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Speaker Pelosi's Plan for Prescription Price Drug Overhaul

Speaker Pelosi's Plan Would Extend Drug Price Protections to All Payers

Kaiser Health News reports that House Speaker **Nancy Pelosi** is finalizing **a plan** that would allow Medicare to negotiate lower prices for more than 200 of the highest priced drugs. All payers, including employers and insurers, would benefit from the prices as well.

The plan is coming at a crucial time. According to ***CBS News***, more than 3,400 drugs have boosted their prices in the first six months of 2019, an increase of 17% in the number of drug hikes from a year earlier. The average price hike is 10.5%, or 5 times the rate of inflation.

Government negotiation would both reduce out-of-pocket costs and lift spending burdens from Medicare, which is projected to take on the fastest-growing portion of drug spending over the next few years. Inflation-adjusted drug prices per capita **increased** from $90 in 1960 to $1,025 in 2017, and are projected to increase even more.

Additionally, the plan would authorize the Secretary of the Department of Health and Human Services (HHS), which includes the Centers for Medicare & Medicaid Services, to work with pharmaceutical corporations to drive down the cost of the 250 most-expensive drugs on the market. These drugs make up 78% of all prescription drug spending.

Robert Roach, Jr
ARA President

"This plan must be finalized, released and act acted on," said Alliance President **Robert Roach, Jr.** "Lawmakers must protect seniors and all consumers now -- many don't have time to wait."

Here's how a growing Social Security impostor scam works

To scammers, your **Social Security number is gold-plated and diamond-encrusted asset**, and now they have **a new way to try to steal yours** and get paid.

Consumer advocates are raising an alert about a twist to an old impostor phone scam. It's called the "Social Security impostor scam." A blog at the Federal Trade Commission recently wrote: "In the shady world of government, the SSA scam **may be the new IRS scam**."

Here's how it works:

You get a call with a warning that your Social Security number has been suspended because of suspicious activity or because it's been used in a crime. You are asked to confirm you number or told you need to withdraw money from the bank and buy gift cards.

The phone call may be a robocaller with a message to "press 1" to speak with a "support representative" from the government to reactivate your Social Security number. The scammers use technology to spoof your Caller ID to make it look like the Social Security Administration is really calling.

In the last 12 months, people filed more than 76,000 complaints about Social Security impostors, reporting $19 million in losses. The median reported loss last year was $1,500, the FTC said.

People are asked to give up the personal identification numbers (PINs) on the back of gift cards or use virtual currencies like Bitcoin to pay. (According to the FTC's consumer alert, people withdrew money and fed cash into Bitcoin automatic teller machines.)

After handing over the gift card numbers to the "Social Security office," one consumer interviewed by **Fraud.org** was told he would receive a refund equal to the amount he paid to unfreeze his account from the Federal Reserve. Of course, the refund never came and the man lost nearly $20,000.

"One scammer will try a new twist on an old scam or try one new wrinkle that gets them more money," said John Breyault, vice president of public policy, telecommunications and fraud with the **National Consumers League**. "Scammers like to keep up with the Joneses when it comes to using the latest techniques to defraud consumers."

The scammers can be clever. With numerous data breaches that have hit corporate America, fraudsters may already have accurate personal information about you, including your real Social Security number, Breyault said. The information is used to build trust and make the call seem more legitimate, he added.

According to Fraud.org and the FTC, here are some important things to remember:

- Don't trust your phone's caller ID. Scammers can make it look as if the Social Security Administration is calling and even use the agency's real number.
- Don't give your Social Security number, other personal information, to a caller on the phone.
- Social Security will never suspend your number, according to Fraud.org. If anyone tells you something different, you're being scammed.
- Social Security will never call you and demand money. No government agency will demand you pay something using gift cards or Bitcoin either.
- If you have a question, check with the real Social Security Administration. The administration will never contact you out of the blue. The agency's number is 1-800-772-1213.

Talk about the scam with friends, family and neighbors. Report government impostor scams to the FTC at **ftc.gov/complaint**.

Affordable Care Act Faces Its Latest Legal Challenge

Last week, the U.S. Court of Appeals for the Fifth Circuit heard oral arguments in *Texas v. U.S.,* the latest legal challenge to the Affordable Care Act (ACA). The appeals court is reviewing a federal trial court's December 2018 **decision** invalidating the ACA.

The underlying lawsuit was brought in 2017 by 20 Republican state attorneys general and governors plus two individuals, challenging the constitutionality of the ACA's individual mandate and related tax penalty.

The individual mandate requires that most people maintain a minimum level of health coverage or pay a financial penalty to the Internal Revenue Service. The Supreme Court **previously upheld** these ACA provisions in 2012, finding the mandate to be an appropriate use of Congress's power to tax.

Subsequently, in the 2017 tax bill, Congress reduced the mandate's penalty to zero. Plaintiffs in *Texas v. U.S.* then filed suit, arguing that absent a financial penalty the mandate is no longer a tax, and the Supreme Court's previous reasoning is no longer valid. They claim the penalty—and the entire ACA—must fall as a result. The district court agreed with this flawed argument, finding both that the individual mandate is unconstitutional and that the court cannot sever it from the rest of the law and leave the remainder of the ACA in place.

If the lower court's ruling is upheld and the ACA is invalidated, the results would be catastrophic, particularly for older adults and people with disabilities. Such a finding would cause millions of Americans to lose health coverage, while jeopardizing it for millions more, including an estimated **133 million** Americans under 65 with pre-existing conditions who rely on the ACA's coverage and consumer protections. Those approaching Medicare eligibility would be disproportionately impacted, as the likelihood of having a pre-existing condition increases with age: up to **84%** of those ages 55 to 64—31 million individuals—have a pre-existing condition for which they could be denied coverage or charged an unaffordable rate absent the ACA's important protections.

The health law's improvements to the Medicare program would also go away—including provisions setting Medicare Advantage payments based on the equivalent costs in Original Medicare, expanding coverage for preventative care, and closing the Part D donut hole. These changes have been critical to strengthening beneficiary access and affordability, as well as the program's sustainability.

