

November 14, 2021 E-Newsletter

Despite Restraints, Democrats' Drug Pricing Plan Could Still Aid Consumers

The Medicare prescription drug pricing plan Democrats unveiled this week is not nearly as ambitious as many lawmakers sought, but they and drug policy experts say the provisions crack open the door to reforms that could have dramatic effects. Tamping down drug expenses has been a longtime rallying cry for consumers beset by rapidly rising prices. Although people in private plans had some protections, those on Medicare often did not. They had no out-of-pocket caps and frequently complained that federal law kept them from using **drugmakers' coupons** or other cost-cutting strategies.

A plan offered earlier this year by House Democrats — which included robust negotiation over drug prices in Medicare — was blocked by a handful of moderates who argued that the price curbs would stifle innovation. The legislation also was on a course to hit roadblocks among senators.

The moderates favored more limited negotiation over drugs only in Medicare Part B — those administered in doctors' offices

and hospitals. Most people in Medicare get their drugs through Part D, which covers medicine dispensed at a pharmacy.

When it appeared that the bill to fund President Joe Biden's social agenda would move forward without a drug pricing proposal, the pressure built, intense negotiations were held, and a hybrid proposal was unveiled. It includes identifying 100 of the most expensive drugs and targeting 10 of them for negotiations to bring those costs down beginning in 2025. It will also place inflation caps on prescription drug prices for all insurance plans, restrict copays for insulin to no more than \$35, and limit Medicare beneficiaries' annual out-of-pocket drug costs to \$2,000.

"There was a sense that the government had its hands tied behind its back. Now a precedent is being set," said Senate Finance Committee Chairman Ron Wyden (D-Ore.), who led the talks for the senators. "There's going to be negotiation on the most expensive drugs: cancer drugs, arthritis drugs or



the anticoagulants. And that's a precedent, and once you set a precedent that you can actually negotiate, you are really turning an important corner."

Drugmakers say the changes could stymie consumers' options. "Under the guise of 'negotiation,' it gives the government the power to dictate how much a medicine is worth," Stephen Ubl, CEO of the trade group PhRMA, said in a statement, "and leaves many patients facing a future with less access to medicines and fewer new treatments."

But how, exactly, will the changes be felt by most Americans, and who will be helped?

The answers vary, and many details would still have to be worked out by government agencies if the legislation passes. House members warned some minor changes were still being made Thursday night, and it all has to pass both chambers.

Controlling Insulin Costs

One of the most obvious benefits will go to those who need insulin, the lifesaving drug

for people with Type 1 diabetes and some with Type 2 diabetes. Although the drug has been around for decades, prices have risen rapidly in recent years. Lawmakers have been galvanized by nightmarish accounts of people dying because they couldn't afford insulin or driving to Canada or Mexico to get it cheaper.

Under **the bill**, starting in 2023, the maximum out-of-pocket cost for a 30-day supply of insulin would be \$35. The benefit would not be limited to Medicare beneficiaries.

That cap is the same as one that was set in a **five-year model program** in Medicare. In it, the Centers for Medicare & Medicaid Services estimated that the average patient would save about \$466 a year.

Detailed analyses of the proposals were not yet available, so it is unclear what the fiscal impact or savings would be for patients outside of Medicare.....[Read More](#)

Drug Companies Fought Against any Legislation that would Force Drug Prices Lower

We are at a strange point in our society where on the one hand, drug companies are heroes for the way they developed vaccines against Covid-19 so quickly — vaccines that have saved many lives and allowed us to think about returning to normal.

One the other hand, they are villains for the way Americans are made to pay the highest prices for prescription drugs in the developed world.

Reaching the agreement to lower drug prices is a major breakthrough because the

pharmaceutical companies opposed any changes to the way things are now. They have spent over \$23 million in the first 9 months of this year lobbying Congress against any legislation regarding drug prices.

They deployed an army of 3 lobbyists for every 1 member of Congress. And yet this new agreement will open the door to regulate drug prices for the first time.

This happened because of pressure from the American



people that was put on Congress through TSCL and other organizations like it, as well as direct pressure from voters on members of Congress

We are pleased and proud to have played a significant part in what appears to be a major victory for seniors throughout the U.S.

However, the House and Senate will not be voting on any legislation this week so we have to wait until at least next week to see if they can reach a final

agreement in the House regarding the over-all bill that contains the measure to reduce prescription drug prices. Once it passes the House, it moves on to the Senate, where changes could still be made, although the agreement appears to include the Democratic majorities in both the House and the Senate.

Republicans, virtually unanimously, have decided to vote against whatever the final legislation looks like when it comes up for a vote.

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Security tax in 2021? Is there a Social Security tax cap?

Although the Social Security tax rate hasn't changed since 1990, the amount of one's earnings that are subject to Social Security tax changes from year to year. The amount liable to Social Security tax is capped at \$142,800 in 2021 but will rise to \$147,000 in 2022.

The change to the taxable maximum, called **the contribution and benefit base**, is based on the National Average Wage Index. The increase for 2022, at 2.9 percent, is less than the 3.7 percent increase for 2021. These annual limits are also applied to the computation to **calculate Social Security benefits** based on one's earnings along with other factors.

How to calculate your Social Security benefits

Will Social Security beneficiaries get a fourth stimulus check?

When to expect Social Security payments

The rules regarding Medicare enrollment

What is the Social Security tax rate?

The Social Security tax rate has remained the same since 1990, the last time it was increased. Workers contribute to the Social Security Trust Funds

through payroll taxes, the Federal Insurance Contributions Act (FICA) tax, and for the self-employed, the Self-Employment Contributions Act (SECA) tax. Workers also pay into the Medicare's Hospital Insurance (HI) program as part of the **FICA and SECA taxes**.

For those who earn a wage or salary, they share the 12.4 percent Social Security tax equally with their employer on their net earnings. The maximum taxable amount for the Social Security tax is \$142,800 in 2021. Likewise, the 2.9 percent Medicare's Hospital Insurance tax is split equally but there isn't an earnings limit for the tax.

For example, an employee that earns \$150,000 pays 6.2 percent of the first \$142,800 he or she earns, or \$8,854, and the employer would put in the same amount for a total of \$17,708 for Social Security. However, both would contribute \$2,175, or 1.45 percent of \$150,000, for a total of \$4,350. Generally, an employer will withhold what an employee owes from a paycheck and send the amount due for both to the government.

The self-employed with net



earnings of \$150,000 must pay the full 12.4 percent on \$142,800 of net earnings in 2021, \$17,708, and 2.9 percent on the whole \$150,000, or \$4,350. However, the self-employed are allowed to deduct half of the SECA tax as a business expense.

How do Social Security contributions work?

