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Shopping For A Better Health Or Drug Plan Could Save Hundreds of Dollars

Making the effort to check health and prescription drug coverage during the Medicare Open Enrollment Period, October 15th through December 7th, can pay off in significant savings for retirees, says **The Senior Citizens League** (TSCL). "The job does not have to be overwhelming," says Mary Johnson, a Medicare and Social Security policy analyst for The Senior Citizens League. "Free one-on-one counseling is available in every area of the country to check coverage options and to switch to other health or drug plans when a better choice is available," Johnson says. "Checking coverage is especially important since the Social Security cost-of-living adjustment for 2020 is just 1.6 percent, and will only raise an average benefit of $1,460 by about $23 per month.

According to research by Johnson, prescription drug costs vary significantly between drug plans — by the hundreds or even thousands of dollars — even for common generics. Unlike other services, Medicare does not negotiate drug prices on behalf of beneficiaries. The plan with the lowest-priced drug can be hundreds or even thousands of dollars less than the highest cost plan for the very same drug. Yet the majority of Medicare beneficiaries rarely shop for their best drug plan during Medicare's annual Open Enrollment Period. Consequently, Medicare beneficiaries in Part D and Medicare Advantage plans overpay for their prescription medications even though less expensive, high quality plan choices are available.

The drugs covered by each plan can vary dramatically, and plans frequently push drugs into a higher formulary tiers which are more expensive, unbeknownst to even the most conscientious consumers. "That can result in a drug price shock next year at the pharmacy counter, unless you nip that in the bud right now," says Johnson.

Since the start of Medicare Part D in 2006, Johnson has volunteered to help friends, neighbors and family members compare Part D plans and switch to new plans when better choices are available. Doing so often results in substantial savings on drug prices — sometimes hundreds of dollars, lower premiums, and better access to brand and pricey drugs.

How should Medicare beneficiaries prepare for Open Enrollment? Here's a checklist from The Senior Citizens League:

♦ **Review**: By now, people covered by Medicare Part D or Medicare Advantage plans should have received an Annual Notice of Changes for 2020 from their current plan. In addition to changes to the premiums, the notice will explain increases, if any, in the deductible, copayments and coinsurance. The notice will tell you where to find information about the pharmacies in the drug plan's network, and it will refer to "the drug list" or plan formulary of covered drugs which usually can be found online or requested from the plan. "What the notice does not include is a list of the drugs you currently take, the tiers that your drugs will be on in 2020, whether coverage has been dropped for any of your drugs in 2020, or what those drugs will cost if co-insurance is charged," Johnson says. "Plans will provide most of that information, but it requires calling your plan directly and speaking to someone who can estimate the cost of your drugs in 2020. Once you have this information, it's very important to compare all your health and drug plan options to find your lowest-costing coverage," Johnson says.

♦ **Gather and write legibly**: Gather all of the drugs you currently take and carefully make a list, printing the name of the drug, dosage, quantity taken per day, and quantity required per month. Do this for each drug taken. Make sure your writing is legible. Type it into a Word document and print it out if possible. Keep this list on file where you can find it easily. Not only will you need it to compare drug plans, it's handy to take with you on each visit to your doctor.

♦ **Get free, unbiased assistance from a Medicare counselor**: You can get great help from a local Medicare benefit counselor who provides free one-on-one counseling through State Health Insurance Programs (SHIPs). Local contact information can be found at: **https://www.shiptacenter.org**. Call and make appointment now, because Open Enrollment will take more time than usual this year. The Medicare Drug Plan Finder comparison tool which counselors use to compare drug plans and estimate costs has recently been re-designed. "It's likely to take longer than usual to sort through plans and determine the best choice for clients while all of us are learning how to use the new system," Johnson says.

♦ **Narrow your choices and contact the prospective drug plans directly to confirm details**: Once you have picked out three or so plans that look like your best bets, contact the plans directly to confirm the details. This includes coverage of all your drugs, estimated co-pays and co-insurance, which pharmacies participate and other questions you may have.

♦ **Switch plans by going through the Medicare website**: It's better to switch plans through the Medicare website than trying to do so directly with the insurer. This way Medicare will make sure your previous plan unenrolls you by the end of the year and your new coverage begins on January 1, 2020 with the new plan. Your SHIP Medicare benefits counselor can help you do this.

2020 Medicare Parts A & B Premiums and Deductibles

On November 8, 2019, the Centers for Medicare & Medicaid Services (CMS) released the 2020 premiums, deductibles, and coinsurance amounts for the Medicare Part A and Part B programs.

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.

Each year the Medicare premiums, deductibles, and copayment rates are adjusted according to the Social Security Act. For 2020, the Medicare Part B monthly premiums and the annual deductible are higher than the 2019 amounts. The standard monthly premium for Medicare Part B enrollees will be $144.60 for 2020, an increase of $9.10 from $135.50 in 2019. The annual deductible for all Medicare Part B beneficiaries is $198 in 2020, an increase of $13 from the annual deductible of $185 in 2019.

The increase in the Part B premiums and deductible is largely due to rising spending on physician-administered drugs. These higher costs have a ripple effect and result in higher Part B premiums and deductible.

From day one, President Trump has made it a top priority to lower drug prices. Currently, for Part B, the law requires CMS to pay the average sales price for a drug and also pays physicians a percentage of a drug's sale price. This incentivizes drug companies to set prices higher and for physicians to prescribe more expensive drugs – because that leads to a higher Medicare payment. Through the President's drug pricing blueprint, the Trump Administration is working to lower drug prices in Medicare Part B drugs.

CMS is committed to empowering beneficiaries with the information they need to make informed decisions about their Medicare coverage options, including providing new tools to help them make those decisions through the eMedicare initiative. In addition to the recently released premiums and cost sharing information for 2020 Medicare Advantage and Part D plans, we are releasing the premiums and cost sharing information for Fee-for-Service Medicare, so beneficiaries understand their options for receiving Medicare benefits. As previously **announced,** as a result of CMS actions to drive competition, on average for 2020, Medicare Advantage premiums are expected to decline by 23 percent from 2018, and will be the lowest in the last thirteen years while plan choices, benefits and enrollment continue to increase. Premiums and deductibles for Medicare Advantage and Medicare Part D Prescription Drug plans are already finalized and are unaffected by this announcement.

