, less threatening way for those who witness an overdose to intervene. Nyxoid, which isn't sold in the U.S., is more expensive than injectable naloxone, running more than $50 a dose in some European countries. A similar product manufactured by another pharmaceutical company has been available for years in the U.S. under the brand name Narcan.

Critics say Nyxoid's price is excessive, particularly when inexpensive naloxone products already exist. Grand declined to say how much Nyxoid costs Mundipharma to manufacture or how profitable it has been.

The Sackler family's pharmaceutical empire has long considered whether it might make money treating addiction, according to lawsuits filed against Purdue and the family. In the U.S., Purdue Pharma called its secret proposal Project Tango, the attorneys general of Massachusetts and New York have alleged, and discussed it in a September 2014 conference call that included family member Kathe Sackler.

In internal documents, the lawsuits allege, Purdue illustrated the connection they had publicly denied between opioids and addiction with a graphic of a blue funnel. ...**Read More**

Patients, Not Hospitals, Most Important to Spinal Fusion Outcomes

Individual patient characteristics -- not the quality of care provided by surgeons and hospitals -- account for most differences in spinal fusion surgery outcomes, according to a new study.

The study included 737 patients, average age 63, who had spinal fusion surgery at 17 U.S. hospitals between 2012 and 2018. Fifty-eight surgeons did the operations.

One year after surgery, nearly 59% of patients said their physical functioning had improved, and 42.5% reported minimal disability.

Initial analysis suggested wide variation in patient outcomes by surgeon and hospital. For example, the percentage of patients reporting functional improvement ranged from 44% to 79% at different hospitals, and from 33% to 84% among different surgeons.

But those differences narrowed after researchers adjusted for factors known to affect outcomes after spinal fusion surgery.

Those factors included patient-related factors such as age, smoking and insurance coverage, as well as clinical factors such as previous spine surgery, type of spinal disease and initial level of disability.

The analysis showed "no detectable statistical differences" overall in spinal fusion surgery outcomes between hospitals or surgeons, the researchers reported in the Dec. 4 online edition of the journal *Spine*.

Differences between hospitals and surgeons were larger among patients with a lower chance of improvement after spinal fusion, while there was little or no variation between hospitals or surgeons among patients with a higher chance of improvement, which included nearly two-thirds of the patients in the study.

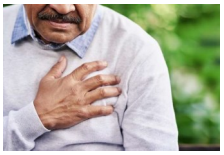
The researchers noted that in recent years, patient-reported outcomes (PROs) have become an important focus of efforts to assess the quality and outcomes of medical care.

Dr. David Flum, a professor of surgery at the University of Washington in Seattle, led the study.

"Differences in PROs after accounting for patient factors across hospitals and surgeons could indicate variation in health care system performance and an opportunity for quality improvement," Flum and his colleagues wrote.

"Our study demonstrated that the overall variability was mainly driven by patient characteristics, suggesting that quality improvement efforts to reduce variation and improve overall functional outcomes may be better if focused at the patient level," the team concluded.

Unexpected signs of an unhealthy heart



What Is a Heart Attack?

A heart attack happens when something blocks the blood flow to your heart so it can't get the oxygen it needs. More than a million Americans have heart attacks each year. Heart attacks are also called myocardial infarctions (MI). "Myo" means muscle, "cardial" refers to the heart, and "infarction" means death of tissue because of a lack of blood supply. This tissue death can cause lasting damage to your heart muscle..

Symptoms can be different from person to person or from one heart attack to another. Women are more likely to have symptoms like an upset stomach, shortness of breath, or back or jaw pain. With some heart attacks, you won't notice any symptoms (a "silent" myocardial infarction). This is more common in people who have diabetes….**Read More**

Caring for Grandkids Might Help Stave Off Loneliness

Caring for a grandchild might be the best way to fight the isolation of old age, new research suggests.

This conclusion is based on 2014 data collected as part of an ongoing German survey of older adults.

Among the nearly 3,900 grandparents in the survey, more than 1,100 said they cared for a grandchild. Those who had grandchildren to care for had lower scores on loneliness and social isolation tests, and a larger social network than those who didn't care for grandchildren.

Meanwhile, grandparents who didn't care for a grandchild had higher loneliness scores and were in regular contact with fewer people important to them, the study authors said.

The findings were unchanged even after the researchers took into account factors such as marital status, domestic arrangements, household income, self-rated health, physical activity levels and depressive symptoms.

The study can't prove that taking care of grandchildren by itself makes older people less lonely, only that there appears to be an association.

It might be that grandparents who felt less lonely and isolated to start with are more likely to care for a grandchild, said study author Eleanor Quirke, of the department for health economics and health services research at Hamburg-Eppendorf University Hospital, and colleagues.

The study also didn't account for how near to their grandchildren grandparents lived or how often they provided care, all of which could have affected the findings.

The report was published online Dec. 17 in the journal *BMJ Open*.