In order to receive Social Security retirement benefits, a worker must earn 40 credits, but can only accumulate a maximum of 4 per year. Some workers can reach that amount in ten years, but the longer you work, the higher your monthly benefits payment should be.

The Social Security Administration uses the average of 35 highest-earnings years as part of their computation, years not worked count as a zero income year lowering the average. As well, a worker can retire at 62 if they have their 40 credits, but they will receive lower monthly payments. If that worker continues working until reaching **full retirement age**, they will receive considerably more each month. In order to receive

the **maximum possible monthly benefits**, a worker needs to keep working until they are 70 years old.

The Social Security taxes you pay from your earnings during your working years fund benefits for existing beneficiaries along with the Social Security Trust Funds. In 2021, there are approximately 176 million workers who are employed in jobs covered by the Old-Age, Survivors, and Disability Insurance (OASDI) tax. They cover the benefits of around 65 million Americans who are receiving benefits in 2021.

According to the Social Security Administration that translates to 2.7 covered workers per each Social Security beneficiary currently. But by 2035 that number will reduced to a ratio of 2.3 to each beneficiary. There are worries about the long-term viability of the program and whether financing shortfalls could affect future benefits. **Lawmakers are considering legislation** to ensure the health of Social Security until a longer-term solution can be developed to guarantee benefits into the future.

As Overdose Deaths Soar, DEA-Wary Pharmacies Shy From Dispensing Addiction Medication

When Martin Njoku saw opioid addiction devastate his West Virginia community, he felt compelled to help. This was the place he'd called home for three decades, where he'd raised his two girls and turned his dream of owning a pharmacy into reality.

In 2016, after flooding displaced people in nearby counties, Njoku began dispensing buprenorphine to them and to local customers at his Oak Hill Hometown Pharmacy in Fayette County. Buprenorphine, a controlled substance sold under the brand names Subutex and Suboxone, is a medication to treat opioid use disorder. Research shows it halves **the risk of overdose** and **doubles people's chances** of entering long-term recovery.

"I thought I was doing what was righteous for people who have illness," Njoku said.

But a few years later, the Drug Enforcement Administration raided Njoku's pharmacy and accused the facility of contributing to the opioid epidemic rather than curbing it. The agency revoked the pharmacy's registration to dispense controlled substances, claiming it posed an "imminent danger to public health and safety." Although two judges separately ruled in Njoku's favor, the DEA's actions effectively shuttered his business.

"I lost everything that I worked for," Njoku said.

Lawyers, pharmacists, harm-reduction advocates and a former DEA employee say Njoku's case



is emblematic of the DEA's aggressive stance on buprenorphine. An opioid itself, the medication can be

misused, so the DEA works to limit its diversion to the streets. But many say the agency's policies are exacerbating the opioid epidemic by scaring pharmacies away from dispensing this medication when it's desperately needed.

Drug overdose deaths **hit record highs last year**, and despite medical experts considering medications like buprenorphine the gold standard, less than 20% of people with opioid use disorder typically **receive them**. The federal government **has taken steps to increase the number of clinicians who prescribe buprenorphine, but many**

patients struggle to get those prescriptions filled. A recent study found that 1 in 5 U.S. pharmacies do not provide buprenorphine.

"Pharmacies are terrified they're going to lose their DEA registration and go out of business," said Charles "Buck" Selby, a former inspector and chief compliance officer for the West Virginia Board of Pharmacy, who retired in 2018.

The ramifications can be particularly acute in rural areas, where a dearth of addiction treatment providers, lack of transportation and stigma against these medications already create barriers. If pharmacies decline to provide buprenorphine too, patients will have few options left, Selby said...**Read More**

‘Covid Hit Us Over the Head With a Two-by-Four’: Addressing Ageism With Urgency

Earlier this year, the World Health Organization announced a [global campaign to combat ageism](#) — discrimination against older adults that is pervasive and harmful but often unrecognized.

“We must change the narrative around age and ageing” and “adopt strategies to counter” ageist attitudes and behaviors, WHO concluded in a [major report](#) accompanying the campaign.

Several strategies WHO endorsed — educating people about ageism, fostering intergenerational contacts, and changing policies and laws to promote age equity — are being tried in the United States. But a greater sense of urgency is needed in light of the coronavirus pandemic’s shocking death toll, including more than 500,000 older Americans, experts suggest.

“Covid hit us over the head with a two-by-four, [showing

that] you can’t keep doing the same thing over and over again and expect different results” for seniors, Jess Maurer, executive director of the Maine Council on Aging, said in an [October webinar on ageism in health care](#) sponsored by KHN and the John A. Hartford Foundation. “You have to address the root cause — and the root cause here is ageism.”

Some experts believe there’s a unique opportunity to confront this concern because of what the country has been through. Here are some examples of what’s being done, particularly in health care settings.

Distinguishing old age from disease. In October, a group of experts from the U.S., Canada, India, Portugal, Switzerland and the United Kingdom called for old age to be removed as one of the causes and symptoms of disease in the [11th revision of](#)



[the International Classification of Diseases](#), a global resource used to standardize health data worldwide.

Aging is a normal process, and equating old age with disease “is potentially detrimental,” the experts wrote in [The Lancet](#). Doing so could result in inadequate clinical evaluation and care and an increase in “societal marginalisation and discrimination” against older adults, they warn.

Identifying ageist beliefs and language. Groundbreaking research published in 2015 by the FrameWorks Institute, an organization that studies social issues, showed that many people associate aging with deterioration, dependency and decline — a stereotype that almost surely contributed to policies that harmed older adults during the pandemic. By

contrast, experts understand that older adults vary widely in their abilities and that a significant number are healthy, independent and capable of contributing to society.

Using this and subsequent research, the [Reframing Aging Initiative](#), an effort to advance cultural change, has been working to shift how people think and talk about aging, training organizations across the country. Instead of expressing fatalism about aging (“a silver tsunami that will swamp society”), it emphasizes ingenuity, as in “we can solve any problem if we resolve to do so,” said Patricia D’Antonio, project director and vice president of policy and professional affairs at the Gerontological Society of America. Also, the initiative promotes justice as a value, as in “we should treat older adults as equals.”...[Read More](#)

Medicare Enrollment Blitz Doesn’t Include Options to Move Into Medigap

Medicare’s annual open-enrollment season is here and millions of beneficiaries — prompted by a massive advertising campaign and aided by a detailed federal website — will choose a private Medicare Advantage plan.

But those who have instead opted for traditional Medicare face a critical decision about private insurance. Too often the import of that choice is not well communicated.

If beneficiaries decide to use traditional Medicare when they first join the program, they can pick a private supplemental plan — a Medigap plan — to help cover Medicare’s sizable deductibles and copayments for hospital stays, physician visits and other services.