Importantly, the ACA is still the law of the land. The Fifth Circuit has placed a stay on the lower court's decision, meaning that no action can be taken until the higher court issues a ruling, which could take months. That decision could then also be appealed—perhaps eventually to the Supreme Court—prolonging the stay that is currently in place.

Medicare Rights continues to be troubled by the lower court's decision and the Department of Justice's failure to defend the law in court. We urge states and the Trump Administration to abandon efforts to undermine the ACA, and instead favor efforts to improve health care and coverage for all Americans.

Read more about the lower court's decision.

Medicare Advantage Overbills Taxpayers By Billions A Year As Feds Struggle To Stop It

Health insurers that treat millions of seniors have overcharged Medicare by nearly **$30 billion the past three years** alone, but federal officials say they are moving ahead with long-delayed plans to recoup at least part of the money.

Officials have known for years that some Medicare Advantage plans overbill the government by exaggerating how sick their patients are or by charging Medicare for treating serious medical conditions they cannot prove their patients have.

Getting refunds from the health plans has proved **daunting**, however. Officials with the Centers for Medicare & Medicaid Services repeatedly have postponed, or backed off, efforts to crack down on billing abuses and mistakes by the increasingly popular Medicare Advantage health plans offered by private health insurers under contract with Medicare. Today, such plans treat over 22 million seniors, more than 1 in 3 people on Medicare.

Now CMS is trying again, proposing a series of enhanced audits tailored to claw back $1 billion in Medicare Advantage overpayments by 2020 — just a tenth of what it estimates the plans overcharge the government in a given year.

At the same time, the Department of Health and Human Services Inspector General's Office has launched a separate nationwide round of Medicare Advantage audits.

As in past years, such scrutiny faces an onslaught of criticism from the insurance industry, which argues the CMS audits especially are technically unsound and unfair and could jeopardize medical services for seniors.

America's Health Insurance Plans, an industry trade group, blasted the CMS audit design when details emerged last fall, calling it "fatally flawed."

Insurer Cigna Corp. warned in a May **financial filing**: "If adopted in its current form, [the audits] could have a detrimental impact" on all Medicare Advantage plans and "affect the ability of plans to deliver high quality care."

But former Sen. Claire McCaskill, a Missouri Democrat who now works as a political analyst, said officials must move past powerful lobbying efforts to hold health insurers accountable and demand refunds for "inappropriate" billings.

"There's a lot of things that could cause Medicare to go broke. This would be one of the contributing factors," she said. "Ten billion dollars a year is real money."

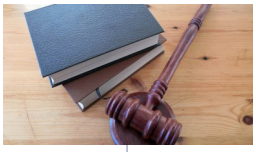
Catching Overbilling With A Wider Net

In the overpayment dispute, health plans want CMS to scale back — if not kill off — an enhanced audit tool that, for the first time, could force insurers to cough up millions in improper payments they've received….**Read More**

Court Blocks Drug Ad Pricing Requirement

A rule from the Trump administration that sought to require prescription drug manufacturers to include pricing information in their television advertisements has been blocked by a federal court. The rule was supposed to go into effect on July 9.

In the decision, the court ruled that only Congress, not the Department of Health and Human Services, has the power to make drug manufacturers disclose drug prices in television commercials. The judge noted that the proposed requirement was impermissible even if it would potentially be effective.



The rule would have required that advertisements for most drugs covered by Medicare or Medicaid that have a list price of more than $35 per month reveal that list price. In some ways, the list price for a drug is like the Manufacturer's Suggested Retail Price, or MSRP, from car ads. Just as with cars, some consumers do pay the list price. If they are uninsured, for example, they may have no choice but to pay the list price. Or if they have a high deductible, they may be paying the list price until their coverage kicks in.

Critics of the proposal pointed out that list price is not a good indication of what a consumer's out-of-pocket cost would be, that the requirement had no enforcement mechanism, and that it did not directly address the larger problem of high and rising drug prices.

At Medicare Rights, we urge the Trump administration and Congress to tackle head on the underlying problem of high drug prices and the massive out-of-pocket costs people with Medicare and their families are forced to pay for needed medications. Transparency in drug pricing is important but not enough to truly fix the problem. We will continue to push for drug pricing reforms and for coverage changes that will help people better afford their health care and prescription drugs.

Read more about the court's decision.
Read more about the drug ad pricing rule.

Striking Down ACA Would Weaken Medicare

Medicare beneficiaries, providers, and plans could face severe harm if the federal courts allow a district court **decision** striking down the Affordable Care Act (ACA) to stand. As we **noted** earlier today, a federal court of appeals will hear oral arguments tomorrow on whether to uphold the decision.

The ACA affected many aspects of Medicare, and invalidating the entire law would call all of them into question. In particular, the ACA altered Medicare's annual payment updates to hospitals, skilled nursing facilities, and certain other health care providers, as well as payments to Medicare Advantage health plans. If the district court's decision stands, it's unclear whether the Centers for Medicare & Medicaid Services could continue paying providers and plans or would first have to establish new regulations resetting all of these payment rates.

