



Message from the Alliance for Retired Americans Leaders

White House Announces First 10 Drugs Up for Medicare Price Negotiation



Robert Roach,
President, ARA

On Tuesday, the Biden-Harris administration **unveiled a list** of the 10 prescription drugs that Medicare will negotiate lower

prices for with drug corporations. **The list has** several drugs that many seniors use, including Eliquis and Xarelto, which are used to treat blood clots, and Jardiance, Jenuvia, Farxiga, and Fiasp (along with Fiasp FlexTouch; Fiasp PenFill; NovoLog; NovoLog FlexPen; NovoLog PenFill), which are used to treat diabetes. **Eliquis is the most widely** used drug on the list, with 3.5 million people with Medicare Part D currently taking it. 282,000 of those users are in Florida and about 277,000 in California. Jardiance and Xarelto **also have a large number of older users**, with 1.6 million and 1.3 million people with Part D taking them respectively.

"For the first time, the price Medicare pays for ten of the most expensive prescription drugs will be determined at a negotiating table, not in a corporate boardroom," said **Alliance President Robert Roach, Jr.** "This would not have happened without the leadership of President Biden and our grassroots members' tireless activism."

The negotiated prices for these drugs will not take effect until 2026, but pharmaceutical corporations are trying to roll

them back in court. So far, eight lawsuits have been filed by drugmakers, including the makers of some of the drugs on the newly released list: Eliquis (Bristol Myers Squibb), Januvia (Merck), and Jardiance (Boehringer Ingelheim).

Biden Administration Releases New Minimum Staffing Standards for Nursing Homes



Rich Fiesta,
Executive
Director, ARA

The Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) **proposed a new rule** to increase the number of staff providing care to nursing home residents. Nearly 1.2 million Americans receive care in facilities covered by the proposal.

The new standards include a mandatory federal floor for staffing levels and increased federal oversight of nursing home performance. They would also make nursing homes safer by increasing enforcement of current staffing standards and enhancing the government's ability to hold providers accountable for inadequate staffing.

Recent data suggests that this measure is especially important, as current standards alone are not robust enough to stop wrongdoing. **Only 4%** of inadequately staffed nursing homes were cited by federal inspectors in 2022.

There is also more support for hard working staff members at nursing home facilities under the proposed rule, including a national nursing careers pathway

program that will work to recruit, train, and retain workers. The rule is open to a 60-day comment period from the public that will end on November 6.

"All older Americans deserve to have access to safe, quality long-term care," said **Alliance Executive Director Richard Fiesta**. "More staff with better training and oversight will mean better care for nursing home residents and a more stable workforce that can provide that care. We look forward to working with the Biden Administration during the regulatory process."

Labor Day: Treasury Department Study Demonstrates Union Benefits for Workers and Labor Unions Approval Rating Reaches Record Levels



Joseph Peters
ARA
Sec.-Trea.

The Treasury Department has **released a new report** demonstrating that unions are vital for worker security and fighting income inequality. The

report shows that union workers earn 20% more on average than non-union workers. In addition to boosting wages, unions **make workplaces safer** and **increase access to retirement plans**. 93% of union workers in private industries have access to a retirement plan, while only 66% of non-union workers have access to a retirement plan. Also, this week, AFL-CIO President Liz Shuler and Secretary-Treasurer Fred Redmond delivered an inaugural State of the Unions address

where they released **new polling**. The poll underscores the American people's support of unions—especially that of young workers—and their view of unions as critical to growing the middle class and providing opportunities for working people to thrive.

The poll found that 7 in 10 Americans (71%) support unions cutting across party lines. A majority of Republicans and more than two-thirds of Independents join 9 in 10 (91%) Democrats in supporting unions. In addition, an unprecedented number of young Americans support unions. Nearly 9 in 10 (88%) people under 30 view unions favorably, a record high.

"The idea of a union may sound complicated, but in reality, unions are just a group of people coming together. They are about each of us becoming the most powerful version of ourselves that we possibly can," said Shuler. "That's all a union is. It's that simple."

"The workers of today are the retirees of tomorrow," said **Alliance Secretary-Treasurer Joseph Peters, Jr.** "Workers in a union not only earn more, they are more likely to have a secure retirement. As we take the time to celebrate this weekend, we must also remember that the fight for workers' rights continues, and that unions are the best way to secure and preserve those rights."

5 Things to Know About the New Drug Pricing Negotiations

The Biden administration has picked the first 10 high-priced prescription drugs subject to federal price negotiations, taking a swipe at the powerful pharmaceutical industry. It marks a major turning point in a long-fought battle to control ever-rising drug prices for seniors and, eventually, other Americans.

Under the 2022 Inflation Reduction Act, Congress gave the federal government the power to negotiate prices for certain high-cost drugs under Medicare. The list of drugs selected by the Centers for Medicare & Medicaid Services will grow over time.

The first eligible drugs treat diabetes, blood clots, blood cancers, arthritis, and heart disease — and accounted for about \$50 billion in spending from June 2022 to May 2023.

The United States is clearly an outlier on drug costs, with drug makers charging Americans many times more than residents of other countries “simply because they could,” Biden said Tuesday at the White House. “I

think it’s outrageous. That’s why these negotiations matter.”

He added, “We’re going to keep standing up to Big Pharma and we’re not going to back down.”

Democratic lawmakers cheered the announcement, and the pharmaceutical industry, which has filed a raft of lawsuits against the law, condemned it.

The companies have until Oct. 2 to present data on their drugs to CMS, which will make initial price offers in February, setting off negotiations set to end next August. The prices would go into effect in January 2026.

Here are five things to know about the impact:

1. **How important is this step?**
2. **How will the negotiations affect Medicare patients?**
3. **What do the Medicare price negotiations mean for those not on Medicare?**
4. **What are drug companies doing to stop this?**
5. **What if a drug suddenly gets cheaper by 2026?**

...[Read More on the above](#)

Drug Price Negotiations Are On

The Biden administration unveiled the first 10 drugs subject to Medicare price negotiations. Here's the lineup:

Drug name	Manufacturer	Conditions treated	▼ Total out-of-pocket spending for 2022
Eliquis	Bristol Myers Squibb/Pfizer	Atrial fibrillation; blood clots	\$1,546,358,000
Xarelto	Johnson & Johnson	Atrial fibrillation; blood clots	\$591,609,000
Jardiance	Boehringer Ingelheim/Eli Lilly	Diabetes; heart failure	\$383,346,000
Januvia	Merck & Co.	Diabetes	\$238,891,000
Entresto	Novartis	Heart failure	\$185,802,000
Farxiga	AstraZeneca	Diabetes; heart failure; chronic kidney disease	\$166,026,000
Imbruvica	Johnson & Johnson/AbbVie	Blood cancers	\$116,489,000
NovoLog	Novo Nordisk	Diabetes	\$92,672,000
Enbrel	Amgen	Rheumatoid arthritis; psoriasis; psoriatic arthritis	\$43,187,000
Stelara	Johnson & Johnson	Psoriasis; psoriatic arthritis; Crohn's disease; ulcerative colitis	\$41,099,000

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services
Credit: Rachana Pradhan/KFF Health News

Federal Government to Regulate Staffing at Nursing Homes for First Time

Nursing homes will soon have to meet federal minimum staffing requirements, the U.S. Department of Health and Human Services (HHS) announced Friday.