But many people don’t realize that, in most states, beneficiaries have guaranteed access to a Medigap plan for only six months after they enroll in Medicare Part B — either at age 65 or when they leave private health insurance and join Part B.

While the Medicare.gov website offers a [guide](#) to these Medigap plans — labeled A

through N — it’s a complicated decision because each plan provides different kinds of coverage — for 10 categories of benefits. Then there are the variants with high deductibles and limited provider networks. Premiums vary sharply, of course. And because seniors enroll in these plans throughout the year as they reach Medicare eligibility, there is far less publicity about the options.

As long as a beneficiary pays the premiums, they cannot be disenrolled from a Medigap plan.

For many who opted at some point for Medicare Advantage but decide later to move to traditional Medicare, getting a Medigap policy may be extremely difficult or impossible.

Lots of people making their plan choice this season may have missed their narrow window for Medigap enrollment. That means they may be stuck in Medicare Advantage or their current Medigap plan.

Ken Singer, 68, of Bridgewater, New Jersey, who retired from an investment management firm, didn’t know about the limited



opportunity to sign up for a Medigap policy.

“Nobody told me that,” he said. “I did a lot of reading about Medigap, but I found it kind of confusing.” He wants a policy because he’s leaving his wife’s employer-based health plan.

“Not that many people aging into Medicare at 65 fully understand that moment may be their only opportunity to opt into Medigap,” said Brian Connell, executive federal affairs director at the Leukemia and Lymphoma Society. “If you miss that short window, you’re left without protection from high out-of-pocket costs.”

While Medigap plans typically carry higher premiums than Medicare Advantage plans, the more expensive ones offer greater out-of-pocket cost protection.

After a beneficiary’s initial six-month window, federal law does not prohibit Medigap insurers from rejecting applicants or charging a very high premium if they have a preexisting medical condition, unlike in the Affordable Care Act insurance market for people under 65. [Only](#)

[four states](#) require insurers to offer Medigap coverage to applicants regardless of age or health. Medigap covers nearly 13 million beneficiaries.

In contrast, federal rules require Medicare Advantage plans to accept all applicants and charge the same premium regardless of their health. Out-of-pocket costs in Medicare Advantage plans are capped at \$7,550 this year for in-network care, not counting prescription drugs. Traditional Medicare has no cost cap, but some of the Medigap plans cover the vast majority of those expenses that otherwise would be out-of-pocket.

At least partly because of these unequal consumer protections, 17% of the 33 million people in traditional Medicare have no supplemental insurance, according to Tricia Neuman, executive director for Medicare policy at KFF. Their out-of-pocket costs can reach tens of thousands of dollars a year for serious conditions like cancer or kidney disease....[Read More](#)

Medicare open enrollment: Don't be misled by ads

When it comes to Medicare, every corporate health insurer seems to have an offer you can't refuse, often from one of your favorite heroes paid to push their products. Don't be misled by the TV ads and other promotional hype; get impartial information from your **State Health Insurance Assistance Program**. And, if you are misled, please know that you now have special rights to disenroll.

Millions of older adults and people with disabilities are receiving misleading information from insurance companies offering Medicare Advantage. These insurers are not telling you the whole story about the health plans they are offering. Medicare Advantage plans offer you coverage from a limited number of physicians and hospitals—generally far fewer than it appears from their provider directories—and often with large out-of-pocket costs if you need costly care. And, you are likely to need prior approval

for your care, as well as to face delays and denials of care.

So many people are signing up for these health plans based on misleading information that the Centers for Medicare and Medicaid Services (CMS) has threatened to penalize Medicare Advantage plans if they or the insurance brokers selling their products mislead people, reports Susan Jaffe for **California Healthline**. Under federal law, they are not allowed to engage in deceptive marketing practices, but that has not stopped them. And, since marketing is always deceptive—highlighting benefits but not costs—what exactly constitutes deceptive marketing?

CMS is seeing a lot of complaints. Does the punishment CMS is threatening fit the crimes the health plans are committing? The Medicare Advantage plans make so much money off of each enrollee that it can be highly profitable for them to try to sell people a free



lunch. When asked, CMS could not name one instance in which it had fined or suspended enrollment in a Medicare Advantage plan for deceptive marketing.

The good news is that CMS has added new protections for people who are misled into joining a Medicare Advantage plan. You have additional rights to disenroll beyond the first three months of the year. According to CMS, enrollees have a “special enrollment period” if you want to disenroll because of deceptive sales tactics, including “situations in which a beneficiary provides a verbal or written allegation that his or her enrollment in a MA or Part D plan was based upon misleading or incorrect information ... [or] where a beneficiary states that he or she was enrolled into a plan without his or her knowledge.”

Most important: Never give a stranger your Medicare or Social Security number. In

some cases, insurance agents are calling people, asking for their Medicare number and enrolling them in a Medicare Advantage plan without telling them.

If you want health insurance that will meet your needs if you take a bad fall or are diagnosed with a serious condition, traditional Medicare gives you the freedom to see the doctors you want to see and use the hospitals you want to use anywhere in the country, generally with no bureaucratic hassle. The tradeoff is that you will need supplemental coverage, either through Medicaid, a former employer or a Medigap plan in order to protect yourself from out-of-pocket costs that have no cap. But, the cost of Medigap can be as low as \$1,500 a year, far lower than the out-of-pocket cap in Medicare Advantage, which averages around \$5,000 a year and can be as high as \$7,550 for in-network care alone.’

Dear Marci: How does Medicare cover flu shots and other vaccines?

*Dear Marci,
Flu season is starting, and I'm eager to get a flu shot. I want to know what to expect, though. How does Medicare cover flu shots and other vaccines?
-Mei (Irvine, CA)*

Dear Mei,
Medicare covers vaccines and immunizations in two ways. Medicare Part D covers **most vaccines and immunizations**. However, some vaccinations are instead covered by Part B:

- ◆ Influenza (flu) shots, including both the seasonal flu vaccine and the H1N1 (swine flu) vaccine
- ◆ Pneumococcal (pneumonia) shots
- ◆ Hepatitis B shots
- ◆ COVID-19 vaccines

Part B also covers vaccines after you have been exposed to a dangerous virus or disease. For example, Part B will cover a tetanus shot if you step on a rusty nail, or a rabies shot if you are exposed to a bat.

Let's start with how Medicare covers the flu shot.

Medicare Part B covers one flu shot every flu season. The flu season usually runs from November through April. Depending on when you choose to get your flu shot, Medicare may cover a flu shot twice in one calendar year. For example, if you get a shot in January 2021 for the 2020/2021 flu season, you could get another shot in October 2021 for the 2021/2022 flu season.

