Rhode Island Alliance for Retired Americans ©

RI ARA

Affiliated with the Rhode Island AFL-CIO
"Fighting for the future of our members."
"NOW, more than ever!!!"

November 15, 2020 E-Newsletter

Publication 2020 Issue 46
Published in house by the
RI ARA

Biden-Harris Victory a Win for Retirees

The following statement was issued by Richard Fiesta, Executive Director of the Alliance for Retired Americans, regarding the 2020 presidential election results:

"The 4.4 million members of the Alliance for Retired Americans extend their congratulations to President-elect Joe Biden and Vice President-elect Kamala Harris on a hard fought, well-deserved and historic victory.

"Vice President Biden put the issues older Americans care about -- expanding Social Security, protecting and expanding Medicare, improving retirement security, ending the pandemic, and making coronavirus vaccines and treatments affordable for all who need them -- at the center of their campaign.

"Older voters compared the Biden record and plan with the Trump record, and **four percent fewer older voters** supported President Trump this year compared to 2016. This is not a surprise given the toll the coronavirus pandemic has taken on older Americans, the skyrocketing prices of prescription drugs, and President Trump's promise to defund Social Security by eliminating the payroll tax if he is re-elected.

Rich Fiesta

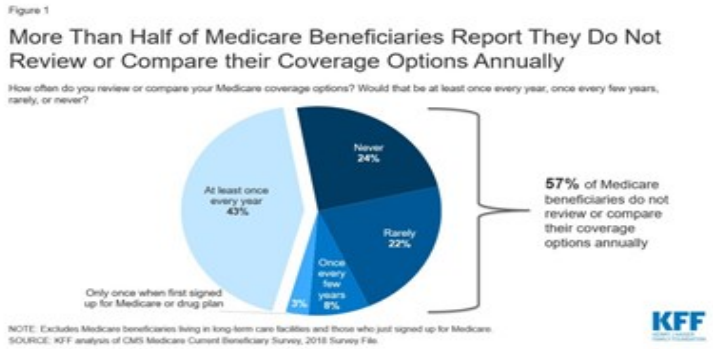
"Our members look forward to working with the Biden-Harris administration to strengthen and expand Social Security and Medicare, defend our pensions, lower prescription drug prices and end the pandemic."

More Than Half of All People on Medicare Do Not Compare Their Coverage Options

Each year, people with Medicare have the opportunity to review their coverage options and change plans during the open enrollment period (October 15 to December 7). Medicare beneficiaries with traditional Medicare can compare and switch Medicare Part D stand-alone drug plans or join a Medicare Advantage plan, while enrollees in Medicare Advantage can compare and switch Medicare Advantage plans or elect coverage under traditional Medicare instead. For 2021, the average Medicare beneficiaries can choose among 33 Medicare Advantage plans and 30 Part D stand-alone prescription drug plans (PDPs).

Medicare Advantage and Part D plans vary significantly from each other in terms of costs and coverage. Plans often change from one year to the next, which could lead to unexpected and avoidable costs for beneficiaries who do not review their options annually. Plan changes can also lead to disruptions for beneficiaries in Medicare Advantage plans, if their doctors do not remain in their plan's network from one year to the next, or if their drug plan no longer covers one of their medications, or makes a change in their pharmacy network, or increases costs for covered drugs. Further, beneficiaries' health care needs, including the list of drugs they take, can change from one year to the next, making it even more important to compare coverage options annually, as the **Centers for Medicare & Medicaid Services (CMS) recommends.**

Previous KFF analysis shows that only a small share of Medicare beneficiaries voluntarily switch plans. This "stickiness" may indicate that beneficiaries are satisfied with their current coverage, but it may also indicate that many people on Medicare find it difficult to compare plans, are unaware of the open enrollment period, or are not confident in their ability to select a better plan. This analysis builds on previous KFF work by examining beneficiaries' knowledge and behavior related to the Medicare open enrollment period, based on an analysis of the 2018 Medicare Current Beneficiary Survey (the most recent year available). All reported results are statistically significant….**Read More**



Trump's present to the middle class on January 1, 2021

Be sure every one you know is aware of this: There's a tax increase starting in January. It is **NOT A BIDEN TAX** it couldn't be. He hasn't been in office the past 4 years! It was part of the GOP Tax Scam and it's going to hit middle class working families hard.

Tucked into the GOP's 2017 $2 trillion tax cut was a provision to increase taxes beginning in 2021 and continuing every other year until 2027. They didn't want to run on a tax increase in a presidential election year And they don't want to run with a tax increase in midterm elections. Hence the increase is every other year!

So when people start squawking about "Biden tax increases," know that the tax increases coming in January are squarely the fault of **#Individual1** and the **#ComplicitGOP**.

ADD YOUR NAME

Get The Message Out:
SIGN THE GPO/WEP PETITION!!!!

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/

2021 Medicare Part B Premiums Remain Steady

Today, the Centers for Medicare & Medicaid Services (CMS) announced the 2021 monthly Medicare Parts A and B premiums, deductibles, and coinsurance amounts in which the Medicare Part B monthly premium remains steady. This news comes as Medicare Open Enrollment started on October 15, 2020 running through December 7, 2020, and follows the announcement that Medicare Advantage (or private Medicare health plans) and Part D prescription drug plan premiums are at historic lows, with hundreds of Medicare Advantage and Part D plans now offering $35 monthly co-pays for insulin starting in January 2021.

"With the 2021 Medicare Part B premium information now available, I encourage everyone with Medicare to take time over the next four weeks to review their options during Medicare Open Enrollment," said CMS Administrator Seema Verma. "Thanks to President Trump's leadership, Medicare Part B premiums remain steady and seniors have more plans than ever to choose from, many new benefits, and historically low Medicare Advantage and Part D premiums."

Medicare Part B Premiums/Deductibles

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and certain other medical and health services not covered by Medicare Part A.

The standard monthly premium for Medicare Part B enrollees will be $148.50 in 2021, an increase of $3.90 from $144.60 in 2020. Recent legislation signed by President Trump significantly dampens the 2021 Medicare Part B premium increase that would have occurred given the estimated growth in Medicare spending next year. Medicare spending is estimated to grow due to people seeking care they may have delayed during the COVID-19 public health emergency, availability of more COVID-19 treatments, and availability of COVID-19 vaccines (for which CMS recently announced that there would be no out-of-pocket costs for seniors).

CMS also announced that the annual deductible for Medicare Part B beneficiaries is $203 in 2021, an increase of $5 from $198 in 2020.

Medicare Part A Premiums/Deductibles

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99 percent of Medicare beneficiaries do not pay a Part A premium since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A inpatient deductible that beneficiaries will pay when admitted to the hospital is $1,484 in 2021, an increase of $76 from $1,408 in 2020.