Click here for the CMS Fact Sheets and tables

What are supplemental benefits?

Dear Marci,
I am making decisions about Medicare coverage options, and one of my friends told me that I should ask the plans that I'm considering whether they have any supplemental benefits. What are supplemental benefits?
-Emmy (Houston, TX)

Dear Emmy,

A supplemental benefit is an item or service covered by a **Medicare Advantage Plan** that is not covered by **Original Medicare**. These items or services do not need to be provided by Medicare providers or at Medicare-certified facilities. Instead, to receive these items or services, you need to follow your plan's rules. Some commonly offered supplemental benefits are

- Dental care
- Vision care
- Hearing aids
- Gym membership

For the most part, supplemental benefits must be primarily health-related. Beginning in 2020, however, Medicare Advantage Plans can begin covering supplemental benefits that are not primarily health-related for beneficiaries who have chronic illnesses. These benefits can address social determinants of health for people with chronic disease. A social determinant of health is a part of your life that can affect your health in some way, such as not having access to transportation. Examples of the kind of benefits that plans can now cover are:

- Meal delivery
- Transportation for non-medical needs
- Home air cleaners
- Pest remediation
- Heart-healthy food or produce

In order to be eligible for this new category of supplemental benefits, you must be considered chronically ill. This means that you:

- Have at least one medically complex chronic condition that is life-threatening or significantly limits your health or function
- Medically complex chronic conditions include cardiovascular disorders, diabetes, chronic lung disorders, neurologic disorders, chronic heart failure, chronic and disabling mental health conditions, cancer, dementia, chronic alcohol or drug dependence, autoimmune disorders, stroke, end-stage renal disease (ESRD), severe hematologic disorders, end-stage liver disease, and HIV/AIDS.
- Have a high risk of hospitalization or other negative health outcomes, and
- Require intensive care coordination

If you meet the above criteria, a Medicare Advantage Plan may offer you one of these new benefits if it has a reasonable expectation of improving or maintaining your health or function.

Since Medicare Advantage Plans will be able to create sets of supplemental benefits for people with specific chronic illnesses, not every member of a Medicare Advantage Plan will have access to the same set of benefits. For example, a plan might cover services like home air cleaning and carpet shampooing to its members who have asthma. A member of that plan who has asthma may be able to get these services covered, while a member who does not have asthma may not.

