Rhode Island Alliance for Retired Americans ©
All Rights Reserved
© RI ARA 2020

RI ARA

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

October 4, 2020 E-Newsletter

Publication 2020 Issue 40
Published in house by the RI ARA

Trump's New Health Care Plan: An Ineffective Executive Order and a Miniscule Bribe

White House officials announced on Thursday that President **Trump** is set to sign an Executive Order "aimed at helping Americans with pre-existing conditions with their healthcare coverage."

Immediately after the Executive Order was announced, the Secretary of Health and Human Services, **Alex Azar**, confirmed that it carries no legal weight and would not protect anyone with pre-existing health conditions from higher insurance prices if the Affordable Care Act (ACA) is struck down by the Supreme Court later this year.

The president also said that 33 million Medicare beneficiaries will receive a one-time card in the mail worth $200 to help pay for prescription drugs -- a paltry amount considering the average senior spends more than $5,000 out of pocket every year on health care.

"President Trump's latest proposal to confuse the situation with a small bribe to seniors is an inferior plan that does not even come close to matching the benefits of the Affordable Care Act that he is dead set on repealing. The Executive Order is not worth the paper it's printed on. Seniors won't be fooled," said **Richard Fiesta**, Executive Director of the Alliance.

"We have a law to cover pre-existing conditions, and it is the ACA. The House of Representatives in December, 2019 passed a bill, H.R. 3, that would lower skyrocketing drug prices by requiring Medicare to negotiate drug prices on the 250 highest priced drugs, including insulin, and use the savings to expand Medicare coverage to include hearing, dental and vision," Fiesta added.

Rich Fiesta, Executive Director, ARA

President Roach Testifies at House "Save Our Social Security Now" Hearing

President Roach **delivered testimony** during a House Ways and Means Social Security Subcommittee Thursday, highlighting the detrimental impact of the President's executive action on the Social Security payroll tax.

According to the Social Security actuary, if the Social Security payroll taxes were permanently terminated, the Disability Insurance (DI) Trust Fund would no longer be able to pay benefits in 2021, and the Old Age and Survivors Trust Fund would follow in 2023.

President Roach noted that the Executive Action will not help retirees, the more than 30 million unemployed Americans, or even workers, who will need to pay double the payroll contributions next year.

"I urge Congress to pass Congressman **John Larson's** bills, H.J.Res. 94, a resolution of disapproval of President Trump's executive action, and H.R. 8171, which bars the Treasury Department from implementing the deferral of payroll contributions," said President Roach.

He added that seniors are already bearing the brunt of the COVID-19 pandemic, with 80% of deaths occurring in Americans 65 and over, and should not lose the Social Security benefits they earned over a lifetime.

Robert Roach, Jr
President, ARA

Trump Declines to Say How Much He Has Paid in Federal Income Taxes

President Trump declined to say how much he has paid in federal income taxes after a new report alleged that he paid $750 a year in 2016 and 2017, and no income taxes in 10 of the previous 15 years.

"I paid tax," Mr. Trump said at the White House on Sunday, without providing specifics.

Mr. Trump disputed a report earlier in the day by the New York Times, which attributed its findings to more than two decades of his tax return data. Asked to give the American people an idea of how much he has paid, he said, "I've paid a lot, and I've paid a lot of state income taxes, too."

During the 2016 campaign, Mr. Trump repeatedly promised to release his tax returns but didn't, breaking a 40-year tradition of major-party presidential candidates and presidents doing so.

Mr. Trump isn't required by law to release his tax returns publicly, though no law prevents him from releasing them. He has cited continuing Internal Revenue Service audits as a reason not to disclose his returns. During the campaign, his tax lawyers said he was still under audit for the tax years dating back to 2009. Mr. Trump has repeatedly declined to release specifics about his taxes. Democrats say the president's tax returns could shed light on conflicts of interest and the president's compliance with tax law, and have sued for access to the records. New York prosecutors are also seeking Mr. Trump's returns as part of a probe into possible bank or insurance fraud.

Mr. Trump paid little to no taxes largely because he reported losing more money than he made in those years, the Times reported.

Between 2010 and 2018, Mr. Trump wrote off some $26 million in consulting fees as a business expense across nearly all of his projects, according to the report, with no detail on the fees.

Some of those fees matched payments that Ivanka Trump, the president's eldest daughter, reported on financial disclosures when she joined the White House staff….**Read More**

ADD YOUR NAME

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

Promises Kept? On Health Care, Trump's Claims of 'Monumental Steps' Don't Add Up

When it comes to health care, President Donald Trump has promised far more than he has delivered. But that doesn't mean his administration has had no impact on health issues — including the operation of the Affordable Care Act, prescription drug prices and women's access to reproductive health services.

In a last-ditch effort to raise his approval rating on an issue on which he trails Democrat Joe Biden in most polls, Trump on Thursday unveiled his "**America First Healthcare Plan**," which includes a number of promises with no details and pumps some minor achievements into what the administration calls "monumental steps to improve the efficiency and quality of healthcare in the United States."

As the election nears, here is a brief breakdown of what Trump has done — and has not done — on some key health issues.

Affordable Care Act

Trump has not managed to repeal and replace the Affordable Care Act, despite his claims that the law is dead.

But his administration, and Republicans in Congress, have made changes to weaken the law while not dramatically affecting enrollment in marketplace plans.

Congress failed to rewrite the law in summer 2017, but Republicans who controlled both the House and Senate at the time included in their year-end tax cut bill a provision that reduced the penalty for failing to have health insurance to zero. That change eliminated what was by far the most unpopular provision of the law.

t also sparked a lawsuit by Republican state attorneys general and governors arguing that the tax change undercuts the law and thus should invalidate it. The case is set to be heard by the Supreme Court the week after the Nov. 3 election. The Trump administration is formally supporting the GOP plaintiffs in that suit.

The administration also used executive and regulatory action to chip away at the law's efficacy. Trump ended disputed cost-sharing subsidies to help insurers lower out-of-pocket costs for policyholders with low incomes. And the administration shortened the open enrollment period by half and slashed the budget for promoting the plans and paying people to help others navigate the often-confusing process of signing up.

Administration officials have complained that plans sold on the ACA marketplaces are not affordable, so they set new rules that allowed companies to sell competing "short-term" policies that were less expensive than ACA-sanctioned plans. But those plans are not required to provide comprehensive benefits or cover preexisting conditions.