"Establishing minimum staffing standards for nursing homes will improve resident safety," HHS Secretary **Xavier Becerra** said in an agency **news release** announcing the proposal.

"When facilities are understaffed, residents suffer. They might be unable to use the bathroom, shower, maintain hygiene, change clothes, get out of bed or have someone respond to their call for assistance," Becerra said. "Comprehensive staffing reforms can improve working conditions, leading to higher wages and better retention for this dedicated workforce."

The proposal would set the minimum staffing that is equivalent to 3 hours per resident per day. Just over a half hour of that time would be from a registered nurse. Facilities would be required to have an RN on staff 24 hours a day, every day.

It is "an important first step," said **Chiquita Brooks-LaSure**, who heads the U.S. Centers for Medicare and Medicaid Services, which oversees nursing homes.

Right now, average U.S. nursing home caregiver staffing is 3.6 hours per resident per day, with an RN working for more than a half hour of that time, according to the *Associated Press*.

Still, officials said most nursing homes would need to increase staffing.

"I would caution anyone who thinks that the status quo -- in which there is no federal floor for nursing home staffing -- is preferable to the standards we're proposing," Becerra aide **Stacy Sanders** told the *AP*. "This standard would raise staffing levels for more than 75% of nursing homes, bringing more nurse aides to the bedside and ensuring every nursing home has a registered nurse on site 24/7."

The United States has nearly 15,000 nursing homes that care



for 1.2 million people. A 2001 study funded by CMS had recommended a much higher threshold of 4.1 hours of nursing care per resident daily,

the *AP* reported.

The announcement of these new, but lower than first sought, thresholds disappointed advocates, who have said the requirements only consider the point at which someone could experience harm not overall quality of life, the *AP* reported.

"This was not the time for an incremental step," **Richard Mollot**, who leads the Long Term Care Community Coalition, told the *AP*. "You really had a once-in-a-generation opportunity."

On the other side of the issue, the American Health Care Association had lobbied against staffing mandates, citing insufficient Medicaid subsidies, hiring and retention issues and home closures.

AHCA President and CEO **Mark Parkinson** pointed out that "nursing homes are

facing the worst labor shortage in our sector's history, and seniors' access to care is under threat.

"This unfunded mandate, which will cost billions of dollars each year, will worsen this growing crisis. It requires nursing homes to hire tens of thousands of nurses that are simply not there," he said in an association news release.

In all, 38 states and the District of Columbia have their own staffing requirements, some quite low.

Residents and low-paid nurse's aides have long dealt with staffing issues, the *AP* reported.

Those shortages were exacerbated during the pandemic, when more than 167,000 U.S. nursing home residents died from the virus.

Yet staffing shrunk afterward, with 218,200 fewer employees now than in February 2020, according to the U.S. Bureau of Labor Statistics.

The proposed minimum staffing rule now enters a public comment period.

The Impact of the 2024 COLA Increase on Your Medicare Coverage

Medicare benefits: The COLA 2024 increment will affect your payments. As we approach the year 2024, discussions about the anticipated **COLA 2024 increase** and its potential implications for **programs like Medicare** are gaining momentum. The term “COLA” stands for Cost-of-Living Adjustment, a crucial financial measure employed in the **United States** to ensure that various benefits and schemes keep pace with inflationary trends.

Although not a perfect metric, COLA generally tracks inflation closely. Notably, **the 2023 COLA increase marked a substantial upswing of 8.7%**, the most significant surge in four decades. This spike significantly impacted Medicare, prompting individuals to ponder how the upcoming **COLA 2024 increase might further shape their Medicare coverage**.

The 2024 Social Security cost-

of-living adjustment (COLA) is anticipated to be approximately **3%**, as forecasted by several sources. This represents a notable decrease compared to the **5.9% and 8.7% COLAs** seen in 2022 and 2023, respectively. Those were the **highest increases** in four decades, primarily due to the **inflationary effects** stemming from the aftermath of the COVID-19 pandemic.

This means two things, one bad and one good: the bad news is that your profits will only grow by 3%, compared to the other two increases that were more than double in different cases. **The good news is that inflation tends to return to normal pre-pandemic values to which we are accustomed in America.**

COLA increase projections from sources such as the Senior Citizens League, a non-partisan advocacy group, also suggest that



the COLA 2024 increase could hover around 3%. This forecast underscores the potential variability and nuanced nature of economic trends that drive these adjustments.

How frequently does the COLA increase?

The frequency of the COLA increases **depends on inflation rates and is determined yearly**. The U.S. Bureau of Labor Statistics (BLS) determines the CPI-W, which the Social Security Administration (SSA) uses to compute COLAs. The COLA formula is determined by applying the percentage increase in the CPI-W from the third quarter of one year to the third quarter of the following year.

Congress ratified a COLA provision to offer **automatic yearly COLAs based on the annual increase in the CPI-W** that went into effect in 1975. Prior to this, Social Security

benefits were increased when Congress approved special legislation. From 1976 to 1983, COLAs were based on the increases in the CPI-W from the first quarter of the previous year to the first quarter of the current year. Since 1983, COLAs have been dependent on the CPI-W from the third quarter of the previous year to the third quarter of the current year.

The COLA increase can fluctuate significantly from year to year. For instance, in the 1970s, inflation levels varied from 3.3% to 11.3%, and the COLA reached its highest level in history at 14.3% in 1980. During the 1990s, lower inflation rates resulted in smaller COLA increases averaging 2% to 3% per year. In the early 2000s, even lower inflation rates resulted in no COLA increases in 2010, 2011, and 2016. The COLA for 2023 was 8.7%, up from 5.9% in 2022 and 1.3% in 2021....**Read More**

Dear Marci, Should I choose Medicare Advantage or Original Medicare with a Medigap?

Dear Marci,
I have Original Medicare and a Medigap but have been seeing a lot of ads for Medicare Advantage Plans that seem great. I don't want to fall for just good marketing, though. Are Medicare Advantage Plans better than Original Medicare? How should I choose?

Dear Colette,

It's great that you are taking the time to learn about your options before enrolling in a plan. There are many important choices to make about your health care coverage, and being informed can help you make the best decisions for your own needs.

People with Medicare can get their health coverage through either **Original Medicare** or a **Medicare Advantage Plan** (also known as a Medicare private health plan or Part C). While there are many differences between the two, remember that Medicare Advantage Plans must provide the same benefits offered by Original Medicare, but may apply different rules, costs, and restrictions.