Next, the pneumonia shot. Pneumonia is an infection that targets the lungs and can cause fever, difficulty breathing, and other symptoms. Pneumonia shots help prevent pneumonia. Medicare Part B covers two separate pneumonia vaccines. Part B covers the first shot if you have never received Part B coverage for a pneumonia shot before. You are covered for a different, second vaccination one year after receiving the first shot. You are not required to provide a



Dear Marci

vaccination history when receiving the pneumonia vaccine.

You can verbally tell the health care professional administering the shot if/when you have received past shots.

Medicare Part B additionally covers hepatitis B shots if you qualify. Hepatitis B is a virus that attacks the liver and can cause chronic liver disease. Hepatitis B shots can help prevent the disease. Medicare Part B covers the hepatitis B vaccine **if you are at medium or high risk for hepatitis B**. If you are at low risk for hepatitis B, the shot will be covered under Part D.

And finally, let's discuss how Medicare covers the COVID-19 vaccines. Original Medicare Part B covers **COVID-19 vaccines**, regardless of whether you have Original Medicare or a Medicare Advantage Plan. You should bring your red, white, and blue Medicare card with you to your vaccination appointment, even if you have a Medicare

Advantage Plan. The Food and Drug Administration (FDA) has approved an additional dose of the COVID-19 vaccine or booster for certain populations. Speak with your doctor to learn more about your eligibility for a third dose or for a booster. If you qualify for the above vaccines, Original Medicare covers them at 100% of the Medicare-approved amount when you receive the service from a **participating provider**. This means you pay nothing (no deductible or coinsurance). Medicare Advantage Plans are required to cover flu shots **without applying deductibles, copayments, or coinsurance** when you see an in-network provider and meet Medicare's eligibility requirements for the service.

Now that flu season is here, it is a great time to schedule your flu shot. Speak to your health care provider about any questions you have!

-Marci

When a Will Won't Work

A will allows you to **distribute your worldly goods**, select a guardian for minor children and name an executor to carry out your wishes.

But you should be aware of what a will can't or shouldn't do. This is particularly true if you're drafting your own document without an attorney's help, since you could unknowingly make a mistake that upends your whole estate plan.

What a will can't do

A will can't avoid probate, the legal process that typically follows death. In probate, your will becomes a public record and the court supervises the distribution of your estate.

In many states, probate isn't particularly expensive or lengthy. In other states — such as California and Florida — probate can be costly and time-consuming, which is why many residents wish to avoid it.

A common way to **bypass probate** is to create a **revocable living trust** and then transfer ownership of your real estate, accounts and other property into the trust. You retain control, but upon your death, the person you

name as your successor trustee can distribute your property without a court's involvement, says Matt Palmer, associate product counsel at online legal site LegalZoom.

You can avoid probate using other means. Jointly held property passes directly to the other owner, bypassing probate. Accounts with beneficiaries, such as life insurance and retirement funds, can also avoid probate. You may be able to use "transfer on death" or "payable on death" documents to designate beneficiaries for other financial accounts. Some states have transfer on death deeds for real estate or transfer on death registration for vehicles.

Your will can't override a beneficiary designation or change who inherits jointly held property, Palmer says. For example, if you forget to change the beneficiary of your life insurance from your previous spouse to your current spouse, your ex usually will get the proceeds regardless of what your will says.

You also can't leave property



to pets with a will or any other estate document, since pets are considered property, Palmer says.

You can, however, use your will to designate someone to care for your pet and leave that person money to do so.

What a will shouldn't do

You may see your will as a way to finally force people to do what you want. You could leave your nephew a **bequest** that he receives only if he finally finishes college, or stops smoking, or meets some other condition.

But putting conditions in a will is often a bad idea, says Betsy Hannibal, senior legal editor at Nolo, a self-help legal site. Some conditions — such as requiring someone to marry, divorce, or change religions — aren't legally enforceable because they're considered contrary to public policy, Hannibal says.

"Such clauses would include conditional gifts that try to control recipients' protected individual freedoms, like their marital status or religious beliefs, as well as gifts that would require the recipient to do something

illegal," she says.

Other conditions are simply unwieldy. Someone must oversee the bequest and decide when the conditions are met, which might be difficult or take a long time, she says.

If you want to impose conditions, consider paying for an attorney to set up a trust rather than using a will. Expect to spend \$2,000 or more, Hannibal says. You'll need to appoint a trustee, who may need to be paid from the trust for their services. Also, when the money is in the trust, it can be subject to high trust tax rates. Only you can decide if putting strings on an inheritance is worth the extra cost.

Another time to use a trust is when you want to leave money to someone with special needs who is receiving government benefits. Even a relatively small bequest could disqualify them from essential benefits such as Supplemental Security Income and health insurance coverage through Medicaid. Special needs trusts must be carefully drafted to be effective, so consider consulting an experienced attorney... **[Read More](#)**

FAQ: How We Rate Nursing Homes

Nurse staffing, health inspections, quality measures and other data determined each facility's ratings.

Nursing home care can be as short as a few days or weeks after a hospitalization, or it can be years if aging family members can no longer live on their own. To help find the best match for a loved one, U.S. News evaluated more than 15,000 facilities throughout the country and rated most of them in two different areas: short-term rehabilitation and long-term care.

This FAQ explains how nursing homes were evaluated and responds to questions that nursing home residents and families may have about the U.S. News ratings.

For more detailed information on how U.S. News Best Nursing Homes ratings were determined, the methodology report can be found here.

Why does U.S. News rate nursing homes?

On any given morning this year, approximately 1.1 million individuals, including 1 in 10 individuals age 85 and above, will wake up in a U.S. nursing home.

The quality of care provided at the more than 15,000 U.S. nursing homes (also sometimes called skilled nursing facilities, or SNFs, post-acute care or sub-acute care facilities) varies widely. U.S. News wants to help families research and find a nursing home that excels in the type of care they need.

The U.S. News Best Nursing Homes Short-Term Rehabilitation, Long-Term Care and Overall ratings offer individuals and families a starting point in their search for a nursing home, whether they are in need of short-term rehabilitation, long-term care or



are interested in a facility's overall care. **When did U.S. News begin rating nursing homes?**

Since their inception in 2009, the U.S. News Best Nursing Home ratings have relied on data from **Nursing Home Compare**, a program run by the Centers for Medicare & Medicaid Services (CMS), the federal agency that sets and enforces standards for nursing homes.

In 2018, U.S. News added a Short-Term Rehabilitation rating, evaluating the care delivered to patients after a hospitalization for surgery, heart attack, **stroke**, injury or similar condition.

In 2019, U.S. News added a Long-Term Care rating, evaluating the care delivered to residents who are no longer able to live independently and need help with daily activities such as eating, getting in or out of bed or wheelchair, using stairs or

getting dressed, as well as administering needed medical care.

Which nursing homes were eligible for rating?