Now, weeks before the election, federal officials are taking credit for premiums coming down, slightly, on ACA plans. "Premiums have gone down across all of our programs, including in healthcare.gov, which had been previously seeing double-digit rate increases," Seema Verma, who runs Medicare, Medicaid and the ACA exchanges, told reporters in a Sept. 24 conference call.

Premiums have come down this past year, confirmed Sabrina Corlette, who tracks the ACA as co-director of the Center on Health Insurance Reforms at Georgetown University, but only after many of the Trump administration's changes had driven them even higher. Insurers were spooked by the uncertainty — particularly in 2017, about whether the law would be repealed — and Trump's cutoff of federal funding for subsidies. "The bottom line is, rates have gone up under Trump," Corlette said.

Women's Reproductive Health

Before he was elected, Trump **pledged his allegiance to anti-abortion activists**, who in turn urged their supporters to vote for him. But unlike many previous GOP presidents who called themselves "pro-life" but pushed the issue to the back burner, Trump has delivered on many of his promises to abortion foes.

Foremost, Trump has nominated two justices to the Supreme Court who were supported by anti-abortion advocates. With the help of the GOP Senate, Trump has also placed 200 conservative judges on federal district and appeals courts….**Read More**

Trump's Executive Order on Preexisting Conditions Lacks Teeth, Experts Say

Protecting people with preexisting medical conditions is an issue that has followed President Donald Trump his entire first term. Now, Trump has signed an executive order that he says locks in coverage regardless of anyone's health history. "Any health care reform legislation that comes to my desk from Congress must protect the preexisting conditions or I won't sign it," Trump said at a **Sept. 24** signing event.

With the executive order, Trump said, "This is affirmed, signed and done, so we can put that to rest."

Health law and health policy experts say Trump has put nothing to rest.

Here's why.

The **core text of the order** is brief.

"It has been and will continue to be the policy of the United States to give Americans seeking healthcare more choice, lower costs, and better care and to ensure that Americans with pre-existing conditions can obtain the insurance of their choice at affordable rates."

Joe Antos with the American Enterprise Institute, a market-oriented think tank, said the order "has no technical content."

"All it really is, is a statement that he wants one or more of his departments to come up with a plan. And he doesn't give any guidance or the vaguest outline of what that plan should be."

It takes more than a bill title to actually deliver guaranteed coverage. A Republican measure in the Senate is a good example. It's called the Protect Act, but it has **loopholes** that would allow insurance companies to drop coverage of certain expensive diseases from all their policies.

So far, Republican proposals **have not matched** what the Affordable Care Act already provides. And University of Pennsylvania law professor Allison Hoffman said Trump's executive order doesn't change that.

"The language itself guarantees nothing near the protections in the Affordable Care Act, and such sweeping protections are only possible by congressional action, not regulation," Hoffman said.

Trump and other Republicans on the campaign trail have faced repeated questioning about what will happen if the U.S. Supreme Court invalidates the Affordable Care Act. The White House is strongly behind a legal case to declare it unconstitutional. Oral arguments before the court are scheduled for **Nov. 10**.

Indiana University health law professor David Gamage said the executive order is no stopgap should the White House win that argument.

"Were the court to hold the Affordable Care Act unconstitutional, the executive order would still do nothing, because it has no enforcement power," Gamage said.

Larry Levitt, head of health policy at KFF, a widely used source of neutral health care data, **called Trump's order** "a pinky promise to protect people with preexisting conditions." **...Read More**

Legislation Introduced to Forgive Deferred Payroll Taxes

Rep. Kevin Brady (R-Texas), the top Republican on the House Ways and Means Committee, has introduced legislation that would make the deferral of payroll taxes from Sept. 1 through the end of the year permanent. His legislation calls it a "Payroll Tax Holiday" but whatever it is called, it would result in an extremely serious threat to the Social Security program.

As we've reported in the past, an analysis by the Social Security Administration on the viability of Social Security if the President's payroll tax deferral is made permanent said in part, the " DI [Disability Insurance] Trust Fund asset reserves would become permanently depleted in about the middle of calendar year 2021, with no ability to pay DI benefits thereafter. We estimate that OASI[Old Age and Survivors' Insurance] Trust Fund reserves would become permanently depleted by the middle of calendar year 2023, with no ability to pay OASI benefits thereafter."

Brady's legislation would make up for any shortfall in the Social Security Trust Funds by transferring funds from the general treasury. However, replacing a dedicated payroll tax with income taxes or other general fund revenues would fundamentally alter Social Security. Its status as a social insurance program, funded by a dedicated tax (or contribution), would be muddled at best. Instead of operating as a guaranteed entitlement supported by that dedicated tax, it would be subject to annual meddling by Congress.

Congress is already unable to finish the work it has on its plate without adding on something as critically important to the seniors of this country as Social Security.

TSCL is opposed to the Brady legislation or any legislation that would permanently forgive the payroll taxes now being deferred because of the President's order. We are glad to see that very few companies and even large parts of the federal government are refusing to implement the payroll tax deferral.

As a final note, last week we reported that the President's payroll tax deferral order was not being widely followed. Since that report, both the Senate and the Supreme Court have joined the House of Representatives in declining to implement the program.

Without Ginsburg, Judicial Threats to the ACA, Reproductive Rights Heighten

On Feb. 27, 2018, I got an email from the Heritage Foundation, alerting me to a news conference that afternoon held by Republican attorneys general of Texas and other states. It was referred to only as a "discussion about the Affordable Care Act lawsuit."

I sent the following note to my editor: "I'm off to the Hill anyway. I could stop by this. You never know what it might morph into."

Few people took that case very seriously — barely a handful of reporters attended the news conference. But it has now "morphed into" the latest existential threat against the Affordable Care Act, scheduled for oral arguments at the Supreme Court a week after the general election in November. And with the death of Justice Ruth Bader Ginsburg on Friday, that case could well morph into the threat that brings down the law in its entirety.

Democrats are raising alarms about the future of the law without Ginsburg. House Speaker Nancy Pelosi, speaking on ABC's "This Week" Sunday morning, said that part of the strategy by President Donald Trump and Senate Republicans to quickly fill her seat was to help undermine the ACA.

"The president is rushing to make some kind of a decision because … Nov. 10 is when the arguments begin on the Affordable Care Act," she said. "He doesn't want to crush the virus. He wants to crush the Affordable Care Act."

Ginsburg's death throws an already chaotic general election campaign during a pandemic into more turmoil. But in the longer term, her absence from the bench could accelerate a trend underway to get cases to the Supreme Court toward invalidating the ACA and rolling back reproductive freedoms for women.

