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Drug prices are rising again

Pharmaceutical makers are barely tapping the brakes when it comes to raising the price of their medications in 2020 - even after heavy pressure from lawmakers last year to stop doing so.

Analysts say list prices for hundreds of top branded drugs will grow faster than inflation this year, although drug companies will avoid the double -digit spikes of years past. AbbVie will hike the price of Humira, its top-selling arthritis medication, by more than 7%. Pfizer will raise prices on more than 50 drugs and GlaxoSmithKline will do likewise on more than 30 drugs.

The price hikes ensure the Trump administration and Congress will continue decrying the cost of prescription drugs this year - even if they continue to do little about it.

House Speaker Nancy Pelosi, D-Calif., arguing for a bill supported only by Democrats:

Congress ended 2019 with a whimper on the drug pricing issue, failing to advance a bipartisan Senate bill and including only a small part of it in the year-end spending deal. As for President Donald Trump, he has also run up against walls despite frequently complaining about prices. All his administration has released is a preliminary proposal to allow some drug importation and a requirement for drugmakers to post list prices in television ads, although that has been blocked by a court.

And now the outlook for drug prices in 2020 is virtually unchanged from last year,according to GoodRx, an online prescription cost service.

Among companies that have so far announced their pricing intentions for the year, 491 drug prices are increasing by an average of 5.2%, according to data compiled by the firm. That's less than 2018's 8% average price hike on 580 drugs, but no improvement over 2019.

Price increases for some of the most commonly prescribed drugs are hovering between 3% and 6%. List prices for Jardiance and Tradjenta, two non-insulin drugs used to treat diabetes, will rise 6 percent. Premarin, which helps with menopause, will go up 5%, and the HIV drug Truvada will go up 4.8%.

The administration has frequently argued that an acceleration in generic drug approvals will stem the tide by allowing more competitors. But that hasn't yet been the case for AbbVie's mega-blockbuster brand-name drug Humira.

"The Food and Drug Administration has approved five generic versions of Humira - the world's biggest-selling drug with global revenue of $20 billion - and two of them have come within the past six months," The Post reported. "But so far the generic biologic drugs (called "biosimilars" in industry parlance) have failed to lower costs and make the therapies more accessible to patients."

AbbVie increased Humira's price more than 7 percent this year after raising it 19 percent in 2017 and 2018. "The cost of Humira, which is injected via syringe, was more than $72,000 a year on prescription drug websites this week and is not expected to come down until at least 2023," Rowland writes.

"Humira's price has defied gravity - and been ensconced as a frequent rhetorical target on Capitol Hill - through AbbVie's aggressive use of patents and deals with generic manufacturers to forestall competition," he adds. The generic competitors, facing a thicket of patents AbbVie has obtained to try to maintain exclusive rights, have reached a settlement which means their alternatives to Humira won't be available until 2023.

Antonio Ciaccia, an analyst for the firm 3 Axis Advisors, told me he expects to see slightly more medications overall undergo a price hike compared to last year.

And some companies have yet to announce anything this year about where they're setting drug prices - notably, the large insulin makers Novo Nordisk and Eli Lilly. Furthermore, the companies that have already announced could make more pricing changes mid-year, something typically done around June or July.

But there may be a tiny bright spot in all of this. Ciaccia says his firm's data indicate the average increases are somewhat lower than in 2019 - possibly a sign of the heightened public scrutiny of the industry. Just one medication - CotemplaXR, used to treat ADHD - is getting a price increase of more than 10 percent, Ciaccia noted.

"Overall, I think drugmakers have moderated their approach to price increases over the last few years," he said

Some pharmaceutical makers have pledged to keep price increases below 10 percent. That's a common threshold set by state regulators for when a company must provide a rationale for a price increase.

"Everyone is keeping it well under the speed limit, if you will," Ciaccia said.

Here's something else to consider. A handful of branded drugs - many of them sold by Pfizer - are undergoing dramatic and unprecedented price cuts. The company is cutting its steroid Medrol by 90% and slashing its medicine Zyvox, which treats bacterial infections, by nearly 98%.

They're not blockbuster drugs by any means, but it's highly unusual for drugmakers to make such deep cuts, Ciaccia said.

TIME TO LOWER DRUG PRICES NOW!!

TAKE ACTION
Sign this Petition

Medicare Rights Testifies to Congress About the BENES Act

On January 8, 2020, Medicare Rights Center President Fred Riccardi testified at a hearing of the House Committee on Energy and Commerce, Subcommittee on Health titled **"Legislation to Improve Americans' Health Care Coverage and Outcomes."**

In the testimony, Medicare Rights urged Congress to pass the bipartisan, bicameral **Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act** (H.R. 2477) without delay.

The BENES Act is urgently needed to modernize and simplify the Medicare Part B enrollment process. Currently, far too many people make honest mistakes when trying to understand and navigate this confusing system. The consequences of such missteps are significant—including late enrollment penalties, higher out-of-pocket health care costs, gaps in coverage, and barriers to accessing needed services.

Unfortunately, many people do make mistakes. Year after year, among the most frequent calls to our National Consumer Helpline are from older adults and people with disabilities eligible for Medicare who inadvertently and through no fault of their own failed to enroll in Part B on time and are experiencing severe repercussions.

Introduced by Representatives Ruiz (D-CA), Bilirakis (R-FL), Schneider (D-IL), and Walorski (R-IN), the BENES Act would help prevent these costly errors. It would fill long-standing gaps in outreach and education, eliminate needless breaks in coverage, and inform future policymaking on enrollment period alignment. The BENES Act's long overdue, commonsense changes would better empower people who are approaching Medicare eligibility to make optimal, timely coverage decisions that build their health and economic security.

To improve the health and financial well-being of current and future Medicare beneficiaries, Medicare Rights urges Congress to pass the BENES Act this year.

The full written testimony is available here.

Majority of Retirees Think Congress Should Modify Social Security COLA

Eighty - five percent of retirees think Congress should modify Social Security to provide a higher annual cost-of-living adjustment (COLA), and they support very gradually raising payroll taxes to pay for it, according to a new survey by **The Senior Citizens League (TSCL)**. "Older Americans feel the COLA does not adequately protect their Social Security benefits from rising costs, and a large majority want Congress to strengthen the COLA and Social Security's financing, says Mary Johnson, a Social Security and Medicare policy analyst for The Senior Citizens League.