Beyond the immediate uncertainty and confusion, letting the decision stand could jeopardize the ACA's Medicare improvements, including:

- **Closing the prescription drug "donut hole."** The ACA gradually eliminated the Medicare Part D **coverage gap** — the range of beneficiaries' drug spending for which the beneficiaries had to pay 100 percent of the costs. The 2018 Bipartisan Budget Act accelerated the timetable for eliminating the gap.
- **Providing preventive services without cost-sharing.** The ACA eliminated beneficiary coinsurance for most preventive services, such as screenings, and added coverage of an annual wellness visit.
- **Promoting delivery system reform.** The ACA introduced a wide range of payment reforms to promote quality and efficiency in health care delivery, including establishing **accountable care organizations** and the **Center for Medicare & Medicaid Innovation** and providing incentives to **reduce unnecessary hospital readmissions**. Subsequent laws and regulations have built on these promising innovations.
- **Reducing Medicare Advantage overpayments**. Before the ACA, Medicare paid private Medicare Advantage plans about 13 percent more per beneficiary, on average, than it would cost to cover those beneficiaries in traditional Medicare. The ACA scaled back those overpayments.
- **Reforming payments in traditional Medicare**. The ACA reduced Medicare's annual payment updates to hospitals, skilled nursing facilities, and certain other providers, partly to account for economy-wide productivity improvements. It also reduced excessive payments to home health agencies and inpatient rehabilitation facilities.
- **Raising the Medicare tax on high-income people.** The ACA raised the Medicare payroll tax rate for individuals with incomes over $200,000 and couples with incomes over $250,000. It also imposed a Medicare tax on those households' dividends, capital gains, and other unearned income.
- **Strengthening Medicare's financing.** These changes in spending and revenues strengthened the financial status of Medicare's Hospital Insurance (HI) trust fund. Before the ACA, the program's trustees projected that the trust fund would become insolvent in 2017. They now project it will remain solvent through 2026. The ACA also eliminated four-fifths of the long-run HI shortfall.

If the ACA were struck down, the courts might give the President and Congress time to enact a new law to take its place. But in the current political environment, an agreement between the House, Senate, and President could prove difficult to achieve. At the very least, Medicare beneficiaries, providers, and plans would face heightened uncertainty, and at least some of the ACA's Medicare improvements would likely be lost.

How to Pay for Nursing Home Costs

This article is based on reporting that features expert sources including **Gabriel Heiser, JD**; **Caroline Haarmann**

ODDS ARE HIGH THAT someone in your family will need a **nursing home** sooner or later. Someone turning age 65 today has almost a 70% chance of needing some type of long-term care, and 20% of people will need it for longer than five years, according to LongTermCare.gov. The average cost of nursing home care is so high that the cost of that care can financially cripple a family. But there are steps you can take – whether a nursing home is needed now, next month or next decade – to minimize the financial strain of nursing home costs.

There are many ways to cover the costs of long-term care, including savings, investments, assets, long-term care insurance, state LTC Partnership programs, the Federal LTC Insurance Program and tax advantages. **Care Conversations**, an initiative led by the American Health Care Association, the National Center for Assisted Living and America's Skilled Nursing Caregivers, offer a helpful list of these private and public payment sources in greater detail.

Planning for Long-Term Care Medicare does not provide an all-inclusive long-term care component. If certain conditions are met, Medicare offers limited coverage (up to 100 days per benefit period) for some beneficiaries. Since Medicare does not cover long-term care, the program does not pay for assisted living costs, though it may cover certain services, such as home health or outpatient therapy benefits for assisted living residents. Additional information can be found on Care Conversations.

Ideally, financial planning for long-term care should occur long before the need arises, says Wendy Boglioli, a spokesperson for insurer Genworth Financial. Long-term care insurance, Medigap and employer-provided or private health insurance plans can offset the cost of long-term care. But if these policies aren't in place before a major health event occurs, they are usually no longer available to consumers.

If your family's facing imminent need for nursing care and doesn't have an insurance plan for it in place, there are still options to help defray the costs. Make no mistake: Those costs can be staggering. In 2018, a private room cost an average of $8,365 a month, or more than $100,000 annually, according to the Cost of Care Survey 2018 by Genworth Financial. A semi-private room ran $7,441 a month, or $89,292 per year. And the average nursing home stay is 835 days, or more than two years, according to the government's latest National Nursing Home Survey.

Costs widely vary from person to person, both because of geographical difference in rates and because each resident's length of stay differs. While nearly 1 in 10 residents age 75 to 84 stays in a nursing home for five or more years, nearly 3 in 10 residents in that age group stay less than 100 days, the maximum duration covered by Medicare, according to the American Association for Long-Term Care Insurance. Convalescent nursing home care, which follows a major surgery or other hospitalization, is typically short-term and can be covered by Medicare.

"Even if you or your loved one doesn't need care right now, but you think it may be coming, at least look at the costs now and in five years to gauge what the hit will be," Boglioli says….**Read More**

Questions To Ask Your Member Of Congress At Your Next Town Hall

.The U.S. House and Senate adjourn at the end of July for a six-week summer recess, and many lawmakers will hold town hall meetings in their home states and districts throughout the month of August. The Senior Citizens League (TSCL) encourages Social Security and Medicare beneficiaries like you to attend these events and to ask important questions of your elected officials about your earned benefits.

To be best prepared, jot down some questions for which you would like answers. Below are six sample questions – feel free to take them with you and share them with others at your next town hall.

- Social Security beneficiaries received a 2.8% cost-of-living adjustment (COLA) this year, but millions of older Americans with low benefits have seen their increases completely offset by higher Medicare Part B premiums. Do you support the *Fair COLA for Seniors Act* (H.R. 1553), which would give beneficiaries a more adequate Social Security COLA?
- Most Americans contribute 6.2 percent of every paycheck to Social Security, but workers earning over $132,900 contribute nothing over that amoun,t due to a payroll tax cap. Around 75% of Social Security beneficiaries believe the Social Security taxable maximum should be eliminated to extend the solvency of the Trust Funds responsibly, without cutting benefits. Do you agree?
- Bipartisan legislation before the House and Senate would repeal the Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO) benefit reductions so that millions of retired teachers and police officers receive the Social Security benefits they have earned and deserve. Will you cosponsor the *Social Security Fairness Act* (S. 521, H.R. 141) when you return to Washington?

- Roughly half of all older taxpaying households paid income taxes on a portion of their Social Security benefits this year, even though many of them had incomes as low as $25,000 or $32,000 for married couples filing jointly. Those modest incomes are just two times higher than the federal poverty level. Do you believe this tax on Social Security benefits is fair and, if not, what are you doing to fix it?
- The government negotiates prescription drug prices for Medicaid and for veterans, but it is barred from doing so for Medicare Part D beneficiaries. As a result, senior citizens enrolled in Part D often pay much higher prices for their prescriptions than other Americans. Will you support the bipartisan *Medicare Prescription Drug Price Negotiation Act* (H.R. 275)?
- Under current law, the Medicare program excludes coverage of most routine and emergency dental care, including cleanings, fillings, root canals, and extractions. As a result, around 70 percent of Medicare beneficiaries are left without comprehensive dental insurance coverage. The *Medicare Dental Benefit Act*(S. 22) would correct this to ensure that seniors have access to essential health care. Will you cosponsor this important bill?