All Medicare- and Medicaid-certified nursing homes that were part of the July 2021 CMS nursing home provider census made available in July 2021 were evaluated by U.S. News. Nursing homes did not apply nor did they provide any data or materials to U.S. News.

To be eligible for a Short-Term Rehabilitation, Long-Term Care or Overall rating, a home must have met both of the following inclusion criteria:

- ◆ Received reimbursement from CMS in July of 2021.
- ◆ Had sufficient data to evaluate quality in that rating... **[Read More](#)**

Medicare Reimbursements to Certain Doctors to be Cut

During the Covid-19 pandemic Medicare increased payments to certain specialty doctors, including cardiologists and radiation oncologists, by 3.75 percent. That pay increase is set to expire in 2022 and Medicare has decided to allow the expiration.

As a result, several specialties, including interventional radiology, vascular surgery, radiation oncology, and cardiology will see their Medicare reimbursements

decrease next year, while other specialty providers like diagnostic testing facilities, portable x-ray, podiatry, hand surgery, and geriatrics will see payment increases, according to the Centers for Medicare & Medicaid Services.

As is to be expected, doctor groups are protesting.

“These cuts will endanger patient access to cancer care,” Laura Dawson, chair of the board of directors of the



American Society for Radiation Oncology, said in a statement.

“Treatment facilities may be forced to cut services or close, which will exacerbate health disparities.”

And another: “Our patients put their trust in us to provide them the best care, but it’s becoming increasingly clear that they cannot trust the system that’s supposed to be set up to support them,” David B. Hoyt, executive director of the American College

of Surgeons, said in a statement. “These Medicare cuts will further exacerbate our pandemic-strained health care system and cause further delay in care to the patients who need it most.”

This is something TSCL will keep an eye on. While every effort must be made to contain the costs of medical care in this country, at the same time we cannot jeopardize the care that is needed by seniors.

What You Need to Know About the Federal Nursing Home Vaccine Mandate

Federal health authorities are expected to release details soon about the vaccine mandate for nursing homes.

The Centers for Medicare & Medicaid Services has **issued an emergency regulation** requiring COVID-19 vaccinations of thousands of eligible staff members at nursing homes that participate in Medicare and Medicaid programs.

The regulation, announced November 4, covers about 17 million health care workers at approximately 76,000 providers nationwide, according to a CMS press release. “The regulation will create a consistent standard

within Medicare and Medicaid while giving patients assurance of the vaccination status of those delivering care,” the statement says.

Federal Vaccine Mandate Deadlines

Facilities covered by the new regulation must establish a policy ensuring that all eligible staff have received the first dose of either a two- or one-dose COVID-19 vaccine by Dec. 5, 2021 before providing any care, treatment or services. All eligible staff must have received either two doses of the Pfizer or Moderna vaccines or a single



dose of the Johnson & Johnson version by Jan. 4, 2022.

The regulation allows for exemptions based on “recognized medical conditions or religious beliefs, observances, or practices,” according to the CMS statement. “Facilities must develop a similar process or plan for permitting exemptions in alignment with federal law.”

In addition to nursing homes, the new vaccination mandate applies to a raft of health care facilities, including:

- ◆ Critical access hospitals.
- ◆ Long-term care facilities.

◆ Intermediate care facilities for individuals with intellectual disabilities.

◆ Psychiatric residential facilities.

◆ Community mental health centers.

“CMS is taking necessary action to establish critical safeguards for the health of all people, their families, and the providers who care for them,” the agency said in its statement announcing the mandate. “CMS knows that everyone working in health care wants to do what is best to keep their patients safe....[Read More](#)

The 3 Most Common Ways Seniors Get Dental Coverage

As seniors find out in retirement — much to the surprise of many — traditional Medicare does not cover dental care. When it comes to keeping your choppers chipper, you are on your own.

That may change at some point. Recently, Congress has been discussing the notion of adding dental coverage, among other benefits, to Medicare. But we remain a long way from seeing such plans become reality.

So, how have those on Medicare been paying for their dental care? A recent Kaiser Family Foundation **analysis of federal data** uncovered the three most common ways seniors accessed such care as of 2019.

1. Medicare Advantage plans

There are two main types of Medicare health insurance: Original Medicare (also known

as traditional Medicare), which is managed by the federal government, and Medicare Advantage plans purchased from private insurers.

Some Medicare Advantage plans cover services that **are not covered by Original Medicare**, including hearing, vision and dental care.

Medicare Advantage plans are becoming more popular with seniors, Kaiser notes. Because of that reality, a larger share of Medicare beneficiaries — 29% — got dental coverage through their Medicare Advantage plan in 2019.

2. Private dental plans

A sizable share of those on Medicare — 16% — get their coverage through dental plans from private insurers.

In some cases, this coverage is



the result of employer-sponsored retiree plans that cover dental care as a post-work perk. In other situations, retirees go out and buy an individual plan directly from an insurer.

3. Medicaid

Some seniors — 11% — get their dental coverage through Medicaid, the federal-state health insurance program for low-income folks. However, this is not an option for all retirees. To qualify for Medicaid coverage, you generally must meet income requirements.

How seniors can save on dental care

It is worth noting that nearly half of Medicare recipients — 47%, or 24 million people — had no dental coverage whatsoever as of 2019, the Kaiser Family Foundation analysis found. These

retirees pay out of pocket for all dental services.

Regardless of whether you have dental coverage, it is important to see your dentist regularly. Don’t wait for Congress to add dental coverage to Medicare — by the time that happens, you might not have any teeth left!

Fortunately, there are ways to save right now. For example, it can help to flash a little green after the dentist looks at your pearly whites. As we have reported:

“Some dentists will discount the cost of their services by a specific amount — 10% is common — if you pay your bill in cash at the time of the visit. Ask your dentist’s receptionist or bookkeeper to find out if the discount is available.”

RI ARA HealthLink Wellness News

Study Compares Bypass, Stenting for Patients With Severe Heart Disease

Bypass surgery is slightly better overall than stenting to open blocked arteries in people with severe coronary artery disease, new research shows.

But decisions may still need to be made on a case-by-case basis: Stenting appeared more beneficial in some patients, particularly if they didn't have complex disease.

The findings should help guide decisions about which treatment is best for individual patients, according to the authors of the study published online Nov. 4 in the *New England Journal of Medicine*.

"The good news for patients is that both groups did better than what was found in previous

studies, and the differences between the two strategies has lessened," said principal investigator Dr. William Fearon. He's professor of cardiovascular medicine and director of interventional cardiology at Stanford Medicine, in California.

"I think it will have an immediate impact on how patients and physicians choose treatment," Fearon added in a university news release.