Let's review some of the main

differences between these two ways to get your Medicare: **Costs**

Original Medicare: You will be charged for standardized **Part A and Part B costs**, including a monthly Part B premium. You are responsible for paying a 20% coinsurance for Medicare-covered services if you see a participating provider after meeting your deductible. **Medicare Advantage:** Your cost-sharing varies depending on the plan. You usually pay a copayment for **in-network** care. Plans may charge a monthly premium in addition to the Part B premium.

Supplemental insurance

Original Medicare: You have the choice to pay an additional premium for a **Medigap policy** to cover Medicare cost-sharing. **Medicare Advantage:** You cannot purchase a Medigap policy.

Provider access

◆ **Original Medicare:** You can see any provider and use any facility that accepts Medicare (participating and non-participating).

◆ **Medicare Advantage:** You can typically only see in-network

providers. **Referrals**

◆ **Original Medicare:** You do not need referrals for specialists.

◆ **Medicare Advantage:** You typically need referrals for specialists.

Drug coverage

◆ **Original Medicare:** You must sign up for a stand-alone Part D plan if you want prescription drug coverage.

◆ **Medicare Advantage:** In most cases, the plan provides prescription drug coverage (you may be required to pay a higher premium).

Other benefits

◆ **Original Medicare:** Does not cover vision, hearing, or dental services.

◆ **Medicare Advantage:** May cover additional services, including vision, hearing, and/or dental (additional benefits may increase your premium and/or other out-of-pocket costs).

Out-of-pocket limit

◆ **Original Medicare:** No out-of-pocket limit.

◆ **Medicare Advantage:** Annual out-of-pocket limit. Plan pays the full cost of your care after you reach the limit.

Between the two options, one is not better than the other for everyone. Medicare Advantage and Original Medicare are just different, and you may prefer one over the other depending on your needs and priorities.

Because you have a Medigap, I do want you to note that if you switch from Original Medicare to Medicare Advantage, you will lose your Medigap. Depending on your state's Medigap enrollment rules, it may be difficult or expensive to purchase a Medigap later. There are only a few specific **protected times to purchase a Medigap** under federal rules, but your state may offer additional rights.

To receive individualized counseling on your options, I recommend calling your local **State Health Insurance Assistance Program (SHIP)**. I hope this helps!

-Marci

Texas docs' 4th courtroom win over HHS interrupts out-of-network billing arbitration yet again

The Texas Medical Association (TMA) is now 4-0 on its legal challenges to the Biden administration's rocky implementation of the No Surprises Act, which bans surprise out-of-network medical bills and outlines processes to resolve payment disputes between providers and payers. **In a decision filed Thursday** (PDF), U.S. District Judge Jeremy Kernodle largely agreed with the association's **late 2022 objection** to certain provisions of the implementation—those related to the calculation of a “qualifying payment amount” (QPA) used during dispute arbitration—that TMA had argued “unfairly disadvantaged physicians in payment disputes with health insurers.”

The No Surprises Act gives

payers and providers 30 days to settle any disputes on an out-of-network charge. If an agreement can't be reached, both parties submit a preferred amount to a third-party arbitrator, which then chooses one—a process referred to as independent dispute resolution.

TMA argued that the Department of Health and Human Services' (HHS') regulations permitted payers to “artificially depress” the QPA, which is typically the median rate an insurer would have paid for the service if it were in-network. Third-party arbitrators are instructed to consider the QPA when ruling on a contested billing.

TMA's filing included additional objections to HHS' disclosure requirements, while



other plaintiffs representing the air ambulance industry who joined the suit contested a regulation extending the deadline for insurers to make an initial payment determination and other QPA calculation rules specific to air ambulances.

Kernodle, who has sided at least in part with TMA on three other occasions, ruled that most of the HHS regulations challenged by the groups were unlawful and must be set aside due to conflicts with the text of the No Surprises Act.

“All but one regulation pertaining to the calculation of the QPA violate the plain text of the Act,” Kernodle wrote in the decision. “Likewise, the regulations extending the deadline for making an initial payment determination and

requiring two proceedings for one air transport conflict with the Act and are unlawful.”

In a statement posted online, the Centers for Medicare & Medicaid Services said it has temporarily suspended all federal independent dispute resolution process operations “until the Departments can provide additional instructions.”

The case and Thursday's ruling were filed in the U.S. District Court for the Eastern District of Texas.

The tossed regulations include those that calculated contracted rate QPAs for services that had not been provided and those that calculated out-of-specialty rate QPAs, among others.... **[Read More](#)**

If you're billed for a Medicare procedure, you likely should not pay

Phil Galewitz reports from **[Kaiser Health News](#)** on Thomas Greene, a patient, with Medicare whose anesthesiologists billed him directly for a procedure because Medicare would not pay the bill. But, as a general rule, if you have Medicare and your treating physician performs a service, you are not responsible for the cost, even if Medicare does not cover the service. So, if you're billed for a Medicare procedure, you likely should not pay the bill. Check out your rights first.

Medicare rules protect you from almost ever being liable for the majority of the cost of medical services you receive. There's always 20 percent coinsurance for medical care in Traditional Medicare. But, if you

have supplemental coverage, you usually have no out-of-pocket costs.

If you're in a Medicare Advantage plan, you should also have most of your medical costs covered with a copay. But, even if Medicare ends up denying coverage, if an in-network provider delivers a treatment, you are not liable for the cost.

With Medicare, the only time that you're responsible for the cost of a service your doctor provides is if the physician tells you in advance that Medicare won't pay for the service, and you sign a written waiver agreeing to pay for the service yourself.

Notwithstanding the rules, some providers might bill you anyway for services. For



example, in the Kaiser Health News story, a large private-equity owned anesthesiology group billed the Medicare patient for its services because it had billed Medicare too late to get paid for the services. When the patient didn't pay, it sent the bill to a collection agency.

For months, the patient had to fend off notices from collection agencies and law firms. They refused to relent. But, the patient's Medicare statement showed he was not liable for the cost of the services.

Fortunately, the patient called a free Medicare hotline in his state and was advised that he should not pay the bill. The counselor then contacted the collection agencies that were billing the

patient and explained that they had no right to bill him. Since then, he has not received a collection notice.

If you receive a bill for a Medicare-covered service you had no reason to believe would not be covered, don't pay it. Contact your State Health Insurance assistance Program or SHIP for free help or call 1-800 Medicare. You can and should also **[file complaints against providers and collection agencies online](#)**.

Medicare rarely punishes providers for violating billing rules and sending bills to collection, when they have no right to do so. Both the providers and the collection agencies should know the rules and should be penalized for violating them.

GOP Presidential Candidates Continue to Attack Earned Benefits



Robert Roach,
President, ARA

Several 2024 Republican presidential candidates are **[publicly](#)** embracing policies that would cut or end earned Social Security and Medicare benefits. In 2020, former President Donald Trump told Fox News “**[we'll be cutting](#)**” Social Security and

[said he was open](#) to looking at entitlement reforms as a second term issue. Last week, former South Carolina governor Nikki Haley **[told Bloomberg Markets](#)** the retirement age “is way too low,” suggesting it should be increased for younger workers.