COLAs have been at unprecedented lows for more than a decade, averaging just 1.4 percent annually. There was no COLA paid at all in 2010, 2011, and 2016, and only 0.3 percent paid in 2017. In contrast, COLAs averaged 3 percent per year from 1999 to 2009 — more than twice the average over the past 11 years. At the same time that COLAs have been at record lows, Medicare Part B premiums have grown nearly three times as fast. Since 2010, COLAs grew by a total of 15.2 percentage points, while Medicare Part B premiums increased by 44.5 percentage points.

When asked how Congress should modify the COLA, The Senior Citizens League's survey found 38 percent of participants support tying the annual inflation boost to a "senior CPI," the Consumer Price Index for the Elderly (CPI-E), which tends to grow .25 percentage point more rapidly than the current CPI. Forty-seven percent support providing a minimum COLA guarantee — of no less than 3 percent.

In 2020, Social Security recipients receive a COLA increase of 1.6 percent, raising the average $1,500 retirement benefit by about $24 per month. A COLA based on the CPI-E, however, would have paid 1.9 percent, and that would raise the average benefit by about $28.50 per month in 2020. A 3 percent minimum would raise average benefits by $45 per month. The difference in the COLA can seem quite small at first but, when compounded over time, a more adequate COLA provides more income when retirees are the oldest and more likely to have spent down retirement savings.

When costs during retirement grow faster than the COLA, that erodes buying power and Social Security benefits are worth less over time," says Johnson. Research by Johnson has found that Social Security benefits have lost about one third of their buying power since 2000.

The Senior Citizens League supports legislation that would provide a modest boost in Social Security benefits and strengthen Social Security financing.

Social Security benefits are relatively small

As often as they can, Republicans in Congress argue to cut Social Security benefits. Some of them insist that Social Security is too generous a program. In truth, Social Security benefits are relatively small.

Social Security benefits are earned benefits, with people contributing over their lifetime into the Social Security Trust Fund. Only money from that Trust Fund goes to pay people's Social Security benefits. So, Social Security benefits do not affect the deficit.

The principal reason that Social Security faces a long-term shortfall is that more people are relying on it. There are more older adults and more people with disabilities than ever before. So, Social Security is paying out more money than it has in the past. Social Security's costs are about five percent of GDP today and are projected to rise to six percent in the 2030's….**Read More**

Social Security Benefits Are Modest

Beneficiaries and average amount, November 2019

	Beneficiaries (millions)	Average amount Monthly	Annually
Retired workers	45.0	$1,478	$17,736
Disabled workers	8.4	1,238	14,856
Aged widow(er)s	3.6	1,399	16,793
Average	57.0	1,438	17,251

Source: Social Security Administration, Office of the Chief Actuary (http://www.ssa.gov/OACT/ProgData/icp.html).

FRAUD ADVISORY: INSPECTOR GENERAL WARNS PUBLIC ABOUT NEW TWIST TO SOCIAL SECURITY PHONE SCAMS

The Inspector General of Social Security, Gail S. Ennis, is warning the public that telephone scammers may send faked documents by email to convince victims to comply with their demands. The Social Security Administration Office of the Inspector General (OIG) has received reports of victims who received emails with attached letters and reports that appeared to be from Social Security or Social Security OIG. The letters may use official letterhead and government "jargon" to convince victims they are legitimate; they may also contain misspellings and grammar mistakes.

This is the latest variation on Social Security phone scams, which continue to be widespread throughout the United States. Using robocalls or live callers, fraudsters pretend to be government employees and claim there is identity theft or another problem with one's Social Security number, account, or benefits. They may threaten arrest or other legal action, or may offer to increase benefits, protect assets, or resolve identity theft. They often demand payment via retail gift card, cash, wire transfer, internet currency such as Bitcoin, or pre-paid debit card.

Inspector General Ennis urges continued vigilance against all types of phone scams **no matter what** "proof" callers may offer. As we continue to increase public awareness of phone scams, criminals will come up with new ways to convince people of their legitimacy. Social Security will **never**:

- threaten you with arrest or other legal action unless you immediately pay a fine or fee;
- promise a benefit increase or other assistance in exchange for payment;
- require payment by retail gift card, cash, wire transfer, internet currency, or prepaid debit card; or
- send official letters or reports containing personally identifiable information via email.

If there is ever a problem with your Social Security number or record, in most cases Social Security will mail you a letter. If you do need to submit payments to Social Security, the agency will send a letter with instructions and payment options. You should **never** pay a government fee or fine using retail gift cards, cash, internet currency, wire transfers, or pre-paid debit cards. The scammers ask for payment this way because it is very difficult to trace and recover.

If you receive a call or email that you believe to be suspicious, about a problem with your Social Security number or account, hang up or do not respond. We encourage the public to report Social Security phone scams using our dedicated online form, at **https://oig.ssa.gov.** Please share this information with your friends and family, to help spread awareness about phone scams.

For more information, please visit https://oig.ssa.gov/scam. Members of the press may make inquiries to Social Security OIG at (410) 965-2671.

Why tighter food stamp rules are causing anxiety

Local food banks are bracing for more business after the Trump administration announced changes to the federal Supplemental Nutritional Assistance Program that will end benefits for hundreds of thousands of people ages 18-49 who don't have kids.

Officials across the nation have called the changes in what people think of as food stamps — which Congress rejected in last year's Farm Bill — a failure in policy.

"When government programs fail, it's nonprofit programs like People to People who pick up the slack," said Diane Serratore, CEO of People to People, Rockland's primary hunger relief organization. "It really shouldn't be our responsibility to do the government's job."

"For people who are struggling to make ends meet, this is exactly the wrong direction," said Leslie Gordon, president and CEO of Feeding Westchester, which provides a network that sources and distributes food and resources to feed people who are hungry in every town in Westchester.

The SNAP change may not seem that significant — on paper the rules are similar for so-called "able-bodied" adults ages 18 to 49 who don't have kids. They are already mandated to work at least 20 hours a week to get SNAP. If they don't, they are technically limited to just three months of SNAP benefits every three years.

But states currently can — and often do — waive the work rules under certain circumstances. The new rules restrict when those waivers can be granted.