Private insurers are the biggest obstacle to guaranteed affordable health care

Although not all the Democratic presidential candidates support Medicare for All, most understand that giving people the choice of Medicare but allowing them to keep their private health insurance will not guarantee health care to all or make health care affordable. Only **Medicare for All** guarantees everyone affordable health care from the private doctors and hospitals they choose to use. Private health insurers are the biggest obstacle to guaranteed affordable health care.

Over at **New York magazine**, Josh Barro does not appear to appreciate that the problem with private insurers goes beyond the fact that they are for-profit and do not rein in provider rates or prescription drug prices. It's that their business interests are at odds with the need of Americans for guaranteed affordable health care.

Barro mistakenly believes that if we simply reined in provider rates through federal rate-setting, we could make health care affordable. Unfortunately, high provider rates are only one way that private insurers do not meet our needs. Insurers **jeopardize our health care in a number of other ways**.

Private health insurers drive up administrative costs to the tune of as much as **$503 billion a year**. These administrative costs contribute to both high provider rates and high premiums. With Medicare for All, these administrative costs largely disappear, and we generate enormous administrative savings.

Yet a third problem with for-profit private insurers is that they are in the business of avoiding risk. To survive financially, private insurers must compete to avoid people with costly conditions. Consequently, our commercial health care system is designed to fail the people who most rely on it. Commercial health insurers cannot compete to meet the needs of people with complex conditions. If they did, they would attract too many people in poor health, their premiums would soar, and everyone who was healthy would flock to their competitors. They would go out of business. So, instead, they do their best to avoid enrolling people with costly conditions and to delay and deny care to their enrollees with complex conditions.

A fourth problem with commercial health insurers is that they treat their data as proprietary. Most of their data is not available for public scrutiny. So, we cannot measure and report their performance, nor can we drive system improvements.

The fact that insurers do not appear to "manage care" in ways that serve the public good is a fifth problem. For example, wittingly or unwittingly they colluded with pharmaceutical companies to fill millions of opioid prescriptions. Even if unwittingly, the fact that they **covered millions of opioid prescriptions without questioning people's need for opioids** vividly illustrates that they do not manage care appropriately or effectively.

Thankfully, virtually all Democratic presidential candidates seem to appreciate that for-profit insurers are at the heart of the problem with our health care system. **Federal rate-setting** alone cannot guarantee access to good affordable health care for all Americans. You need Medicare for All in order for the federal government to bring down exorbitant and irrational hospital and doctor rates, lower administrative costs, eliminate cost-sharing and give people access to the doctors and hospitals they want to use when and where they need to use them.

Did Your Health Plan Deny You Care? Fight Back.

Have you ever stepped up to the pharmacy cash register only to learn your new prescription will cost you hundreds of dollars — instead of your typical $25 copay — because your insurance doesn't cover it? Or received a painfully high bill for a medical test because your health plan didn't think it was necessary?

Most people have, but only a tiny fraction ever appeal such decisions. In 2017, for example, enrollees in federally run Affordable Care Act marketplace plans appealed fewer than one-half of 1% of denied medical claims, according to an **analysis** by the Kaiser Family Foundation. (Kaiser Health News is an editorially independent program of the foundation.)

If you do appeal, your chance of getting the health plan's decision overturned is a lot better than you might think. "About half of appeals go in favor of the consumer," says Cheryl Fish-Parcham, director of access initiatives at Families USA, a health care consumer advocacy group.

There's no sugarcoating it, though: Getting to "yes" with your health plan can be an ordeal, and you may need help from friends, family members, your doctor, insurance counselors, even legal aid societies.

In California, health plans are supposed to help facilitate the appeals process. When they deny coverage, they must inform members in writing how to appeal. And when they receive enrollee complaints, they are required to acknowledge them formally, which sets the clock ticking on a series of steps to resolve the dispute.

Unfortunately, insurers don't always comply with these requirements.

Last month, the Department of Managed Health **Care fined Anthem Blue Cross**$2.8 million in a settlement covering more than 200 grievance and appeal violations. In some cases, Anthem classified grievances as "inquiries," which means many enrollees did not get important information about their appeal rights, says Shelley Rouillard, the department's director.

Mike Bowman, an Anthem Blue Cross spokesman, says the company "is making significant changes in our grievance and appeals process."

Rouillard says Anthem has had more grievance and appeal violations than other insurers, but "this happens with all the plans."

Regardless of the type of insurance you have, you can do several things to strengthen your position even before you file an appeal….**Read More**

Trump's Health Care Plan Would Do Much the Same Damage as His Effort to Repeal the ACA Through the Courts

Center on Budget and Policy Priorities

A federal appeals court will hear oral arguments tomorrow in *Texas v. Azar*, the lawsuit in which the Trump Administration and 20 Republican attorneys general are asking the courts to invalidate the entire Affordable Care Act (ACA). If the courts ultimately adopt the Administration's position, **20 million** people would lose health coverage, and millions more would pay more for coverage or care. Although the Administration has sought to distinguish its stance in the lawsuit from its policy position on health care, its health care proposals would have much the same consequences.

President Trump has **repeatedly promised** a legislative ACA repeal plan that would maintain coverage, reduce costs, and protect people with pre-existing health conditions. But the Administration has already endorsed at least six separate ACA repeal plans.

In 2017, the President supported four separate ACA repeal plans that Congress ultimately rejected — proposals that the Congressional Budget Office (CBO) **concluded would eachca use** millions of people to lose coverage and raise costs for many more.

