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Strengthening Social Security Act

On May 9, 2019, Representative Linda Sanchez (D-CA) introduced the Strengthening Social Security Act, H.R. 2654, in the U.S. House of Representatives. This legislation will strengthen the Social Security system while improving the economic and retirement security of millions of Americans.

Strengthening Social Security

For more than 80 years, Social Security has delivered its guaranteed benefits on time and without interruption. While Social Security's hard-earned benefits are modest – they are vitally important to all who rely on them, including seniors, people with disabilities and families of deceased workers. Today over 62 million Americans – 1 out of every 4 households – rely on Social Security's lifetime, guaranteed benefits.

The Strengthening Social Security Act includes provisions that would strengthen Social Security by improving the solvency of the Social Security Trust Funds and, at the same time, improve the benefit calculations and annual cost-of-living adjustments (COLA) for all Social Security programs.

Increases Social Security Benefits: By adjusting the benefit formula, the Strengthening Social Security Act increases Social Security benefits on average by about $65 per month or $800 per year.

Adopts the CPI-E to Calculate Cost of Living Adjustments: In requiring the use of the Consumer Price Index for Elderly Consumers (CPI-E) to measure Social Security's COLA, the Strengthening Social Security Act ensures that Social Security benefits keep pace with the rising costs of goods and services typically used by older Americans.

Improves Benefits for Widows and Widowers – Ensures that surviving spouses receive 75% of the total household Social Security benefits that they received prior to their spouse's death.

Strengthens the Social Security Trust Fund: To pay for these benefit improvements and ensure Social Security is solvent for years to come, the Strengthening Social Security Act raises and ultimately scraps the cap on earnings subject to Social Security contributions (currently capped at $132,900) over a 5- year period. This change alone extends the life of the Social Security Trust Fund through 2041.

Strengthening Health Care & Lowering Drug Costs Act

On May 16th, 2019, the Strengthening Health Care and Lowering Prescription Drug Costs Act (H.R. 987) was passed in the House of Representatives with a vote of 234 to 183 and sent to the Senate.

H.R. 987 lowers prescription drug prices and reverses some of the sabotage of the Affordable Care Act (ACA). It blocks short-term health insurance plans, improves ACA enrollment, and lowers insurance costs for people with preexisting conditions. Five million Americans aged 50 to 64 have at least one preexisting health condition. The prescription drug price measures included in H.R. 987 accomplish the following:

Implements the CREATES Act

This provision will bring more low-cost generic medicines to market. It allows generic drug manufacturers to purchase samples of brand-name drugs, so they can confirm that their version of a drug is biologically similar to the brand name drug. Today brand-name pharmaceutical corporations can prevent generic manufacturers from buying samples of their most well-known drugs.

Bans "Pay-for-Delay" Agreements

This provision makes "Pay-for -Delay" agreements between prescription drug manufacturers illegal. According to the U.S. Federal Trade Commission, "payfor- delay" agreements cost American taxpayers and consumers $3.5 billion every year by keeping drug prices high. Currently, brand name pharmaceutical corporations can offer generic companies patent settlement payments that keep lower-cost generics off the market.

Stops Generic Companies from Keeping a Drug Off the Market

The BLOCKING Act provisions shorten the amount of time it takes to get generic drugs on the market. Today, the first generic filers to obtain FDA approval for a drug are granted 180 days of market exclusivity. During this time period no other generic manufacturer can bring the same drug to market. However, some generic companies don't release the drugs immediately after gaining approval, a practice called "parking." H.R. 987 prohibits companies from "parking" their market exclusivity.

MedPAC Calls for Improvements in Medicare Part B Enrollment Process

MEDICARE RIGHTS CENTER
Getting Medicare right
Blog

In its June 2019 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommends improvements to the complex Medicare Part B enrollment process, including strengthening notification requirements which is, in part, what the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act proposes to do (S. 1280/ H.R. 2477).

Currently, only individuals who applied for or are receiving Social Security benefits at age 65 are notified about their Medicare Part B eligibility. Everyone else must make an active Medicare enrollment choice, taking into consideration specific timelines and existing coverage. If this transition is mismanaged—as it often is—individuals new to Medicare may face lifetime late enrollment penalties, higher health care costs, gaps in coverage, and disruptions in care continuity.