'LESS MONEY TO PAY RENT'

The change will affect about 700,000 people nationwide. Albany-based Hunger Solutions New York estimates that some 107,000 New Yorkers will be impacted.

Hunger New York Executive Director Linda Bopp said the change "will cause serious harm to individuals, communities, and the nation while doing nothing to improve the health and employment of those impacted."

Cuts to SNAP will have a ripple effect, Sen. David Carlucci said.

"That's less money to pay rent, utility bills, prescription costs," he said.

'RESTORE THE DIGNITY OF WORK'

U.S. Department of Agriculture Secretary Sonny Perdue said that the SNAP reforms would be taken "in order to restore the dignity of work to a sizable segment of our population and be respectful of the taxpayers who fund the program." About 36 million Americans rely on SNAP.

But People to People board President Joe Allen said that the cuts aren't partnered with any expanded federal initiatives that would ensure people the ability to work.

"There's no added job training connected to this," Allen said. The current job market demands very specific skills to secure employment that offers steady hours and a livable wage, Allen said.

According to an official at USDA's Food Nutrition and Consumer Services, the change would save roughly $5.5 billion over five years.

The work rule is just the first of three anticipated changes to the way SNAP will be granted. Other anticipated changes include: families could no longer be automatically enrolled in SNAP when they receive other forms of federal aid, and states could change the requirements for families to get SNAP; and applications for food stamps would no longer allow deductions for the cost of housing and utilities. Family size, citizenship status, household income, and certain expenses are considered in calculations to determine SNAP qualifications.

Conservative group with pharma ties makes clear there are drug pricing reforms they can support

WASHINGTON — The conservative American Action Network launched a $4 million advertising campaign Tuesday to throw its weight behind congressional Republicans' alternative to Speaker Nancy Pelosi's **marquee drug pricing bill.**

It's a striking show of support for the GOP bill, which party leaders rushed to introduce the same week that the House was set to vote on Pelosi's bill in December. Until now, the group has focused only on opposing the Pelosi bill — not on pushing for the Republican alternative.

Republicans maintain that their bill, which would cap seniors drug costs at $3,100 a year and crack down on certain so-called bad behaviors by the drug industry, is bipartisan and could be signed into law by President Trump — unlike, they say, the Pelosi bill, which includes far more aggressive drug pricing reforms and is almost unanimously opposed by Republicans and the Trump administration.

The American Action Network, which received $2.5 million from PhRMA in 2018, has derided the Pelosi drug pricing plan as socialism. The group spent $2.5 million in the

While AAN's activism so far has been to no avail — Pelosi's bill passed the House resoundingly and Pelosi is unlikely to take up the Republican alternative — the campaign is the latest sign of the drug industry's allies coalescing around their preferred reforms as Capitol Hill attempts to pass something to address high drug prices in 2020.

AAN's ads will run in 28 Republican House districts. The ads target key Republican lawmakers, like Rep. Kevin Brady (R-Texas) and Greg Walden (R-Ore.), who already support the Republican bill. The ads implore viewers to call the lawmakers and thank them for their support.

But the biggest audience for these new ads may be Senate Majority Leader Mitch McConnell (R-Ky.) and Senate Finance Chair Chuck Grassley (R-Iowa).

Half a dozen Republicans senators, including industry allies Sens. Thom Tillis (R-N.C) and Richard Burr (R-N.C.), introduced a Senate version of the GOP house bill last month. The bill is strikingly similar to Grassley's since-stalled drug pricing package, except that it does not include a hotly controversial provision that would cap drug prices at inflation.

The introduction of the Senate package was a clear sign that Republicans would be willing to pass Grassley's signature drug pricing bill if he was willing to scrap the price hike policy. Grassley has so far refused to do that, even as pressure increases from his own party and conservative activists.

Congressional Inpass On Prescription Drug Legislation

Because they could not reach a deal to lower prescription drug prices last year, members of Congress are feeling the pressure this year to get something done to accomplish that goal. But that runs headlong into the fact that an election year is a very difficult time to get any significant legislation passed.

Nonetheless there are indications they are going to try. And you can be sure that we at TSCL are going to redouble our lobbying efforts to keep the pressure on them to get the costs of prescription drugs down.

As we have been writing about for so long, the two main legislative measures aimed at lowering drug prices are the Pelosi bill (H.R. 3), which was passed by the House last year and has been sent to the Senate for action, and the Grassley-Wyden bill in the Senate. However, Senate Majority Leader Mitch McConnell (R-Ky.) has said he does not intend to bring either bill up for consideration.

The Senate bill is the one introduced by Senate Finance Committee Chairman Chuck Grassley (R-Iowa) and the top Democrat on that committee Ron Wyden of Oregon. However, even though the bill has been co-authored by one of the most senior and powerful Republican members of the Senate (Grassley), McConnell continues to refuse allowing it to be considered by the full Senate.

The two most likely times for legislation to make headway will be after the impeachment trial of the President in the Senate until sometime in May, and then after the November elections until sometime in December. If nothing happens by then we will have to start all over at the beginning of next year.

Despite McConnell's refusal to consider legislation to lower drug costs, new information has come out that may increase the pressure on him. News that the major drug companies have raised the prices of their drugs once again came out just this week. Reports have said that around 85 drug companies increased the prices of at least 324 drugs by an average of 5.1 percent in the first few days of 2020. And as we reported previously, the drug companies have been spending millions of dollars to lobby Congress to try and prevent legislation that would lower drug prices.

This all comes even though the President and the Congress committed to pass some kind of legislation to lower prices even though the Senate Majority Leader is putting a stop on things right now.

We should add that people with insurance generally pay much less than the list price of a drug although someone, somewhere pays for the increased drug prices.

On top of all this news comes another new report that the Trump administration is considering an action that would make it even more difficult to pass the Grassley-Wyden bill. The proposal would tie Medicare reimbursements to foreign countries' drug prices. In other words, the proposal would match payments for drugs administered in a doctor's office more closely with what other countries pay.

Without getting into too much detail, legislation that would cost money is always sent to the Congressional Budget Office (CBO) for an estimate of its cost. That gives lawmakers the information they need to make a judgement about how to pay for the new cost.