The President then embraced legislation introduced by Senators Bill Cassidy, Lindsey Graham, Ron Johnson, and Dean Heller ("Cassidy-Graham") that also would repeal the ACA. In his 2020 budget, released in March, he called on Congress to first enact legislation based on Cassidy-Graham and then cut $765 billion over ten years from health care programs.

Like the President's push for ACA repeal through the courts, his budget proposal would:

- **Cause millions to lose coverage.** If the courts struck down the ACA, the number of non-elderly Americans without health insurance would rise from about 30 million under current law to **50 million**, the Urban Institute estimates. Cassidy-Graham would also leave **an estimated 50 million** Americans uninsured. And the President's budget proposes over $700 billion in additional cuts to federal coverage programs, compared to Cassidy-Graham.
- **End nationwide pre-existing conditions protections.** Cassidy-Graham **would** letinsurers return to charging higher premiums based on pre-existing conditions, ending the ACA's nationwide ban on that practice. That's why **patient groups, physicians, hospitals, insurers**, **experts**, and independent fact checkers (for example, here and here) concluded that the bill would restore discrimination based on pre-existing conditions.
- **End other critical consumer protections.** Cassidy-Graham would also let health plans return to excluding essential health benefits — such as maternity coverage, mental health care, and substance use treatment — as **many plans** did before the ACA.
- **End the ACA's Medicaid expansion.** Cassidy-Graham would end the Medicaid expansion to low-income adults outright, replacing it with a temporary, underfunded, and structurally flawed block grant to states.
- **End or sharply cut financial assistance for individual market consumers.** Cassidy-Graham would end federal financial assistance (premium tax credits and cost-sharing subsidies) altogether, replacing it, too, with a temporary, underfunded, and structurally flawed block grant to states.
- **Destabilize health care markets.** Striking down the ACA would throw much of the health care system into chaos. Similarly, the Cassidy-Graham legislation would "severely disrupt states' individual insurance markets, with sharp premium increases and insurer exits likely to occur in the short term and over time," according to 36 current and former **insurance commissioners** of both parties.

Prescription drug costs soar for people with Medicare Part D

A new Kaiser Family Foundation **issue brief** reports that out-of-pocket prescription drug costs are soaring for people with Medicare Part D, particularly for people who use a lot of medicines. In 2020, the Part D benefit will shrink, so out-of-pocket costs are sure to rise further.

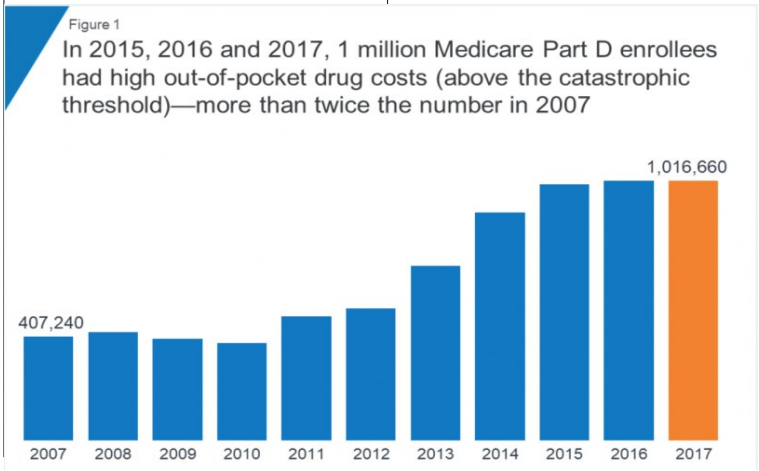
Nearly 45 million people with Medicare–70 percent of the Medicare population–are enrolled in Medicare Part D, either in a stand-alone plan if they have traditional Medicare or in a plan that they get through their Medicare Advantage plan.

On average, people with Part D spent $486 out of pocket for their prescription drugs in 2017. But, beware! If you need expensive medications, your out-of-pocket costs with Medicare Part D can be thousands of dollars. Two percent of people with Part D spent an average of $3,214 out of pocket in 2017.

One million people–one in fifty with Medicare Part D–had out-of-pocket drug costs above the **Part D catastrophic cap** in 2017. Once you reach that cap, you are still liable for five percent of the cost of your drugs. Their average annual out-of-pocket costs were just over $3,200.

Another 2.2 million people with Medicare Part D had total drug costs above the catastrophic cap. But they had a Low-Income Subsidy. That subsidy, **Extra Help**, helps pay Part D premiums and cost-sharing for about three in ten people enrolled in Part D.

Premiums, copays and coinsurance vary tremendously, depending upon the plan you choose and the drugs you take. As of 2019, premiums ranged from **$10.40 to $156 a month**. In 2018, the average monthly drug plan premium was $41….**Read More**



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RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

How having a close relative with Alzheimer's may affect cognition

New research suggests that having a family history of Alzheimer's may impair cognition throughout a person's lifetime, but it also identifies factors that could offset these adverse effects. The findings may enable people at risk to take active measures for delaying or even preventing this form of dementia.

Having a close relative with **dementia** is a known risk factor for **Alzheimer's disease**.In fact, it is one of the two most significant risk factors, together with age. Having a first-degree relative with Alzheimer's raises relative risk by **30%,** which means that a person's existing risk goes up by almost a third.Having a copy of the gene *APOE4* that encodes the protein apolipoprotein E raises Alzheimer's risk by threefold. Having both copies of the gene — which is a rare occurrence — increases the risk by 10 to 15 times.However, the medical research community has not given much attention to the effect that a family history of dementia has on a person's cognition throughout their lives.So, a team of scientists set out to explore this aspect by examining the link between having a first-degree relative with Alzheimer's and cognitive performance in almost 60,000 individuals aged between 18 and 85.

Alzheimer's-related cognitive risk

Talboom and colleagues asked 59,571 participants to complete an online questionnaire that inquired about their sex, educational level, age, language, country, overall health, and family history of Alzheimer's.

The researchers also tested the participants' cognitive abilities. They asked the participants to memorize 12 word pairs and then retested their memory of the new pairs by asking them to fill in the matching word that was missing.