Former New Jersey Governor Chris Christie **[referred to politicians](#)** reluctant to pursue Social Security cuts as “liars and

cowards,” and **[doubled down](#)** on his position during a conference in Atlanta last weekend. Mike Pence **[has called for](#)** Social Security privatization as well as “common sense” solutions for “entitlement reform.” Ron DeSantis and Tim Scott **[have both voted](#)** in favor of raising the retirement age in the past.

“Older Americans need to pay attention because our earned

benefits are on the line,” said **Alliance President Robert Roach, Jr.** “Instead of attacking retirees and our earned benefits, these candidates should be working to strengthen retirement security.”

Government can easily cut \$500 billion in Medicare Advantage waste

In an opinion piece for [The Boston Globe](#), Andrew Ryan and David Meyers expose the waste and fraud in Medicare Advantage, the part of Medicare administered by corporate health insurers. While our divided Congress has little power to fix massive overpayments to these insurers, they explain how the Centers for Medicare and Medicaid Services (CMS) can cut \$500 billion in waste over the next decade, without jeopardizing patient care.

Ryan and Meyers explain that the waste and fraud in Medicare Advantage (MA) stem from three "big choices by CMS that allow the profiteering to go unchecked." If the profiteering

continues, it threatens to deplete the Medicare Trust Fund, endangering the Medicare program. In the meantime, it drives up Medicare premiums not only for people in Medicare Advantage but for people in Traditional Medicare, which is administered directly by the federal government.

Ryan and Meyers find that, overall, people in Medicare Advantage plans are less ill than their MA medical records indicate. Moreover, they are healthier than people in Traditional Medicare. CMS can change the way it calculates MA payments, so that Medicare Advantage plans cannot game the



system and they are not overpaid. Right now, Medicare Advantage plans do "chart reviews" of their enrollees. When they do, CMS permits Medicare Advantage plans to change their enrollees' diagnoses codes to make them look less healthy than they are and increase their government payments.

Medicare Advantage plans also do home assessments of some of their enrollees, again with an eye to adding diagnoses codes to their medical records or otherwise making their health seem poor. Ryan and Meyers have found that ending the MA plans' ability to change or add diagnosis codes through chart reviews and home

assessments and/or prioritizing diagnosis codes from physician-patient encounters when calculating payments could reduce Medicare Advantage overpayments by \$14.1 billion a year.

CMS should also be auditing Medicare Advantage plans far more often than it does to protect against overpayments. It needs resources to undertake these enforcement efforts, but they should more than pay for themselves. The IRS returns \$12 for every dollar it spends on enforcement. If CMS shifted resources to enforcement, it could reduce Medicare Advantage overpayments by \$10 billion a year....[Read More](#)

Medicare Savings Programs can help cover your out-of-pocket costs. Here's who qualifies

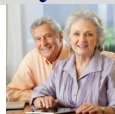
While Medicare covers most health care costs for more than 65 million Americans, it does not cover all of them and the remaining bills can add up quickly. For Medicare beneficiaries who qualify based on having low-income and limited assets, the Medicare Savings Programs (MSP) will cover some of those costs.

Medicare beneficiaries need to pay out of pocket for their premiums and they need to pay their deductibles, coinsurance, and copayments when buying prescription drugs, seeing a doctor or other health care providers, and if they need inpatient or outpatient hospital

care, says Kata M. Kertesz, a senior policy attorney for the [Center for Medicare Advocacy](#), a national, nonprofit law organization in Willimantic, Conn., and Washington, D.C.

"In traditional Medicare, there is no maximum amount beneficiaries can incur in out-of-pocket costs each year for Medicare Part A (hospital insurance) and for Medicare Part B (for physician and outpatient care)," Kertesz explains.

"Therefore, these out-of-pocket costs can be substantial, which is especially concerning given the limited incomes and assets of most Medicare beneficiaries."



About half of all Medicare members are enrolled in Medicare Advantage (MA) plans in which private health insurers require

beneficiaries to pay varying amounts out-of-pocket depending on the plan you choose. Medicare Advantage members should check with their insurers about cost-sharing and the plan's out of pocket cap, which can change every year, Kertesz advises.

For Medicare beneficiaries unable to afford these costs, there are [four Medicare Savings Programs](#) that help members pay for their premiums, deductibles, copayments, and coinsurance. When you qualify for all but one

of the MSPs, you also qualify for the Medicare Part D Low-Income Subsidy program which helps pay for prescription medications, she says.

Enrolling in an MSP could save you \$1,978.80 annually, according to the [National Council on Aging](#).

Only about half of eligible Medicare beneficiaries were enrolled in MSPs, according to a federal study in 2017. For anyone on a low or fixed income, therefore, it's important to apply, Kertesz says.'...[Read More](#)
[What is the Medicare Savings Programs. Who qualifies. What is the income limit. How to apply](#)

CMS suspects auto-renewal process at fault for wrongful Medicaid disenrollments

In a [letter sent to all states](#) (PDF), the Centers for Medicare & Medicaid Services (CMS) said it is requiring states to determine whether an eligibility systems issue is to blame for disenrolling adults and children from Medicaid or the Children's Health Insurance Program (CHIP) despite many terminated individuals still being eligible for coverage.

CMS said in the letter that it believes eligibility systems, which utilize auto-renewals (otherwise known as ex parte renewals), have been programmed incorrectly and are conducting renewals at the family level but not at the individual

level.

The agency said sometimes children have higher eligibility thresholds than their parents do, so they are more likely to be eligible for Medicaid or CHIP than their parents are. For most states, Medicaid and CHIP eligibility is set at 255% of the poverty level, but parents are covered up to 138% of the poverty level, according to Georgetown University Center for Children and Families Executive Director Joan Alker in a statement.

"CMS has learned of additional systems and operational issues affecting multiple states, which may be resulting in eligible



individuals being improperly disenrolled," according to a news release from CMS. "These actions violate federal renewal requirements and must be addressed immediately."

States have resumed the regular processes for Medicaid and CHIP enrollment after the pandemic-era pause was lifted earlier this year. If a state finds that CMS' assumption is correct, they must pause procedural disenrollment for impacted individuals, reinstate coverage, implement mitigation strategies to prevent the situation from arising again and fix systems and processes moving forward.

"We don't know yet how many states have this problem but we expect at least half or more are likely impacted by this issue," said Alker. "A functioning ex parte process is essential to a smooth process for children. Some states, most notably Texas, are barely doing any ex parte determinations at all, which is a related challenge. While there are scenarios where adults could be impacted by this glitch, the reality is that children are undoubtedly the vast majority of those losing coverage inappropriately as a consequence."...[Read More](#)

Should you allow your health plan into your home?

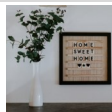
If you're enrolled in a Medicare Advantage plan and are in fair or poor health, it is more than likely that your health plan will ask whether they can do a home risk assessment. Should you allow your health plan into your home?