The support among Senators for the Grassley-Wyden bill is fragile as a result of opposition from McConnell and drug companies and releasing the administration's proposed rule could blow up the current coalition of supporters. Grassley's camp is hoping that they can get enough support to get McConnell to bring the legislation to a Senate floor vote.

Medicaid expansion may have saved thousands from drug overdose deaths

Local food banks are bracing for more business after the Trump administration announced changes to the Expanding Medicaid rolls under the Affordable Care Act may have saved as many as 8,132 people from fatal opioid overdoses, virtually all involving heroin and fentanyl, **a study released Friday suggests**.

The research is the latest evidence that allowing more people to enroll in Medicaid has saved lives and improved health.

The researchers concluded that additional access to drug-abuse treatment was linked to a six percent lower overdose rate for states that allowed more people to enroll in Medicaid than in states that did not. That translated into 1,678 to 8,132 fewer deaths in those states from 2015 to 2017, they wrote in an examination of data from 49 states and the District of Columbia.

The research, published in JAMA Network Open, was not designed to prove cause and effect. Rather, it found an association between the decline in overdose deaths in the 32 states and the District of Columbia that had expanded Medicaid at the time of the study.

Other reviews of Medicaid expansion have shown that **low-income people with asthma and diabetes were less likely to be admitted to hospitals**; that smokers received help quitting tobacco; and **that some states sharply increased spending on services for people with substance use disorders.**

With the Affordable Care Act's future in doubt, evidence grows that it saves lives

Critics of President Trump's efforts to undermine the Affordable Care Act, also known as Obamacare, have frequently said that doing so conflicts with his work to stem the nation's opioid crisis, which has taken more than 400,000 lives over the past two decades.

The new study appears to be the first to conduct a county-by-county examination of overdose deaths and Medicaid expansion. It found an 11 percent decline in the death rate from heroin overdoses and a 10 percent drop in deaths from illegal fentanyl and its analogues.

"As states invest more resources in addressing the opioid overdose epidemic, attention should be paid to the role that Medicaid expansion may play in reducing opioid overdose mortality," most likely through the provision of anti-addiction medication, the researchers wrote.

The study found no link between Medicaid expansion and declines in overdose deaths from prescription narcotics. In an interview, the leaders of the research team — Nicole Kravitz-Wirtz of the University of California at Davis School of Medicine, and Magdalena Cerda of New York University's Grossman School of Medicine — said that Medicaid expansion probably brought many of the poorest Americans into the insurance program. That group was more likely to be using street drugs than prescription narcotics, they said.

Other research has indicated that by dramatically increasing the availability of the overdose antidote naloxone on the streets, Medicaid expansion also may have cut the number of overdose deaths.

The study unexpectedly found a rise in overdose deaths caused by methadone in states that expanded Medicaid. The drug is most commonly known as a treatment for opioid use disorder, but it is also prescribed for pain, though much less frequently than drugs like oxycodone.

Kravitz-Wirtz said that Medi-caid recipients are more likely to receive the drug as a painkiller, and that further research is needed to explain why the review found the increase in those deaths. Previous research has shown methadone to be safe and effective in suppressing the use of opioids, particularly heroin.

More Information

Deep brain stimulation tested for severe opioid use disorder

NIH awards nearly $1 billion for research against addiction and chronic pain

Chronic pain patients agonizing over forced tapering off opioids

Block Granting Medicaid is a Dangerous Step for Older Adults and People with Disabilities

Just before the New Year, the Medicare Rights Center responded to a proposal that would damage the Medicaid program by allowing Tennessee to convert its Medicaid funding into a block grant. Our comments note that doing so would cause harm to older adults and people with disabilities, as well as the Medicaid program as a whole.

Today, federal Medicaid funding automatically changes to match a state's spending and enrollment needs—increasing in near real-time if a state's costs go up. A block grant, by contrast, provides only a set amount of federal funding for a state. It typically does not include a mechanism that allows for adjustment in times of need or due to enrollment variances. In exchange for receiving lower, capped funding, states often request exemptions from certain federal Medicaid program requirements. Because of this, such proposals threaten to leave states fully responsible for all costs in excess of the annual federal allocation and can jeopardize residents' access to Medicaid.

States often claim they can save money through block grants by being more "flexible" with their program. However, these "flexibilities" save money by reducing the number of people served, the benefits for those who are eligible, or both.

In Tennessee's proposal, the state would no longer be bound by federal standards for its managed care, prescription drug formularies, eligibility for the program, or paperwork requirements. For example, in an effort to control costs, Tennessee could seek to roll back critical but non-mandatory Medicaid benefits that are often among the services most utilized by older adults and people with disabilities, like Home- and Community-Based Services (HCBS). The state says it does not intend to restrict eligibility or benefits, but the proposal does not require Tennessee to maintain current levels. In addition, the state would be able to redirect any resulting "savings" away from Medicaid to pay for other state expenses, creating an incentive for the state to make such cuts.

Over time, coverage and eligibility restrictions would become inevitable. The initial funding caps would likely be tied to inflation rates that are too low to fully cover the cost of providing care, leaving Tennessee to make up the difference. Each year, the gap between the amount the state gets and the amount the state needs would grow, exposing Tennessee to higher and higher costs. Facing an ever-increasing funding shortfall, Tennessee would have no choice but to cut the program significantly in order to curtail spending.

We strongly oppose any efforts to block grant or otherwise cap Medicaid. Such efforts put the health and well-being of millions of older adults and people with disabilities at risk of losing coverage or access to care. The purpose of the Medicaid program is to provide health coverage for people who need it, and Tennessee's proposal does not advance that purpose.

Why the Government Pension Offset is WRONG!

Social Security Fairness

Repeal the Government Pension Offset and the Windfall Elimination Provision

The Government Pension Offset reduces the spousal or survivor Social Security benefit by 2/3 of the amount of the pension earned from a public agency which doesn't pay into Social Security for its workers. Most people affected are women. This penalty usually eliminates ALL the Social Security retirement benefits a public worker's spouse has paid in for them.

1. This particularly affects women who have earned only a partial pension. Women usually have made less money over their lifetimes than men have. In addition to the well-known pay inequities, women often work fewer years than men. As homemakers and family caregivers they may be out of the workforce for many years. This often results in their having fewer years to build up either Social Security credits or a robust pension. It contributes to greater poverty among retired women.