Let's take them one at a time.

The ACA Under Fire — Again

The GOP attorneys general argued in February 2018 that the Republican-sponsored tax cut bill Congress passed two months earlier had rendered the ACA unconstitutional by reducing to zero the ACA's penalty for not having insurance. They based their argument on Chief Justice John Roberts' 2012 **conclusion that the ACA was valid**, interpreting that penalty as a constitutionally appropriate tax.

Most legal scholars, including several who challenged the law before the Supreme Court in 2012 and again in 2015, find the argument that the entire law should fall to be unconvincing. "If courts invalidate an entire law merely because Congress eliminates or revises one part, as happened here, that may well inhibit necessary reform of federal legislation in the future by turning it into an 'all or nothing' proposition," wrote a group of conservative and liberal law professors in a **brief filed in the case.**

Still, in **December 2018**, U.S. District Judge Reed O'Connor in Texas accepted the GOP argument and declared the law unconstitutional. In **December 2019**, a three-judge 5th Circuit appeals court panel in New Orleans agreed that without the penalty the requirement to buy insurance is unconstitutional. But it sent the case back to O'Connor to suggest that perhaps the entire law need not fall.

Not wanting to wait the months or years that reconsideration would take, Democratic attorneys general defending the ACA asked the Supreme Court to hear the case this year. (Democrats are defending the law in court because the **Trump administration** decided to support the GOP attorneys general's case.) The court agreed to take the case but scheduled arguments for the week after the November election.

While the fate of the ACA was and is a live political issue, few legal observers were terribly worried about the legal outcome of the case now known as *Texas v. California*, if only because the case seemed much weaker than the 2012 and 2015 cases in which Roberts joined the court's four liberals. In the 2015 case, which challenged the validity of federal tax subsidies helping millions of Americans buy health insurance on the ACA's marketplaces, both Roberts and now-retired Justice Anthony Kennedy voted to uphold the law.

But without Ginsburg, the case could wind up in a 4-4 tie, even if Roberts supports the law's constitutionality. That could let the lower-court ruling stand, although it would not be binding on other courts outside of the 5th Circuit. The court could also put off the arguments or, if the Republican Senate replaces Ginsburg with another conservative justice before arguments are heard, although it would not be binding on other courts outside of the 5th Circuit.

The court could also put off the arguments or, if the Republican Senate replaces Ginsburg with another conservative justice before arguments are heard, Republicans could secure a 5-4 ruling against the law….**Read More**

Congress can control hospital rates or allow them to soar

Because most hospitals have **monopoly pricing power**, private insurers are now paying on average 2.5 times more for hospital care than Medicare. Private health insurers have no way to rein in prices. Congress can control these costs, as it does for **traditional Medicare**, or it can allow them to soar.

Traditional Medicare uses the leverage of the federal government to rein in prices, as it always has. Right now, **Medicare Advantage plans,** private plans that offer Medicare benefits, have been able to piggyback off those prices to keep their costs lower than private insurers catering to working people. If Congress doesn't act swiftly, hospital rates, much like pharmaceutical prices, will likely continue to rise.

According to a **new study by RAND**, people with private health insurance paid an average of 247 percent more than people with Medicare for their hospital care in 2018. (Some states had private rates that were twice Medicare rates or less, including Rhode Island, Michigan and Arkansas.) Today, people are likely paying even more. If the private insurers had been paying Medicare rates over the three years between 2015 and 2018, they would have saved almost $20 billion.

Congressional legislation allowing people to join an expanded Medicare program, if done right, would let everyone benefit from lower rates. The question is whether Congress will enact such legislation or whether most members are in the pocket of the hospital industry and will not be willing to rein in hospital rates.

The RAND analysis finds that hospital rates are increasing at 5.1 percent a year. RAND looked at data from more than 3,000 hospitals, including $33.8 billion in claims over three years. The American Hospital Association, not surprisingly, is questioning the analysis and any data that supports reining in hospital prices.

RAND also looked at the price paid by private health insurers for hospital outpatient services as compared with Medicare prices. RAND found that private insurers paid 267 percent of Medicare for the same services, on average. In Florida, South Carolina, Tennessee and West Virginia, private insurers paid more than three times what Medicare paid for these services –325 percent.

RAND did not see any correlation between Medicare rates and private insurer rates. In other words, it did not appear that providers charged private insurers more to make up for the lower Medicare rates when they saw more Medicare patients. RAND found that hospital consolidation was the driving force behind the higher commercial rates.

Also, RAND did not see a correlation between higher rates and better quality providers. There were high quality providers with commercial rates close to Medicare rates.

RAND did not think **burdening patients** with finding lower-cost inpatient and outpatient care was much of a solution to bringing down prices. Among other things, only 43 percent of care is elective.

Trump promotes health care 'vision' but gaps remain

CHARLOTTE, N.C. (AP) — More than three-and-a-half years into his presidency and 40 days from an election, President Donald Trump on Thursday launched what aides termed a "vision" for health care heavy on unfulfilled aspirations.

"This is affirmed, signed, and done, so we can put that to rest," Trump said. He signed an executive order on a range of issues, including protecting people with preexisting medical conditions from insurance discrimination.

But that right is already guaranteed in the Obama-era health law his administration is asking the Supreme Court to overturn.

House Speaker Nancy Pelosi dismissively said Trump's "bogus executive order on pre-existing conditions isn't worth the paper it's signed on." Democrats are betting heavily that they have the edge on health care this election season.

Trump spoke at an airport hangar in swing-state North Carolina to a crowd that included white-coated, mask-wearing health care workers. He stood on a podium in front of a blue background emblazoned with "America First Healthcare Plan." His latest health care pitch won accolades from administration officials and political supporters but failed to impress others.

"Executive orders issued close to elections are not the same thing as actual policies," said Katherine Hempstead, a senior policy adviser with the nonpartisan Robert Wood Johnson Foundation, which works on a range of health care issues, from coverage to quality.

Trump's speech served up a clear political attack, as he accused Democrats of wanting to unleash a "socialist nightmare" on the U.S. health care system, complete with rationing. But Democratic nominee Joe Biden has rejected calls from his party's left for a government-run plan for all. Instead, the former vice president wants to expand the Affordable Care Act, and add a new public program as an option.

Trump returned to health care amid disapproval of his administration's handling of the coronavirus pandemic and growing uncertainty about the future of the Obama-era law.

In a rambling speech, he promised quality health care at affordable prices, lower prescription drug costs, more consumer choice and greater transparency. His executive order would also to try to end surprise medical bills.