Medicare Open Enrollment

Medicare beneficiaries can choose to enroll in fee-for-service Original Medicare (Parts A and B) or can select a private Medicare Advantage plan to receive their Medicare benefits. Premiums and deductibles for Medicare Advantage and Medicare Prescription Drug plans (Medicare Part D) are already finalized and are unaffected by this announcement.

During the ongoing Medicare Open Enrollment – which began on October 15, 2020 and ends December 7, 2020, more than 60 million Medicare beneficiaries can compare coverage options like Original Medicare (Part A and Part B) and Medicare Advantage, and choose health and prescription drug plans for 2021. Medicare health and drug plan costs and covered benefits can change from year-to-year. CMS urges Medicare beneficiaries to review their coverage choices and decide on the options that best meet their health needs. Over the past three years, CMS has made it easier for seniors to compare and enroll in Medicare coverage. The redesigned Medicare Plan Finder makes it easier for beneficiaries to:

- Compare pricing between Original Medicare, Medicare Advantage plans, Medicare prescription drug plans (Medicare Part D), and Medicare Supplemental Insurance (Medigap) policies;
- Compare coverage options on their smartphones and tablets;
- Compare up to three Medicare Part D drug plans or three Medicare Advantage plans side-by-side;
- Get plan costs and benefits, including which Medicare Advantage plans offer extra benefits;
- Build a personal drug list and find Medicare Part D prescription drug coverage that best meets their needs.

Highlights for 2021 Open Enrollment include:

- A 34 percent decrease in average monthly premiums for Medicare Advantage plans since 2017. This is the lowest average monthly premium since 2007. Beneficiaries in some states, including Alabama, Nevada, Michigan, and Kentucky, will see decreases of over 50 percent in average Medicare Advantage premiums.
- More than 4,800 Medicare Advantage plans are offered for 2021, compared to about 2,700 in 2017. Similarly, more Medicare Part D plans are available, and the average basic Part D premium has dropped 12 percent since 2017.
- Medicare beneficiaries can join a prescription drug plan that will offer many types of insulin at a maximum copayment of $35 for a 30-day supply. More than 1,600 Medicare Advantage and Part D prescription drug plans are participating in the Part D Senior Savings Model for 2021. People who enroll in a participating plan could save up to an estimated $446 a year in out-of-pocket costs on insulin. CMS has added a new "Insulin Savings" filter on Medicare Plan Finder to display plans that will offer the capped out-of-pocket costs for insulin. Beneficiaries can use the Medicare Plan Finder to view plan options and look for a participating plan in their area that covers their insulin at no more than a $35 monthly copay.
- Free, personalized counseling on Medicare options is also available through the **nonprofit State Health Insurance Assistance Program**, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- For a fact sheet on the 2021 Medicare Parts A & B premiums and deductibles, please visit: **https://www.cms.gov/newsroom/fact-sheets/2021-medicare-parts-b-premiums-and-deductibles**

For more information on the 2021 Medicare Parts A and B premiums and deductibles (CMS-8074-N, CMS-8075-N, CMS-8076-N), please visit:

- (CMS-8074-N)- **https://www.federalregister.gov/public-inspection/2020-25024/medicare-program-cy-2021-inpatient-hospital-deductible-and-hospital-and-extended-care-services**
- (CMS-8075-N): https://**www.federalregister.gov/public-inspection/2020-25028/medicare-program-cy-2021-part-a-premiums-for-the-uninsured-aged-and-for-certain-disabled-individuals**
- (CMS-8076-N): **https://www.federalregister.gov/public-inspection/2020-25029/medicare-program-medicare-part-b-monthly-actuarial-rates-premium-rates-and-annual-deductible**

What to Know as ACA Heads to Supreme Court — Again

The Supreme Court on Tuesday will hear oral arguments in a case that, for the third time in eight years, could result in the justices striking down the Affordable Care Act.

The case, ***California v. Texas***, is the result of a change to the health law made by Congress in 2017. As part of a major tax bill, Congress reduced to zero the penalty for not having health insurance. But it was that penalty — a tax — that the high court ruled made the law constitutional in a 2012 decision, argues a group of Republican state attorneys general. Without the tax, they say in their suit, the rest of the law must fall, too.

After originally contending that the entire law should not be struck down when the suit was filed in 2018, the Trump administration **changed course** in 2019 and joined the GOP officials who brought the case.

Here are some key questions and answers about the case:

What Are the Possibilities for How the Court Could Rule?

There is a long list of ways this could play out.

The justices could declare the entire law unconstitutional — which is what a **federal district judge in Texas** ruled in December 2018. But legal experts say that's not the most likely outcome of this case.

First, the court may avoid deciding the case on its merits entirely, by ruling that the plaintiffs do not have "standing" to sue. The central issue in the case is whether the requirement in the law to have insurance — which remains even though Congress eliminated the penalty or tax — is constitutional. But states are not subject to the so-called individual mandate, so some analysts suggest the Republican officials have no standing. In addition, **questions have been raised about the individual plaintiffs in the case**, two consultants from Texas who argue that they felt compelled to buy insurance even without a possible penalty.

The court could also rule that by eliminating the penalty but not the rest of the mandate (which Congress could not do in that 2017 tax bill for procedural reasons), lawmakers "didn't mean to coerce anyone to do anything, and so there's no constitutional problem," University of Michigan law professor Nicholas Bagley said in a **recent webinar** for the NIHCM Foundation, the Commonwealth Fund and the University of Southern California's Center for Health Journalism. Or, said Bagley, the court could rule that, without the tax, the requirement to have health insurance is unconstitutional, but the rest of the law is not. In that case, the justices might strike the mandate only, which would have basically no impact.

It gets more complicated if the court decides that, as the plaintiffs argue, the individual mandate language without the penalty is unconstitutional and so closely tied to other parts of the law that some of them must fall as well.

Even there the court has choices. One option would be, as the Trump administration originally argued, to strike down the mandate and just the pieces of the law most closely related to it — which happen to be the insurance protections for people with preexisting conditions, an extremely popular provision of the law. The two parts are connected because the original purpose of the mandate was to make sure enough healthy people sign up for insurance to offset the added costs to insurers of sicker people.

Another option, of course, would be for the court to follow the lead of the Texas judge and strike down the entire law.

While that's not the most likely outcome, said Bagley, if it happens it could be "a hot mess" for the nation's entire health care system. As just one example, he said, "every hospital is getting paid pursuant to changes made by the ACA. How do you even go about making payments if the thing that you are looking to guide what those payments ought to be is itself invalid?"

What Impact Will New Justice Amy Coney Barrett Have?