2. The way the Government Pension Offset works, it ignores the number of years a spouse may be truly dependent on the earner, earning neither a public pension nor a FICA-Social Security contributing income. If the not-employed spouse at a later date earns a pension, the years of dependency are not counted, despite the spouse's having been in a marriage situation which normally would qualify that person for spousal or survivor benefits. There are ways the Federal Government could use these years of "no pension/ no FICA" information to calculate a lesser GPO reduction for many spouses, but even this level of mitigation is not being attempted. Receiving a public pension should not nullify the spousal or survivor Social Security benefits rightfully earned during other parts of a person's life.

3. The effects of the Government Pension Offset can be erratic and produce unequal results that are grossly unfair. Social Security regulations generally are designed to provide a higher-percent return for their investment for low-income retirees than for higher-income retirees. Both the GPO and WEP subvert this purpose and produce crude inequities that would be nearly impossible to correct. Here is an example using the GPO survivor benefit. For a higher-earning retiree with a governmental pension of $3,600 a month and a deceased spouse with the average monthly Social Security benefit of $1,470, the GPO would reduce the survivor's benefit income by 29%. For a lower-earning retiree with a pension of $2,400, and a deceased spouse with the same monthly average Social Security benefit of $1,470, the GPO would reduce the survivor's monthly income by 38%. (The two charts below demonstrate these figures.)

Trying to make the offset "more fair" by correcting for individual income anomalies would be a logistically daunting effort for the Social Security Administration.

4. A particularly onerous provision of the GPO is that, because of the way the law was written, every time you get a cost-of-living increase in your non-Social Security pension, the Social Security Administration is supposed to reduce your spousal or survivor SS benefits by two-thirds of that amount. For example, when you get a $30-a-month cost-of-living raise in your pension, the SSA is supposed to reduce your spousal or survivor benefit by $20. Everyone else gets a fair cost-of-living raise, but you don't. You are responsible for informing the SSA of this raise in your pension. https://secure.ssa.gov/poms.nsf/lnx/0204030090

5. The most prominent argument in favor of maintaining the Government Pension Offset is that its application is necessary to maintain a parallel process with the Social Security Dual Entitlement Reduction. According to current law, a retired dependent spouse is entitled to an amount equal to half of the amount the worker spouse receives; or the person can choose to receive their own earned benefit instead. This lower reimbursement for the lower earner runs counter to the ideas of equality in marriage and community property, which mandate that earnings by either spouse during the marriage must be shared equally. To be fair, the Social Security retirement earnings of both partners gained during the marriage should be added together, and each marriage partner should be allotted half. The fact that the Social Security Dual Entitlement rule discriminates unfairly against the spouse who earns a smaller retirement benefit does not justify the indefensible treatment of spouses by the Government Pension Offset.

The only clean solution to the Government Pension Offset is FULL REPEAL!

The following statistics are from the 6/21/19 Congressional Research Service report. (Statistics as of 12/19/18).

- 695,059 retirees were affected by the Government Pension Offset.
- 1% of all Social Security beneficiaries were affected by the GPO.
- 54% of those affected were spouses; 46% were widows or widowers.
- 83% of those affected were women.
- Of all potential beneficiaries, 72% lost ALL Social Security benefits.
- *It is believed that an unknown number of potential spouses or survivors have not applied for benefits because they believe the GPO would eliminate all money for which they might be eligible. (See the whole report on our website at:* https://ssfairness.org/wp-content/uploads/2019/11/CRS-GPO-6-2019.pdf)
- The these examples illustrate the effects of the GPO on lower-income and higher-income workers.
- The Government Pension Offset can have a more dramatic effect on lower-income married workers than on higher-income workers. In these cases, both the spousal benefits and the survivor benefits are totally eliminated by the amount of the pension. The figures below use the 2019 average Social Security retirement benefit: $1,470.
- Example 1. Higher teacher/government worker pension $3,600 per month
- Average SS benefit for SS earner $1,470
- Total amount couple receives in retirement $5,070
- GPO applied:
- 2/3 of government pension equals $2,400 which:
- Eliminates potential spousal income: $735
- Eliminates potential survivor income: $1,470
- Percentage lost to GPO: $1,470 divided by original family total of $5,070=29%
- At death of Social Security earner, percent of income lost: 29%
- Example 2. Lower teacher/government worker pension $2,400 per month
- Average SS benefit for SS earner $1,470
- Total amount couple receives in retirement $3,870
- GPO applied:
- 2/3 of government pension $1,600 which:
- Eliminates potential spousal income: $735
- Eliminates potential survivor income: $1,470
- Percentage lost to GPO: $1,470 divided by original family total of $3,870=38%
- At death of Social Security earner, percent of income lost: 38%
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Social Security Fairness

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RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Seniors Still Wary of Online Reviews When Picking Doctors

Most older Americans don't fully rely on or trust online ratings of doctors, a new study finds.

Among men and women between the ages of 50 and 80, only 43% have looked online to see how patients rated a doctor, researchers report.

Of these, two-thirds chose a doctor because of good online ratings and reviews, according to the National Poll on Healthy Aging, conducted by the University of Michigan Institute for Healthcare Policy. More than 2,000 older adults were canvassed and the results were published Jan. 6.

But online reviews were given as much weight as what these older adults heard from family and friends.

"People of all ages are turning to the web to find information, so it is not surprising that older Americans are looking up physician ratings online," said researcher Dr. David Hanauer, an associate professor at the University of Michigan.

"But it is a bit of a surprise that these online ratings now carry as much weight as recommendations from family and friends," he said in a university news release.

More than online ratings or word of mouth, 61% of older adults were swayed by the wait time for an appointment and about 40% by recommendations from other doctors or the doctor's level of experience.

Only 7% said they had posted a review or rating of a doctor online, the researchers found.

"Finding a new doctor can be stressful. Online rating might be one of many sources of information that can help older adults navigate this process," poll director Dr. Preeti Malani said in the release. She is a professor of internal medicine at the University of Michigan.

The poll showed that older adults are media-savvy, the researchers noted.

Among those who did look at reviews, 69% said they wouldn't choose a doctor who had mostly negative reviews and 71% said that some bad reviews among lots of positive reviews wouldn't stop them from choosing a doctor.