Before enrolling in a Medicare Advantage Plan that has these new supplemental benefits, check if you meet the plan's criteria for coverage. Contact your plan to find out how to access these and other supplemental benefits.

~~~~Marci
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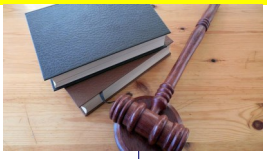
Court Blocks Sweeping Rule that Would Negatively Impact Patient Access to Care



This week, a federal court blocked a Trump administration rule that would have allowed health plans and providers to refuse to provide certain types of care they disagreed with on moral or religious grounds. Set to take effect on November 22, the rule would have permitted individuals to deny care even in circumstances where performing the refused service was a significant portion of their jobs, and even where the refusal could prevent patients from receiving the service altogether.

The **court found** that this broad rule violated several statutes, including the **Civil Rights Act of 1964** and the **Emergency Medical Treatment and Labor Act** that ensures access to emergency care. In addition, the court determined that the administration did not comply with proper rulemaking and used "factually untrue" arguments to justify this rulemaking.

Existing civil rights laws require careful balancing of the rights of providers and the rights of patients, and do not require employers to hire and employ individuals if accommodating those employees would create an undue hardship for the employer. For example, a surgical practice is not required to employ as a surgeon a doctor who is morally opposed to surgery. This rule would have upended such balancing by requiring employers to staff around objecting health care providers. The court found that the rule could force employers to double or even triple staff under some circumstances, driving up costs in the health care system and reducing the ability of employers to adjust staffing appropriately.

In addition, the rule failed to establish exceptions for emergency situations, potentially putting the lives and health of patients at risk.

The administration claimed this rule was necessary because of a large spike in complaints from health care workers about perceived violations of their religious and conscience rights, announcing they had **received 343 such complaints in 2018** alone. But during oral arguments, the administration admitted that they had not actually received such a huge influx of complaints and the true number was around 20.

Medicare Rights welcomes this decision. As outlined in our **public comments**, we have serious concerns with the rule, including its failure to balance the potential conflict between providers' conscience rights and the rights of citizens to access needed heath care without discrimination or undue barriers. People with Medicare must be able to trust they will receive the care they want and need.

Read more about this court's decision.
Read the court's decision.

New Report Details High Out-of-Pocket Costs for Some with Medicare

More than 60 million older adults and people with disabilities rely on Medicare for trusted health coverage. However, the program's benefit design and lack of financial protections can leave some beneficiaries exposed to high premiums and cost-sharing amounts for Medicare-covered services, and on the hook for the full cost of services that are not covered by Medicare, such as comprehensive dental, vision, and hearing care, as well as long-term services and supports (LTSS).

A **new analysis** from the Kaiser Family Foundation (KFF) underscores these challenges. According to the report, people with Original Medicare spent an average of $5,460 out of their own pockets for health care in 2016. Nearly half of this spending was for services outside of Medicare, such as LTSS (32%) and dental care (14%). The other half was largely devoted to meeting beneficiary cost-sharing obligations, including for provider-based care (22%) and prescription drugs (21%).

While high out-of-pocket costs were widespread, some groups—including women, people with multiple chronic conditions, and those with no supplemental coverage—spent substantially more than others. And the financial burden of these costs fell disproportionately on people with lower incomes. Half of all beneficiaries living on $10,000 or less spent at least 18% of their total income on health care, compared to 7% of those with annual incomes of $40,000 or more.

These findings mirror Medicare Rights' experience. Every day on our National Consumer Helpline, we hear from older adults and people with disabilities who are struggling to cover their health care and prescription drug costs. Given that many people with Medicare live on fixed or limited incomes, the perennial nature of these calls is alarming, but not surprising.

Currently, half of all Medicare beneficiaries—nearly 30 million older adults and people with disabilities—live on $26,200 or less per year, while one quarter have incomes below $15,250 and less than $14,550 in savings. Simply put, most people with Medicare cannot afford to pay more for their care.

The consequences of health care and prescription drug unaffordability are significant, often eroding beneficiary health and economic security. Beneficiaries who cannot purchase their medications or pay for coverage may be forced to go without care—leading to worse health outcomes and quality of life. Troublingly, **bankruptcy is on the rise among older adults**, having increased 204% from 1991 to 2016. Medical debt is big reason why; 60% of those 65 and older who file for bankruptcy do so because of medical bills.

And the cost to the Medicare program is also extreme, as beneficiaries who forgo needed care and experience declining health as a result may need more costly interventions later, like emergency department or inpatient care.

This KFF report comes as lawmakers in the U.S. **House** and **Senate** are considering legislation that would address the problem of high and rising prescription drug prices and improve the Medicare program.

The Medicare Rights Center supports these bills, and in particular the provisions that would strengthen Medicare as well as beneficiary health and financial well-being—including by better protecting beneficiaries against burdensome spending, filling longstanding gaps in coverage, and reducing program and out-of-pocket costs. We look forward to continuing to work with policymakers on these and other critical reforms, to ensure that all people with Medicare have meaningful access to affordable, high-quality care.

New York judge sets opioid crisis trial for January

A New York judge on Wednesday scheduled what could be the second state-level trial in the U.S. on the toll of opioids.

Judge Jerry Garguilo set a trial date of Jan. 20 for claims brought by the state attorney general and the Long Island counties of Nassau and Suffolk against a group of drug manufacturers and distributors.

The judge has selected those claims to move ahead while dozens of other cases he is overseeing from local New York governments are on hold.

He is also not hearing claims against OxyContin maker Purdue Pharma or members of the Sackler family who own it. They are attempting to settle some 2,700 claims against the company through federal bankruptcy court. States have agreed to put their suits against the company and family members on hold for now.

Other companies have also been trying to reach a settlement of more than 2,000 cases across the U.S. A proposed framework under consideration with the drugmakers Teva and Johnson & Johnson and distributors AmerisourceBergen, Cardinal Health and McKesson could be worth up to $48 billion in cash and treatment drugs nationally over time. But the plan has a ways to go before it's accepted by states and other parties.

All the companies in the national settlement talks are among the defendants in the New York case.

An Oklahoma judge this year ordered Johnson & Johnson to pay $572 million in the nation's first opioid liability trial. Other defendants settled before that trial.