Tia Sawhney writes for [Newsweek](#) on the pros and cons of allowing your Medicare Advantage plan insurer into your home. You should know that you do not have to let anyone into your home or to have a health assessment if you don't want one. If you have one, it should benefit you so be sure to ask whether the visiting nurse will treat any conditions she finds and whether your Medicare Advantage plan will let your primary care doctors

know about any new conditions found.

Best case, the insurer will learn more about your health conditions, including safety risks in your home if you allow the insurer in. And, the insurer might even take steps to improve your health and mitigate safety risks. For sure, you should get a written summary of the nurse's assessment. If the nurse turns up new diagnosis, you should let your primary care doctor know. Don't assume your Medicare Advantage plan will do so.

The insurer has another reason to visit your home, which is neither in your interest or in the interest of the Medicare program. Insurers can profit handsomely off these home visits if they can



use them to add diagnoses codes to your medical records or change diagnosis codes to make your condition appear more severe. The insurers' only interest could be financial.

The government pays the Medicare Advantage plans more for enrollees with more severe conditions reflected on their medical records, even if the health plans do not treat the conditions. Payments to Medicare Advantage plans are completely unrelated to the cost of services they deliver. To maximize profits, they "upcode" or enter more diagnosis codes in people's records and then try to spend as little as possible on their care.

The problem of "upcoding" is

widespread and massive, leading by some projections to \$40-\$75 billion in MA overpayments this year alone. The Justice Department has charged all the biggest insurers offering Medicare Advantage plans with upcoding and fraud, for wrongly adding diagnosis codes to patient records or not properly documenting diagnosis codes. At the end of 2022, the US Attorney in Manhattan charged Cigna with using home assessments purely to add invalid and false diagnosis codes to patients' records.

Cigna allegedly did not even permit the nurses doing home assessments to treat patients they visited at home. And, Cigna and other medical providers who treated these people did not even

The big decision: Should I stay with original Medicare or choose a Medicare Advantage plan?

As you approach age 65, you'll have some decisions to make about medical coverage. On one hand, you can enroll in Medicare. But you may be tempted to choose another option instead: a Medicare Advantage (MA) plan instead.

If you've seen the advertisements for MA plans, you might think they're more cost-effective and comprehensive than [Medicare](#). But according to Keith Armbrrecht, Founder of Medicare education company, Medicare on Video, that's not necessarily true.

Here's why he's not a fan of these plans.

What is a Medicare Advantage plan?

Medicare Advantage plans are alternative insurance plans to

Medicare, and they're offered by Medicare-approved private companies. These plans are sometimes called "Part C" or "MA," and they include Medicare Part A (hospital insurance) and Part B (medical insurance).

Those interested in MA have more than 40 different plans to choose from. The main reasons to explore them include:

- ◆ The potential for lower premiums compared to Medicare. In 2022, the average premium was \$58, according to 2022 data from the U.S. Senate Committee on Finance.
- ◆ Out-of-pocket costs may be capped. In 2023, [the maximum was \\$8,300](#) for approved services.



- ◆ Most plans include dental, vision, hearing and fitness benefits. That being said, there are a few downsides to Medicare

Advantage plans. Here are some important things to consider before locking into an MA plan.

Limited choice

If you opt for an MA plan, your choice of doctors can be limited and you're likely to face obstacles in getting approved for procedures or seeing specialists.

"The primary reason I would absolutely choose original Medicare and would never choose Medicare Advantage is because I want control over what I do," says Armbrrecht. With an MA plan, he warns, you can face wait times of "weeks, even months," to get referrals or have procedures

authorized.

You're typically limited to doctors in the plan network and service area, as well, according to the [government's Medicare website](#).

Deceptive marketing

The Medicare Advantage plan industry has a history of deceptive practices.

In 2022, the Majority Staff of the U.S. Senate Committee on Finance [found](#) that Medicare beneficiaries were being inundated with aggressive marketing tactics, false and misleading information and overall predatory marketing from MA providers. According to the report, deceptive Medicare Advantage marketing practices are, "widespread, not isolated events."[...Read More](#)

Key Changes to Medicare Part D in 2024

Medicare continues to make efforts to lower the cost of prescription drugs for Medicare Part D beneficiaries. Our expert explains changes to occur in 2024.

As the fourth quarter of 2023 approaches, Medicare beneficiaries can expect phased in changes resulting from the Inflation Reduction Act.

Medicare expert and author of "Maximize Your Medicare," Jae Oh, explains that these changes are largely in favor of Medicare Part D beneficiaries. Medicare

Part D has made headlines recently due to attention from the Inflation Reduction Act allowing drug price negotiations. The federal government is making efforts to lower drug prices after inflation-related cost rises and a report from the [Kaiser Family Foundation](#) revealing that just [10 drugs](#) accounted for \$48 billion in Medicare Part D spending in 2021

Oh reports that the [Extra Help Program](#) will expand in 2024 as another attempt to make



prescriptions drugs more affordable. The previous cut off - based on income - will be increased, allowing more people to be eligible.

According to the National Council on Aging, nearly 3 million people are eligible for the Extra Help Program but are not enrolled. Considering the program's expansion, Oh urges readers to explore their eligibility and take advantage if possible.

In addition to broadening eligibility for the Extra Help Program, changes will be made to

Catastrophic coverage. Individuals enter Medicare's Catastrophic phase once they have accrued more than \$7,400 in out-of-pocket expenses. Previously, Part D beneficiaries would still be responsible for 5% of the cost.

"In 2024, that number goes to 0%," Oh explained about the decrease in payment responsibilities coming in the next year.

[Watch the full video for more details.](#)

Artificial Intelligence May Influence Whether You Can Get Pain Medication

Elizabeth Amirault had never heard of a Narx Score. But she said she learned last year the tool had been used to track her medication use.

During an August 2022 visit to a hospital in Fort Wayne, Indiana, Amirault told a nurse practitioner she was in severe pain, she said. She received a puzzling response.

"Your Narx Score is so high, I can't give you any narcotics," she recalled the man saying, as she waited for an MRI before a hip replacement.

Tools like Narx Scores are used to help medical providers review controlled substance prescriptions. They influence, and can limit, the prescribing of painkillers, similar to a credit score influencing the terms of a

loan. Narx Scores and an algorithm-generated overdose risk rating are produced by health care technology company Bamboo Health (formerly Appriss Health) in its NarxCare platform.

Such systems are designed to fight the nation's opioid epidemic, which has led to an alarming number of overdose deaths. The platforms draw on data about prescriptions for controlled substances that states collect to identify patterns of potential problems involving patients and physicians. State and federal health agencies, law enforcement officials, and health care providers have enlisted these tools, but the mechanics behind



the formulas used are generally not shared with the public.

Artificial intelligence is working its way into more parts of American life. As AI spreads within the health care landscape, it brings familiar concerns of bias and accuracy and whether government regulation can keep up with rapidly advancing technology.

The use of systems to analyze opioid-prescribing data has sparked questions over whether they have undergone enough independent testing outside of the companies that developed them, making it hard to know how they work.