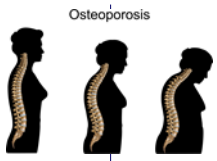
"This survey makes it clear that although online physician reviews and ratings are important to older consumers, they are savvy about information gathered on the internet and have a healthy dose of skepticism around them, too," said Alison Bryant, senior vice president of research for AARP, which helped fund the poll.

Osteoporosis: Researchers find another possible risk factor

Osteoporosis affects millions of people around the world, and it is not possible to change some of the primary risk factors, such as aging. However, more and more environmental risk factors are coming to light, and air pollution appears to be one of them.

Osteoporosis is a condition characterized by impaired bone density, which causes them to become brittle and fragile.

This condition tends to affect older individuals, particularly females, but some environmental factors — such as a lack of **vitamin D** — can also contribute to its development.



As research into the causes of and best preventive strategies against this condition continue, researchers keep on uncovering potential risk factors.

A new study led by the Barcelona Institute for Global Health — whose findings appear in ***JAMA Network Open*** — now suggests that poor air quality is associated with a lower bone density among aging populations.

"This study contributes to the limited and inconclusive literature on air pollution and bone health," says first author Otavio Ranzani, Ph.D.

'Air pollution is relevant for bone health'

In their study, the researchers analyzed data regarding the bone health and living conditions of 3,717 participants, including 1,711 women, from 28 villages in the proximity of the city of Hyderabad in India.

The investigators used estimates of outdoor exposure to air pollution, referring to the presence of carbon and fine particulate matter in the air. These are minuscule particles that come, for instance, from car exhausts. These particles remain airborne for a long time and infiltrate the human body through the lungs.

In addition to this, the researchers also took into account self-reported data from questionnaires asking the participants what kind of fuel they used when cooking…..**Read More**

SLEEP DISORDER INFORMATION

Sleep disorders are any form of illness or disability that disrupts normal, healthy sleeping patterns. A wide variety of conditions fit the definition of a sleep disorder, and they can range from mild, easily treatable issues to life-threatening illnesses. In some instances, a sleep disorder develops as a complication of another disease or condition.

Common Sleep Disorders

Insomnia, the inability to sleep, is perhaps the most common sleep disorder. Insomnia may involve periods of sleep and wakefulness throughout the night, waking up too early or the inability to fall asleep at night. It can be caused by a variety of factors, and when it lasts for four weeks or longer, it's known as chronic insomnia.

Another fairly common and potentially dangerous sleep disorder is obstructive sleep apnea. In this disorder, breathing is interrupted briefly but multiple times during sleep as the airway gets blocked. Sleep apnea not only disturbs the quality of sleep, but it can eventually lead to dangerous complications like heart disease and memory problems.

Other Types of Sleep Disorders

A variety of other illnesses are classified as sleep disorders as well. In children, bed-wetting is a common sleep disorder. Some adults have sleep interrupted by a frequent urge to urinate. Narcolepsy is a brain disorder that causes sleepiness during the day. Some people have restless legs syndrome, which affects their ability to sleep at night. In addition, there are a number of conditions that can cause sleeping problems as a complicating symptom. This includes disorders that affect breathing, such as chronic obstructive pulmonary disease (COPD). Epilepsy, chronic pain syndromes like fibromyalgia as well as allergies are other conditions that can affect the ability to get a good night's sleep.

Treatments for sleep disorders vary widely, depending on the cause and severity. Some mild forms of insomnia can be treated through adopting better bedtime habits or using over-the-counter sleep aids. People with apnea may require breathing devices to help them breathe normally while they sleep at night.

SOURCES: National Sleep Foundation; American Academy of Family Physicians

Having New Year's Resolutions As You Age Might Just Save Your Life

NEW YEAR'S RESOLUTIONS might seem trite, especially as you age. But think again. When you look at them, resolutions are goals. And when you have goals, you have purpose.

Studies in the past have hinted at the benefit of purpose for older adults. But a study published in 2019 actually shows that having purpose may extend your life.

Data from 7,000 Americans ages 51 and 61 explored the relationship between mortality and purpose. Purpose was defined as "a self-organizing life aim that stimulates goals."

People without strong purpose were more than twice as likely to die during the study period, regardless of income, gender, race or education. Purpose, it seems, is better at attaining longevity than reducing drinking, stopping smoking and conversely, even better than exercising regularly.

The Practicality of Organization

Organize your medical records. **Researchers** have found that people who keep a **personal health record** enjoyed better health. Seeing your whole health picture and having records at the ready in an emergency can be life-saving. From paper to electronic, there is no shortage to organizing systems. It's the getting started that matters. Caregivers can help their loved ones, and many health systems offer resources. Patient advocates and geriatric life professionals can also assist.

It's estimated that hoarding impacts 2% to 5% of the population. Most of us aren't hoarders, but we certainly do accumulate stuff. And that can become a safety hazard at home. There are tripping and falling hazards; the toxic effects of an unclean environment; the potential hazards of expired medications and food. Here again, there are numerous resources and apps that can help. It's easy to see how hoarding can impact quality and length of life: A person may not feel comfortable letting health aides or other professionals into their homes, for example, and a cluttered environment might prevent someone from using walkers or wheelchairs.

Organize your finances.

It's not uncommon to detect the first signs of dementia in a loved one when they start having problems with their finances. That, in turn, makes someone vulnerable for fraud and abuse. As you step in as a caregiver to help, it's important to learn your own lessons. Scattered accounts can lead to costly financial mistakes and fraud, so experts suggest whittling down accounts. Automate payments and use direct deposit for income sources. When you reduce vulnerability, you decrease stress.

Nola Ochs became the oldest college graduate at 95 and lived to 105. After graduation, Princess Cruises hired Ochs as a guest lecturer on a nine-day Caribbean cruise.

Hubert Jones was 69 when he founded the Boston Children's Chorus, which includes young people of different ages, races, ethnicities and socioeconomic backgrounds. Its mission combines artistic excellence and an agenda for social change. The group has performed all over the world.

Ernestine Shepherd is an American bodybuilder best known for being, at one point, the oldest competitive female bodybuilder in the world. She will be 84 this year and is still an active, albeit no longer competitive, bodybuilder.