The first federal trial had been scheduled to start in October but was stopped when most of the defendants reached settlements with the two Ohio counties who brought the claims.

A federal judge has suggested moving ahead with four different federal trials around the U.S., but the next cases have not been finalized.

At height of opioid crisis, Walgreens handled nearly one in five of the most addictive drugs

At the height of the opioid epidemic, Walgreens handled nearly one out of every five oxycodone and hydrocodone pills shipped to pharmacies across America.

Walgreens dominated the nation's retail opioid market from 2006 through 2012, buying about 13 billion pills - 3 billion more than CVS, its closest competitor, according to a Drug Enforcement Administration database of opioid shipments. Over those years, Walgreens more than doubled its purchases of oxycodone.

The company had "runaway growth" of oxycodone sales because it continued to send pills to stores "without limit or review," Edward Bratton, Walgreens manager of pharmaceutical integrity, wrote to another employee in 2013. The email is among thousands of documents recently disclosed in a federal lawsuit that seeks to hold Walgreens and other businesses responsible for the nation's opioid crisis.

While most chain and independent pharmacies relied heavily on wholesalers to supply their prescription opioids, Walgreens obtained 97% of its pain pills directly from drug manufacturers, a Washington Post analysis of the data shows. This arrangement allowed Walgreens to have more control over how many pain pills it sent to its stores.

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From 2006 through 2012, Walgreens ordered 31% more oxycodone and hydrocodone pills per store on average than CVS pharmacies, and 73% more than other pharmacies nationwide, according to The Post's analysis of the DEA database, known as the Automation of Reports and Consolidated Orders System (ARCOS).

When Walgreens considered surveying its pharmacies in Florida in 2011 to identify questionable pain pill customers, a company attorney advised caution: "If these are legitimate indicators of inappropriate prescriptions perhaps we should consider not documenting our own potential noncompliance," according to an email disclosed in the case.

In 2012, a drug distributor produced a report for Walgreens that flagged nearly half of the chain's roughly 8,000 stores for dispensing high numbers of controlled substances, including oxycodone, court records show.

After warnings from the DEA, Walgreens agreed in 2013 to pay $80 million - a record settlement for the agency at the time - to resolve allegations that the company failed to sufficiently report suspicious orders and negligently allowed controlled substances, such as oxycodone and other prescription pain medications, to be diverted for abuse and illegal black market sales.

The large volume of pills flowing into Walgreens pharmacies made some stores targets for crime, including armed robberies and employee theft, according to police officials, board of pharmacy records and other published reports. In 2014, a pharmacy technician who stole about 25,000 pain pills from a Walgreens in Missouri told state investigators that another employee gave him instructions on how to pilfer the pills and sell them during breaks in the store bathroom and pharmacy parking lot.

Now, Walgreens is one of the holdouts in the federal suit playing out in Cleveland after other major distributors and drug manufacturers reached a settlement with two Ohio counties on Oct. 21. The trial for Walgreens was postponed until next year. CVS and other major pharmacy chains are also defendants.

"Because Walgreens had full visibility into all dispensing related information necessary to reveal red flags and criteria of suspicion, Walgreens might even be viewed as more culpable due to the wealth [of] data at its complete disposal," the plaintiffs allege

The company denied that it incentivized pharmacists to inappropriately fill prescriptions and defended its practices in statements.….**Read More**

How should we address drug shortages?

It's hard to believe, but some prescription drugs are hard to come by. A new federal report by the **Food and Drug Administration** (FDA) attributes these drug shortages to a combination of low profitability and a "broken" health care marketplace. The FDA's market-based recommendations for addressing these drug shortages likely means we can expect them to continue.

These days, **more than 150 prescription drugs are in short supply** in the US. Both generic drugs and brand-name drugs can be hard to come by. They include anesthesia drugs such as lidocaine, palliative care drugs such as bleomycin for patients with cancer, drugs for septic shock such as norepinephrine, and vaccines. Medical supplies, such as sterile water, can also be unavailable.

To be clear, drug shortages mean treatment delays or changes in treatment regimens for patients. This can jeopardize their health. One study found that more than half of hospitals (56 percent) reported they had delayed or changed patient treatment because of drug shortages.

Unfortunately, the problem is not getting better. In fact, it's getting worse. An increasing number of drugs are in short supply. Moreover, shortages of drugs tend to last longer and longer.

As unfortunate, no one is keeping good data on the issue. We need good evidence of the number of drugs unavailable at any given time and the consequences of their lack of availability. As the report says, we need to know the frequency, persistence and intensity of drug shortages if we are going to best prevent them.

Most of the 163 drugs that are hard to get are **generic drugs** that have been on the market for decades. But, more than 50 are brand-name drugs. The reason that about half of these drugs are so hard to get is quality-control problems where the drugs are manufactured.

The FDA report recommends that the price of these drugs **go up** to address the shortages. It suggests that there be quality ratings of these drugs as a possible way to help pharmaceutical companies command higher prices for them.

Notably, the authors did not recommend government intervention to ensure these drugs are available, even though some of these medications are critical for saving lives. Vincristine, for example, is a cancer drug, that treats a variety of common childhood cancers. Pfizer, which makes the drug, says it is addressing the shortage.

Current Drug Shortages

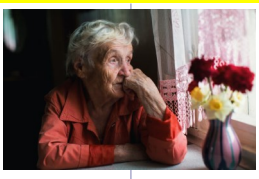
Drug shortages can have a significant impact on patient care and public health. Drugs in short supply often include sterile injectables and potentially life-saving oncology (cancer) treatments. Besides the lack of effective drug treatment, many other areas of medical care can be impacted, including medical procedure delays, treatment protocol delays, rates of medication errors, patient health outcomes, and cost. Notice from manufacturers to the FDA about impending or current drug shortages allows the FDA to work with the manufacturers to prevent a drastic shortage..

Link to FDA Drug Shortages

Lonely Lives: Alarming Number Of Seniors Go Entire Week Without Talking To Anyone

For most of us, the older we get, the more we slow down physically. But for some, growing old also means slowing down socially — so much to the point that some home-bodied seniors go days with little to no human interaction. A new survey of British elders sheds light on this sad, but true effect of aging, noting that hundreds of thousands of people often go a week without speaking to a single person.

According to the survey of 1,896 seniors over 65 in the United Kingdom, more than one in five (22%) will have a conversation with no more than *just three people* over the span of an entire week! That translates to nearly 2.6 million **elderly folks** who don't enjoy regular human contact on a daily basis. Perhaps most alarming though is researchers say an alarming 225,000 individuals will go a week without talking to anyone face-to-face.