"'If we win we will have a better and less expensive plan that will always protect individuals with preexisting conditions," Trump declared.

But while his administration has made some progress on its health care goals, the sweeping changes Trump promised as a candidate in 2016 have eluded him.

The clock has all but run out in Congress for major legislation on lowering drug costs or ending surprise bills, much less replacing the Affordable Care Act, or "Obamacare."

Pre-election bill signing ceremonies on prescription drugs and surprise medical charges were once seen as achievable — if challenging — goals for the president. No longer.

Trump's speech Thursday conflated some of his administration's achievements with policies that are in stages of implementation and ones that remain aspirational.

Democrats are warning Trump would turn back the clock if given another four years in the White House, and they're promising coverage for all and lower drug prices.

Health and Human Services Secretary Alex Azar said Trump's executive order would declare it the policy of the U.S. government to protect people with preexisting conditions, even if the ACA is declared unconstitutional. However, such protections are already the law, and Trump would have to go to Congress to cement a new policy.

On surprise billing, Azar said the president's order will direct him to work with Congress on legislation, and if there's no progress, move ahead with regulatory action...**Read More**

Could Walmart be where you go for health care?

Until Congress steps in to regulate our health care system effectively, it appears that **corporations** are going to take advantage of the great potential revenue in the health care sector, even if they have little experience delivering care. Last year, Walmart opened a health superstore in Dallas, Georgia, strange as that might seem. Now, **Health Care Dive** reports that Walmart is planning to open Walmart Health superstores around the country.

Walmart is investing millions to deliver health care. The superstores are expected to provide urgent care, dental care, therapy, and diagnostic services as well as primary care services. Pricing is intended to be affordable and significantly less than what **CVS Health** charges. But, prices are not set yet, and there is likely to be variability.

Right now, in Georgia, an adult primary care visit is $40. An adult dental checkup is $50. And, an eye appointment is $45. The store charges $1 a minute for therapy services.

Visits to Walmart Health in Georgia are for primary care about half the time and specialty care the other half. People who come for primary care often then continue to come for chronic care management.

The value of health superstores to Walmart extends beyond the revenue from delivering health care services. As a result of offering these services, Walmart has found that it fills more prescriptions and gets additional sales.

At the moment, there are six Walmart Health venues. There are five in Georgia. And, there is one in Arkansas. Before the year is out, there will be seven more Walmart Health locations in Georgia and two in the Chicago metropolitan area.

In the first months of 2021, Jacksonville, Florida will see seven Walmart Health superstores. And, Walmart Health superstores will sprout up soon in Orlando and Tampa. Next up for Walmart, health insurance policies.

Meanwhile, CVS and Walgreens are also hoping to provide more health care services and build their patient base. CVS plans to grow from 275 HealthHUBs to 1,775 HealthHUBs by the end of 2021. It also has 1,100 walk-in MinuteClinics. Walgreens is putting $1 billion towards installing doctor's offices in 500 -700 retail stores over the next five years. These stores will have doctors on hand to provide patients primary care.

'The Drug Became His Friend': Pandemic Drives Hike in Opioid Deaths

BARRE, Vermont — On the first Friday in June, Jefrey Cameron, 29, left his home around midnight to buy heroin. He had been struggling with addiction for seven years but had seemingly turned a corner, holding down a job that he loved at Basil's Pizzeria, driving his teenage sister to the mall to go shopping and sharing a home with his grandmother. But then the coronavirus pandemic hit.

When he returned home that night and tried the product, it was so potent that he fell and hit his head in the bathroom. Mr. Cameron texted a friend soon after, saying that he had messed up and would go to a 12-step meeting with a friend that weekend.

"I promise I'm good and I can't get in any more trouble tonight," he wrote. "Sweet dreams, if you wake up before you hear from me definitely call me. The sooner I get up and into town the better." When Mr. Cameron woke up, he used the rest of the powder — largely fentanyl, not heroin, his family would later learn — from a small bag with a bunny stamped on it. Less than five hours after he sent the text, his grandmother found him dead.

In the six months since Covid-19 brought the nation to a standstill, the opioid epidemic has taken a sharp turn for the worse. More than 40 states have recorded increases in opioid-related deaths since the pandemic began, according to the American Medical Association. In Arkansas, the use of Narcan, an overdose-reversing drug, has tripled. Jacksonville, Fla., has seen a 40 percent increase in overdose-related calls. In March alone, York County in Pennsylvania recorded three times more overdose deaths than normal.

For Mr. Cameron, the shutdown of daily life in the spring not only led him back to drugs, but led him to use alone — an especially dangerous proposition.

"Usually he would use with somebody, especially if it's a different dealer or different batch," said his mother, Tara Reil. "I don't think he had that person to use with, to have that safety net."

Mr. Cameron lived in East Barre, a tiny town about 20 minutes outside of the state capital, Montpelier. He drove a red Subaru Legacy, had a pet snake named Lucy and was passionate about making food for others. For two days after he died, the pizza shop he worked for closed its doors; now his pictures plaster the windows and customers can buy car decals, T-shirts and bracelets made in his memory.

When Vermont shut down in March, so did Mr. Cameron's job, which provided his biggest support network. He was lonely and had money to spare: the $600 per week he received in extra unemployment benefits from the federal government was more than he earned from his job.

"Jefrey hated being alone. And the last couple of weeks, he was," said Ms. Reil, who is 47. His grandmother had gone to Atlanta to visit her other children and had delayed flying home for fear of catching Covid-19. In her absence, Mr. Cameron started keeping the television tuned to her favorite channel, blaring Western movies and "Bonanza" reruns.

"He was home alone a lot more," Ms. Reil said. "And I think the drug became his friend."

Mr. Cameron had stopped taking Suboxone, a medication that helps suppress the cravings and withdrawal symptoms that plague people addicted to opioids, last fall; it has been found to sharply reduce the risk of dying from an overdose, but he had grown tired of taking it after three years, his mother said.

Opioid addiction has been a scourge in Vermont for more than two decades. When dealers and illegal drug organizations realized they could charge more for narcotics here than they could in nearby cities such as Boston, New York or Montreal, the market was flooded. As the painkillers that many young Vermonters became addicted to in the early 2000s grew harder to get starting about a decade ago, heroin moved in. Then came fentanyl, which is far more potent and has driven up deaths in almost every corner of the country.