Perhaps a lot. Before the death of Justice Ruth Bader Ginsburg, most court observers thought the case was highly unlikely to result in the entire law being struck down. That's because Chief Justice John Roberts voted to uphold the law **in 2012**, and again when it was challenged in a less sweeping way **in 2015**.

But with Barrett replacing Ginsburg, even if Roberts joined the court's remaining three liberals they could still be outvoted by the other five conservatives. Barrett was coy about her views on the Affordable Care Act during her confirmation hearings in October. But **she has written** that she thinks Roberts was wrong to uphold the law in 2012….**Read More**

Explaining California v. Texas: A Guide to the Case Challenging the ACA

The Affordable Care Act's (ACA) future continues to be uncertain as the law's constitutionality will once again be considered by the U.S. Supreme Court in *California v. Texas*[1] (known as *Texas v. U.S.* in the lower courts). Oral argument is **scheduled** for Tuesday, November 10, 2020. This ongoing litigation challenges the ACA's minimum essential coverage provision (known as the individual mandate) and raises questions about the entire law's survival. The individual mandate provides that most people must maintain a minimum level of health insurance coverage; those who do not do so must pay a financial penalty (known as the shared responsibility payment) to the IRS. The individual mandate was upheld as a constitutional exercise of Congress' taxing power by a five member majority of the Supreme Court in ***NFIB v. Sebelius*** in 2012.

In the 2017 Tax Cuts and Jobs Act (TCJA), Congress set the shared responsibility payment at zero dollars as of January 1, 2019, leading to the current litigation. In December 2019, the U.S. Court of Appeals for the 5th Circuit affirmed the trial court's decision that the individual mandate is no longer constitutional because the associated financial penalty no longer "produces at least some revenue" for the federal government.[2] But, instead of deciding whether the rest of the ACA must be struck down, the 5th Circuit sent the case back to the trial court for additional analysis. However, the Supreme Court has now agreed to review the case.

The ACA remains in effect while the litigation is pending. However, if all or most of the law ultimately is struck down, it will have **complex and far-reaching consequences** for the nation's health care system, affecting nearly everyone in some way. A host of ACA provisions could be eliminated, including protections for people with pre-existing conditions, subsidies to make individual health insurance more affordable, expanded eligibility for Medicaid, coverage of young adults up to age 26 under their parents' insurance policies, coverage of preventive care with no patient cost-sharing, closing of the doughnut hole under Medicare's drug benefit, and a series of tax increases to fund these initiatives….**Read More**

Harmful Georgia Waiver Will Limit Access to Unbiased Information about HealthCoverage

Over the weekend, the Centers for Medicare & Medicaid Services (CMS) **approved a harmful** policy waiver in Georgia that will limit residents' access to information about their health care options. This approval comes despite widespread alarm about the dangers the waiver would pose for thousands of Georgians. The Medicare Rights Center, along with over 1,800 other individuals and organizations, **submitted comments in opposition to this waiver in September**, while the Trump administration received a total of eight comments in support.

The waiver, called a 1332 waiver, is not legally permissible if it will lessen coverage. For various reasons, the Georgia waiver is likely to do just that, and neither CMS nor the state have provided a convincing argument otherwise. Georgians can currently see their individual insurance options by using HealthCare.gov. This one-stop shop gives unbiased information about Affordable Care Act compliant plans and triggers Medicaid referrals for people with low incomes. Georgians have always been free to use insurance brokers and agents, but in 2020 most people (79%) chose to use HealthCare.gov for its ease and objective information.

Starting in 2023, Georgians' access to HealthCare.gov will be taken away, and **the website** will not be replaced by any publicly available, unbiased source for information. They will, instead, be forced to rely solely on brokers and agents, an often less popular, less accessible, and less convenient option that risks bias and conflicts of interest. CMS and the state argue, without support, that having less access to information, no single source of high-quality information, and fewer ways to enroll will increase enrollment rather than decreasing it.

The reliance on agents and brokers is risky for enrollees. Unlike HealthCare.gov, these entities can have incentives to steer people into specific plans, including "junk" plans that do not cover pre-existing conditions and do not meet other quality requirements for inclusion on the HealthCare.gov marketplace. These brokers may also be less likely to help people connect with Medicaid.

Perhaps most importantly, Georgians will likely be confused about where to turn. Instead of a one-stop shop, they will face a fractured market. This could lead to many people being overwhelmed and unsure what to do. In our experience, it is important for people to have a single, clear, unbiased source of coverage information, not a jumble of biased sources.

In response to these concerns, Georgia argues that they will do statewide outreach and will streamline Medicaid eligibility. These are good policies, in theory, but they should already be in place, used in conjunction with HealthCare.gov rather than as a replacement. Advocates have long urged states to do more to educate and inform residents about their health coverage options and to ease enrollment into Medicaid.

This is a very disappointing decision from CMS and Georgia. Comments on the waiver reveal overwhelming opposition and demonstrate how the application failed to adhere to the legal requirements of a 1332 waiver. Litigation appears likely.

- **Read CMS's approval letter for the Georgia waiver.**
- **Read Medicare Rights' comments in opposition to the waiver**.

VA Joins Pentagon in Recruiting Volunteers for COVID Vaccine Trials

The Department of Veterans Affairs is recruiting 8,000 volunteers for the Phase 3 clinical trials of at least four COVID-19 vaccine candidates at 20 federal medical facilities across the U.S., according to officials with the VA and Operation Warp Speed, the Trump administration's initiative to fast-track a coronavirus vaccine.

The largely unpublicized effort follows a Department of Defense announcement in September that it has partnered with AstraZeneca to recruit volunteers at five of its medical facilities, which are separate from the VA system.

DOD is also is in talks with developers of other vaccine candidates, although officials won't say which ones.

Both federal departments have long experience in medical research and diverse populations — a crucial component of effective clinical trials, said J. Stephen Morrison, senior vice president and director of global health policy at the Center for Strategic and International Studies, a bipartisan think tank in Washington, D.C.

Since active troops are essential to national security, and veterans are extremely vulnerable to COVID-19, both departments have a vested interest in supporting the development of safe, effective vaccines, Morrison said.

"On the DOD active servicemen and -women side, it's a question of making sure they're ready, they are protected," Morrison said. "With VA, their population, all elderly and infirm with underlying conditions, they could really be suffering if we don't get a vaccine."

According to a VA website, of its 20 medical centers involved, 17 would be part of the Johnson & Johnson vaccine trial, while the three others are recruiting — or have completed recruitment — for advanced-stage trials for Moderna, AstraZeneca and Pfizer vaccines.

Dr. Matthew Hepburn, head of vaccine development at Operation Warp Speed, said the VA effort lets veterans contribute to the overall well-being of the country.