"A friendly 'hello' or 'how are you?' is something most of us take for granted – it's just part of every day life, but these latest figures show that hundreds of thousands of older people in the UK will spend today and the rest of this week alone, with no one to share even a few simple words with," says Caroline Abrahams, charity director at **Age UK**, which partnered with **Cadbury Dairy Milk** to commission the research, in a statement.

The survey also revealed that 38% of seniors admit to feeling lonely at times as they've aged, with 12%, or about one in eight, agreeing that **loneliness** has kept them from leaving their home.

"Loneliness is a **huge problem** because retirement, bereavement and ill health mean many older people find they are spending a lot less time enjoying the company of others than they'd like," says Abrahams. "Loneliness can affect your health, your wellbeing and the way you see yourself – it can make you feel invisible and forgotten."

About 40% of seniors say they'd feel more confident to head out each day if they knew their neighbors. Just the thought of **someone stopping to chat** with them brightens their outlook: 54% of respondents agree that even a short conversation with a neighbor or acquaintance would greatly improve their day overall. And a quarter of older adults say it makes them feel good when someone smiles or acknowledges them while waiting in line at places like the bank or grocery store. One in five would be thrilled if someone stopped to ask them how their day had gone.

Meanwhile, another survey of 2,000 people ages 16-45 in the UK shows that 55% of younger folks admit to worrying about being lonely in their elder years. With that in mind, two-thirds of this segment say they're willing to do something to help boost the confidence of a lonely senior, but 37% worry that such a gesture wouldn't be well-received. Another 30% feel too shy to spark up a conversation with seniors, 27% admit they aren't sure how to help, and a quarter say they're **simply too busy** themselves.

To help in that area, Cadbury and Age UK have launched a new campaign called "**Donate Your Words**" to help cheer up lonely seniors. The campaign encourages people to help fight loneliness by pledging to stop and chat with elders in their communities.

Pharmacy Benefit Managers (PBMs) Profits Soars

The high cost of prescription drugs continues to beleaguer seniors, while Pharmacy Benefit Managers (PBMs) earned an estimated $22.6 billion in gross profits last year. PBMs act as middlemen between the drug manufacturers, insurance companies and consumers. There is suspicion that the PBM's may be applying incredible markups to the prescriptions for their own financial benefits and not passing any savings on to the pharmacies that actually sell the drugs, who could then pass the savings onto consumers. Congresswoman Spanberger (VA-7) introduced legislation earlier this year with immediate support from Congressmen Jodey Arrington (TX-19), and Bredan Boyte (PA-2) to force transparency of the drug markups. There was no way to tell what those mark ups were until this past Tuesday, in a rare show of bi-partisanship the *Public Disclosure of Drug Discounts and Real-Time Beneficiary Drug Cost Act* - passed the House by 403 to 0. Congratulations are in order for Congresswoman Spanberger.

Introduced by Rep. John Larson (CT), the Social Security 2100 Act adjusts the payroll wage cap so that the very wealthy begin paying more by raising the tax cap, along with a 1.2 percent payroll tax increase phased in over 24 years. The bill also includes a 2 percent across the board increase in benefits and a more accurate inflation formula for calculating cost-of-living adjustments, the Consumer Price Index for the Elderly (CPI-E).

The Congressional Budget Office (CBO) found that the Social Security Trust Fund would still become insolvent — in 2036 under The Social Security 2100 Act. The Social Security Administration's Office of the Chief Actuary (OCACT) shows this legislation having very different impacts on the financing of the trust fund. The OCACT says the 2100 Act would completely eliminate the shortfall and keep the program solvent for 75 years. So, which is right? Most experts are leaning towards the estimates provided by the OCACT claiming that agency took more variables into consideration.

This week Voters went to the polls in no fewer than 39 states on Tuesday, voting for governors, ballot initiatives and a multitude of various referendums. Now that those elections are in the bag, we can all start looking towards the federal elections in 2020!

Voters Say Congress Needs To Curb Drug Prices, But Are Lawmakers Listening?

House Democrats are poised to pass sweeping legislation to lower drug prices using strategies President Donald Trump has endorsed. A Trump aide urged the Republican-controlled Senate to vote on a different package curbing drug prices that was drafted by a senior Republican.

But at least right now, neither measure appears likely to attract enough bipartisan support to become law.

Nearly **8 in 10 Americans** say the cost of prescription drugs is unreasonable, with voters from both parties agreeing that reducing the cost of prescription drugs should be one of Congress' top priorities, according to a poll last month by the Kaiser Family Foundation. (KHN is an editorially independent program of the foundation.)

With such broad and bipartisan support, why do the odds look grim for Congress to pass significant drug pricing legislation this year?

Because whether it's sharing the credit for a legislative victory with the other party or running afoul of the powerful drugmaker lobby, neither Democrats nor Republicans are sure the benefits are worth the risks, according to several of those familiar with the debate on Capitol Hill.

Complications From 'Medicare For All,' Impeachment

Senate Majority Leader Mitch McConnell, who is a Republican and controls what legislation gets to the Senate floor, has said he will not allow a vote on the House Democrats' legislation. Among other things, the bill written by House Speaker Nancy Pelosi and other Democratic leaders would enable federal health officials to negotiate the prices of as many as 250 of the most costly drugs. Although Trump has endorsed that tactic, most Republican lawmakers oppose it because they are philosophically opposed to interfering with the market.

On Friday, Trump's chief domestic policy adviser, Joe Grogan, said any drug pricing legislation would need bipartisan support, saying of Pelosi's plan: "It is not going to pass in its current form." He said the White House supports the bipartisan package drafted by Sen. Chuck Grassley (R-Iowa), who chairs the Finance Committee, and the committee's top Democrat, Sen. Ron Wyden of Oregon.

But many Senate Republicans in particular are uncomfortable with one of the bill's key provisions: a requirement that drugmakers not raise their prices on drugs covered by Medicare faster than the rate of inflation.

Asked whether the White House supports the inflation caps, Grogan said they were "not the administration's proposal, but they are the product of a bipartisan compromise, and they are the route to a bipartisan bill, in our opinion."

In a recent interview, Grassley spokesman Michael Zona dismissed the call from other Republicans to eliminate the provision. "There's no need," he said. "The bill passed with a bipartisan two-thirds majority in committee, and support's growing for the bill every week among Republicans."

While the Senate Finance Committee did vote 19-9 in July to send the Grassley-Wyden bill to the full Senate for consideration, some Republicans who voted to advance it cautioned then that they may not ultimately vote for the bill.

While considering the bill, all but two of the committee's Republican members voted to kill the provision to prevent Medicare drug prices from rising faster than inflation. Grassley, however, got Democratic support and it stayed in the bill.