Lacking the ability to see inside these systems leaves only clues to

their potential impact. Some patients say they have been cut off from needed care. Some doctors say their ability to practice medicine has been unfairly threatened. Researchers warn that such technology — despite its benefits — can have unforeseen consequences if it improperly flags patients or doctors.

"We need to see what's going on to make sure we're not doing more harm than good," said Jason Gibbons, a health economist at the Colorado School of Public Health at the University of Colorado's Anschutz Medical Campus. "We're concerned that it's not working as intended, and it's harming patients." ...[Read More](#)

Rising COVID Hospitalizations, New Variants Have Americans on Edge

A new COVID-19 surge is underway, with seasonal changes and new variants fueling an increase in hospitalizations and deaths.

A new Omicron variant, named Eris, has become dominant in the United States amid signs that an even more highly evolved COVID variant called BA.2.86 is starting to spread across America.

However, experts say the public should react to this latest surge not with fear, but with a healthy appreciation for the risk that the virus poses to some people.

"No one should panic about the new variants," said [Dr. Steven Gordon](#), chief of infectious disease at the Cleveland Clinic.

"While cases are increasing, overall hospitalizations are lower than what we have seen at other points of the pandemic."

"Most people have at least some immunity due to either vaccination or infection — or both — so we have been seeing less severe illness and hospitalization due to COVID," Gordon added. "However, your level of concern may also depend on your risk. Those who are immunocompromised or live with someone who is immunocompromised will want to be more cautious."

There were 12,613 hospital admissions for COVID-19 between Aug. 6 and 12, a 21.6%



increase in the most recent week, according to the U.S. Centers for Disease Control and Prevention.

Further, about 1.7% of COVID-19 infections the week of Aug. 19 resulted in death, a 21.4% increase over the prior week.

At least some of the current surge can be chalked up to COVID's seasonal nature, said [Dr. Amesh Adalja](#), a senior scholar with the Johns Hopkins Center for Health Security in Baltimore.

"This uptick happens every summer and may have to do with people moving indoors to avoid heat, where transmission is more efficient," Adalja said. [Dr. William Schaffner](#), a

professor of preventive medicine and infectious diseases at the Vanderbilt University School of Medicine in Nashville, Tenn., agreed.

"It's been quite warm outdoors, which means that we go indoors and enjoy the air conditioning, which means that people have been congregating," Schaffner said. "And of course, Americans have been traveling a great deal, and just the hurly burly of travel exposes you to a lot of people. And folks have been generally traveling mask-free. It's pretty unusual to see someone wearing a mask at the present time." ...[Read More](#)

This Fall, talk to your doctor about getting an RSV vaccine

It's just about that time of year again, when flu season hits. This year, there's a new vaccine, covered in full under Medicare Part D, which helps prevent coughs and shortness of breath resulting from an RSV respiratory infection. But, the New York Times reports that some pharmacies are charging people with Medicare more than \$300 for the vaccine.

RSV or respiratory syncytial virus kills as many as 10,000 people in the US every year and

leads to as many as 160,000 hospitalizations. Two new FDA-approved vaccines have a very high likelihood of preventing hospitalizations and death from respiratory tract disease. But some commercial insurers are not covering it.

According to the CDC, RSV is a common respiratory virus. Symptoms tend to be mild and cold-like, a runny nose, coughing, sneezing, fever or wheezing. But, sometimes people



become short of breath or face lower oxygen levels. You can catch RSV from other people, usually through coughs or sneezes coming in contact with your nose or mouth or eyes. You can also catch it from touching a surface that has the virus on it.

The [CDC](#) recommends that adults 60 years and older get a single dose of RSV vaccine, if your primary care doctor agrees. Older adults and people with weakened immune systems are at

the highest risk of hospitalization from RSV. Older adults living in nursing homes or long-term care facilities are also at high risk. You can get the vaccine at the same time that you get your flu shot or other vaccines.

Blue Cross, Blue Shield won't cover the vaccine because it is not yet on the centers for Disease Control's vaccine schedule for older adults.

Activist Misuses Federal Data to Make False Claim That Covid Vaccines Killed 676,000

A blog post shared on Facebook claimed that covid-19 vaccines have killed some 676,000 Americans. The **post was written** by anti-vaccine **activist Steve Kirsch**, who has made other **vaccine claims debunked** by PolitiFact and **other fact-checkers**.

Kirsch's Aug. 6 post referred to the Vaccine Adverse Event Reporting System, a **federal database**.

"VAERS data is crystal clear," the headline read. "The COVID vaccines are killing an estimated 1 person per 1,000 doses (676,000 dead Americans)."

The blog post was shared on social media and flagged as part of Meta's efforts to combat false

news and misinformation on its News Feed. (Read more about **PolitiFact's partnership** with Meta, which owns Facebook and Instagram.)

The data Kirsch used is from an anti-vaccine group's alternative gateway to VAERS. VAERS, which includes unverified reports, cannot be used to determine whether a vaccine caused death. Kirsch did not reply to our request for information.

"Statements that imply that reports of deaths to VAERS following vaccination equate to deaths caused by vaccination are scientifically inaccurate, misleading and irresponsible," the Centers for Disease Control and Prevention, which co-manages



the database with the FDA, told PolitiFact. The CDC added that it "has not detected any unusual or unexpected patterns for deaths

following immunization that would indicate that COVID vaccines are causing or contributing to deaths, outside of the nine confirmed" thrombosis with thrombocytopenia syndrome, or TTS, deaths following the Johnson & Johnson/Janssen vaccine, which is no longer offered in the U.S.

TTS, which causes blood clots, has occurred in approximately four cases per million doses administered, **according to the CDC**.

VAERS helps

researchers collect data on vaccine aftereffects and detect patterns that may warrant a closer look.

The CDC cautions that VAERS results, which come from unverified reports anyone can make, are not enough to determine whether a vaccine causes a particular adverse event. For the covid vaccines, VAERS has received a flood of reports, and they have become especially potent fuel for misinformation.

Kirsch made his claim not by using VAERS directly, but with an **alternative gateway** to VAERS from the anti-vaccine National Vaccine Information Center....**Read More**

Anxious Driver? There Are Ways to Ease Your Stress

It's not unusual to experience driving anxiety. Living in cities with heavy traffic, five-lane highways and little public transportation can make it even harder.

A psychologist offers some suggestions for easing those fears.

"One of the biggest challenges centers around anxiety related to the trigger, and that can be exacerbated by a variety of things like weather, traffic or concerns about road rage," said Dr. Eric Storch, vice chair of psychology in the department of psychiatry and behavioral sciences at Baylor College of Medicine in Houston.

Someone experiencing driving anxiety might feel distress. Another common symptom is avoidance.

When anxiety is extreme, that

might mean not driving at all, getting rides from others or using ride-share apps like Uber.

Someone may only drive when others are present or under certain conditions, such as during the day or not on highways.

However, these options are just not practical for many and might cause greater anxiety and avoidance over time, Storch said.

It's crucial that someone learns how to confront driving fears gradually and progressively.

Start driving on backroads, then move to non-highway roads. Then drive those same roads during high-traffic times.