The study found that people who had a close relative with Alzheimer's — such as a parent or a sibling — matched 2.5 fewer word pairs than people who did not have a family history of the disease.

Living with **diabetes** also seemed to influence the results, amplifying the cognitive impairment in people who had a relative with Alzheimer's. "It is not surprising that diabetes exacerbates the effects of [family history] on cognition," write the authors, "since diabetes has been linked to worse cognitive deficits in [Alzheimer's disease.]"

Finally, the researchers collected blood and saliva from a subgroup of 742 study participants who had a family history of Alzheimer's and tested the samples for the *APOE4* gene. However, the research also revealed that a higher educational level could offset the increased risk of premature cognitive decline among people with a family history of Alzheimer's. This led the authors to draw empowering conclusions.

"Our study supports the importance of living a healthy lifestyle, properly treating diseases, such as diabetes, and building learning and memory reserve through education to reduce the cognitive decline associated with Alzheimer's disease risk factors."

Joshua Talboom

"Identifying factors that reduce or eliminate the effect of a family history of Alzheimer's disease is particularly crucial since there is currently no cure or effective disease-slowing treatments," adds the study's lead author….**Read More**

"Silent" heart attacks may help explain strokes of mysterious origin

Silent heart attacks—those that occur but are not detected—are a cause of increased risk for strokes, especially strokes of unknown origin that can baffle healthcare providers, according to an NIA-led study. A comparison of heart and brain imaging data from a longitudinal study of older adults in Iceland showed that while undetected heart attacks aren't noticeable enough to send patients to the hospital, they can scar and damage heart tissue in ways that may raise the risk of a stroke.

In a collaboration between NIA, NHLBI, Weill Cornell Medical College, and the Icelandic Heart Association, the research team analyzed data from the ICELAND MI study, an offshoot of the Age, Gene/Environment Susceptibility-Reykjavik Study (AGES) study that examines genetic and environmental risk factors for age-related disease and disability. Results were published in the May 20 issue of *JAMA Neurology*.

The team identified 930 study participants (average age, 75.9) who had undergone both cardiac and brain magnetic resonance imaging (MRI). The cardiac MRI imaging, which is more sensitive than standard echocardiograms, showed that 153 participants had experienced an undetected heart attack, or myocardial infarction, and 308 had cardiac MRI evidence of a cerebral infarction, or stroke.

More than one-third (43.8 percent) of patients who showed signs of having had a silent heart attack also showed evidence of a stroke in their brain imaging.

These undetected heart attacks were closely associated with a type of stroke known as embolic stroke of undetermined source (ESUS). ESUS strokes account for one-third of all ischemic strokes, which are caused by loss of blood supply to the brain. They seem to be triggered by clots or other vascular debris in the body, possibly a byproduct of the cardiac scarring caused by undetected heart attacks. ESUS strokes make it more difficult to target the most effective prevention or treatment strategy.

While the scientists caution that the cross-sectional data make it difficult to pinpoint the timing of the infarctions, results provide strong evidence for unrecognized heart attacks as a new risk factor for strokes. They are planning future studies to explore how this connection could affect interventions targeting stroke recurrence and prevention.

This research was supported by the Intramural Research Program of NIA with additional support from the National Heart, Lung, and Blood Institute (NHLBI); and the Icelandic Heart Association.

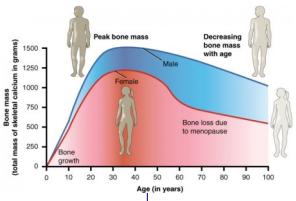
Poor Social Life Could Spell Trouble for Older Women's Bones

A lack of positive connections with others may do more than make older women lonely, with new research suggesting it can also weaken their bones.

In a long-term study of more than 11,000 postmenopausal women in the United States, lower bone mineral density was associated with higher "social strain," a measure of negative social interactions and relationships. Weaker bones were also tied to lower levels of social activity.

Higher social strain was associated with greater bone mineral loss of the total hip, lumbar spine (lower back) and femoral neck (just below the ball of the ball-and-socket hip joint).

The women's social strain scores ranged from 4 to 20, with higher scores indicating more strain. Each point higher was associated with 0.08% greater loss of femoral neck bone mineral density, 0.11% greater loss of total hip bone mineral density and 0.07% greater loss of lumbar spine bone mineral density.



Lower social activity was associated with greater bone loss at the total hip and femoral neck, according to the study published July 9 in the *Journal of Epidemiology & Community Health*.

The associations between bone mineral density and social strain and social activity were found after the researchers adjusted for age, education, existing health conditions, weight, smoking status, alcohol use, hormone therapy use, age at menopause, physical activity and history of fracture after age 55.

Because this was an observational study, it can't prove that poor social connections actually cause bone mineral density loss, the authors noted.

However, the findings show that "bone loss is among the physiological stress responses more strongly related to the quality of social relationships than quantity," according to Shawna Follis, from the University of Arizona's department of epidemiology and biostatistics, and colleagues.

The researchers also pointed to prior studies, which have suggested that factors such as major stressful events and lower levels of optimism, life satisfaction and education, may be associated with fractures.

Based on the findings, community-based efforts to help older women have healthy, active social lives might end up helping their bone health, too, the study authors said.

More information

The U.S. National Library of Medicine has more on **bone density**.

SOURCE: *Journal of Epidemiology & Community Health*, news release, July 9, 2019

Healthy Living Can Cut Odds for Alzheimer's in People at Genetic Risk

Even if you are unlucky enough to carry genes that predispose you to Alzheimer's disease, a healthy lifestyle can minimize that risk, new research shows.

The study tracked the genetics, lifestyles and Alzheimer's disease incidence of nearly 200,000 British people over 60 for an average of eight years.

Researchers found that people who had a high genetic risk for Alzheimer's and who followed unhealthy lifestyles had nearly triple the odds of getting the disease, compared to people with low genetic risk and a healthy lifestyle.