The bipartisan BENES Act is a commonsense solution that is long overdue. The BENES Act would fill the long-standing gap in outreach and education by directing the federal government to notify individuals who are approaching Medicare eligibility about their enrollment options and responsibilities.

As MedPAC notes "[t]he lack of a notification process ensuring that individuals are aware of their eligibility for and their need to enroll in Medicare as they turn 65 should be addressed. Improvement in the timeliness of notification to eligible individuals about Medicare enrollment and potential late-enrollment penalties is essential. The Secretary could work with the SSA to ensure that prospective beneficiaries receive adequate and timely notification of their pending Part B eligibility and the consequences of delaying enrollment." As people work later in life and defer their Social Security benefits, and as the eligibility ages for Medicare and full Social Security continue to widen, an ever-growing number of people aging into Medicare will be exposed to the pitfalls and harms of the current Part B enrollment system.

MedPAC estimates about 800,000 beneficiaries were paying a late-enrollment penalty for Part B in 2016.

Every day on our National Consumer Helpline we hear from people who inadvertently made a Part B enrollment mistake because, regrettably, they didn't know or understand the rules or they were misinformed about them. Immediate policy changes—namely the BENES Act—are needed to improve the health and financial security for millions of current and future Medicare beneficiaries.

Medicare Rights also supports several of MedPAC's other recommendations to improve the Part B enrollment process, including by increasing funding for State Health Insurance and Assistance Programs (SHIPs) and expanding the availability of Special Enrollment Periods (SEPs) to people with pre-Medicare coverage other than employer-sponsored group health plans.

We also agree with the Commission that the Secretary should examine the efficacy of the Part B late enrollment penalty structure. While it is important that a penalty appropriately deter anyone who might actively seek to avoid Medicare enrollment, it must not punish those who make honest mistakes. Currently, it is not known if or to what extent the penalties are having the desired effects.

- **Read the full MedPAC report.**
- **Reach Medicare Rights' BENES Act fact sheet.**
- **Read the BENES Act bill text.**

Inefficient Medicare Part D Appeals Process Can Result in Dangerous Medication Delays

MEDICARE RIGHTS CENTER
Getting Medicare right
Blog

The Medicare Rights Center applauds Senators Ben Cardin (D-MD) and John Cornyn (R-TX) for introducing the bipartisan Streamlining Part D Appeals Process Act (S. 1861).

The bill would eliminate unnecessary steps in the Medicare Part D appeals process, making the system less burdensome for people with Medicare, providers, and plans. Specifically, the Cardin-Cornyn bill would simplify the process for Part D enrollees who experience medication denials at the pharmacy counter.

Currently, when beneficiaries are told at the pharmacy counter that their Part D plan will not cover a prescription, they must then work with their prescribing physician to file an exception request with the plan. Only upon receipt of a written denial in response to this request—called a "coverage determination"—may the beneficiary request a formal appeal from the plan.

This multi-step process is overly onerous for all involved. It requires people with Medicare to correspond with both their plan and their prescriber on multiple occasions, which may involve many phone calls and long wait times, often up to several days. For many older adults and people with disabilities, this is dangerously too long to go without needed medication.

The Cardin-Cornyn bill would streamline this process—limiting delays in beneficiary access to needed therapies and reducing administrative requirements for plans and prescribers—by allowing a denial at the pharmacy counter to qualify as a coverage determination.

The Medicare Rights Center strongly supports this legislation.

Year after year, questions concerning access to affordable prescription drugs are a top trend on Medicare Rights' National Consumer Helpline. We consistently observe that many Part D enrollees struggle to navigate the highly complex appeals process—resulting in delays in access to needed prescriptions, abandonment of prescribed medications, reduced adherence to treatment protocols, worse health outcomes, and higher costs.

The Streamlining Part D Appeals Process Act's sensible efficiencies would help address these challenges. We thank Senators Cardin and Cornyn for their leadership and urge lawmakers to pass this bill without delay...**Read the bill text.**

An examination of surprise medical bills and proposals to protect consumers from them

The term "surprise medical bill" describes charges arising when an insured person inadvertently receives care from an out-of-network provider. Surprise medical bills can arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers. Surprise bills can also arise when a patient receives planned care. For example, a patient could go to an in-network facility (e.g., a hospital or ambulatory surgery center), but later find out that a provider treating her (e.g., an anesthesiologist or radiologist) does not participate in her health plan's network. In either situation, the patient is not in a position to choose the provider or to determine that provider's insurance network status.