"This is another way they can continue to serve in this way, fighting the pandemic as a volunteer," Hepburn said during a discussion of vaccine and therapeutics development hosted by the Heritage Foundation on Oct. 27.

It's not unusual for the military to participate in multicenter trials for treatments of ailments as diverse as cancer and trauma. Historically, many vaccines have been tested first by the military.

In the general population, clinicians often have difficulty recruiting African Americans and other minorities for medical research, and "the military provides a rich opportunity to find volunteers for those groups," said retired Rear Adm. Thomas Cullison, a doctor and former deputy surgeon general for the Navy.

Military health facilities are held to the same standards as private research facilities, he said.

No service members will be required to participate in the COVID vaccine trials. All volunteers will be paid by the developer.

Support for routine vaccinations runs high in the military, but some have expressed concerns about new vaccines and mandatory inoculations, especially for anthrax. In a **2002 federal study**, 85% of those who received that vaccine reported an adverse reaction, with just under half noticing minor redness at the injection site….**Read More**

Litigation Around Public Charge Rule Continues

A court case that may invalidate controversial changes to immigration rules has had two developments this week. The case, which challenges changes that the Department of Homeland Security (DHS) made to the "public charge rule," is one of several that have been brought asking courts to review the policy.

The **new public charge rule** increases the type and number of public programs where enrollment can negatively impact a person's immigration application or status. Historically, only the use of cash programs like Temporary Assistance for Needy Families (TANF) could be held against applicants. Under the new rule, many programs, including public health insurance, can impact a decision.

This has both a direct impact on immigration and can also cause a chilling effect where even people who are not at risk from the new rule fear to participate in programs for which they or their family members are eligible. For example, while Medicare programs like the Medicare Savings Programs (MSP) and Extra Help were included in the proposed rule, the final rule changes did not include those programs. Some people may still be reluctant to enroll in those programs because they fear further changes or because the fine differences between, for example, the MSP and Medicaid are not obvious.

This week, the district court in Illinois issued a **ruling** that erased these new rules, finding that they are invalid under the Administrative Procedure Act (APA), which is the federal law that sets out how the administration must obtain and consider public input before making new rules or changing existing ones. After that decision was issued, the government appealed to the Seventh Circuit.

That court issued a stay pending appeal, which means that the lower court's decision is put on hold until the appeals court reviews the case. DHS can therefore implement the changed rule while the case moves forward.

Read previous Medicare Watch articles about the public charge rule

With private insurance, patients are not protected from bills sent in error

Whatever good can be said about our current multi-payor health care system, it does not protect people from erroneous or surprise health care bills. What's worse is that Congress is unable to do much about it. The CARES Act provides money to hospitals for COVID care for Americans without health insurance, so that they can get care without worry about the cost. But, most people are not told about this protection and are not protected from bills sent in error.

Blake Farmer reports for **Kaiser Health News** that hospitals are not always telling uninsured patients that they are covered and continue to bill them for the care they receive.

Indeed, **millions of uninsured patients** are eligible for free or low-cost care and are unaware.

Farmer profiles one young healthy man, Darius Settles, who received COVID-19 care from his local for-profit chain hospital in Nashville, Tennessee. He was between jobs, uninsured, and concerned about the cost. He ended up dying. And, no one told him that costs should not be a concern.

Under the CARES Act, the Centers for Medicare and Medicaid Services has contracted with hospitals across the country to cover the bills of uninsured COVID-19 patients. But, the program does not require hospitals to inform their uninsured patients that they are covered. And, it appears that most do not.

Consequently, many patients without insurance do not get needed COVID-19 care. Doctors generally are not aware of how the program works and do not inform their patients. Some feel uncomfortable guaranteeing costs will be covered, given that patients could end up receiving bills. Some do not want to raise cost as an issue.

And, hospitals often end up billing patients when they should not. Who's to stop them? The for-profit chain hospital treating Darius Settles, HCA, sent his family a bill notwithstanding that his care was covered in full. The hospital told the reporter who followed up that the bill was sent "in error."

In a single-payer **Medicare for All** system, everyone would have coverage, and hospitals would not bill patients for their care. Without Medicare for All, erroneous bills, surprise bills and overcharges will continue. **Good luck fighting them.**

Supreme Court Appears Likely To Uphold Obamacare

The Supreme Court, with a newly constituted and far more conservative majority, took another look at Obamacare on Tuesday. But at the end of the day, even with three Trump appointees, the Affordable Care Act looked as though it may well survive.

To many, it may have seemed like déjà vu.

Yes, the Supreme Court did uphold Obamacare eight years ago. It ruled that the so-called individual mandate, requiring people either to have health insurance or pay a penalty, was constitutional because it amounted to a tax. But in 2017, Congress decided it did not need the penalty and zeroed it out. At the time, not only congressional leaders but also President Trump crowed about "terminating" the mandate.

But on Tuesday, the Trump administration and a group of GOP-dominated states, including Texas, were back in the high court with a new challenge. They contended that because the mandate language is still on the books, and because the mandate was so interwoven with other provisions of the Affordable Care Act, the whole law should be struck down in its entirety.

Defending the law, California Solicitor General Michael Mongan, representing 20 states that support the ACA, set out the stakes.

"What's before the court today is an enormously consequential statute," he said. "It provides health insurance and other lifesaving benefits and protections to hundreds of millions of Americans."

Also defending the law was the House of Representatives, and its lawyer, Donald Verrilli, who eight years ago successfully defended the mandate as the Obama administration's solicitor general. Chief Justice John Roberts reminded Verrilli of that argument.

"Eight years ago, those defending the mandate emphasized that it was the key to the whole act," Roberts said. "But now the representation is that, 'Oh no, everything's fine without it.' Why the bait and switch?" .**Read More**

First COVID-19 Vaccine Doses To Go To Health Workers, Say CDC Advisers

Health care workers will almost certainly get the first doses of COVID-19 vaccine in the U.S. when one is approved, according to Dr. José Romero, head of the committee that develops evidence-based immunization guidelines for the Centers for Disease Control and Prevention.

That's a decision based on the science of what will quell the pandemic fastest. "It's not just the doctors and nurses that are interacting with patients, but also the support personnel that help," Romero said in an interview Thursday with NPR. "It could include those persons that are delivering food, or maintenance people that could come in contact with them," so they can protect themselves and patients from the virus, and stay healthy to keep the U.S. health care system running.

Romero chairs the **Advisory Committee on Immunization Practices**, or ACIP, a longstanding CDC advisory group that includes 15 voting members, plus other vaccination experts who weigh in.

Once the Food and Drug Administration judges a COVID-19 vaccine to be safe, effective and authorized for use, ACIP will make rapid recommendations to the CDC on how a COVID-19 vaccine should be used and who should get the first shots.