Conversely, living well -- exercising regularly, eating a balanced diet, not smoking, and drinking moderately -- appeared to cut the odds for Alzheimer's, even among those at high genetic risk.

Among people found to be at highest genetic risk, healthy living appeared to reduce the chances of developing the disease by 35%, said a team led by David Llewellyn at the University of Exeter Medical School in England.

That implies that "1 case of dementia would be prevented for each 121 individuals per [every] 10 years with high genetic risk who improved their lifestyle from unfavorable to favorable," the researchers reported July 14 in the *Journal of the American Medical Association*. The findings were reported simultaneously at the Alzheimer's Association International Conference, in Los Angeles.

There was one caveat, however: The UK Biobank database from which the data came only focused on white people of European descent, so it's unclear if the findings might apply to other populations.

Still, the results should give hope to people worried about their Alzheimer's risk -- and an incentive to adopt healthy life habits, one expert said.

"No one can guarantee you'll escape this awful disease," but certainly healthy living can cut the odds, John Haaga, of the U.S. National Institute on Aging, told the *Associated Press*.

In the British study, a "high genetic risk" was based on the presence of genes known to be associated with Alzheimer's disease, such as a particular form of the APOE gene and other DNA more recently tied to the brain-robbing illness.

A "favorable lifestyle" was defined as people who met American Heart Association exercise guidelines of 150 minutes of moderate physical activity per week or 75 minutes of vigorous exercise; who didn't smoke; ate a heart-healthy diet; and drank no more than an average of one glass of wine or beer per day.

Both genes and lifestyle did seem to impact a person's odds for Alzheimer's. As someone's genetic "risk score" got higher, so did their odds for the disease, and the same was true as lifestyle became less healthy.

Of course genes can't be modified, but lifestyle can, Llewellyn and his group found.

They believe that healthier living may give a boost to brain blood flow. That could reduce "oxidative damage" to brain cells and help prevent brain-damaging clots and inflammation that could boost Alzheimer's risk.

Another expert said that the new study proves that when it comes to Alzheimer's, genes are not necessarily destiny.

Rudy Tanzi directs the Genetics and Aging Research Unit at Massachusetts General Hospital in Boston. Speaking the *AP*, he stressed that less than 5% of genes connected to Alzheimer's have such a strong connection to the disease that they would guarantee you'll get the illness.

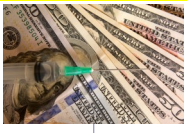
"That means that with 95% of the mutations, your lifestyle will make a difference," Tanzi explained. His advice: "Don't be too worried about your genetics. Spend more time being mindful of living a healthy life."

The new study was partially funded by the U.S. National Institutes of Health.

Study: Almost half of new cancer patients lose their entire life savings

According to a new study published in the **American Journal of Medicine**, 42% of new cancer patients lose all of their life savings in two years because of treatment. The average amount a cancer patient lost was $92,098.

After tracking 9.5 million cancer patients from 2000 to 2012, researchers also learned that 62% of all cancer patients are in debt because of their treatment, and 55% of them owe at least $10,000.



Overall, the total medical costs for cancer are **$80 billion i**n the US. Even if you have insurance, it may not cover all the medical costs associated with cancer. From high deductibles to large copayments, cancer patients can end up with a huge stack of bills.

In addition, 40% to 85% of all cancer patients have to quit working while undergoing treatment, which creates a financial burden that can last for six months or longer.

Medicare may cover acupuncture for lower back pain

The **Washington Post** reports that, under a new proposal, the Centers for Medicare and Medicaid Services would permit Medicare to cover acupuncture for lower back pain in limited situations. Until now, Medicare has **not deemed acupuncture a covered service** for treatment of any condition.

The CMS proposal would offer acupuncture to patients with lower back pain in clinical trials funded by the National Institutes of Health.

Acupuncture has been a source of healing in Asia for thousands of years. But, the evidence is not clear that acupuncture can help lower back pain. Acupuncture may only be a placebo, a treatment that offers no therapeutic effect; though, placebos can offer a psychological benefit.

The American College of Physicians supports testing alternatives to prescription drugs, particularly opioids, for lower back pain. These alternatives include yoga, exercise and acupuncture.

The **Agency for Healthcare Research and Quality** found that people with lower back pain who receive acupuncture may see some improvements in function and feel less pain in the short term. However, AHRQ did not find long-term improvements in function or pain.

An NCBI study found that, for short-term outcomes, acupuncture showed significant improvement over a placebo for back pain. For long-term outcomes, however, acupuncture outcomes were inconsistent. The study did not determine whether the overall benefit of acupuncture is meaningful and cost-effective.

For back pain, Medicare covers some drugs, as well as injections, braces and chiropractic care. In some cases, it covers implanted neurostimulators..

Common Medications Can Masquerade As Dementia In Seniors

By all accounts the woman, in her late 60s, appeared to have severe dementia. She was largely incoherent. Her short-term memory was terrible. She couldn't focus on questions that medical professionals asked her.

But Dr. Malaz Boustani, a professor of aging research at Indiana University School of Medicine, suspected something else might be going on. The patient was taking Benadryl for seasonal allergies, another antihistamine for itching, Seroquel (an antipsychotic medication) for mood fluctuations, as well as medications for urinary incontinence and gastrointestinal upset.

To various degrees, each of these drugs blocks an important chemical messenger in the brain, acetylcholine. Boustani thought the cumulative impact might be causing the woman's cognitive difficulties.

He was right. Over six months, Boustani and a pharmacist took the patient off those medications and substituted alternative treatments. Miraculously, she appeared to recover completely. Her initial score on the Mini-Mental State Exam had been 11 of 30 — signifying severe dementia — and it shot up to 28, in the normal range.

An estimated 1 in 4 older adults take anticholinergic drugs — a wide-ranging class of medications used to treat allergies, insomnia, leaky bladders, diarrhea, dizziness, motion sickness, asthma, Parkinson's disease, chronic obstructive pulmonary disease and various psychiatric disorders.