But it's not clear if the bill will come to the floor. McConnell is known to be unwilling to corner Senate Republicans with votes that could be politically risky during campaign season, whether due to criticism from Democrats or pressure from the drug industry.

Kim Monk, a health care analyst and partner at Capital Alpha Partners who used to work for Republicans in the Senate.

"Why would Republicans stick their neck out while Democrats are fighting over Medicare for All?" she asked…..**Read More**

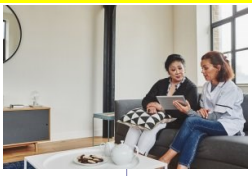
Questions to Ask on a Nursing Home Visit

FINDING THE RIGHT nursing home fit for a loved one can be a challenging proposition. The options are many, but the industry may seem completely opaque if you haven't had interaction with any **long-term care facilities** in the past. This is why visiting a home – and asking a lot of questions – before you place a loved one there is a critical part of the process of securing **good care** for them.

There's so much to think about when considering whether to place a loved one in a particular home, that it can be challenging to know where to start. The following list of **questions** may help guide you through some of the most important questions and help you avoid becoming overwhelmed when visiting a home.

Answers to these questions, which can be broken into five main categories, can help you understand whether a specific nursing home is right for your loved one:

1. Questions for a top administrator or director of nursing. These top-line questions determine whether your loved one's basic needs can be met in the facility and **how the facility is run.**



2. Questions for the nursing staff. Speaking with nurses who work in a home can provide important insight into what their workload is like and whether they enjoy their work. Lisa Zamosky, senior director of consumer affairs for eHealth, one of the largest online health insurance exchanges in the U.S., urges you to "learn as much as possible about the staff that will be caring for your loved one." Consistency in staff and a low turnover rate are important clues that a home may be well run.

3. Questions for residents. Other residents may be the best source of information about what it's really like to live in a particular nursing home. If they seem alert, clean, happy and relaxed, that can be a good sign that this is a top-notch home.

4. Questions for other families. Talking to other families can also provide insight on what life is like inside the home and how your loved one will be cared for. If they've had a good experience, your family might too.

5. Questions you can answer yourself. After all these conversations, take a moment to review what you've learned and look around. Ask yourself some important questions about the facility and the people you meet there and asses your gut response.

n addition to speaking with as many people who are affiliated with the home as you can, you should also tour the buildings and grounds. Zamosky says that "when visiting a nursing home, first take in and assess the appearance of the living spaces and the residents you come in contact with."

Figuring out **how to pay for care** is also a key component of **finding the right place** for a loved one. Zamosky recommends asking about what insurance plans the home honors and whether your loved one's insurance plan covered nursing home care. "Many people are surprised to learn that **Medicare** generally does not pay for most nursing home care except for up to 100 days in a skilled nursing facility after a qualifying hospital stay of at least three days. For long-term care in a nursing facility, people either pay out-of-pocket or tap into **long-term care insurance** if they have that type of coverage."

Medicaid is the state-federal program that covers medical expenses for people with low incomes and will provide some financial assistance to people living in nursing homes. The catch is, the individual must first spend down all their assets before Medicaid kicks in. Not all homes accept Medicaid, so be sure to ask about financial arrangements before moving a loved one into a home.

For a list of questions that can help guide you through the series of interviews you should seek to conduct when **assessing whether a certain nursing home is right** for your loved one.

Best Nursing Homes

COMMON ROBOCALL SCHEME SPOOFS LOCAL NUMBERS

Spoofing is a form of robo-calling that is becoming alarmingly frequent, with many of us receiving these nuisance calls seemingly every day. Scammers use third-party technology to call your phone while showing a phone number that appears to be from your specific area code, hoping this will trick you into answering because it looks like a phone number you recognize.

It is easy to be duped by this tactic. Spoofed calls look like a regular phone call. They typically happen during the day and appear on your caller ID as though they are from someone you may know. People answer expecting a call from a doctor's office, pharmacy or a family friend and end up listening to a robocall instead.

The spoofed calls are generally for fraudulent activities, claiming you need to act on things like an outstanding tax bill, expiring auto warranty, or computer software update. The aim is to get you to provide the caller with personal information like a Social Security number, bank account or credit card number which can be snatched for identity theft.

Because scammers are spoofing local numbers, there's a chance one might even mimic your own phone number. If this happens, people may call and ask why you called them. Obviously, this can be confusing to both parties, so understanding that your number could be spoofed helps mitigate this awkward situation. So, what should you do if you suspect you're receiving a spoofed call? Here are a few tips.

Don't answer or return calls from phone numbers you don't recognize. Let the call go to voicemail instead, even if the number appears to be local.

Enter the number in an Internet search. This allows you to check if the number is listed as being from a legitimate company, or if the company has mention of a scam that is going on using their number. It also allows you to see what other people are saying about the number.

Familiarize yourself with call blocking options for your cellphone.

List your phone number on the National Do Not Call Registry. While this will not prevent unscrupulous callers from contacting you, it can help to limit the number of calls you receive.

If your number is on the registry and you receive unwanted calls, report them. This can help expose and catch callers who are engaging in fraud.

Unfortunately, it requires real diligence to stay ahead of phone scammers these days. But by staying alert and taking the right precautions, you can make sure that robocallers and call-spoofers don't prosper at your expense.

RI ARA HealthLink Wellness News

Stroke Death Rate Increasing for Middle-Aged Americans

(American Heart Association News) -- In more than half of all counties across the country, a growing percentage of middle-aged Americans are dying of strokes, according to a new study.

The study – which examined stroke mortality rates at the county level – reveals a statistical jump previously masked by national data showing a leveling off of stroke mortality rates following years of decline. The study was published Nov. 8 in the American Heart Association journal *Stroke*.

"Everyone needs to pay attention to this," said Eric Hall, lead author on the study and a Ph.D. student in the department of epidemiology at Emory University's Rollins School of Public Health in Atlanta.

"At the national level, we know that stroke mortality had been steadily declining for a few decades and started to stagnate around 2010. We took a look at those mortality rates at the county level and saw they were increasing in many counties. That this was happening among middle-aged groups was particularly surprising."

Nationally, stroke mortality rates – the number of stroke deaths per year divided by the number of people in a population – fell slightly, by 0.7%, each year from 2010 to 2016 for people ages 35-64. It fell 3.5% for those 65 and older.