"We anticipate having some vaccine for the high-risk individuals — health care providers — sometime in December or early January," Romero told NPR's Mary Louise Kelly on *All Things Considered*. "And then more and more vaccine will be rolled out."

The committee's **goals for deploying a COVID-19** vaccine are to "decrease death and serious disease as much as possible" to keep society functioning and to reduce the burden of health disparities, according to the CDC website.

Beyond health care workers, **three additional groups** are considered by ACIP to be especially vulnerable to COVID-19, based on their exposure or susceptibility to the virus: essential workers, people age 65 and older, and anyone with **underlying medical conditions** associated with getting seriously ill from COVID-19.

The order of which of those groups would get their first doses — and when — may depend on the particular characteristics of whichever vaccine or vaccines are ultimately approved by the FDA. Such characteristics might include whether a particular vaccine has been demonstrated to be effective in older people, safe in people with conditions such as cancer or heart disease, or safe during a pregnancy. It's too soon to say which of the possible vaccines might be most suitable for which groups of people, he said.

"We haven't seen the data yet," Romero said, because vaccine clinical trials are still underway.

While they wait for that data, the committee members have been reviewing possible scenarios, using tools such as **CDC computer models** that project the number of lives that would be saved, based on assumptions about how effective a vaccine is and how many people get immunized

By reviewing these potential outcomes now, the committee hopes to be able to move quickly once a vaccine is authorized. "There will be an emergency meeting of ACIP within 24 to 48 hours after the FDA has made [its] recommendations on the approval," Romero said.

At that meeting, ACIP members will vote on recommendations on dosage and a list of priority groups, which will become part of public health guidance issued by the CDC to states and territories, on how to vaccinate populations effectively against disease. Those guidelines will also signal the federal government to start shipping vaccine vials out to hospitals and vaccination sites across the country.

"We want shots in arms within 24 hours [of ACIP's recommendations]," Paul Mango, a top official with the U.S. Department of Health and Human Services, told reporters in a call last month.

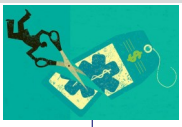
The urgency with which the committee intends to move is motivated by the intention to save lives, Romero said — and is free from political influence.

"I've had no contact with the [Trump] administration or with pharmaceutical companies influencing my decision," he said. "No shortcuts should be taken for this vaccine, and it should be scrutinized the same way we would advise any other vaccine for prevention of infectious diseases."

State health officials are responsible for determining where vaccines should be distributed within their borders. Romero plays a key role regarding that distribution in Arkansas, where he also is health secretary.

"We've identified the top 10 hospitals to receive the initial allotment of vaccine," he said. "And as the vaccine becomes more available, we'll add more and more hospitals to that list."

If we reduce administrative costs, we lower health care costs



In the **Health Affairs Blog**, Harvard economics professor, David M. Cutler, explains why health care administrative costs are extremely high and the need to lower them. Drs. Steffie Woolhandler and David Himmelstein have found that a move to a single-payer, Medicare for all, health care system would both guarantee everyone coverage and cut **$600 billion in administrative waste**, lowering health care spending substantially. Cutler recognizes these features of Medicare for All, but is not willing to advocate for it. You have to wonder who's lining his pockets.

Cutler sees the myriad benefits of lowering administrative health care costs. He appreciates that they consume as much as 25 percent of our health care spending. And, he knows reducing administrative costs would generate significant savings.

Cutler also understands that some significant part of administrative spending goes to undermining people's ability to get care. Administrative costs kick in every time you need a pre-authorization or a referral; every time you call your health plan to figure out who is in its network; every time your doctor needs to get on the phone for an approval; every time you have to fight a denial of care.

Indeed, more than one in five health care workers, 22 percent, are engaged in administrative jobs. For each doctor and dentist, there are just under four administrative employees. In addition, doctors and nurses undertake considerable administrative work.

The majority of administrative expense is in billing and insurance-related services. Before you can see a doctor, the doctor's office needs to check your insurance coverage. It has to determine the amount you owe out of pocket. It needs to put codes on the care you receive. And, the insurer must pay the claim.

Cutler acknowledges that a Medicare for all system would save a lot of these costs. In part, Medicare for all minimizes the paperwork. He makes the case for reducing administrative costs, but he then dismisses moving to Medicare for all, claiming that its tradeoffs "may not be appealing."

As Don McCanne, MD, writes in response, Medicare for all has many appealing qualities, not simply reduction of administrative waste. It offers guaranteed universal coverage, affordable and easy access to care, transparency, the ability to make health care system improvements, promotion of the public health and lower health care spending. What is it about our multi-payer for-profit system that Cutler does not want to lose?

How does Medicare cover outpatient skilled therapy?

Dear Marci,
I have been struggling with back pain. My doctor prescribed me physical therapy, but I am not sure what coverage or costs I should expect. How does Medicare cover outpatient skilled therapy?
- Cameron (Bangor, ME)

Dear Cameron,

Skilled therapy services are services from licensed therapists or skilled therapy providers. There are three main types of skilled therapy covered by Medicare:

- **Physical therapy (PT):** Exercise and physical activities used to condition muscles and improve levels of activity. It is helpful for those with physically debilitating illness. PT will help you regain movement and strength in a body area.
- **Speech/language pathology (SLP):** Therapeutic treatment of speech impairments (such as lisping and stuttering) or speech difficulties that result from illness. SLP will help you regain and strengthen speech and language skills.
- **Occupational therapy (OT):** Therapy using meaningful activities of daily living to assist people who have difficulty acquiring or performing meaningful work due to impairment or limitation of physical or mental function. OT helps you regain the ability to do usual daily activities by yourself such as eating and putting on clothes.

People commonly get skilled therapy on an outpatient basis. Medicare Part B will cover skilled therapy when received as an outpatient (not formally admitted to a hospital or skilled nursing facility). You can get therapy services in a doctor's office, outpatient hospital setting, rehabilitation agency, Comprehensive Outpatient Rehabilitation Facility (CORF), public health agency, or your home (if your home health care is covered by Part B). You are eligible for Medicare coverage of outpatient therapy services if:

- You need skilled therapy services, and the services are considered safe and effective treatment for you
- Your doctor or therapist creates a plan of care before you start receiving services
- Your doctor or therapist regularly reviews the plan of care and makes changes as needed

If you meet Medicare's eligibility requirements, Medicare covers therapy on a temporary basis to improve or restore your ability to function, or on an ongoing basis to prevent you from getting worse. Medicare should cover your outpatient therapy regardless of whether your condition is temporary or chronic. Original Medicare covers outpatient therapy at 80% of the Medicare-approved amount and you may pay a 20% coinsurance after you meet your Part B deductible ($198 in 2020). There is no cap for how much outpatient therapy Medicare covers each year. However, once you reach $2,080 in total therapy costs in 2020, Medicare requires your provider to confirm that your therapy is medically necessary. If you are in a Medicare Advantage Plan, your costs may differ. You should contact your plan directly to find out what your estimated costs may be.