"Assisting their families to balance work and family by providing supplementary grandchild care may boost grandparents' self-esteem, and may also facilitate ongoing positive relationships with their children and grandchildren," Quirke's team suggested.

"Moreover, caring for grandchildren may also expand the social circle of grandparents and allow for further opportunities to establish relationships with other parents or grandparents," the study authors explained in a journal news release.

But it's also possible the positive effect might wear off if grandparents have to spend so much time caring for a grandchild that it interferes with their lives, the researchers added.

Bottled Water DOES Expire—And You Should Take It Seriously

You may know that you shouldn't drink out of the water bottle that you left in a hot car. But how recently have you checked the expiration date on your bottled water?

That's right! Bottled water DOES expire. And while the reason why meat or dairy products have a sell-by date is pretty self-explanatory, you might be surprised that bottled water comes with a time stamp, too.

As it turns out, it isn't the water quality you should be worried about. It's the plastic that the water comes packaged in: usually polyethylene terephthalate (PET) for retail bottles and high-density polyethylene (HDPE) for water cooler jugs. These plastics "will leach into the liquid the bottle once expired or especially when exposed to heat, including sunlight, and hot cars or storage trucks," according to **Amy Leigh Mercee**, holistic health expert and bestselling author. "The toxicity contained in the plastic material enters the water." Also, you'd be surprised by **how often you should be washing your refillable water bottle**, too.

And not only does this affect the taste of the water, it could create a serious health hazard. "It is disruptive to the endocrine system, causing reproductive symptoms, various cancers, [and] neurological problems, and damaging the immune system." The porous plastic can also cause the water to accumulate odors and other nasty accompaniments from outside.

So how do those expiration dates keep you safe from this? "Many bottled water companies print a standard two-year expiration date," Mercree says, but admits that this is a rather arbitrary number. There's no precise way to predict exactly when the water in the bottle is no longer good to drink, but "it stands to reason that the longer the bottle has been in circulation, the more likely it was exposed to heat or has started to generally degrade," Mercree says, hence the "standard" two years.

But she warns that the quality of the water can depend on several different factors. "Even a brand new plastic bottle that sat in a hot delivery truck for hours or more can already have adverse and toxic compounds present in the water even when first delivered to the grocery store," she says. But, as a general rule, as long as you drink it reasonably soon after you buy it, don't expose it long-term to intense heat or keep it too close to any household chemicals, and refrigerate it once it's open, your bottled water should be perfectly safe. You should also be keeping an eye out for these other **non-food items you didn't know had expiration dates**

As Diabetes Costs Soar, Many Turn to Black Market for Help

Skyrocketing prices and insurance limits are driving many people with diabetes to seek medications and supplies from an underground supply chain, a new study found.

"The cost of insulin, which is required in type 1 diabetes and a subset of type 2 diabetes, has increased substantially over the last decade. As the price of insulin rises and insurance premiums and deductibles go up, too, the situation has become untenable," said the study's lead author, Michelle Litchman. She is a nurse practitioner and assistant professor at the University of Utah College of Nursing, in Salt Lake City.

Litchman explained that if people who need insulin ration it or stop using it, they can end up in the hospital and even risk dying.

"People with diabetes want to stay healthy and because of that, they're going to this extreme of seeking out insulin and diabetes supplies through nontraditional sources," she added.

Litchman noted that people seem to be aware that there are risks involved in getting medication and supplies from family, friends or online sources. But there's also a risk in not taking medications like insulin, which are needed to stay alive…..**Read More**

The power of self-care

Tara Parker Pope reports for the **New York Times** on the power of self-care. Haenim Sunim, a Buddhist, writes about self-care in his book, *Love for Imperfect Things*. Self-care recognizes the value of paying attention to your own wellbeing before caring for others.

There's evidence that self-care can lead to a better quality of life. Self-care includes physical activity, **healthy eating** and getting **enough sleep**. It also means **mindfulness, meditation**, self-compassion and stress management.

Self-care is not easy, especially when your parents, kids, partners and dear friends need your attention. Self-care takes time. And, it's hard to know how to allocate that time. Haemin Sunim offers five simple steps.

Breathe. Accept. Write. Talk. Walk.

You can begin by breathing deeply. Taking deep breaths can bring calm to your life. It helps ground you. And, it need only take a few minutes each day.

Accept your struggles. Life is not perfect. There are many things we cannot control or change. It will help quiet your mind.

To help you accept life's struggles, put pen to paper. Write down the things you are struggling with and how you can best move forward. Putting your struggles on paper can help you let go of them and ease your mind. Then, after a good night's sleep, do something easy that moves you forward. Once that's done, you can move to more difficult tasks.

Reach out to a **close friend** who is good at hearing your concerns and let them out. As you talk, you will gain better insight into how to move forward. You will have a better sense of the issues.

And, take a walk. **Walking** also calms the mind and can alleviate stress. It not only is good for the body, it is good for your mental health. Focus on nature.