Last year, after aggressive efforts to expand access to treatment, Vermont saw its first **decrease in opioid-related deaths** since 2014; that year, then-Gov. Peter Shumlin **devoted** his entire State of the State Message to what he called "a full-blown heroin crisis" gripping Vermont. But Vermont saw **82 opioid overdoses** through July of this year, up from 60 during the same period last year….**Read More**

The Medicare Advantage scam and beyond

Kay Tillow writes for **Daily Kos** about the "Medicare Advantage scam" and beyond. She explains that these for-profit health plans that deliver Medicare benefits are using stars like Joe Namath to mislead people into signing up for coverage that very well might not meet their needs if they get sick or need a lot of costly care. Medicare Advantage plans, in fact, could keep them from accessing critical care.

What Namath does not tell you is that if you choose the wrong Medicare Advantage plan, you might face inappropriate denials of care, along with other administrative and financial barriers to care. Indeed, new research finds that the wrong choice of Medicare Advantage plan **might literally kill you**. That's what Yale economics professor Jason Abaluck found when analyzing data about these corporate health plans. But, the plans won't let you have access to their mortality data, and Congress is not requiring them to give you access.

Instead, the Centers for Medicare and Medicaid Services ("CMS") is allowing Medicare Advantage plans to send you to "the Medicare Coverage Helpline." And, while you might think that it is a government, independent agency, it is in fact a corporate marketing agency, designed to seduce you into giving up your public health insurance under traditional Medicare and to sign up for a private insurance Medicare Advantage plan.

No question that you take a big gamble when you sign up with a **Medicare Advantage plan**. If you're lucky and are healthy, you can save money because you won't need to buy **supplemental coverage**, as most people need to do in traditional Medicare. But, if you get sick, you might find that you can't see the doctors you want to see, your plan **refuses to pre-authorize procedures** your doctors say you need and, if you get care, the copays and deductibles add up to thousands of dollars….**Read More**

Small non-profit helps lower price of some ineffective drugs

Caroline Humer reports for **Reuters** on the value of the Institute for Clinical and Economic Review (ICER) in holding drug prices down. ICER is a small not-for-profit research organization that determines the value of particular drugs and what they should cost. ICER has been effective at helping to lower the price of some prescription drugs.

Most other wealthy countries partner with independent research organizations like ICER to set prices for virtually all prescription drugs. The US government does not have its own agency or a partnership with an independent agency that determines the value of drugs. In this research vacuum, ICER has developed influence.

For example, some people thought that Gilead could charge as much as $10,000 for **remdesivir** because it was found to be helpful in treating COVID-19 patients. But ICER said that the drug did not justify a price of more than $5,000. Gilead ended up charging $5,700 for a ten-day supply.

ICER's budget is not large enough to establish the value of all drugs or even most drugs. But, some say it has helped reduce the cost of almost 100 drugs. And, some health insurers keep off of their formularies certain drugs that ICER deems do not offer good value.

Drugs that ICER has determined cost way too much and are not cost-effective include Aubagio, for the treatment of multiple sclerosis, Ninlaro, for the treatment of multiple myeloma, Austedo, for the treatment of Huntington's disease, and Rebif, an anti-inflammatory for the treatment of multiple sclerosis.

Not surprisingly, the pharmaceutical industry is not accepting ICER's influence, which is reducing its profits. It is attacking the non-profit **any way it can**. Often, it relies on **non-profits that are funded by pharmaceutical companies** to attack ICER.

ICER's goal is simply to help insurers and other prescription drug purchasers choose drugs that are cost-effective for a given condition, assessing the drug's price and benefit to quality of life. To establish the fair value of a drug, it relies on a time-tested formula, QALY or quality-adjusted life year, what it costs to extend someone's life with one year of good health. That is what other countries' health systems do.

The federal government does not negotiate drug prices for Medicare or Medicaid. In fact, Congress forbade the federal government from using QALY to negotiate drug prices. ICER has been taking on that role, in a way.

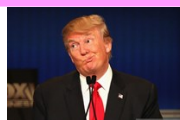
Unfortunately, the pharmaceutical industry holds so much sway over pharmacies and other health care providers that CVS Health Corp was not successful at keeping drugs, which ICER has determined are not cost effective, off its formulary for employers.

ICER plans to look at prices for the novel coronavirus vaccine and COVID- 19 treatments with the goal of helping to ensure they are fair.

The Mask Hypocrisy: How COVID Memos Contradict the White House's Public Face

While the president and vice president forgo masks at rallies, the White House is quietly encouraging governors to implement mask mandates and, for some, enforce them with fines.

In reports issued to governors on Sept. 20, the White House Coronavirus Task Force recommended statewide mask mandates in Iowa, Missouri and Oklahoma. The weekly memos, some of which have been made public by the **Center for Public Integrity**, advocate mask usage for other states and have even encouraged doling out fines in Alaska, Idaho and, recently, Montana.



Masks, a political flashpoint since the beginning of the coronavirus pandemic, are considered by public health officials to be a top safeguard against spreading the COVID-19 virus as the country awaits a vaccine. But the president's own **actions on masks** have wavered: He has called them "patriotic" but often doesn't wear one himself and has contradicted the advice of the Centers for Disease Control and Prevention director. During the presidential debate Tuesday, the president said masks were "OK" and then mocked Democratic presidential candidate Joe Biden's mask-wearing habits. In the audience, some **Trump family members and staffers were not wearing masks**, despite the rules set by the Cleveland Clinic, which hosted the debate.

The mixed messages and ensuing confusion leave governors, and often state and local health officials, holding the bag of political consequences….**Read More**

How should I choose a Medicare Advantage Plan?

Dear Marci,
I have had Original Medicare for a few years. I'm considering enrolling in a Medicare Advantage Plan during Fall Open Enrollment this year. What should I consider when I'm looking at Medicare Advantage Plans?
-Reva (Detroit, MI)

Dear Reva,

Fall Open Enrollment runs from October 15 through December 7 each year. During this time, you can make changes to your health insurance coverage, including adding, dropping, or changing your Medicare coverage. Even if you are happy with your current health and drug coverage, Fall Open Enrollment is the time to review what you have, compare it with other options, and make sure that your current coverage still meets your needs for the coming year.

Ask yourself the following questions before choosing a **Medicare Advantage Plan:**

- How much are the premium, deductible, and coinsurance/copay amounts?
- What is the annual maximum out-of-pocket cost for the plan? This amount may be high, but can help protect you if you have expensive health care costs.
- What service area does the plan cover?
- Are my doctors and hospitals in the plan's network?
- What are the rules I have to follow to access health care services and my drugs?
- Does the plan cover additional health care benefits that are not covered by Original Medicare?
- How will this plan affect any additional coverage I may have?