As many as 40% of Americans older than 60 have some narrowing of their coronary arteries, according to the American Heart Association. Most cases can be treated with statins or aspirin, while others



require stents or surgery. Stents, especially, have improved over time, Fearon's group noted. They are thinner nowadays than earlier versions, and are most often "drug-eluting" — made with a special coating that slowly emits medicines that help prevent artery re-narrowing around the site of the stent. Newer stents also have special polymer coatings that tend to reduce inflammation.

The new study included 1,500 patients, average age 65, who had severe heart disease leading to three blocked coronary arteries. About half received tiny mechanical stents to help prop open arteries, while the other half

underwent bypass surgery.

After one year, rates of major complications — such as death, heart attack, stroke and the need for a repeat procedure — were 10.6% in the stent group and 6.9% in the bypass group, the Stanford team said

But when the need for a repeat procedure wasn't included in the analysis, the rates fell to 7.3% and 5.2%, respectively — not a statistically significant difference, according to Fearon.

The researchers also found that patients with less complex coronary artery disease did better with stents, because they required fewer stents than those with complex disease. ...[Read More](#)

Pfizer Says New COVID Pill Cut Severe Disease by 89%

Pfizer Inc. announced Friday that its experimental COVID-19 pill slashed the risk of hospitalization and death by 89% in infected high-risk people.

The five-day treatment, when given within three days of infection, was so effective in a clinical trial that an independent monitoring committee recommended the trial be stopped early, Pfizer said.

The antiviral pill, the second of its kind to show the power to guard against severe COVID, appears to be even more effective than a similar offering from Merck.

Merck's pill, molnupiravir,

halved the risk of severe disease in high-risk patients. British regulators cleared the pill for use this week in people who are diagnosed with COVID-19 and have at least one risk factor for severe illness, the *Washington Post* reported. In the United States, a U.S. Food and Drug Administration advisory committee plans to meet shortly after Thanksgiving to assess Merck's pill. Merck has said it can produce 10 million treatment courses in 2021.

As for Pfizer's antiviral pill, the findings haven't been peer-reviewed or published yet, but



the data will be submitted to regulators "as soon as possible," the company said in

a [news release](#).

The drug, which will be sold under the name Paxlovid, is designed to prevent the coronavirus from making copies of itself.

"The results are really beyond our wildest dreams," Annaliesa Anderson, a Pfizer executive who led the drug's development, told *The New York Times*. She expressed hope that Paxlovid "can have a big impact on helping all our lives go back to normal again and seeing the end

of the pandemic."

"We're looking at end-to-end protection and treatment," Anderson told the *Post*. "We have the vaccine for protection, and now we have an opportunity for treatment."

Pfizer has already started making the drug and expects to produce more than 180,000 pill packs by the end of this year, boosting that to a total of 50 million in 2022, the *Post* reported.

No price for the pill has been disclosed by the company.

More Proof That COVID Vaccines Guard Against Severe Disease

The risk of serious illness or death is lower among vaccinated people who get breakthrough COVID-19 infections than among unvaccinated people who get infected, two new studies confirm.

An ongoing study of 780,000 U.S. veterans found that all three vaccines available in the United States provide strong protection against severe disease and death, despite a significant decline in their effectiveness against mild and asymptomatic infection, *CNN* reported.

"Although breakthrough infection increased risk of death, vaccination remained protective against death in persons who became infected during the Delta surge," the researchers wrote in the study published Nov. 4 in the journal *Science*.

"Our analysis by vaccine type, including the Pfizer-BioNTech, Moderna and [Johnson & Johnson's] Janssen vaccines, suggests declining vaccine effectiveness against infection over time, particularly for the



Janssen vaccine," the researchers said. "Yet, despite increasing risk of infection due to the Delta variant, vaccine effectiveness against death remained high, and compared to unvaccinated Veterans, those fully vaccinated had a much lower risk of death after infection."

The second study found that unvaccinated people with infections were much more likely to end up in the hospital on a ventilator or to die than people who had breakthrough

infections after being fully vaccinated with the Pfizer or Moderna vaccines.

Researchers analyzed data on more than 4,500 patients admitted to 21 U.S. hospitals with respiratory diseases between March and July and found that unvaccinated patients accounted for 84.2% of COVID-19 hospitalizations, 91% of COVID-19 deaths and nearly 94% of those who either needed a ventilator or who died, *CNN* reported.

Democrats Plan to Expand Medicare Hearing Benefits. What Can Consumers Expect?

President Joe Biden's mammoth domestic spending bill would add hearing benefits to the traditional Medicare program — one of three major new benefits Democrats had sought.

The Biden administration appears to have fallen short of its ambition to expand dental and vision along with hearing benefits. Sen. Bernie Sanders (I-Vt.) and other progressives have long pushed for more generous benefits for seniors. Citing the cost, Sen. Joe Manchin (D-W.Va.) opposed such expansion.

Biden and Democratic leaders in Congress pared back the scope of the new benefits after the total budget bill — which funds health care and other

domestic initiatives — was whittled from a proposed \$3.5 trillion to \$1.75 trillion to meet demands of the party's moderates. The new hearing benefits would become available in 2023.

Democrats have little room for maneuvering on the bill. They need all 50 Democratic senators to support it and can lose only three members of the House on a vote. Those tight margins have made for difficult negotiations and boosted the ability of any one lawmaker to set terms. The progressive and moderate wings of the party have been at odds on the deal for months, and negotiations are ongoing.

Nonetheless, if the hearing proposal survives, it would be a



significant change. Here are answers to questions seniors might have about the benefit.

Q: What does the plan do?

The draft legislation unveiled in the House proposes adding coverage to traditional Medicare that includes hearing assessment services, management of hearing loss and related treatment. About 36 million people are enrolled in original Medicare. Many of the private Medicare Advantage plans other seniors have opted to join already offer similar hearing services. According to the Centers for Medicare & Medicaid Services, roughly 27 million seniors are enrolled in a Medicare Advantage plan this

year. CMS projects that number will increase to 29.5 million next year.

The new benefits include coverage of certain hearing aids for "individuals diagnosed with moderately severe, severe, or profound hearing loss," and allows seniors enrolled in traditional Medicare to get a hearing aid for each ear every five years. The new benefits cover devices furnished after a written order from a physician, audiologist, hearing aid professional or other clinician. The Food and Drug Administration separately has moved **to make hearing aids available over the counter**, in a bid to make them cheaper....[**Read More**](#)

Nearly 3 in 10 U.S. Adults Say They Have a Disability

(HealthDay News) --A growing number of American adults say they have a physical or mental disability, a new study finds.

Of more than 400,000 adults who responded to a 2019 U.S. Centers for Disease Control and Prevention survey, 27% reported a disability. That's a 1% increase since 2016, and represents about 67 million Americans, according to researchers at Johns Hopkins University who analyzed the data.