Older adults are highly susceptible to negative responses to these medications. Since 2012, anticholinergics have been featured prominently on the **American Geriatrics Society Beers Criteria** list of medications that are potentially inappropriate for seniors.

"The drugs that I'm most worried about in my clinic, when I need to think about what might be contributing to older patients' memory loss or cognitive changes, are the anticholinergics," said Dr. Rosemary Laird, a geriatrician and medical director of the Maturing Minds Clinic at AdventHealth in Winter Park, Fla.

Here's what older adults should know aboutthese drugs:

The Basics

Anticholinergic medications target acetylcholine, an important chemical messenger in the parasympathetic nervous system that dilates blood vessels and regulates muscle contractions, bodily secretions and heart rate, among other functions. In the brain, acetylcholine plays a key role in attention, concentration, and memory formation and consolidation.

Some medications have strong anticholinergic properties, others less so. Among prescription medicines with strong effects are antidepressants such as imipramine (brand name Trofanil), antihistamines such as hydroxyzine (Vistaril and Atarax), antipsychotics such as clozapine (Clozaril and FazaClo), antispasmodics such as dicyclomine (Bentyl) and drugs for urinary incontinence such as tolterodine (Detrol).

In addition to prescription medications, many common over-the-counter drugs have anticholinergic properties, including antihistamines such as Benadryl and Chlor-Trimeton and sleep aids such as Tylenol PM, Aleve PM and Nytol.

Common side effects include dizziness, confusion, drowsiness, disorientation, agitation, blurry vision, dry mouth, constipation, difficulty urinating and delirium, a sudden and acute change in consciousness….**Read More**

For your peace of mind and for the people you love, plan in advance for your care

No matter how old you are, planning for your future care needs is one important gift you can give yourself and your family. It ensures that the care you get is the care you want, even if you're not able to reveal your wishes. Without an advance directive–a health care proxy and a living will–it may be difficult for family and other loved ones to speak on your behalf and know whether they are honoring your care wishes.

Through a living will, you make clear your health care wishes should you not be able to express them. Through a health care proxy, you name someone you trust to speak on your behalf if you cannot speak for yourself.

Only three out of ten Americans have advance directives. Many people don't realize they need them. And, even if you want one, it's easy to put off completing the advance care plan. So, if you don't yet have a living will or health care proxy, here are three steps to take on your own, when you're spending time with family. Ideally, you should have a living will and health care proxy **before a hospital stay**.

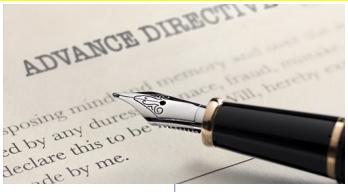
- ♦ ♦ Talk to your parents and kids about the kind of care you would want if something were to happen to you and you could not decide for yourself the care you need. Consider as well whether you would want **hospice care, which Medicare covers**.
- ♦ ♦ Pick someone whom you trust to make decisions for you if you can't make them yourself, your "health care proxy."
- ♦ ♦ Complete a written health care proxy and living will, and share them with the person you have chosen to make decisions on your behalf, your family and loved ones, as well as with your doctors. You might also consider giving your health care proxy a power of attorney. You should consult an elder care lawyer if you can. For a free advance directive from Caring Connections, **click here.**

Click here for advice from Dr. Atul Gawande about planning for end-of-life care.

What's a dementia directive?

You may have heard of an advance directive, a document all adults should prepare, naming a person to speak for them if they cannot speak for themselves and setting forth their care wishes. Now, the **New York Times** reports that a group of experts in care for older people have developed a dementia directive. It is designed specifically to honor the care wishes of people living with dementia, a cohort of about **5.3 million older Americans**.

Unlike an advance directive, with a **dementia directive,** people specify their care wishes at each stage of dementia. It explains the effects of mild or early-stage dementia, as well as moderate or mid-stage dementia, and severe or end-stage dementia. And, it asks people to set forth the kind of medical interventions they would want at each stage, offering a set of options.



Advance directives can be enormously helpful in most instances in which patients are unable to express their care wishes. But, the creators of the dementia directive say that advance directives do not address the care needs of patients with dementia. They tend to be written for people who have been deemed to be terminally ill, with six months or less to live.

People may live for many years with dementia. So, the dementia directive offers four different types of care options for people with dementia at each stage, ranging from "full efforts to prolong my life" to "comfort-oriented care only, focused on relieving suffering."

The dementia directive is a new concept and time will tell whether it takes off or not. Regardless, people should speak with the people they know and trust about their care wishes down the road. You should have those conversations to help ensure you enjoy the quality of life you want to enjoy and are not forced to live a life that you would find unacceptable. Whatever your age, share your views on the kinds of medical interventions you would want and those you would not want if you could not express your wishes yourself.

Fight cancer: Eat cruciferous vegetables

The **Harvard Gazette** reports on new research from Beth Israel Deaconess Medical Center's Cancer Center and Cancer Research Institute finding that Brussels sprouts, broccoli, and other cruciferous vegetables all contain a compound that may keep you from developing certain types of cancer. It adds to the large body of research showing that diet affects health. And, it's more reason to eat cruciferous vegetables!

The cancer-fighting compound, called I3C, appears to free a gene that suppresses tumors to win the battle with other tumors fighting to grow and spread. It's all about the chemical warfare taking place in our bodies.

The PTEN gene, which suppresses tumor growth, is constantly attacked by an enzyme that promotes cancer growth. This enzyme fights hard to destroy or inactivate the PTEN gene. The compound that blocks the enzyme is found in cruciferous vegetables. So, the PTEN gene can continue to suppress tumor growth.

Some people do not have enough PTEN. They are more likely to develop cancer and developmental defects. The findings from this study may help them.

If you're interested in switching up your diet to include PTEN, you can find it in a range of vegetables, including broccoli, Brussels sprouts, arugula, cabbage, kale, and cauliflower. They all have cancer-fighting properties. But, there's a catch. Based on the effective dose in mice, the effective dose in human beings is likely more than six pounds a day! The pill equivalent is desperately needed.