In this analysis, we use claims data from large employer plans to estimate the incidence of out-of-network charges associated with hospital stays and emergency visits that could result in a surprise bill. We find that millions of emergency visits and hospital stays put people with large employer coverage at risk of receiving a surprise bill. For people in large employer plans, 18% of all emergency visits and 16% of in-network hospital stays had at least one out-of-network charge associated with the care in 2017. We also examine state and federal policies aimed at addressing the incidence of surprise billing. Our analysis finds a high degree of variation by state in the incidence of potential surprise billing for people with large employer coverage, who are generally not protected by state surprise billing laws if their plan is self-insured. For people with large employer coverage, emergency visits and in-network inpatient stays are both more likely to result in at least one out-of-network charge in Texas, New York, Florida, New Jersey, and Kansas, and less likely in Minnesota, South Dakota, Nebraska, Maine, and Mississippi.

KFF HENRY J KAISER FAMILY FOUNDATION

Background

Surprise medical bills generally have two components. The first component is the higher amount the patient owes under her health plan, reflecting the difference in cost-sharing levels between in-network and out-of-network services. For example, a preferred provider health plan (PPO) might require a patient to pay 20% of allowed charges for in-network services and 40% of allowed charges for out-of-network services. In an HMO or other closed-network plan, the out-of-network service might not be covered at all.

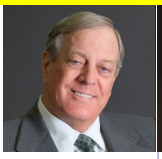
The second component of surprise medical bills is an additional amount the physician or other provider may bill the patient directly, a practice known as "balance billing." Typically, health plans negotiate discounted charges with network providers and require them to accept the negotiated fee as payment-in-full. Network providers are prohibited from billing plan enrollees the difference (or balance) between the allowed charge and the full charge. Out-of-network providers, however, have no such contractual obligation. As a result, patients can be liable for the balance bill in addition to any applicable out-of-network cost sharing.

Unexpected medical bills, including surprise medical bills, lead the list of expenses most Americans worry they would not be able to afford. **Two-thirds of Americans** say they are either "very worried" (38 percent) or "somewhat worried" (29 percent) about being able to afford their own or a family member's unexpected medical bills….**Read More**

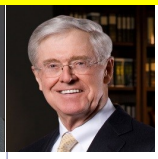
Koch-Backed Tech Group Behind Tool Used to Push Union Opt-Out Campaigns

The Lincoln Network, a group started with **seed money** from the Charles G. Koch Foundation, is behind online technology called "Edunity" that is being deployed to encourage teachers and other public sector union members to leave their unions.

According to an **online member update** from the State Policy Network (SPN), the tool was designed in "partnership with several SPN member organizations." SPN is a network of corporate-backed think tanks. Many of the groups in the network have also **received funding** from the Koch network of organizations and foundations. Other **donors to SPN** have included AT&T, Altria, Microsoft, Kraft Foods, Philip Morris.



David Koch



Charles Koch

According to SPN: "Lincoln designed and developed a technology platform to handle the end-to-end opt-out process from a public-sector union and provide leaving union members competitive benefits."

The benefits to union members who quit their union using Edunity, would include "discounts to useful major retailers, from Target to Microsoft."

Since June 2018 when the U.S. Supreme Court ruled in **Janus v. AFSCME**, SPN and its member groups have been promoting anti-union opt-out campaigns. SPN was well positioned to take advantage of the Janus decision. The Illinois Policy Institute, the SPN group in Illinois, was behind the lawsuit. Soon after the court issued its ruling, the Illinois Policy Institute **hired Mark Janus.**

As Rachel Cohen and myself wrote about recently for ***The Intercept***, SPN is engaging in long and multi-faceted campaign to drain unions of members and resources. SPN publicly talks about empowering workers, but on a call with their donors that was published with our article, SPN leaders were more straightforward about their motivations. Describing the Janus case to the donors, Tracie Sharp, CEO of SPN said: "Once this ruling comes down -- and we do expect it to come down in our favor -- everything will change. The door to pass a dream list of free-market reforms is going to swing open for us."