What is the plan's star rating?

Medicare Advantage Plans usually include prescription drug coverage. You should also consider these questions when choosing a Medicare Advantage Plan to make sure that the prescription drug coverage that the plan offers meets your needs:

- Does the plan cover all the medications I take?
- Does the plan have restrictions on my drugs (i.e. prior authorization, step therapy, or quantity limits?)
- Prior authorization means that you must get approval from your Part D plan before the plan will pay for the drug.
- Step therapy means that your plan requires you to try a cheaper version of your drug before it will cover the more expensive one.
- Quantity limits restrict the quantity of a drug you can get per prescription fill, such as 30 pills of Drug X per month.
- How much will I pay for monthly premiums and the annual deductible?
- How much will I pay at the pharmacy (copay/ coinsurance) for each drug I take?
- Is my pharmacy in the plan's preferred network? You pay the least if you used preferred network pharmacies.
- Can I fill my prescriptions by mail order?
- If I have retiree coverage, will the Medicare drug plan work with this coverage?

What is the plan's star rating?

You may find it helpful to use Medicare's Plan Finder tool, which gives you a list of Medicare Advantage and Part D plans, the drugs they cover, and their estimated costs for the year. You can access Plan Finder by going online at **www.medicare.gov** or calling 1-800-MEDICARE.

-Marci

Don't Bet on $200 Drug Discount Card Just Yet

As part a press conference last week President Trump announced that some seniors "will soon receive a card in the mail containing $200 that they can use to help pay for prescription drugs." He added that the cards "will be mailed out in coming weeks."

However, according to one report a White House official said the idea of a drug discount card was a "last-minute thing that is still being worked out."

In his announcement the President did not give any specifics about how the government would pay for the cards or which of the nation's Medicare recipients would receive it. White House officials estimated the price tag would be about $7 billion.

A report in *Politico*, a Washington, D.C., based newspaper, pointed out that, "Congress also hasn't authorized spending money on the cards. Administration officials at a briefing Friday morning did not tell senior congressional staff about what pots of money would be tapped to launch the effort, though one former administration official with knowledge said the Medicare trust fund is a likely target."

The *Politico* report also pointed out that, "It's not the first time that a president has tested his power ahead of an election to make a sweeping health care change.

"Barack Obama bypassed Congress to reward top-performing private Medicare plans ahead of his re-election campaign. The plan to provide bonus payments sparked Republican-led congressional investigations, and watchdogs at the Government Accountability Office called on the Obama administration to shut it down. The program ended in 2014."

Last week we told you that the Trump administration will soon announce its plan to allow states to import some prescription drugs from Canada. We also said that drug makers are objecting to this policy and are expected to sue the federal government if it is put in place, claiming it violates both the U.S. Constitution and federal laws.

In the same press conference where he announced the drug discount card, President Trump his administration has issued a final rule that clears the way for Florida and other states to implement the drug importation program from Canada.

But it does not allow states to import biologic drugs, including insulin.

The new drug importation plan must be run through the states. Florida is one of six states to pass laws seeking federal approval to import drugs.

The Canadian government has made known its objections to the policy. It says the Canadian drug industry is too small to provide prescription drugs for both its own citizens and for the U.S. market.

It also has stated it will do whatever is necessary to safeguard the availability of drugs for Canadians. Resistance on the part of Canada is very important because many who have studied the situation believe that without cooperation by the Canadian government, the drug importation plan would fail.

The drug importation plan is projected to eventually save the Medicare Trust Fund significant dollars that would otherwise be used to help extend the solvency of Medicare. Now, instead of that, those funds would apparently be used to pay for these new drug discount cards.

The process for implementing Presidential executive orders is a complicated one but this drug importation rule will not be in effect for at least 60 days, making it late November, at the earliest. But states will still have to set up a system for importation and the drug companies could still sue to stop the program. If there are no lawsuits, it still seems likely that the earliest Florida and the other states could begin importing drugs would be well into next year.

All of this uncertainty is why we tell you not to count on receiving these drug discount cards anytime soon, if ever. The reality is that the funds to pay for these discount cards do not exist, and it remains unclear whether they will in the future.

RI ARA HealthLink Wellness News

HealthLink Wellness
"Taking Control"

National breast cancer awareness 2020 October 1-31

A cancer that develops in the breast cells and progresses in stages.

- Common (More than 200,000 cases per year in US)
- Often requires lab test or imaging
- Treatment from medical professional advised
- Can last several months or years

Cancer develops in the tissues of breasts, affecting both men and women due to different reasons like family history or changes in genes and progress through stages. Symptoms would be the presence of a lump in the breast and change in the appearance of the breast. Breast cancer is treated based on the stage of the cancer using medication radiation therapy or surgery.

Symptoms

- A lump or mass in the breast that feels different from the surrounding tissue
- Change is the shape, size, or appearance of the breast
- Breast rash
- Changes in the skin over the breast, for example, dimpling
- Breast pain
- Inverted or pulling- in of the nipple
- Scaling, peeling, or flaking skin over the breast, particularly the dark area around the nipple
- Redness and/or pitting of the breast skin, resembling the skin of orange
- Discharge from the nipple

Treatments

Treatment is primarily based on the type and stage of cancer.

Medication

- Chemotherapy**:** Drugs may be recommended before or after the surgery to reduce the mass size and prevent spread or recurrence.
  Capecitabine · **Carboplatin** · **Doxorubicin** · **Vinorelbine**
- Hormone therapy**:** Drugs used in hormone therapy help in regulating the proliferation of hormone sensitive cancer cells and prevent the production of hormones or reduce their action.
  Raloxifene · **Tamoxifen** · **Fulvestrant** · **Leuprolide**

Self care

- Eat healthy and nutritious food
- Avoid alcohol
- Practice gentle exercises upon doctor's advice
- Visit doctor for regular examination

Medical procedures

Lumpectomy · Mastectomy · Breast reconstruction

Therapies

Radiation therapy

Causes

The exact cause is not known, but may include:

- Family history
- Hormonal changes
- Growing age
- Ethnicity: Hispanic, Black, Asian and Pacific Islander women are at increased risk
- Personal history of breast cancer: A cancer in one breast increases the chances of having cancer in the other breast
- Lifestyle, including alcohol consumption
- Environmental factors, including exposure to radiations
- Obesity and over weight
- Menarche: Having periods at younger age and menopause at an older age
- Pregnancy: Becoming pregnant at an older age or never being pregnant
- Hormone use, including long-term contraceptive use or postmenopausal hormone therapy

...Read More

What We Know About the Airborne Spread of the Coronavirus

The federal government did a quick pivot on the threat of the coronavirus spreading through the air, changing a key piece of guidance over the weekend.