But when researchers looked at the data on the county level, they found stroke death rates went up in 56.6% of counties during that time period for adults 35-64, with 1 in 4 counties actually experiencing a 10% or more increase. That was even as stroke mortality rates fell for adults 65 and older.

Overall, twice as many counties saw an increase in stroke deaths during that period for middle-aged people compared to older adults. Nearly half of middle-aged adults, or 60.2 million Americans, lived in counties for which stroke mortality rates went up.

The county-level increases don't mean national data are wrong, said Hall.

"National or state-level data show an average," he explained. "These data are important because they give high-level perspective on trends in disease. But they don't reflect changes or disparities occurring at the local level."

Another surprising finding, said Hall, was that increases in mortality rates occurred in counties across the country, including outside the traditional "stroke belt" of the Southeast, so named because of the prevalence of stroke and risk factors in the region.

Although the highest stroke mortality rates remain in the Southeast, most of the greatest increases for middle-aged adults were seen outside that area, the study shows.

The fact that stroke mortality is increasing in many counties outside the stroke belt suggests risk factors that have been typical to that region have broadened nationally, said Dr. Mitchell Elkind, head of the Division of Neurology Clinical Outcomes Research and Population Science at Columbia University in New York.

For example, the nationwide rise in obesity and type 2 diabetes over the past few decades could be having an impact now on the number of people dying from strokes across the country, he said.

"These conditions don't lead to stroke immediately," said Elkind, who was not involved in the new research. "What we are seeing now in terms of stroke may reflect what was going on 10 or 12 years ago."

He and Hall hope the information can give community organizations and health professionals the data they need to help tailor prevention programs.

"This will help them tailor resources and policies to their individual community health needs," Hall said.

High consumption of carbohydrates, processed foods and sugar-sweetened beverages combined with high levels of inactivity and "people addicted to their screens" contribute over time to greater obesity levels and the development of Type 2 diabetes, Elkind said.

"We need not just individual behavior changes but changes at the societal level," he said, "such as better urban design and more physical activity for kids in school, so they grow up with a different attitude towards physical activity."

Vaccination in Nursing Homes

EVERY FALL AND WINTER, the United States sees an uptick in the number of people who fall ill to influenza and other seasonal illnesses. This so-called **flu season** typically stretches from October to May, with spikes of activity between December and February.

The Centers for Disease Control and Prevention reports that between 12,000 and 79,000 people die of the flu each year. Influenza, or the flu, is caused by a viral infection. The people most at risk of developing potentially fatal complications of the flu are adults aged 65 and older. This is because the immune system tends to weaken with age, and **older adults are less able to fight off infections** naturally.

Pneumonia, an infection in the lungs, is another potentially deadly illness that sickens many people living every year. The CDC reports that in the U.S., pneumonia causes more than 250,000 people to seek care in a hospital and about 50,000 deaths. As with the flu, the risk of dying of pneumonia increases with age and frailty.

In response to this pattern, many health care providers and institutions launch campaigns beginning shortly after the back-to-school sales have ended to get more people vaccinated. This vaccination effort includes those living in nurisng homes. And for good reason – **flu and pneumonia are dangerous illnesses**. But they can be prevented or mitigated with widely available vaccines.

Infection Risk in Nursing Homes

For older adults living in **nursing homes,** the threat of flu and pneumonia is especially pronounced. “When we talk about the population of older adults who live in a nursing home, they are by definition frail. They are not healthy,” says Dr. Preeti Malani, professor of medicine at the University of Michigan Medical School and director of the University of Michigan/AARP **National Poll on Healthy Aging**, a recurring national survey looking at various aspects of health and aging in America…..**Read More**

Many Lung Cancer Patients Not Getting Recommended Treatment

Only two-thirds of lung cancer patients in the United States get the minimal recommended treatment, a new study finds.

And race and age appear to play a role in who gets the best care, the researchers said.

Black patients were only 78% as likely to receive the minimum care, compared with white patients, the findings showed. Meanwhile, those aged 80 and older were only 12% as likely to receive the minimum treatment, compared with those under 50.

"While these findings are very concerning, it has always been easier to identify disparities in care than it has been to understand why they persist," said study co-author Dr. Douglas Arenberg, a pulmonologist at the University of Michigan.

"There may be good reasons why less-intensive treatment is in fact medically appropriate," he said in an American Thoracic Society news release.

The findings are based on a review of nearly 442,000 lung cancer cases diagnosed between 2010 and 2014 in the U.S. National Cancer Database.

The researchers found that 62% of all the patients received treatment according to the guidelines, and nearly 22% received no treatment. The rest received treatment that was less intensive than recommended.

Patients with advanced non-small cell lung cancer were the least likely to get treatment that complied with the guidelines, the investigators found.

Treatment for lung cancer includes surgery, chemotherapy and radiation therapy. Depending on the type of lung cancer and its stage, the guidelines may recommend combinations of these therapies, the study authors explained. Treatment can extend both life and the quality of life.

The first step to ensure that everyone with lung cancer gets the best care is to identify those at risk for not getting that care, the researchers added.

The report was published online Nov. 1 in the *Annals of the American Thoracic Society*.

More information

For more on lung cancer, head to the **American Cancer Society**.

Is there a link between muscle mass and cardiovascular risk?

A new study has found a link between lower muscle mass and a higher risk of cardiovascular events — at least in males aged 45 and over. This association, the research indicates, is valid even for males with no history of heart disease.

A new study has found a link between lower muscle mass and a higher risk of cardiovascular events — at least in males aged 45 and over. This association, the research indicates, is valid even for males with no history of heart disease.

Share on PinterestMuscle mass loss is linked to a higher risk of cardiovascular problems in males aged 45 and over.

Some loss of skeletal muscle mass occurs naturally as people age. This process especially affects males.

In fact, research shows that after the age of 30, muscle mass tends to decrease by **3–5%** per decade in males.

People can prevent and minimize this loss by staying active. If they do not, it may contribute to poor health and well-being.

Some past studies have suggested that people with cardiovascular disease who experience higher loss of muscle mass also have a **higher risk of premature death.**

However, to date, little to no research has looked into the possible associations between muscle mass and cardiovascular risk in people without preexisting heart or circulatory problems