"The flexible opt-out workflow feature is plug-and-play, and it can break through any type of barrier a union builds to prevent an opt-out," SPN boasted.

One in Four Americans Are Skipping Medical Treatment Because They Worry About the Cost

One in four Americans chose not to receive treatment for a health issue over the last year due to its high cost, according to a **new survey** released by Gallup and West Health, a health care nonprofit.

Not only that, but 45% of Americans worry a major health issue could send them into bankruptcy and 19% have delayed purchasing medicine due to its cost.

The findings, released Tuesday, display the personal and financial impacts caused by the rising cost of health care in the United States. Tens of millions of Americans are borrowing money to afford health care and cutting out other household expenses. And Americans share a concern over the rising cost of health care and how it will impact their finances and the U.S. economy.

Indeed, Americans borrowed around $88 billion to pay for health care over the last year, the study found. About 12% of Americans borrowed money for health care, and 23% cut back on household spendings to afford it.

Health care spending in the U.S. rose to **$3.5 trillion** in 2017 — a 3.9% jump from 2016. In 2017, the U.S. spent more than $10,700 on health care per person. The U.S.'s health spending per capita far exceeds those of other countries, according to data from the **Organization for Economic Co-operation and Development**.

Forty-eight percent of Americans said they believe the quality of the U.S. health care system is "the best or among the best in the world." But when asked about the quality of care compared to costs, 31% said it was "worst of among the worst in the world."

Americans are collectively concerned about the impact of the rising cost of health care. Seventy-seven percent worry it will "cause significant and lasting damage to the economy."

"The impact of out-of-control healthcare costs is indisputable, although Americans's feelings about their healthcare system are complicated and at times conflicted," said Dan Witters, a senior researcher at Gallup, in a statement. "At a macro level, large numbers think healthcare in America is among the best in the world, but on an individual basis, most agree they are paying too much and getting too little in return, and they are worried not only for themselves but for their country."

The results of this survey come as lawmakers spar over health care policy. Last week, the Trump administration filed a brief in a federal appeals court to invalidate the Affordable Care Act — and House Democrats unveiled a bill aimed at strengthening the landmark health care law. In a series of tweets on Monday, however, President Donald Trump said Republicans would not present a replacement for Obamacare until after the 2020 presidential election.

Gallup and West Health surveyed 3,537 adults living in all 50 states and Washington, D.C., from Jan. 14 through Feb. 20.

In Germany, for patients, new drugs cost the same as older drugs

Noam Levey reports for the **LA Times** that, in Germany, people can get the newest cancer treatments for as little as $11. Patients don't have to think about costs. For patients, new drugs cost the same as older drugs. And, insurers only pay higher prices for drugs proven to improve long-term health outcomes.

In the US, almost everything having to do with a new drug's value is cloaked in secrecy. In Germany, pharmaceutical companies are not able to charge high prices for their new drugs unless they can demonstrate to an independent non-governmental agency that the new drugs deliver better long-term outcomes than drugs already on the market. And, the process for determining whether a new drug delivers a better outcome is fully transparent, with everyone–doctors, hospitals and patients alike–getting access to the clinical trial data and other independent assessments of the new drug.

The evaluation takes three months and ends with a public report. Anyone is free to comment on the report's findings. More than 40 percent of the time, the evaluators find the drug offers no significant additional value over drugs already on the market.

Regardless of the findings, the patient's cost for a drug does not increase. Sickness funds cannot charge a deductible and cannot impose a copay for a drug higher than 10 euros or $11.

If a new drug is determined to deliver a better outcome than drugs already on the market, pharmaceutical companies negotiate a price with non-profit insurers, "sickness funds." The sickness funds have leverage both because drugmakers want their drugs on the market in Germany and because they negotiate collectively for the drug's price. When they fail to reach agreement, about one in five times, the matter goes to arbitration.

The German government requires sickness funds to pay the list price for a new drug, found to deliver a better health outcome, in its first year. As a result, prescription drug costs in Germany are still higher than in many other wealthy countries, with 2016 per person spending averaging $777 as compared to $1,200 in the US.

The German government does not regulate prices, but it does limit patient out-of-pocket costs, and it does require the sickness funds to cover all new drugs as they enter the market. An international survey finds that only one in 14 Germans struggle to afford health care as compared to one in three Americans.