Moreover, about 12% said they had more than one disability. The most common types were: mobility; cognitive/mental; independent living (requiring help for daily tasks and outings); hearing; vision;

and self-care (needing help with bathing, dressing and other personal care tasks).

To reduce discrimination and create more inclusive communities, "our country must be equipped with data on the prevalence of disabilities and who is most impacted by them," said study co-author Bonnielin Swenor, director of the Hopkins Disability Health Research Center and an associate professor of ophthalmology at the school of medicine, in Baltimore.

An aging population may have contributed to the increase in disabilities since 2016, Swenor said in a Johns Hopkins Medicine news release.



The researchers also found racial and social disparities in disability rates.

Disabled adults were more likely to be older, female, Hispanic, have less than a high school education, and have low income. They also had higher odds of being unemployed, bisexual, transgender or gender nonconforming, the findings showed.

Black women were more likely to have a disability than women of other races. However, gay or bisexual Black adults were less likely to have a disability than gay or bisexual adults of other races.

The findings were published online recently in [**JAMA Network Open**](#).

The data used in the study was collected before the COVID-19 pandemic, so the percentage of U.S. adults with disabilities may be even higher now due to long-term effects of COVID-19, Swenor noted.

"Developing effective measures and policies to include people with disabilities in all aspects of life needs to account for the variability in how people among different ethnic, socioeconomic, demographic and geographic groups experience disability," Swenor said.

"With robust data, we can strengthen the foundation of our knowledge about disability and develop tangible solutions," she added.

Women Feel More Stigma From 'Spare Tire' Around Middle Than Men

Belly fat. No one wants it, but women are much harder on themselves about extra pounds wrapped around their middle than men are, regardless of how much they weigh.

And the more they beat themselves up about their "spare tire," the more likely women are to gain weight in this high-risk area, new research suggests. Visceral (belly) fat wraps around the organs in the abdomen, and is thought to be more dangerous than other types of fat.

"This study contributes to a growing evidence base which shows that blaming oneself for one's weight and engaging in self-stigma may be harmful to health, particularly for women," said Rebecca Puhl, deputy director at the Rudd Center for Food Policy and Health at the University of Connecticut.

This isn't surprising given how societal ideals of female beauty emphasize thinness, said Puhl,



who has no ties to the new research. "Women who have bodies that deviate from this unrealistic ideal are vulnerable to blame, shame and stigma, often publicly, as we see so frequently on social media platforms," she noted.

They feel like they're at fault, and turn the stigma inward. As a result, women may be more likely to use food as a way to cope with stress and other negative emotions, Puhl said.

Researchers led by Natalie Keirns, a doctoral candidate in clinical psychology at Oklahoma State University, set out to understand how self-stigma about weight affects belly fat in men and women. Seventy men and women completed a questionnaire that rates self-stigma about weight on an ascending scale of 1 to 7. Researchers also used scans to measure visceral and total body fat in all participants....[**Read More**](#)

Memory Help for Seniors: 11 Proven Tips for Boosting Your Brain

Do you wonder if it's possible to improve your own or another senior's memory? Help definitely exists. And you don't have to buy some overhyped "miracle" brain booster to start enhancing your ability to remember things. In fact, many of the most effective ways to gain a better memory involve actions that you can take today—without spending a lot of money.

Of course, it's natural to worry about the kind of memory decline associated with Alzheimer's disease and other forms of **dementia** that require **memory care**. But did you know that, according to an article in *The BMJ*, only about one in 10 people over the age of 65 develop mild cognitive impairment (which can sometimes mimic very mild dementia)? It's true. And only around 15 percent of those people develop Alzheimer's.

So our fears and expectations are often exaggerated. In a **Pew Research Center survey**, about 57 percent of younger adults between the ages of 18 and 64 said that they expect to have memory loss during their senior years. However, only about 25 percent of older adults over the age of 65 said they actually experience memory loss. That's a big gap.

Nevertheless, everybody wants to retain their memory. After all, memories form a major part of who we are. When we lose them, we feel like we lose pieces of ourselves. Plus, having a good memory serves all kinds of practical functions in our daily lives. Every single day, your memory helps you accomplish both basic and complex tasks. So it's vital to keep your brain as healthy and fit as possible.

Older adults who take



proactive steps to prevent memory loss are often more adaptable, independent, and satisfied during their senior years. That's because the human brain has an amazing **ability to change**, collect new information, create new neural connections, and store important information in its long-term memory. By developing good habits and seeking out new learning opportunities, you can also improve or maintain your short-term memory (aka your working memory).

Plus, the field of neuroscience is still **relatively young**. With each passing year, scientists are discovering things about the human brain that we never knew before. In the future, we may be able to retrieve "lost" memories and improve our cognitive abilities with brain implants or targeted electrical stimulation.

Genetic research may also lead to preventive therapies or targeted treatments that stop or reverse memory loss.

In the meantime, here are some of the best tips for maintaining or improving your memory:

Contents

- ◆ **Use the method of loci and other practical tricks**
- ◆ **Get your health checked**
- ◆ **Keep challenging yourself**
- ◆ **Improve your sleep habits**
- ◆ **Change your mindset about aging**
- ◆ **Remove distractions and sources of stress**
- ◆ **Take time to do absolutely nothing**
- ◆ **Get frequent exercise**
- ◆ **Socialize and have fun**
- ◆ **Consider dietary changes**
- ◆ **Be careful with supplements**

Get Your Dietary Fat From Plants, Cut Your Stroke Risk

People who get their dietary fat from olive oil rather than steak may help reduce their risk of suffering a stroke, a preliminary study suggests.

The study, of more than 100,000 health professionals, found that those who favored vegetable oils and other plant foods as their source of fat generally had a lower risk of stroke over the years.

Overall, the 20% of people with the highest intake of vegetable fats had a 12% lower risk of suffering a stroke over 27 years, compared to people with

the lowest intake of those fats.

On the other end of the spectrum were people who got much of their dietary fat from meat. The 20% with the highest intake of those fats were 16% more likely to suffer a stroke, compared to the 20% with the lowest intake.

Many studies have looked at the relationship between dietary fat and stroke risk. This one focused on the food sources of that fat, said lead researcher Fenglei Wang, a postdoctoral fellow at the Harvard School of



Public Health in Boston. And the findings, he said, favor replacing beef fat with vegetable oils like olive, soybean or corn.

Wang will present the results Saturday at an online meeting of the American Heart Association (AHA). Studies released at meetings are generally considered preliminary until they are published in a peer-reviewed journal.

The findings do not imply that dietary fat is the whole story when it comes to cardiovascular health, said Alice Lichtenstein, a

professor of nutrition science at Tufts University in Boston.