- Marci

Four things to think about when choosing a plan to fill gaps in Medicare, a "Medigap" or Medicare supplemental insurance plan

While people with Medicare have the choice of public insurance, government-administered traditional Medicare, or private insurance, a commercial Medicare Advantage plan that provides Medicare benefits, **most people opt for traditional Medicare.** Traditional Medicare gives them easy access to the doctors and hospitals they know and trust anywhere in the U.S. Moreover, with traditional Medicare, you can protect yourself against high out-of-pocket costs.

With a Medicare Advantage plan, each year you can have **up to $7,550 in annual out-of-pocket costs,** including deductibles and copays for medical and hospital care and excluding these costs for your drugs, for which you cannot budget.

There are three ways to fill gaps in traditional Medicare: A "Medigap" policy, sometimes called Medicare supplemental insurance, that you buy in the individual market, **Medicaid** (including **Medicare Savings Programs administered through Medicaid**) or retiree coverage, if it's available to you from a former employer.

Here are four things to think about when choosing a Medigap plan:

- **Enrollment:** To avoid what could be high out-of-pocket costs if you need care, you should sign up for a Medigap plan at the same time you enroll in traditional Medicare. You will then be fully covered for medical and hospital care. (Your local area agency on aging, **www.eldercare.gov**, can provide you with a list of private insurers that sell Medigap policies in your state. You also can call your local **State Health Insurance Assistance Program (SHIP)** for free assistance choosing a Medigap policy. And, you can go to Medicare.gov for **Medigap options in your state**.) If you wait to buy Medigap insurance, you might not be eligible to get it right away and, in many states, your premium will be based on your health status. (N.B. You cannot buy a Medigap plan to fill gaps in coverage in a **Medicare Advantage plan**,)
- **Choice:** You have a choice of many different Medigap plans lettered A through N. Every plan covers basic gaps in traditional Medicare coverage, including gaps in medical and hospital coverage and 365 days of additional hospital coverage. Plan A is the most stripped down of the plans but does cover the basics, including the 20 percent coinsurance for doctors' services. Plans D, covers almost all your basic needs. Plan G is also popular and covers a little more. (As of 2020, if you are new to Medicare, you can no longer buy Plans C or F).
- **Standardization:** With Medigap coverage, the gaps filled by plans A, B, C, D, F, G, K, L, M, N, will be the same no matter which insurer you buy the coverage from. (Keep in mind that these lettered plans are different from Medicare Parts A, B, C and D.) These plans can be compared on price alone.
- **Premiums:** Premiums can be based on the age at which you buy the policy (issue-age rated), your current age (attained age-rated) or the cost of providing the coverage to everyone in your area (community-rated). Community-rated premiums will be the same for everyone in your area no matter what age you buy the policy, so they tend to cost more at 65 and less later in life. The lowest priced policy at 65–usually the age-rated policy–will likely not be the lowest priced policy over time.

Choose your Medigap plan carefully. The cost of a policy can vary considerably, depending upon the insurer from whom you buy the policy and how the premium is calculated. And, if you are considering a switch to Medicare Advantage, for which you do not need a Medigap plan, keep in mind that depending upon where you live and your health status, you might not be able to switch back to traditional Medicare and buy a Medigap plan. Only four states require companies to sell people Medigap policies regardless of their health condition: New York, Connecticut, Massachusetts and Maine.

RI ARA HealthLink Wellness News

Pfizer says COVID-19 vaccine is looking 90% effective

Pfizer Inc. said Monday that its COVID-19 vaccine may be a remarkable 90% effective, based on early and incomplete test results that nevertheless brought a big burst of optimism to a world desperate for the means to finally bring the catastrophic outbreak under control.

The announcement came less than a week after an election seen as a referendum on President Donald Trump's handling of the scourge, which has killed more than 1.2 million people worldwide, including almost a quarter-million in the United States alone.

"We're in a position potentially to be able to offer some hope," Dr. Bill Gruber, Pfizer's senior vice president of clinical development, told The Associated Press. "We're very encouraged."

Pfizer, which is developing the vaccine with its German partner BioNTech, now is on track to apply later this month for emergency-use approval from the U.S. Food and Drug Administration, once it has the necessary safety information in hand.

Even if all goes well, authorities have stressed it is unlikely any vaccine will arrive much before the end of the year, and the limited initial supplies will be rationed.

Dr. Anthony Fauci, the U.S. government's top infectious-disease expert, said the results suggesting 90% effectiveness are "just extraordinary," adding: "Not very many people expected it would be as high as that."

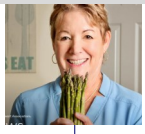
"It's going to have a major impact on everything we do with respect to COVID," Fauci said as Pfizer appeared to take the lead in the all-out global race by pharmaceutical companies and various countries to develop a well-tested vaccine against the virus.

Dr. Bruce Aylward, the World Health Organization's senior adviser, said Pfizer's vaccine could "fundamentally change the direction of this crisis" by March, when the U.N. agency hopes to start vaccinating high-risk groups.

Global markets, already buoyed by the victory of President-elect Joe Biden, rallied on the news from Pfizer. The S&P 500 finished the day with a gain of 1.2%, while the Dow Jones Industrial Average rose more than 800 points. Pfizer stock was up more than 8%.

Still, Monday's announcement doesn't mean for certain that a vaccine is imminent: This interim analysis, from an independent data monitoring board, looked at 94 infections recorded so far in a study that has enrolled nearly 44,000 people in the U.S. and five other countries….**Read More**

AHA News: She Had a Bleeding Stroke and a Clot-Caused Stroke – at the Same Time



Cathy Brophy went into the guest room to enjoy her guilty pleasure – the reality series "Below Deck." She fell asleep, only to eventually wake up, turn off the television and return to sleep.

Around 4:30 a.m., she woke up and tried turning onto her left side. She couldn't.

Cathy's only explanation was that she'd slept awkwardly and something on her right side had gone numb. Her solution was to climb out of bed.

She scooched her way to the end of the bed, expecting to stand. Instead, she fell with a thud.

With her left arm and fist, she banged on the wall of the adjoining bedroom, screaming "Tom! Tom!" to wake her husband from his deep sleep.

The door eventually opened and Tom, a retired police officer, rushed in.