Now, specialists from the Centro de Investigación Biomédica en Red de Salud Mental in Madrid, Spain, the University of Canberra in Australia, and the University of Athens in Greece have conducted a study with the aim of filling in that research gap.

The new study — the results of which appear in the *Journal of Epidemiology & Community Health*, and whose first author is Stefanos Tyrovolas — has analyzed the data of a cohort of male participants aged 45 and over covering a follow-up period of 10 years….**Read More**

What are the effects of lowering blood pressure targets?

In 2017, the American Heart Association (AHA) lowered the threshold for what constitutes hypertension. However, what is the impact of this, and is implementing these new guidelines cost effective? Two new studies set out to investigate.

According to the AHA, around **103 million** adults in the United States have **high blood pressure**. They expect that this number will continue to rise.

Meanwhile, the Centers for Disease Control and Prevention (CDC) estimate that around **1,100Trusted Source** people die of a condition related to **hypertension** each day, including **heart disease** and **stroke**. These are some of the leading causes of death in the U.S.

The healthcare costs of hypertension are not negligible, either. The CDC suggest that hypertension results in almost $50 billion per year in costs, including the price of medications and missed days of work.

What are some of the measures that people with high blood pressure and healthcare professionals can take to prevent these adverse outcomes and increase lifespan? In 2017, the AHA recommended lowering **blood pressure** thresholds and treating people at risk more intensively.

Now, two new studies — both of which featured at the **AHA's Scientific Sessions 2019**, which takes place in Philadelphia, PA — have investigated the costs and benefits of treating hypertension more intensively, and of tailoring treatment according to degrees of cardiovascular risk.

These new guidelines lowered blood pressure thresholds to define hypertension as anything from 130/80 mm Hg to 140/90 mm Hg.

The new guidelines also recommend medication treatment for people with a blood pressure reading of 130/80 mm Hg to 139/89 mm Hg if they have a history of heart attack or stroke, or if they have a high 10 year risk of experiencing such an event….**Read More**

Many Older Americans Misuse Antibiotics: Poll

A new poll delivers good and bad news: Half of American seniors report taking antibiotics in the last two years, but many also say they have misused them.

As many as 1 in 5 say they take leftover antibiotics without checking with their doctor, and 2 in 5 expect doctors to prescribe them for viral conditions, which don't respond to antibiotics.

Even though 89% of older adults know that overuse of antibiotics may mean the drugs won't work in the future, they still overuse them, researchers found.

"We obviously have work to do to help older adults understand safe and appropriate use of these medications so that we can preserve the effectiveness of antibiotics for patients who need them most," said poll director Dr. Preeti Malani, from the University of Michigan.

These findings are based on responses to questions from the university's National Poll on Healthy Aging, released Nov. 4. The poll included more than 2,250 U.S. adults aged 50 to 80.

"These findings should be a reminder to physicians, nurses, pharmacists and other providers to step up their wise-prescribing practices and patient education," Malani said in a Michigan news release.

The researchers also found that:

- One in 8 had leftover pills, even though a course of antibiotics for an illness is supposed to be finished completely.
- Although 56% said that doctors overprescribe antibiotics, 23% said they didn't prescribe them when they should.

Overprescribing antibiotics has led to a significant increase in bacteria that are resistant to antibiotics.

"It's important to remember that antibiotics don't treat viruses like colds and flu, and shouldn't be prescribed unless necessary," said Alison Bryant, senior vice president of research for AARP, which helped fund the poll. "If you want to avoid getting the flu, be sure to wash your hands regularly, stay home if you feel sick and get an annual flu shot."

More information

Are you misusing antibiotics? Find out more from the **Mayo Clinic**.

Common Muscle Relaxant Could Pose Mental Dangers for Seniors

A commonly prescribed muscle relaxant known as baclofen can leave older kidney patients so disoriented that they land in the hospital, a new study warns.

"It can present with acute stroke-like symptoms, even though it's not a stroke," said senior researcher Dr. Amit Garg, a professor of nephrology at Western University in Ontario, Canada. "It can present with dementia-like symptoms."

About 1 in 25 people with low kidney function prescribed high doses of baclofen wound up being admitted to a hospital for severe confusion, according to a study of nearly 16,000 older Canadians with chronic kidney disease.

By comparison, only one in 500 kidney patients not prescribed baclofen wound up hospitalized for confusion.

"There was a pretty marked difference in risk," Garg said, noting that these findings "highlight a potential risk associated with these drugs that hasn't been fully appreciated."

Other seniors might also face this risk, since kidney function often declines as people grow older, he added.

Baclofen is typically prescribed to people suffering muscle spasms, Garg said. Doctors hand out more than 8 million prescriptions of baclofen every year. It's sold under a number of different brand names, including Lioresal, Gablofen and Kemstro.

The drug leaves the body when the kidneys filter it out of a person's blood, Garg explained.

"If someone's kidney function isn't working very well, that means the drug is accumulating in the system," he said.

Garg and other doctors had started noticing that kidney patients on baclofen sometimes became disoriented and dazed.

For example, nephrologist Dr. Holly Koncicki remembers some dialysis patients showing up with noticeably clouded mental capacity.

"Of those I can remember, they often presented with confusion or being very sleepy and lethargic," said Koncicki, of the Icahn School of Medicine at Mount Sinai, in New York City.

In the Canadian study, Garg and his colleagues combed the medical literature and found 30 prior case reports linking baclofen to hitches in brain function, so they decided to more closely study this potential problem.

The researchers pulled health data on nearly 16,000 older Ontario residents with chronic kidney disease who had been prescribed baclofen between 2007 and 2018.

The investigators compared those patients' hospitalizations for mental conditions against those from a group of almost 300,000 kidney patients who'd not been prescribed the drug.

Patients were at greatest risk of hospitalization for confusion if their kidney function was very impaired -- 30% or less -- and they had been prescribed a high dose of baclofen, more than 20 milligrams (mg) per day.

But even patients with kidney function as high as 60% had an increased risk of confusion when prescribed high doses of baclofen, the findings showed. About 1 in 5 older adults live with kidney function of less than 60%.

Kidney patients prescribed baclofen at 20 mg/day or higher had nearly 20 times the relative risk of being hospitalized for an altered mental state, compared with patients not taking the drug, the researchers found.

Doses lower than 20 mg/day were associated with a nearly sixfold increase in kidney patients' risk of hospitalization.

The results were published online Nov. 9 in the *Journal of the American Medical Association*, to coincide with a planned presentation at the American Society of Nephrology annual meeting, in Washington, D.C.

Koncicki, who was not involved with the study, said, "In our older patients with impaired kidney function, there should be cautious use of this medication."...**Read More**