The goal is not perfection. That's not possible. The goal is to find meaning and comfort in the imperfect.

FDA says Amarin can market fish-oil derived therapy for reducing heart attack

U.S. health regulators on Friday approved expanding the heart benefit claims Amarin Corp can make in promoting its drug Vascepa to include reducing the risk of heart attacks and strokes in high-risk patients, opening a multibillion-dollar market opportunity.

The decision comes a month after an independent panel of experts to the Food and Drug Administration voted unanimously in favor of allowing the broader claims based on positive clinical trial data.

Vascepa, a highly purified form of omega-3 fatty acid, won U.S. approval in 2012 to lower high triglycerides - a type of blood fat that can increase the risk of heart disease.

The expanded label allows the company to tap into a market of up to 15 million Americans at risk of developing cardiovascular complications despite being on statin treatment to lower cholesterol.

Roth Capital Partners expects Vascepa to capture about 12% of the U.S. market over the next decade, forecasting peak annual sales of $3.2 billion by 2030

Vascepa has been heralded as a potential game changer in the cardiovascular disease market by Wall Street analysts.

In clinical trials, Vascepa cut the combined rate of heart attacks, strokes, heart-related death, need for artery-clearing procedures and hospitalizations for unstable angina by 25% compared to placebo. That comes on top of the heart attack risk reduction of about 25% patients already get from statins.

Heart disease is the leading cause of death in the United States. By 2035, 45% of the U.S. population is estimated to be diagnosed with some form of cardiovascular disease, resulting in annual treatment costs in excess of $1 trillion, according to The American Heart Association.

Vascepa has been highlighted as a cost-effective add-on to statins by the Institute for Clinical and Economic Review. The therapy's annual cost based on list price of around $3,600 is much lower than the non-profit group's recommended value-based price range of $6,300 to $9,200.

Insurers are expected to further embrace the pill now that the expanded heart benefit claim is official.

"Some have contracted and agreed in writing to improve their coverage, based upon approval and others have suggested that we contact them promptly after the approval," Chief Executive Officer John Thero told Reuters ahead of the decision.

European health regulators are expected to announce a decision on Vascepa's heart benefit claims before the end of 2020.

Heart Medicines Priced Out of Reach for Many Americans

Many working-age Americans struggle to pay for the heart medications that protect them from heart attack, stroke and heart disease, a new study reports.

About one in eight adults suffering from a high-risk heart problem say financial strain has caused them to skip taking their meds, delay filling a prescription, or take a lower dose than prescribed, the researchers said.

Those not yet old enough to go on Medicare were most strongly affected, said senior researcher Dr. Khurram Nasir. He is chief of cardiovascular prevention and wellness at Houston Methodist Hospital in Texas.

under 65 years old, the study authors found.

"Elderly patients covered by Medicare have a higher burden of disease, and they are less likely to be actively employed," Nasir said. "Still, they had two to three times lower risk of being noncompliant due to cost."

The results bolster the argument that a public insurance option such as Medicare-for-All could promote better health among Americans, he added.

"Our study suggests the current for-profit private insurance system is failing to protect at lot of people from financial risk," Nasir said.

Skipping prescribed blood pressure meds, cholesterol-lowering drugs and other therapies is a risky financial tactic that increases patients' chances of developing heart failure or suffering a heart attack or stroke, Nasir explained....**Read More**

Even simple surgeries carry serious risks for frail older people

Gina Kolata reports for the **New York Times** on new findings reported in JAMA surgery showing that frail older people can be at serious risk even when receiving simple surgeries. Typical good surgical outcomes do not tell the whole story. Frail older patients are far more likely to die prematurely from "low-risk surgery" than younger patients in better health.

Put differently, surgery on a frail older patient is never low-risk. Frail patients tend to be physically and mentally weak, underweight with multiple health conditions. They often struggle to get their strength and independence back post-surgery.

Surgical procedures for people who are frail have high risks. They increase frail older people's likelihood of death within 30 days after surgery by one and a half percent or more. And, for the most frail people, there's a 10 percent increase in likelihood of death. High risk procedures for people who are not frail increase their likelihood of death by as little as one percent.

Doctors may not be aware of the high risks of surgery for frail older patients. Even something as simple as a gall bladder removal has a five percent higher risk of death for them in the 30 days after surgery and 19 percent higher risk if they are very frail. In the 90 days after surgery, the risk of death is still higher. And, it's higher still in the six months after surgery.

The researchers cannot say what precisely causes death in frail older patients. It could be factors other than their surgeries. And, sometimes, surgeries can increase quality of life for frail older patients.

Given its risks, before surgery, talk to your doctor. Ask your doctor about your choices for treating your condition. And, ask about the possible outcomes of these choices. You want to know the best and worst case scenarios and what is most likely to happen from a given choice.

And, if you are frail and opt for surgery, you may want to take some time pre-surgery to "pre-habilitate" or improve your strength and ability to withstand