APPENDIX 1. Eleven-Country Summary Scores on Health System Performance

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL PERFORMANCE SCORE	**0.36**	**-0.26**	**-0.45**	**0.07**	**0.27**	**0.13**	**0.13**	**0.08**	**0.08**	**0.37**	**-0.75**
Care Process	**0.38**	**0.15**	**-0.42**	**-0.12**	**0.29**	**0.36**	**-0.60**	**-0.82**	**-0.03**	**0.56**	**0.23**
Preventive Care	0.06	0.57	-0.38	-0.96	0.43	0.11	-0.34	-0.20	-0.07	0.46	0.25
Safe Care	0.89	0.03	-0.38	0.08	0.18	0.29	-1.08	-0.82	-0.49	1.03	0.29
Coordinated Care	-0.11	-0.23	-0.22	0.37	0.06	0.64	-0.11	-1.07	0.41	0.30	-0.04
Engagement and Patient Preferences	0.69	0.22	-0.71	0.04	0.49	0.40	-0.86	-1.17	0.04	0.45	0.42
Access	**0.19**	**-0.77**	**-0.14**	**0.58**	**0.70**	**0.02**	**0.14**	**0.06**	**-0.11**	**0.39**	**-1.07**
Affordability	0.06	-0.31	-0.59	0.67	0.28	0.15	0.46	0.69	-0.52	0.97	-1.87
Timeliness	0.32	-1.23	0.31	0.48	1.13	-0.10	-0.18	-0.56	0.31	-0.19	-0.27
Administrative Efficiency	**0.74**	**0.08**	**-1.41**	**0.08**	**-0.15**	**0.60**	**0.54**	**0.26**	**-0.12**	**0.59**	**-1.21**
Equity	**-0.14**	**-0.39**	**-0.53**	**0.01**	**0.46**	**-0.24**	**0.14**	**0.37**	**0.34**	**0.93**	**-0.94**
Health Care Outcomes	**0.62**	**-0.35**	**0.23**	**-0.18**	**0.03**	**-0.12**	**0.42**	**0.55**	**0.32**	**-0.63**	**-0.76**

Note: "Performance Score" is based on the distance from the 11-country average, measured in standard deviations.

52% of Retirees Spend at Least $376 Per Month on Healthcare Costs

A new survey by The Senior Citizens League (TSCL) indicates that 52 percent of retirees spend *at least* $376 per month on healthcare costs. If that doesn't sound like enough of a challenge, at a time when the average Social Security benefit is about $1,400 per month, one-in-five survey participants reported spending $1,000 per month or more. The same survey also found that, of those who currently receive Social Security benefits, 48 percent reported that, in 2019, after the deduction of the Medicare Part B premium from their Social Security benefits, they had only $10 or less left over from their annual cost-of-living adjustment (COLA) boost.

"High Medicare costs and low COLA increases are clearly raising new adequacy issues for today's retirees," says Mary Johnson, a Medicare and Social Security policy analyst for The Senior Citizens League.

Medicare premiums and out-of-pocket costs are the most frequently - cited challenge for adults age 65 and older. "Many people underestimate both the impact healthcare costs will have on their Social Security benefits, and the amount of retirement income and savings they will need in retirement to make up for those rapidly rising costs," Johnson notes.

In addition to Medicare Part B premiums, there's a considerable number of other costs not covered by traditional Medicare. Most Medicare recipients also have the cost of premiums for additional coverage which can take the form of a Medigap supplement, with a free - standing Part D drug plan, or Medicare Advantage managed care plan with prescription drug coverage. Even with the extra coverage, there can be high deductibles, and out-of-pocket cost requirements which grow each year. Those costs can run into the thousands of dollars each year for the oldest and sickest. Medicare also does not cover routine dental, vision or hearing care, nor is there any coverage at all for most nursing home stays.

Congress is considering a number of bills which would help older Americans with these challenges three primary ways:

- *Strengthening Social Security income* by providing a modest boost in benefits and tying the annual COLA to the Consumer Price Index for the Elderly (CPI-E) which would better reflect the inflation experienced by older adults. Another bill in Congress would guarantee a minimum COLA increase of at least 3 percent in years when inflation is lower than that.
- *Giving Medicare power to negotiate drug prices to bring down costs*. Since 2000, prescription drug costs have increased 253 percent, making it the fastest - growing cost for older Americans. In addition to bills that would allow Medicare to negotiate drug prices, other bills under consideration in Congress would allow the importation of FDA -approved prescription drugs from other countries, like Canada, where prices are lower, and would prohibit deals that delay generics from reaching the market.
- *Improving Medicare coverage* by including coverage for dental, vision and hearing services.