In Cathy's mind, she told him what had happened. But all Tom heard was gibberish. Her right arm and leg were oddly bent. He knew the signs.

"I'm calling 911," he said. "You've had a stroke."

Seeing the severity of the stroke, the receiving hospital transferred Cathy to a more specialized medical center in nearby Charlotte, North Carolina.

Doctors determined Cathy had suffered two calamities at once: An aneurysm in her brain had burst, causing a hemorrhagic stroke, and a blood clot simultaneously caused an ischemic stroke.

The neurosurgeon in charge said she'd need immediate – and risky – surgery.

"I'm going to put some stents in her brain," he said. "It's the only way to save her."

Tom recalled the doctor showing him the brain scans, pointing out where blood was going – and where it was supposed to go.

"If this takes hold, she'll live," the doctor told him. "And if not, she won't make it through the night."

Three days later, Cathy woke up in intensive care, with Tom by her bedside.

"Am I OK?" she whispered.

"You're alive!" he said with a smile.

The surgeon had placed one stent in Cathy's left carotid artery in her neck and two stents in the middle cerebral artery in her brain. The procedure was performed by inserting a catheter through an artery in her groin.

Doctors saw no obvious reason for Cathy's double stroke, which occurred in 2015, when she was 64 and in good shape. While she had no family history of stroke, five years earlier she had open-heart surgery to repair a congenital heart problem and an aneurysm. Cathy bounced back quickly from the heart surgery. A month later, she was back to running her book publishing company.

But her return to work after the double stroke was not so swift. Although she was home within a week, Cathy needed speech and occupational therapy for about six months. Every day she and Tom would play word games suggested by the therapist.

"The speaking part was really challenging," Cathy said. "In my head I knew what I wanted to say, but I couldn't access the words. As a writer and a publisher, that was terrible."

One day, she overheard her sister tell their brother, "She's only 50% of the sister I used to know."

Cathy was devastated. But the comment also motivated her to work harder at therapy and seek a healthier lifestyle.

In 2016, she sold her business, something that had already been in the works before the stroke, and started a pet-sitting service. Last year, she decided to devote all her time to her health. Changes included switching to a plant-based diet, a major decision for someone who avoided vegetables her entire life, and exercising daily – going for long walks, practicing yoga and doing breathing exercises.

"This is my second year on a plant-based diet and I feel wonderful," she said.

Tom followed her lead and has benefited, too.

"I've dropped 20 pounds and have a lot more energy," he said. "We've developed a lot of good recipes now and we eat a salad a night with a lot of different things on it."

Cathy became so interested in the subject that she earned a plant-based nutrition certificate and now gives talks on the topic to local groups.

While she knows another neurological event could occur, she no longer stresses about it.

"If it happens, at least I'm living happy for now," she said. "Before the stroke, I was tense all the time. Now I'm happy."

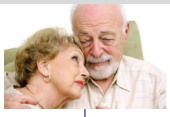
When Your Spouse Gripes About Aging, It Might Harm Your Health

In older couples, one spouse's negative thoughts about aging can affect the other spouse's health, a new study indicates.

It also found that these effects differ by gender. A wife's views about aging are linked with her husband's physical health, while a husband's view about aging are associated with his wife's mental health.

The findings suggest that having a negative view about aging can become a self-fulfilling prophecy, according to study co-author Lydia Li, a professor of social work at the University of Michigan.

The researchers analyzed data from nearly 6,000 Americans older than 50 and their spouses.



They found that women with less negative views of aging are more likely to look after their own health and to encourage their husband to seek health care and follow medical advice.

But women with more negative views of aging are less likely to look after their own health or that of their spouse.

The researchers also found that a husband's negative views about aging can affect his wife's depressive symptoms, but not her physical health, according to the study published recently in the *Journal of Aging and Health*.

"The fact that the husband's self-perception about aging is not associated with their wife's physical health further supports that it is usually women doing the health care work within the couple's context," said study lead author Meng Sha Luo, an associate professor of sociology at Zhejiang University in China.

The gender differences identified in the study suggest that health care officials need to pay attention to the influence of spouses when creating programs to improve older adults' health.

For example, when husbands have major health challenges, improving their own as well as their wife's views about aging may be helpful, Li suggested.

And when wives have depressive symptoms, they may benefit from efforts to improve their own and their husband's negative views about aging.

Previous research has shown that many adult men are reluctant to acknowledge their health problems or seek help, perhaps because doing so threatens their sense of masculinity.

"For these men, efforts to engage their wives may be a feasible approach and are beneficial to both the husbands and wives," Luo said in a University of Michigan news release.

Health Tip: November is Lung Cancer Awareness Month

November is Lung Cancer Awareness Month, a time to bring awareness to the second most common type of cancer in the U.S. Lung cancer is more likely to be successfully treated if found early, which is why awareness and screening are so important. Therefore, the American Cancer Society has a **lung cancer screening guideline** and recommends that those who meet the conditions schedule yearly lung cancer screenings with LDCT scans (low-dose CAT scans or CT scans). It is also important to be aware of the common **signs and symptoms** of lung cancer; while most lung cancers do not cause any symptoms until they have spread, some people with early lung cancer may have symptoms. Talk to your doctor if you notice any symptoms of lung cancer or want to discuss yearly LDCT scans….**American Cancer Society**

Five Important Questions About Pfizer's COVID-19 Vaccine

Pfizer's **announcement on Monday** that its COVID-19 shot appears to keep nine in 10 people from getting the disease sent its stock price rocketing. Many news reports described the vaccine as if it were our deliverance from the pandemic, even though few details were released.

There was certainly something to crow about: Pfizer's vaccine consists of genetic material called mRNA encased in tiny particles that shuttle it into our cells. From there, it stimulates the immune system to make antibodies that protect against the virus. A similar strategy is employed in other leading COVID-19 vaccine candidates. If mRNA vaccines can protect against COVID-19 and, presumably, other infectious diseases, it will be a momentous piece of news.

"This is a truly historic first," said Dr. Michael Watson, the former president of Valera, a subsidiary of Moderna, which is currently running advanced trials of its own mRNA vaccine against COVID-19. "We now have a whole new class of vaccines in our hands."

But historically, important scientific announcements about vaccines are made through peer-reviewed medical research papers that have undergone extensive scrutiny about study design, results and assumptions, not through company press releases.

So did Pfizer's stock deserve its double-digit percentage bump? The answers to the following five questions will help us know.

1. How long will the vaccine protect patients?

Pfizer says that, as of last week, 94 people out of about 40,000 in the trial had gotten ill with COVID-19. While it didn't say exactly how many of the sick had been vaccinated, the 90% efficacy figure suggests it was a very small number. The Pfizer announcement covers people who got two shots between July and October. But it doesn't indicate how long protection will last or how often people might need boosters.