So resolve this year to live a life with purpose. As Casey Kasem famously said: "Keep your feet on the ground and keep reaching for the stars."

Cancer group finds biggest one-year drop in US death rate

- Researchers reported the largest-ever one-year decline in the U.S. cancer death rate, a drop they credited to advances in lung-tumor treatments.
- The overall cancer death rate has been falling about 1.5% a year since 1991. It fell 2.2% from 2016 to 2017, according to the new American Cancer Society report.
- It is the largest drop ever seen in national cancer statistics going back to 1930.

Researchers on Wednesday reported the largest-ever one-year decline in the U.S. cancer death rate, a drop they credited to advances in lung-tumor treatments.

The overall cancer death rate has been falling about 1.5% a year since 1991. It fell 2.2% from 2016 to 2017, according to the new American Cancer Society report. That's the largest drop ever seen in national cancer statistics going back to 1930, said Rebecca Siegel, the lead author.

"It's absolutely driven by lung cancer," which accounts for about a quarter of all cancer deaths, she said. Take lung cancer out of the mix, and the 2017 rate drop is 1.4%, she added.

Government researchers previously reported a slightly lower drop in the cancer death rate for the same period. But the Cancer Society calculates the death rate differently, and on Wednesday said the decline was larger — and record-setting.

Most lung cancer cases are tied to smoking, and decades of declining smoking rates led to falling rates of lung cancer illnesses and deaths.

But the drop in deaths seems to have been accelerated by recent lung cancer treatment advances, Siegel said.

Experts mainly credit advances in treatment. Topping

the list are refinements in surgery, better diagnostic scanning, and more precise use of radiation.

They also celebrate the impact of newer drugs. Genetic testing can now identify specific cancer cell mutations, which allow more targeted therapy using newer pharmaceuticals that are a step beyond traditional chemotherapy.

"It's an exciting time," said Dr. Jyoti Patel, a Northwestern University lung cancer expert.

Even patients with late-stage cancers are surviving for several years — rather than months — after treatment starts, she said. "That was very, very uncommon a decade ago," she said.

New immunotherapy drugs could accelerate the death rate decline, Patel said.

Cancer Society researchers also found:

The overall cancer death rate fell by nearly 30% from 1991 through 2017.

— Death rates from one type of skin cancer dropped even more dramatically than lung cancer — falling 7% a year recently. That decline in melanoma patients is attributed to drugs that came on the market about nine years ago.

— Declines in the death rates from prostate, breast, and colon cancer are slowing, for a range of reasons.

— The rising liver cancer death rate seems to have leveled off somewhat. That may be related to better treatment of hepatitis C infections, which are tied to about 25% of liver cancer cases, Siegel said.

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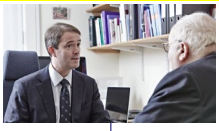
Should you be screened for prostate cancer?

Prostate cancer is one of the leading causes of cancer death in the US. It is also the most common cause of cancer among men, according to the **Centers for Disease Control**. That said, **most men survive prostate cancer.** Virtually all men survive for several years, with 98 percent surviving for 10 years, and 96 percent surviving for at least 15 years. The five-year survival rate falls to 29 percent for men with prostate cancer that has spread to other parts of the body. Should you be screened for prostate cancer?

Should you get a prostate cancer screening?

The **US Preventive Services Task Force** (USPSTF) advises that men between the ages of 55 and 69 should decide for themselves whether to get a prostate-specific antigen (PSA)-based screening for prostate cancer. They should consult with their physicians about the risks and benefits and factor in their preferences in their decision.



The USPSTF says that screening offers a small possible benefit of lowering the risk of death from prostate cancer for some men. It also says that screening can cause many harms, including extra testing and perhaps prostate biopsy, as well as overtreatment. Overtreatment can lead to incontinence and erectile dysfunction.

As a result, the USPSTF gives the prostate cancer screening a "C" grade. And, for men who are 70 or older, it gives the screening a "D" grade.

Why shouldn't I get a prostate cancer screening?

The Prostate-Specific Antigen (PSA) blood test cannot differentiate between cancers that will be aggressive and benign cancers that are slow-growing and will never produce symptoms. Even so, most people with prostate cancer (aggressive or otherwise), never have symptoms. Invasive treatments for prostate cancer, like chemotherapy and radiation, in people with a benign slow-growing form are likely to cause significant harm.

The Prostate Cancer Foundation reports that as many as two in five men treated for prostate cancer had tumors that would never have presented a risk to their health or lives. But, the radiation treatment many men opt for can cause incontinence and erectile dysfunction. And, hormone therapy treatment can lead to depression and osteoporosis.

On the other hand, screening could reduce the chance of death from prostate cancer. The medical community recommends shared decision-making around screening. Individuals should weigh the risks and benefits of screening and make an informed decision on whether to proceed.

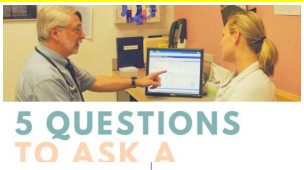
What does Medicare cover?

If you decide to proceed with a prostate cancer screening, Medicare covers a prostate screening each year, including a Prostate-Specific Antigen (PSA) blood test and a digital rectal exam (DRE). If you have traditional Medicare and your doctor takes assignment, the PSA test is covered in full. If you are enrolled in a Medicare Advantage plan, it is also covered in full if you see an in-network doctor. You will be responsible for coinsurance or a copay with the digital rectal exam.

Medicare covers these tests more frequently for people whose doctors say they are medically necessary for diagnostic purposes.

Five questions to ask your doctor to avoid overtreatment

When your doctor suggests a particular test or treatment, it's OK to have questions. (**Overtreatment can be a problem.**) These five questions, adapted from the book **Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer**, are intended to help you start a conversation and get the right care. If your doctor feels like there isn't time to answer all of these questions in one appointment, it's OK to ask for another.