On **Sept. 18**, the Centers for Disease Control and Prevention warned that tiny airborne particles, not just the bigger water droplets from a sneeze or cough, could infect others. It cited growing "evidence."

By **Sept. 21, that warning was gone from its website**, with a note saying it had been posted in error and the CDC was in the process of updating its recommendations.

The move put the CDC in the middle of a debate over how the coronavirus infects people. Its guidelines could make the difference between restaurants, bars and other places where people gather fully reopening sooner or much later.

And it raised more questions about politics at the public health agency and whether White House officials are dictating policy to health authorities.

So what does the science on airborne transmission actually say?

The emerging picture is a work-in-progress, but many of the pieces do point toward the potential for airborne transmission.

The Challenge of Proving Airborne Transmission

The CDC's **retracted language** said, "There is growing evidence that droplets and airborne particles can remain suspended in the air and be breathed in by others, and travel distances beyond 6 feet (for example, during choir practice, in restaurants, or in fitness classes)."

Why is this a big deal? It means the guidelines for proper physical distancing might need to be increased.

Six feet is the benchmark for safety that has helped shape the reopening of schools and businesses nationwide. The number is based on the long-held finding that larger water drops from a cough are so heavy that most of them fall to the ground before the 6-foot mark.

But much smaller droplets can hang in the air longer. The debate is whether they carry enough of the virus to infect another person. If the answer is yes, the implications for everyday life could be substantial.

University of Maryland Medical School professor Donald Milton sees plenty of evidence that airborne transmission is a major factor, but he emphasized that a definitive answer is hard to come by.

No one disagrees that being near someone with the disease is the main threat. But Milton said what happens during that time is tough to untangle.

"It could be they cough and you get infected by getting a direct hit on your eye or mouth," Milton said. "Or could it be through an airborne particle that you inhale. Or you might have touched something and then touched your nose or your mouth. It's fiendishly difficult to sort that out."

That said, many incidents and studies point toward the idea that airborne particles play a bigger role than has been thought.

The Research

.....**Read More**

Older Patients at Risk When Dentists Prescribe Opioids

(HealthDay News) -- Seniors who take depression and anxiety drugs shouldn't be prescribed opioid painkillers by their dentist because it puts them at increased risk for problems, researchers warn.

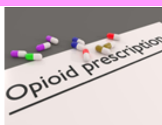
They analyzed 2011-15 dental and medical data for 40,800 patients aged 65 and older across the United States. There were 947 emergency room visits and hospitalizations in the 30 days after a dental visit.

One in 10 of those who were prescribed opioids were also using medications that shouldn't be taken with them. These patients were 23% more likely to visit the ER or require hospitalization within a month of the dental visit where they received the opioid prescription, the study found.

The longer they took the painkillers, the greater their risk. Those whose opioid prescription overlapped with their existing non-compatible medication for more than three days were 47% more likely to require some form of acute medical care.

Even though electronic health records have improved in recent years, dentists often don't have their patients' full medication history, and patients may not remember every medication they're taking, the Oregon State University (OSU)researchers noted.

As a result, dentists may



inadvertently prescribe painkillers that shouldn't be taken with other medications, especially those that act on the central nervous system.

"There is this unfortunate opportunity for dentists to prescribe opioids for any acute or chronic pain that the elderly adult is having, and it may actually pose dangerous interactions for those other medications they're on and place them at greater risk of 30-day ER visits and cause hospitalizations," said study co-author Jessina McGregor. She is an epidemiologist and associate professor in the OSU College of Pharmacy in Corvallis.

One challenge is that seniors are more likely to take multiple kinds of medication than younger dental patients, and may also metabolize drugs differently because of age and changes in their kidney function, according to McGregor.

The findings suggest dentists should be better integrated into electronic health systems so they have access to patient records, and that patients need to be more aware of the importance of providing an accurate medication history, researchers said.

The authors added that pharmacists should take a more active role in explaining medications and their possible negative interactions to patients

Hazardous Ingredients Make 'Smart Drug' Supplements a Not-So-Smart Buy

(HealthDay News) -- Maybe you're a senior concerned that your mind has started to lag a bit. Or maybe you're a college student looking for an edge in your classes.

Either way, a new study warns that you should seriously reconsider taking any over-the-counter supplement that promises a powerful brain boost.

A review of so-called "smart drug" nutritional supplements found a handful that were packed with foreign pharmaceuticals not approved in the United States, often in potentially dangerous combinations and dosages.

In some cases, these illegal drugs were brazenly promoted on packaging, said lead researcher Dr. Pieter Cohen, an associate professor of medicine with Harvard Medical School, in Boston.

"We found there were foreign drugs that have never been approved by the [U.S. Food and Drug Administration] openly listed on product labels," Cohen said.

In testing 10 sample supplements available for sale on the internet, Cohen and his colleagues discovered they contained five different unapproved drugs, sometimes substituted one for the other, and with no way for a consumer to know what they're actually taking.

"A product might list drug A on the label but contain drug B in the actual pill," Cohen said. "We found oftentimes they would have dosages that were as potent as the prescription version found in foreign countries, and surprisingly, and very concerningly, sometimes dosages that were much greater than prescription."

The researchers also found that the foreign drugs were blended in some pills, in ways that could be potentially dangerous to consumers.

"One of the drugs might have been studied for something in Russia, but never before have three or four of these drugs been mixed together and studied in humans. They're really completely novel cocktails of prescription drugs that have never been studied," Cohen said.

"The fact we found some drugs at four times normal doses and we found some products that contain up to four different drugs, now all bets are off," Cohen concluded. "It's impossible to say what the effect of that would be in humans, because it hasn't been studied."

The Council for Responsible

Nutrition (CRN), the leading dietary supplement trade association, dismissed the new study as making "sweeping conclusions about the brain health category of dietary supplements based on a narrow selection of 10 illegal products found on the internet."

"We encourage the public to avoid taking the findings of this analysis out of context and recognize this small sample is not representative of the brain health supplement category as a whole," CRN president and CEO Steve Mister said in a prepared statement. "The mainstream dietary supplement market is made up of responsible and ethical companies that are dedicated to providing consumers with safe, quality and beneficial products to improve their health and wellness."