Over time, step it up to more traffic situations.

If you fear driving on big bridges, start by driving on small



bridges and then drive on larger bridges.

"The whole time, you're reflecting on being in that moment and emphasizing what you learned after

confronting the feared trigger of driving, which is that you can handle it, the feared outcome typically does not occur and that anxiety decreases the more you confront it," Storch said in a Baylor news release.

If your concern is road rage, try to be courteous when others are acting up. If someone targets you with rage, it can be helpful to avoid engagement.

"Have a good cognitive sense — buying into someone else's rage doesn't get you any further," Storch said.

Storch offers some suggestions for calming nerves in anxious

drivers who encounter people with road rage.

Give people the benefit of the doubt. You do not know what is going on in their life. Forgive others for the mistakes they make, giving yourself the opportunity to let it go, he said.

Remember that your goal is to get from point A to point B, and getting in a road rage incident will work against that. Take deep breaths to calm yourself.

"The reality is it is difficult to drive... on busy roads, especially during traffic. But avoiding those things doesn't help you accomplish what you need to in life," Storch said. "If you're anxious about something, it's all about taking small steps toward confronting it and learning what happens as you confront it."

New COVID Variant May Be Less Threatening Than First Feared

When new COVID variant BA.2.86 emerged in late July, scientists had concerns about its ability to evade immunity. But early lab tests seem to be easing those fears, as well as concerns over the variant's ability to spread widely.

Also called Pirola, the variant is highly mutated, with more than 30 changes to its spike protein compared to its close ancestor BA.2 and to XBB.1.5, *CNN* reported. That big leap in evolution is similar to

what happened when Omicron first emerged.

But scientists, including those in Sweden and China, are finding in lab tests that the variant appears to be less concerning than first thought.

U.S. scientists are among those who will release lab results soon, *CNN* reported.

So far, BA.2.86 has spread to the United States and 10 other countries. Denmark has reported the most sequences. In all, about



three dozen sequences have been seen in a global repository over the past month, *CNN* reported.

"My friends, this is not the second coming of Omicron. If it were, it is safe to say we would know by now," **Dr. Bill Hanage**, an epidemiologist who is co-director of Harvard University's Center for Communicable Disease Dynamics, said in a **social media post**.

In China, researchers determined that BA.2.86 looks different to

the immune system than earlier COVID variants. It can escape some immunity, *CNN* reported.

Among the findings are that there was a twofold drop in the ability of vaccination and recent infection to neutralize BA.2.86, compared to viruses from XBB.1.5, **Yunlong Cao** from the Biomedical Innovation Center at Peking University, told *CNN*. But it was also 60% less infectious than XBB.1.5 variants....**Read More**

Cardiac Arrest: Many People Experience Warning Signs the Day Before

Sudden cardiac arrest may not come on so suddenly after all.

Fully 50% of people who experienced a sudden cardiac arrest had a telling symptom 24 hours before, and these symptoms are different in men than women, a new study suggests. For women, the most prominent symptom of an impending sudden cardiac arrest is shortness of breath; for men, it is chest pain and pressure.

"Yes, warning symptoms are associated with cardiac arrest, and these symptoms are sex-specific," said study author **Dr. Sumeet Chugh**. He is the chair in cardiac electrophysiology research and medical director of the Heart Rhythm Center in the

department of cardiology at the Smidt Heart Institute of Cedars-Sinai in Los Angeles.

It's been thought that cardiac arrest comes on without warning, which is why the overwhelming majority of people who experience it outside of a hospital die within minutes, but that may not be the case and identifying any warning signs can give folks a fighting chance, Chugh said.

Typically caused by heart rhythm abnormalities, cardiac arrest occurs when the heart stops pumping. When this happens, blood stops flowing to the brain and other organs. Every year, as many as 450,000 Americans die from cardiac arrest, according to



the U.S. National Heart, Lung, and Blood Institute.

When the researchers reviewed data from two community-based studies of people who experienced sudden cardiac arrest and compared their symptoms to those in people who sought emergency care but didn't experience cardiac arrest, they found that 50% of people who had a sudden cardiac arrest experienced at least one telltale symptom the day before, namely chest pain in men and shortness of breath in women.

What's more, smaller groups of men and women experienced palpitations, seizure-like activity and flu-like symptoms before

they suffered cardiac arrest. One study took place in Ventura, Calif., and the other took place in Portland, Ore. And both yielded similar results.

Still, Chugh cautioned that chest pain and shortness of breath can occur for other reasons and don't necessarily mean a person is on the verge of cardiac arrest. However, when these occur in someone who also has high blood pressure, diabetes or underlying heart disease, they are more likely to be associated with cardiac arrest. In the future, apps or smart watches may further narrow down who is most at risk for sudden cardiac arrest, he said....[Read More](#)

Should Folks Get Hip Replacements in Their 90s?

If you are in your 90s, is hip replacement surgery too dangerous for you?

That depends, new research shows: While elderly patients have more complications and higher death rates after such a procedure, the surgery can be "appropriately considered."

That's because the risks for total hip replacement depend not just on patients' age, but also on their overall health and fitness.

Dr. Vincent Leopold and his colleagues of the Charité-University Hospital in Berlin

analyzed the characteristics and outcomes of more than 263,000 patients over 60 who had hip replacement surgery between 2012 and 2021.

Of this large group, 1,859 patients were in their 90s.

The analysis focused on how patient age and health status affected the risks of complications and death associated with hip replacement surgery.

Nonagenarians did have overall higher complication and death rates, compared with younger age



groups.

The study found major complications for nearly 20% of patients in their 90s, compared with 10.7% for patients in their 80s, 6.2% in those in their 70s and 3.7% for those in their 60s.

Among these major complications were acute kidney failure, delirium and blood-clotting abnormalities.

The rate of minor complications also increased with age, up to 62.7% for nonagenarians. Patients in their 90s also had the highest death

rate, at 26.5%. This compared to 11.8% for patients in their 80s, 6% in their 70s and 2.8% in their 60s.

Preexisting health issues have a major impact on risks.

The risk of major complications following hip replacement surgery was about 17 times greater for patients with clotting abnormalities, nine times greater for those with paralysis and nearly eight times greater for those with pulmonary/circulation disorders, the study found....[Read More](#)

Fruit and vegetable "prescriptions" linked to better health and less food insecurity, study finds

"Prescribing" **fruits and vegetables** to adults and children is associated with increased consumption of these foods and multiple health benefits, according to a new study. The analysis, published in the American Heart Association's peer-reviewed journal **Circulation**, looked at people at increased risk for cardiovascular disease who participated in produce prescription programs for an average of six months, and found they increased their consumption of fruits and vegetables. This shift was associated with improved body mass index, blood sugar and blood pressure levels, researchers found, as well as a decrease in **food insecurity**.