1. **What are my options?** For many conditions and illnesses, there can be more than one treatment. Sometimes changing your lifestyle, such as your eating or exercise habits, can reduce your symptoms or risk of a bad outcome enough to make additional treatment unnecessary. Sometimes, not getting treated at all is a reasonable choice. Ask your doctor what your options are, and to explain each one carefully.
2. **How exactly might the treatment help me**? Sometimes patients have one idea about what a treatment can do, and the doctor has another idea.You need to know exactly what you stand to gain. A hip replacement, for example, might allow you to walk again with greater ease, but it won't cure your arthritis, and you might need another replacement in 10 to 20 years. A drug might be able to relieve some symptoms and not others. Ask your doctor how the proposed drug or procedure is supposed to help you.
3. **What side effects can I expect, and what bad outcomes might happen?** Every test, **drug**, **surgery**, and medical procedure has side effects, and some can be very serious. Simply being in the hospital exposes you to the possibility of bad reactions, medical errors, and hospital-acquired infections. You need to know the risks so you can decide if the danger or discomfort of your condition is more worrisome to you than the risks of the proposed treatment.
4. **How good is the evidence that I'll benefit from the treatment?** Many of the treatments and tests that doctors prescribe have never been adequately tested to find out if they work, or if they work in patients like you. You need to know if the treatment your doctor is recommending is a proven therapy. If not, your doctor should explain why he or she thinks it's a good idea.
5. **If it's a test, what do you expect to learn from it, and how might it change my treatment?** If the test won't change the treatment, ask your doctor if you really need the test.
6. When you or someone you care about is in the hospital for a serious condition, such as heart failure, cancer, kidney failure, emphysema or any other advanced chronic condition, all of these questions are relevant. In addition, there is one more question and request you should make.
7. **Do you have a palliative specialist in this hospital?** If so, ask for a "palliative care consult." Palliative care specialists are nurses, doctors ad other health professionals who are expert in controlling pain. They also help patients and their families with important decisions, such as whether or not to have surgery. For patients who are in the terminal stage of their disease, palliative care can explain various options patients have around end-of-life care, and help them and their families decide what kind of care they want and need. You should not have to pay out of pocket for a palliative care consult.

Tips for Living Alone with Early-Stage Dementia

Have you been diagnosed with early-stage Alzheimer's disease, vascular dementia, Lewy body dementia, or a frontotemporal disorder and live alone? Or, do you have mild cognitive impairment (MCI)? If so, these tips are for you.

These tips offer ways to help you cope with changes in memory and thinking, prepare for the future, and stay active.

Learn about ways to cope with changes, prepare for the future, and stay active.

Use the links below for more information.

- **Make Everyday Tasks Easier**
- **Scan Your Home for Safety**
- **Prepare for the Future**
- **Strengthen Your Support System**
- **Keep Your Mind and Body Healthy**

Edith's Story

It took Edith more than a year to accept what the doctor had said—she had Alzheimer's disease. At first, she was anxious and had trouble thinking. But having strong support from her family, friends, and community helped her go from asking "why me?" to "what's next?" Now, Edith organizes her days and stays involved with the activities she loves. She's also taken steps to prepare for the future.

Find Help in Your Community

- To learn about community-based support services, including food and transportation options:
- Contact the Eldercare Locator (**1-800-677-1116).**
- Look on your State government or tribal organization's website.
- Reach out to social service agencies, community centers, and houses of worship.

Are you concerned about someone who lives alone with dementia?

NIA offers several resources on caregiving for family members and other caretakers of people with Alzheimer's disease or a related dementia. Dementia Friendly America offers resources to help community members support people living with dementia in their area.

Medicare covers physical, speech and occupational therapy

Whether it's because of an illness or an injury, or simply to improve balance, at some point in our lives, many of us will need therapy to regain or maintain our ability to function. Medicare covers physical, speech and occupational therapy in a variety of settings. Talk to the doctor about whether therapy would benefit you or someone you love.

Medicare offers several outpatient therapy options. You can receive outpatient therapy services at a **Comprehensive Outpatient Rehabilitation Facility**, hospital, public health agency or from a private therapist, so long as the provider is Medicare-certified and you qualify for coverage. You can also receive outpatient therapy services from a Medicare-certified home health agency, **so long as you qualify for the Medicare home health benefit**.

For Medicare to cover outpatient therapy, you must meet the eligibility criteria:

- Therapy must be a safe and effective treatment for you.
- A therapist must deliver the services or direct the delivery of the services.
- Your doctor must certify you need the therapy to regain or maintain your ability to function and set up a plan of care for you in advance of your receiving services. And, if you need ongoing therapy, your doctor must review it and recertify your need.

Medicare now covers as much outpatient physical, speech and occupational therapy as people need. In February, Congress lifted the cap on outpatient therapy services retroactive to January 1, 2018. (In 2017, Medicare generally only covered up to $1,980 of outpatient speech and physical therapy and the cap in 2018 was originally $2,010. Only if your doctor made the case that additional therapy was medically necessary to regain or maintain function, **Medicare sometimes would cover additional services**.)

Traditional Medicare pays 80 percent of the cost of these covered services. **Supplemental coverage**, such as Medicare supplemental insurance or "Medigap," retiree coverage or **Medicaid**, should pay the rest.

Medicare also offers several inpatient therapy options. It covers physical, speech and occupational therapy in a **nursing home** as well as in a rehabilitation hospital. Coverage is limited. If you want inpatient care in a nursing home, you will need to have been **hospitalized as an inpatient** for at least three days in the 30 days prior to admission. You must receive care in a Medicare-certified skilled nursing facility. (Note: You can spend three nights at a hospital and the hospital may still deem it an outpatient stay.)

If you simply need rehabilitation services–be it nursing, therapy, social worker help or psychological services–Medicare will **cover care in a rehabilitation hospital** under its hospital benefit.

Medicare also covers cardiac rehabilitation care. **Click here to read more about this coverage.**

19 Cancer Survivors Reveal the Symptoms That Saved Them

19 Cancer Survivors Reveal the Symptoms That Saved Them

According to the **National Cancer Institute,** approximately 1,762,450 new cases of cancer were diagnosed in the United States in 2019 alone. And while some cancer symptoms may feel glaringly obvious, there are just as many that can be dismissed as signs of a run-of-the-mill virus. Others are so subtle they go completely unnoticed until a routine checkup reveals something's amiss. To keep you healthy and informed in the coming year, we've teamed up with 19 cancer survivors to reveal which symptoms led to their diagnoses. And to separate the fact from the fiction when it comes to this all-too-common disease, check out these **23 Myths About Cancer You've Always Believed**.

Read Their Stories