Lichtenstein, who was not involved in the study, is lead author of the AHA's latest dietary advice, published earlier this week.

She said overall diet quality is the key, and not any single nutrient.

"People who eat a lot of vegetable fats are probably doing many other things, too -- like eating fruits and vegetables, exercising and not smoking," Lichtenstein said....**Read More**

As Pandemic Cut Air Pollution, Heart Attacks Declined

Urban air cleared during the COVID-19 pandemic lockdowns as fewer commuters hit the road daily, and that might have resulted in one unexpected heart health benefit for Americans, a new study suggests.

Those reductions in air pollution appear to be linked to a decrease in heart attacks during the shutdowns, according to research slated for presentation Saturday at the American Heart Association's online annual meeting.

The number of heart attacks

dropped by 6% for every 10 microgram-per-cubic-meter decline in fine particle pollution, researchers found.

"The main message from our research is that efforts to reduce ambient pollution can prevent the most severe form of heart attacks," said lead researcher Sidney Aung, a fourth-year medical student at the University of California-San Francisco. "We hope that this would provide a greater impetus for increased public health efforts aimed at



reducing air pollution." Prior research had found a reduction in fine particle pollution while people stayed home during lockdowns, Aung said.

There was about a 4.5% drop in fine particle pollution during the last two weeks of March 2020, compared to the same period in previous years, Aung said. Such pollution dropped by more than 11% when looking at counties in states that instituted early closures of non-essential businesses.

To see how cleaner air might have improved health, Aung's team used federal data to compare the frequency of heart attacks with air quality in different regions of the United States.

It turned out there was a direct correlation. Nearly 61,000 heart attacks occurred from January through April 2020, and then the number of heart attacks declined as air grew cleaner in specific parts of the nation...**Read More**

Why Are So Few Seniors Getting Heart Failure Rehab?

Heart failure remains a major killer among the millions of Americans on Medicare. So, it's alarming that fewer than 10% of eligible Medicare beneficiaries get recommended heart failure rehab treatments, researchers say.

Gaps in Medicare coverage and certain criteria are major reasons why, say the authors of a new study focused on the problem.

"Despite clear benefits of cardiac rehabilitation in preventing death, reducing hospitalizations and improving physical ability, cardiac rehabilitation is used by very few," said study author Dr. Vinay Guduguntla. He's a third-year internal medicine resident at the University of California, San Francisco.

"Based on the current data, more than 90% of people with heart failure will not receive a treatment that could improve their health and survival," he added in a news release from the American Heart Association

(AHA). According to the research team, there's strong evidence that the exercise regimens that are a part of rehab can boost function and keep heart failure patients out of the hospital.

Guduguntla's team plans to present its data next Monday at the AHA's online annual meeting.

In 2014, Medicare expanded coverage for cardiac rehabilitation to include adults with "heart failure with reduced ejection fraction" -- which is when the heart's left ventricle isn't pumping well -- after studies showed that the benefits of cardiac rehab.

Between 2014-2017, enrollment in cardiac rehab among Medicare beneficiaries with heart failure did rise a bit -- from 4.3% of patients to about 5.5%. But that translates to an annual increase of only about 10%, Guduguntla's team noted.

Money could be one big factor keeping folks from rehab.



Even for Medicare recipients, "our study highlights insurance coverage as one important factor that impacts increasing cardiac rehabilitation participation," Guduguntla said.

Another significant barrier is the U.S. Centers for Medicare and Medicaid Services (CMS) participation criteria, according to Dr. Randal Thomas. He's a past chair of the AHA's Council on Clinical Cardiology and a professor of medicine in the Mayo Clinic's Cardiac Rehabilitation Program in Rochester, Minn. He wasn't involved in the study.

"CMS criteria requires that patients wait at least six weeks after a heart failure hospitalization to participate in cardiac rehabilitation," Thomas explained. "Studies show that any delay in starting cardiac rehabilitation after hospitalization decreases participation rates and worsens patient outcomes."

In the meantime, "there are nearly 1.1 million hospitalizations for heart failure annually, making it one of the most common reasons for hospital admission among people 65 years of age or older, whose health care costs are primarily covered by Medicare," Guduguntla said.

Two other heart experts agreed that few patients are using rehab services.

"It is now becoming imperative to establish newer models to reach patients who cannot access this therapy," said Dr. Benjamin Hirsh. He directs preventive cardiology at Northwell Health's Sandra Atlas Bass Heart Hospital, in Manhasset, N.Y.

Virtual (online) cardiac rehabilitation offers one possible solution to the problem, according to Hirsh. It could "provide a much greater number of patients with the treatment they currently find inaccessible," he said....[Read More](#)

80 Top Games for Seniors and the Elderly: Fun for All Abilities

Get ready to play! It's time to learn about the best games for seniors so that you can reap the benefits of **having fun**. After all, joy, amusement, and mental stimulation are necessary for every senior's overall well-being. And we all have days when we just want to pass a little time by doing something engaging.

Games provide convenient ways to have fun, either alone or as part of a group. They eradicate boredom, relieve stress, and make parties and

other social engagements easier, more enjoyable, and less intimidating. They also help exercise our brains. For some people, playing certain types of games might be beneficial for things like mood, memory, concentration, reasoning, and imagination. Games might be especially helpful for your brain if they require you to learn something new.

Plus, countless games can be modified for seniors or elderly



people who have physical or cognitive limitations. For example, it's easy to

find or create games that have large type, which is good for older people who have vision problems. And if time or attention spans are a concern, many games can be played and completed in less than 30 minutes.

The variety of senior-friendly games that are now available is astonishing. So to help you narrow down the possibilities,

we've provided some of the best examples within seven main categories:

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- ◆ [Puzzle, tile, and board games](#)
- ◆ [Video games](#)
- ◆ [Card games](#)
- ◆ [Dice games](#)
- ◆ [Word and number games](#)
- ◆ [Indoor games for large groups](#)
- ◆ [Outdoor games](#)

Do Old People Smell Different? The Facts About Changing Body Odor for Seniors and Caregivers

Does an "old people smell" really exist? Or is that term just another untrue stereotype about seniors? The answer isn't entirely straightforward. Although scientists have discovered that older people experience physiological changes that can lead to a distinct scent, that smell isn't necessarily as unpleasant as

the term often implies. And it's usually not the result of poor hygiene or housekeeping.

Fortunately, there are many things you can do to minimize its causes if the smell bothers you.

This article will teach you why people's natural scent can change with age. You'll also learn tips



for preventing the distinctive odor. And you'll find out why you shouldn't panic if you notice that your body smells different than it used to. Plus, you'll discover other factors that can influence a senior's scent and get tips on how to talk to a loved one about body odor.

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- ◆ [Why do people smell different as they get older?](#)
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