"Poor nutrition and nutrition insecurity are major drivers of

chronic disease globally, including cardiometabolic conditions like Type 2 diabetes and their cardiovascular consequences, including heart failure, heart attack and stroke," Dr. Mitchell Elkind, chief clinical science officer of the American Heart Association and a tenured professor of neurology and epidemiology at Columbia University, said in a **news release**. "This analysis of produce prescription programs illustrates the potential of subsidized produce prescriptions to increase consumption of nutritious fruits and vegetables, reduce food insecurity and, hopefully, improve subjective and objective health measures."

In produce prescription programs, patients receive



electronic cards or vouchers to access free or discounted produce at grocery stores or farmers' markets, the authors explain.

The analysis, which is thought to be the largest study of the impact of produce prescriptions, encompassed more than 3,800 participants across nine programs around the country. Almost half (1,817) were children with the average age of 9, while 2,064 were adults with an average age of 54. More than half of households in the study reported experiencing food insecurity.

Participants received a median of \$63 per month to buy produce and completed questionnaires about fruit and vegetable consumption, food insecurity and health status. Routine testing was also performed to check health

status, but there was no control group to compare results, a limitation of the study.

Still, the results suggest produce prescriptions could be an important tool for improved health. For example, adults reported their fruits and vegetables intake increased by nearly one cup per day, and children's intake increased by about a quarter cup per day. The odds of **being food insecure** also dropped by one-third.

"Future research will need to include randomized controlled trials to offset any potential bias and prove more rigorously the benefits of produce prescription programs," Elkind added. "The American Heart Association's new Food Is Medicine Initiative will be focused on supporting such trials."

Too Much Paperwork Is Delaying Cancer Patients' Care, Study Finds

Red tape is getting in the way of cancer patients receiving the treatment they crucially require; a new study has found.

Patients were 18% more likely to experience cancer care delays or be unable to stick to a treatment plan if they had to fill out a lot of paperwork, compared to patients who faced less red tape, the researchers found.

Results also showed that the more paperwork a patient had to deal with, the more likely they were to experience delays in treatment.

"These are patients who are under incredible amounts of stress, who are often physically and emotionally nowhere near their best, and now having to try to jump through these hoops, the challenge becomes way more difficult and, quite frankly, unacceptable," said **Dr. Joe Betancourt**, president of the

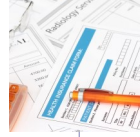
Commonwealth Fund, a health policy think tank.

"We need to really advocate for decreasing these administrative and bureaucratic burdens on patients who are suffering from chronic diseases and need care," added Betancourt, who was not involved in the study.

These delays were worse for younger patients who were less experienced at navigating the health care system, researchers reported Aug. 30 in the journal **Cancer Epidemiology, Biomarkers & Prevention**.

Black Americans also reported more paperwork-related delays than white Americans, the study found.

The U.S. health care system requires a complex series of communications among patients, health care providers and insurance companies, said lead



researcher **Meredith Doherty**, an assistant professor at the University of Pennsylvania School of Social Policy & Practice.

Unfortunately, America's blend of health care and capitalism has resulted in a "buyer beware" system where responsibility for figuring out the costs of care and fixing billing errors often falls to the patients, she said

"It's fairly unique to our for-profit U.S. health care system for the consumer to be responsible for acquiring the knowledge and skills needed to effectively use those goods or services and to ensure they're of high quality," Doherty said in a news release. "In the United States, health care is largely treated as a consumer product, so the onus is on the consumer."

For the study, Doherty and her colleagues analyzed survey data

gathered by the nonprofit group CancerCare.

In the survey, 510 U.S. cancer patients and survivors were asked about the administrative tasks they confronted during care.

Patients were asked how often they had to estimate their out-of-pocket costs before agreeing to treatment, picking up a prescription or undergoing a lab test.

They also were asked if they ever had to ask their insurance company for help understanding coverage, or had to appeal a denial of benefits.

Patients also were asked about delays they experienced, and times they couldn't adhere to their cancer care plan....**Read More**

Marijuana appears to offer several benefits...and risks

Sanjay Gupta writes for **CNN.com** about his change of heart on the benefits of marijuana, notwithstanding its risks. In traveling the world, Gupta spoke directly to people for whom marijuana was the only treatment that offered relief. He also learned that the proportion of older adults using marijuana in the US is growing more rapidly than any other age cohort.

Gupta is clear that marijuana is not a cure-all. But, for example, it sometimes can prevent seizures in children. Still, it does

not work to offer relief to everyone. What's worse, marijuana can contribute to falls, which often land older adults in the emergency room.

Until 1996, cannabis was illegal in every state for all purposes. Today, marijuana is legal in 38 states as well as the District of Columbia. Some of the remaining states make it a crime to possess marijuana, even for medicinal purposes. The federal government, however, still treats marijuana as a "Schedule 1 substance," with no



accepted medical use and a likely chance of abuse. Apparently, federal law notwithstanding, many older adults use marijuana daily to address sleep issues, pains, anxiety and depression. They tend to like it better than anti-depressants, opioids and sleeping pills.

Marijuana could reduce the number of prescription drugs older adults take. Today, three in 10 older adults take at least five prescription drugs daily.

Gupta says that our bodies actually produce cannabis and

have cannabinol receptors. Our endocannabinoid system balances our body, but it weakens as we age. That's why older adults tend to struggle more with sleep and pain and mood.

If you are thinking, you'd like to try cannabis, Gupta suggests you start with a low dose and take it slowly. There are more than 100 cannabinols, so we don't generally have a good idea of how any particular cannabis you take will affect you. All we know is that it could give you a very good night's sleep.

Blood Test Might Help Diagnose Parkinson's Disease Much Earlier

As it stands, no one blood test or brain scan can definitively diagnose Parkinson's disease.

But researchers report this may soon change if a new blood test continues to show promise.

The test measures DNA damage in the mitochondria of cells, which is known to be higher in people with Parkinson's disease. Earlier research from the same group also showed there is an accumulation of mitochondrial DNA damage in the brain tissue of people who died from Parkinson's disease.

"While more work is needed to validate the blood test, our goal

is to get this to the bedside as quickly as possible," said study author **Laurie Sanders**, an associate

professor of neurology and pathology at the Duke School of Medicine, in Durham, N.C. "A clear-cut diagnosis would accurately identify patients who could participate in drug studies, leading to the development of better treatments and potentially even cures."

The new test also identified high levels of this damaged DNA in the blood of people who have a genetic mutation known as ***LRRK2***, which has also been



associated with an increased risk of developing Parkinson's disease.

"We were able to see this marker in people who carry a genetic mutation, but don't have Parkinson's disease yet," she said. "This is something that may be happening very early in the disease process, and we may be able to screen people who are at high risk and intervene earlier. A simple and cheap blood test could let people know if they should seek further care." Sanders and her colleagues also tested a therapy that targets

this ***LRRK2*** mutation. There were lower levels of mitochondrial DNA damage in cells treated with an ***LRRK2*** inhibitor compared to those in people who did not receive the inhibitor, the study showed. There are no approved ***LRRK2*** inhibitors on the market yet.

The research was published Aug. 30 in the journal **Science Translational Medicine**....**Read More**