For this study, Cohen's team searched the U.S. National Institutes of Health Dietary Supplement Label Database and the Natural Medicines Database for cognitive supplements that listed drugs similar to piracetam, a drug previously found in supplements but not approved by the FDA. Piracetam is sold in Europe as a drug to improve memory and brain function.

In the 10 supplements they examined, the researchers detected five unapproved drugs. Two were analogs of piracetam called omberacetam and aniracetam. The others were the unapproved drugs vinpocetine, phenibut and picamilon.

Omberacetam is a medication available in Russia to treat traumatic brain injury, mood disorders and cerebral vascular disease. Aniracetam is a drug approved to treat dementia in several countries, including Italy, Argentina and China.

Vinpocetine, a pharmaceutical drug available in Germany, Russia and China, is used to treat acute stroke and cognitive impairment.

The FDA has issued A warning that vinpocetine should not be taken by women of childbearing age, and known side effects of the other drugs include increased or lowered blood pressure, agitation, sedation and hospitalization, the researchers noted.

All 10 supplements tested contained the Russian drug omberacetam, sometimes in doses four times greater than what you'd find recommended abroad, the researchers said….**Read More**

America's COVID Pandemic Is Now Skewing Younger

(HealthDay News) -- Young adults in their 20s now account for more cases of COVID-19 than any other age group, according to a new study from the U.S. Centers for Disease Control and Prevention.

From June through August, people in their 20s accounted for more than 20% of all COVID infections in the United States, CDC researchers found.

Unfortunately, these cases have implications for older folks who are more vulnerable to severe and potentially fatal COVID infections, the CDC says.

In the southern United States, increases in the percentage of COVID cases among 20- to 39-year-olds preceded increases among seniors 60 or older by an average of more than eight days.

"Younger individuals, who may not require hospitalization, spread the virus to older, more vulnerable persons," said Dr. Amesh Adalja, a senior scholar with the Johns Hopkins Center for Health Security in Baltimore. "This change in infection patterns underscores the need to fortify vulnerable populations, especially those in nursing homes and assisted living centers, to insulate them from chains of viral transmission."

It's not in the United States alone that COVID cases are trending younger, the CDC added.

A similar age shift occurred in Europe, where the average age of COVID patients dropped from 54 between January and May to 39 in June and July, with people in their 20s representing nearly 20% of cases.

It makes sense that young adults will be more vulnerable to infection, given how they work and play, said Dr. Robert Glatter, an emergency physician at Lenox Hill Hospital in New York City.

"Younger adults also make up a significant percentage of workers in front-line jobs, including retail, public transit, child care and other positions with higher potential for exposure to the public [restaurants, bars, entertainment] where it may be difficult to consistently adhere to social distancing and wearing masks," Glatter said.

Young adults might also feel less inclined to follow social distancing rules and are more drawn to large gatherings, as seen in massive parties at several colleges when students returned to campus. Those parties, of course, presaged COVID outbreaks at a number of universities.

"This includes peer pressure to socialize and drink alcohol, which makes people more likely to remove their masks, move closer together and speak more loudly -- all behaviors that increase spread of the virus," Glatter said.

And while younger people are less likely to have severe COVID, the virus will make some drastically ill, Adalja added.

"Younger people are not entirely immune from severe disease -- especially if they have comorbidities -- and some percentage may develop protracted symptoms that interfere with their lives," he said.

In light of such findings, Glatter emphasized how important it is for younger adults to wear masks, adhere to social distancing and practice good hand hygiene.

"These are three behaviors that matter the most for reducing the overall risk to others in the community -- but especially to older persons at higher risk for severe COVID-19," Glatter said.

Bullying in Senior Living: What to Do

WHAT IF I TOLD YOU THAT bullying occurs in senior living? As one of my activity professionals describes it, "It's middle school with wrinkles." Fistfights at karaoke. Gossip and cruelty.

Yeah, it's a thing.

I explored this topic with Eleanor Feldman Barbera, who goes by "Dr. El." She's an accomplished eldercare coach and speaker and writes extensively about mental health and aging.

What Is Senior Bullying?

As Dr. El explains, it's the kind of bullying that you might have seen in junior high. But if you want an official definition, senior bullying is intentional, repetitive and aggressive behavior that involves some sort of imbalance in power or strength. So, it's something that happens on purpose, and it involves some kind of aggression. It happens in situations where people are having a power imbalance; for example, an aggressive bully picking on someone who's shy and reserved.

Example include:

- Verbal aggression. It could be somebody saying something about how someone looks.
- Exclusion from an activity or table in the dining room (even when there is "open" seating).
- Physically aggressive bullying that could involve kicking, hitting or another physical behavior.
- Spreading gossip and rumors.

I can relate to the open seating issue. My mom was at a table with bullies, and changing her table became a huge process, not just logistically but diplomatically.

You will most likely never witness bullying firsthand when visiting your mom or dad. It takes place quietly when nobody's around to see it. So, you might want to come back in the evenings or on the weekends when there aren't as many staff present. You might talk to some of the other families that have loved ones there. Even speak with some of the other residents and ask how people are getting along and if they've ever seen any bullying problems. In my mom's community, I observed a lot by just having lunch at her table. People don't realize they're bullying when they're doing it, and you can observe quite a lot.

Back to the Future

Dr. El told me she relates some of this to the movie "Back to the Future." In the film, the character Biff is the bully – and he would likely grow up to be the bully in senior living. Personality traits tend to hold true over a lifetime.

Of course, you can see bullying behaviors from people with no history of that behavior. Dementia, including Alzheimer's, can make people aggressive. Then you have to look at intent. A lot of the behaviors that you might see with someone who has dementia can be frightening. People with dementia like to wander, and sometimes they'll wander into somebody's room. So, if you're in your room and you can't get up and out of bed without assistance, that could be quite frightening, and it might happen repeatedly. But it's not being done intentionally.

More Frequent Than You Think

Research suggests that every community has some kind of senior bullying. The tendency would be to move mom or dad out of the community, but the grass isn't always greener.

However, when you're "shopping" around, you should come right out and ask the tour guide if there is senior bullying. Staff should acknowledge that there's some sort of bullying going on, so press them on how they handle it. If they say "no, we never have bullying here," then you know that either the person that you're touring with or the facility isn't paying attention. You want to hear them say, "yes, that's sometimes a problem," and then find out how they're handling it. Keep in mind, too, that a new arrival at a community is also the most vulnerable to bullying because they don't have a posse…..**Read More**