An ageless question: When is someone 'old'?

As much as I try to stay in the moment, I sometimes get obsessed with the future — as in, "How much time have I got left?" Not long ago, curious about this life-or-death question, I used the Social Security Administration's **life expectancy calculator to see** how long I might live. Based on my age and gender, the calculator told me I've probably got another 22 years ahead of me, that is until I kick the bucket at 83. (Of course, an accident or a serious illness could ruin my calculation.)

Determining my life expectancy, it turns out, led to another conundrum that's a frequent topic of conversation among my friends: Are we old? Typically, people decide who is "old" based on how many years someone has already lived, not how many more years they can expect to live, or even how physically or cognitively healthy they are. I will soon turn 62. What does that actually tell you? Not very much, which is why, like many of my sexagenarian friends, I'm apt to claim, "Yes, age is just a number."

So what does "old" really mean these days?

This isn't an idle question — not only does the definition of "old" have an outsized impact on how we feel about ourselves (not to mention how others view us) it also matters to policymakers determining how to plan for aging populations.

The United Nations historically has defined older persons as people 60 years or over (sometimes 65). It didn't matter whether you lived in the United States, China or Senegal, even though life expectancy is drastically different in each of those countries. Nor did it depend on an individual's functional or cognitive abilities, which can also be widely divergent. Everyone became old at 60. It was as though you walked through a door at midnight on the last day of 59, emerging a completely different person the next morning: an old person.

Demographers Sergei Scherbov and Warren Sanderson at the International Institute for Applied Systems Analysis, who study aging, are evangelists about overturning the one-size-fits-all-across-the-globe definition of old. For nearly 15 years, they've been beating the drum that what they call "chronological age" (the number of years lived) is wrongheaded. In their forthcoming book, "**Prospective Longevity: A New Vision of Population Aging**," they write that chronological age "tells us how long we've lived so far. In contrast, prospective age is concerned about the future. Everyone with the same prospective age has the same expected remaining years of life."

At a conference this past winter on population aging, I asked Scherbov the big questions: What makes someone old? It's not when you turn 60 or 65, he replied, but when your specific life expectancy is 15 years or less. That, he says, is when most people will start to exhibit the signs of aging, which is to say when quality of life takes a turn for the worse…..**Read More**

The Federal Communications Commission Helps Consumers Avoid Scam Calls

You know those robocalls from scammers that you keep getting on your phones? We get them at the Federal Communications Commission (FCC), too.

Scammers use a technique known as spoofing to mask their caller ID on your phone and disguise their identities to steal valuable personal information, including your bank account passwords and Social Security number. In one recent case, the toll-free number of the FCC's Consumer Center was used to disguise the actual incoming call number.

We've alerted the public to the problem and have taken measures to prevent this from happening again. We're aware that **the same thing happens with Social Security's** phone number. Some callers may pressure you for personal information or immediate payment; others offer deals that seem too good to be true. The number of calls is daunting, but we are taking action to turn the tide against spoofed robocalls.

The first line of defense is consumer awareness. The FCC provides guidance about spoofing **scams** and **robocalls,** including consumer resources for call-blocking apps and other services. We also post timely articles on the **FCC Consumer Help Center** website to alert you to the latest scams and amplify consumer warnings from Social Security and other government agencies. Consumers can keep track of these alerts by following @FCC on Twitter.

We recommend the following tips to avoid becoming a victim of a call scam:

- Don't answer calls from numbers you don't recognize.
- If the caller is not who you were expecting, hang up immediately.
- Never give out personal information such as account numbers, passwords, Social Security numbers, mother's maiden names, or other identifying information if a call seems suspicious.

In its continuing efforts to help stifle malicious phone scams, the FCC empowered phone companies to aggressively block by default unwanted and illegal robocalls before they reach consumers.

It's all about safeguarding the American public. We'll continue to partner with Social Security, the **Federal Trade Commission**, and other federal agencies to get the job done.