"It's a reasonable bet, but still a gamble that protection for two or three months is similar to six months or a year," said Dr. Paul Offit, a member of the Food and Drug Administration panel that is likely to review the vaccine for approval in December. Normally, vaccines aren't licensed until they show they can protect for a year or two.

The company did not release any safety information. To date, no serious side effects have been revealed, and most tend to occur within six weeks of vaccination. But scientists will have to keep an eye out for rare effects such as immune enhancement, a severe illness brought on by a virus's interaction with immune particles in some vaccinated persons, said Dr. Walt Orenstein, a professor of medicine at Emory University and former director of the immunization program at the Centers for Disease Control and Prevention.

2. Will it protect the most vulnerable?

Pfizer did not disclose what percentage of its trial volunteers are in the groups most likely to be hospitalized or to die of COVID-19 — including people 65 and older and those with diabetes or obesity. This is a key point because many vaccines, particularly for influenza, may fail to protect the elderly though they protect younger people. "How representative are those 94 people of the overall population, especially those most at risk?" asked Orenstein.

Both the National Academy of Medicine and the CDC have urged that older people be among the first groups to receive vaccines. It's possible that vaccines under development by Novavax and Sanofi, which are likely to begin late-phase clinical trials later this year, may be better for the elderly, Offit noted….**Read More**

Easy Bruising: Common as You Age

If you're experiencing easy bruising, you might have questions about what's causing the problem and what you can do about it. Find out what role aging plays and when to consult a doctor.

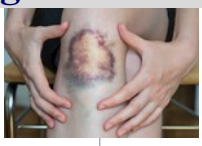
Yet another unsightly bruise. You don't recall bumping into anything, but lately you seem to be bruising frequently. Is this cause for concern?

Easy bruising is common with age. Although most bruises are harmless and go away without treatment, easy bruising can sometimes be a sign of a more serious problem.

Most bruises form when small blood vessels (capillaries) near the skin's surface are broken by the impact of a blow or injury — often on the arms or legs. When this happens, blood leaks out of the vessels and initially appears as a black-and-blue mark. Eventually your body reabsorbs the blood, and the mark disappears.

Generally, harder blows cause larger bruises. However, if you bruise easily, a minor bump — one you might not even notice — can result in a substantial bruise.

Some people — especially women — are more prone to bruising than others. As you get older, your skin also becomes thinner and loses some of the protective fatty layer that helps cushion your blood vessels from injury.



Aspirin, anticoagulant medications and anti-platelet agents reduce your blood's ability to clot. Antibiotics might also be associated with clotting problems. As a result, bleeding from capillary damage might take longer than usual to stop — which allows enough blood to leak out to cause a bigger bruise.

Topical and systemic corticosteroids — which can be used to treat various conditions, including allergies, asthma and eczema — cause your skin to thin, making it easier to bruise. Certain dietary supplements, such as ginkgo, also can increase your bruising risk due to a blood-thinning effect.

If you experience increased bruising, don't stop taking your medications. Talk to your doctor about your concerns. Also, make sure your doctor is aware of any supplements you're taking — especially if you're taking them while on a blood-thinning drug. Your doctor might recommend avoiding certain over-the-counter medications or supplements.

Easy bruising sometimes indicates a serious underlying condition, such as a blood-clotting problem or a blood disease. See your doctor if you:

- Have frequent, large bruises, especially if your bruises appear on your trunk, back or face, or seem to develop for no known reasons
- Have easy bruising and a history of significant bleeding, such as during a surgical procedure
- Suddenly begin bruising, especially if you recently started a new medication
- Have a family history of easy bruising or bleeding
- These signs and symptoms can indicate:
- Low levels of the blood components that help it clot after injury (platelets)
- Abnormally functioning platelets
- Problems with proteins that help the blood clot

To find the cause of your bruising, your doctor might check your blood platelet levels or do tests that measure the time it takes your blood to clot.

Other serious causes of bruising include domestic violence or abuse. If a loved one has an unexplainable bruise, particularly in an unusual location such as on the face, be aware of the possibility of abuse.

To prevent minor bruising, take steps to avoid falling:

- Use good lighting in your home.
- Avoid clutter and throw rugs, especially on stairs.
- Arrange furniture and electrical cords so that they're not in your way when you walk.
- Find out about the side effects of medications you take. Tell your doctor or pharmacist if a medication makes you dizzy or sleepy.
- Have your vision and hearing tested. Even small changes in sight or hearing can cause you to fall.

Unfortunately, once a bruise has formed, not much can be done to treat it. Most bruises eventually disappear as your body reabsorbs the blood, although healing might take longer as you age. It might help to elevate the affected area and apply ice.

As You Age: You and Your Medicines

As you get older you may be faced with more health conditions that you need to treat on a regular basis. It is important to be aware that more use of medicines and normal body changes caused by aging can increase the chance of unwanted or maybe even harmful drug interactions. The more you know about your medicines and the more you talk with your health care professionals, the easier it is to avoid problems with medicines.

As you get older, body changes can affect the way medicines are absorbed and used. For example, changes in the digestive system can affect how fast medicines enter the bloodstream. Changes in body weight can influence the amount of medicine you need to take and how long it stays in your body. The circulatory system may slow down, which can affect how fast drugs get to the liver and kidneys. The liver and kidneys also may work more slowly, affecting the way a drug breaks down and is removed from the body.

Drug Interactions

Because of these body changes, there is also a bigger risk of drug interactions among older adults. Therefore, it's important to know about drug interactions.

- **Drug-drug interactions** happen when two or more medicines react with each other to cause unwanted effects. This kind of interaction can also cause one medicine to not work as well or even make one medicine stronger than it should be. For example, you should not take aspirin if you are taking a prescription blood thinner, such as warfarin, unless your health care professional tells you to.
- **Drug-condition interactions** happen when a medical condition you already have makes certain drugs potentially harmful. For example, if you have high blood pressure or asthma, you could have an unwanted reaction if you take a nasal decongestant.
- **Drug-food interactions** result from drugs reacting with foods or drinks. In some cases, food in the digestive tract can affect how a drug is absorbed. Some medicines also may affect the way nutrients are absorbed or used in the body.
- **Drug-alcohol interactions** can happen when the medicine you take reacts with an alcoholic drink. For instance, mixing alcohol with some medicines may cause you to feel tired and slow your reactions.

It is important to know that many medicines do not mix well with alcohol. As you grow older, your body may react differently to alcohol, as well as to the mix of alcohol and medicines. Keep in mind that some problems you might think are medicine-related, such as loss of coordination, memory loss, or irritability, could be the result of a mix between your medicine and alcohol….**Read More**