How can I file an appeal if the deadline has passed?

Dear Marci,

I received a health care service that I believe should be covered by Medicare, but a few months ago, I got a notice saying that it would not be covered. Because I was very sick at the time, I missed the deadline for appealing that is listed on the notice. Is there any way I can still appeal the denial?
-Evelyn (Durham, NC)

Dear Evelyn,

You may still be able to appeal Medicare's decision to deny coverage for your care. An appeal is a formal request for review of a decision made by **Original Medicare** or your **Medicare Advantage** **or** **Part D plan.**

When initially filing a Medicare appeal (and at each level of appeal), there is a limited time to file. However, after the deadline has passed, if you can show good cause for not filing on time, your late appeal may be considered. **You can request a good cause extension at any level of appeal,** and it is available for Original Medicare, Medicare Advantage, and Part D appeals. Extension requests are considered on a case-by-case basis, so there is no complete list of acceptable reasons for filing a late appeal, but some examples include:

- The notice you are appealing was mailed to the wrong address.
- A Medicare representative gave you incorrect information about the claim you are appealing.
- Illness—either yours or a close family member's—prevented you from handling business matters.

The person you are helping appeal a claim is illiterate, does not speak English, or could not otherwise read or understand the coverage notice.

If you think you have a good reason for not appealing on time, follow the instructions on the notice for appealing, and include a clear explanation of why your appeal is late. If the reason has to do with illness or other medical condition, a letter or supporting documentation from your health care provider can be helpful.

Some other general rules to follow when appealing the denial of a health service or item are:

- Try to understand the reason that your plan is denying coverage for your health service or item.
- Address any relevant coverage rules in your appeal letter, and encourage your doctor to do the same.

If you need assistance understanding the coverage rules surrounding the service or item in question, you can contact your State Health Insurance Assistance Program (SHIP) for assistance by calling 877-839-2675 or visiting **www.shiptacenter.org**

- Keep good records of all your communications throughout the appeals process. Some ways to do this are:
- Submit your requests in writing.
- Keep proof of when you send your appeal.
- Keep all fax transmission reports, mail information by certified mail, or return receipts.
- Write down details about phone calls regarding your appeal. This includes what you discussed, who you spoke to, and the date and time of the call.
- If you think you need help appealing, you can appoint a representative. The representative can be a friend, family member, doctor, or lawyer.

-Marci

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RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

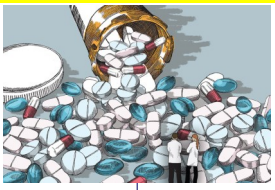
Surgeons' Opioid-Prescribing Habits Are Hard To Kick

A new data analysis by KHN and Johns Hopkins researchers shows that even as the CDC issued warnings, surgeons handed out many times the number of opioid pills needed for post-op pain.

As opioid addiction and deadly overdoses escalated into an epidemic across the U.S., thousands of surgeons continued to hand out far more pills than needed for postoperative pain relief, according to a **KHN-Johns Hopkins analysis** of Medicare data.

Many doctors wrote prescriptions for dozens of opioid tablets after surgeries — even for operations that cause most patients relatively little pain, according to the analysis, done in collaboration with researchers at Johns Hopkins School of Public Health. It examined almost 350,000 prescriptions written for patients operated on by nearly 20,000 surgeons from 2011 to 2016 — the latest year for which data are available.

Some surgeons wrote prescriptions for more than 100 opioid pills in the week following the surgery. The total amounts often exceeded current guidelines from several academic medical centers, which call for zero to 10 pills for many of the procedures in the analysis, and up to 30 for coronary bypass surgery.



While hundreds of state and local lawsuits have been filed against opioid manufacturers, claiming they engaged in aggressive and misleading marketing of these addictive drugs, the role of physicians in contributing to a national tragedy has received less scrutiny. Research shows that a significant portion of people who become addicted to opioids started with a prescription after surgery.

In sheer numbers, opioid prescribing in the U.S. **peaked in 2010,** but it remains **among the highest in the world**, according to studies and other data.

In 2016, opioids of all kinds were linked to 42,249 deaths, up from the 33,091 reported in 2015. The opioid-related death rate jumped nearly 28% from the year before, **according to the CDC**.

Yet long-ingrained and freewheeling prescribing patterns changed little over the six years analyzed. KHN and Johns Hopkins examined the prescribing habits of all U.S. surgeons who frequently perform seven common surgical procedures and found that in the first week after surgery:

- Coronary artery bypass patients operated on by the highest-prescribing 1% of surgeons filled prescriptions in 2016 exceeding an average of 105 opioid pills.
- Patients undergoing a far less painful procedure — a lumpectomy to remove a breast tumor — were given an average of 26 pills in 2016 the week after surgery. The highest-prescribing 5% of surgeons prescribed 40 to 70 pills on average.
- Some knee surgery patients took home more than 100 pills in the week following their surgery.

Those amounts — each "pill" in the analysis was the equivalent of 5 milligrams of oxycodone — are many times what is currently recommended by some physician groups to relieve acute pain, which occurs as a result of surgery, accident or injury. The analysis included only patients not prescribed opioids in the year before their operation

"Prescribers should have known better" based on studies and other information available at the time, said Andrew Kolodny, co-director of opioid policy research at Brandeis University and director of the advocacy group Physicians for Responsible Opioid Prescribing.

While the dataset included only prescriptions written for patients on Medicare, the findings may well understate the depth of the problem, since doctors are more hesitant to give older patients the powerful painkillers because of their sedating side effects. Surgeons' prescribing habits are significant because **studies show** that 6% of patients who are prescribed opioids after surgery will still be taking them three to six months later, having become dependent The likelihood of persistent use rises with the number of pills and the length of time opioids are taken during recuperation.....**Read More**

Seven things to do before you or someone you love leaves the hospital

It's hard enough to be in the hospital. Most of us can think only of getting out as quickly as possible. But, leaving the hospital can have its own set of risks if you're not prepared. So, before you or someone you love leaves, here are seven things that you should do:

1. **Understand and decide what will happen after discharge**. Discuss your options after you leave the hospital with your doctors so that there are no surprises. Make sure all your questions are answered.
2. If you are not going home, make sure you know **where you will be going and the reasons for going there**, be it a **nursing home** or a rehab facility or another setting.
3. Know **who to call** and have that person's number if you have questions after you leave the hospital.
4. Make a **list of your medications**, including any new ones, and keep the list on you. Also, understand whether there are **side effects** and what to do if you experience them.

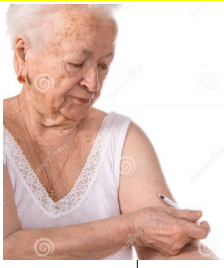
5. Know what care is needed to help **prevent your condition from getting worse**, what symptoms you need to look out for, and who to call if you experience any of them.
6. **Schedule follow-up appointments** with your doctor and arrange for transportation to get there.
7. **Get a discharge plan.** The hospital is required to give you a written plan. If at all possible, have a family member or friend with you—**a health care buddy**—to help ensure you understand what care you will need after you leave. If you still have questions, review the written discharge plan with your doctor or hospital social worker.

More than a Quarter of People with Diabetes in the U.S. Report Rationing Insulin

According to a new survey, more than a quarter of U.S. citizens with diabetes report having rationed insulin in an attempt to escape the skyrocketing prices of insulin. This practice is becoming increasingly popular over time, despite the obvious dangers, because many people feel they simply have no other option.

The survey was conducted by the nonprofit diabetes advocacy group T1 International and involved about 200 people with type 1 or 2 diabetes. Results showed that almost **26 percent** of people with insulin-dependent diabetes have rationed the life-saving drug within the past year. That number is more than four times the percentage of insulin rationing found in other affluent countries.

The survey broke their results down into age categories and found that the problem is most significant among young people with the disease. Of those ages 18-44, 32 percent reported underusing insulin, compared to 24 percent of those aged 44-64 and 21 percent of those older than 64. More than a third of these patients say they decreased their use of insulin without consulting a physician.



Insulin rationing has become increasingly popular as insulin prices rise, regardless of patients' incomes. Insulin prices have roughly tripled from 2007 to 2017, and they continue to rise. Many patients pay hundreds of dollars per month for the drug, even with insurance, and they simply can't afford to keep it up.

"Between 2010 and 2015, the monthly wholesale price of Humulin, the most popular insulin, rose to nearly $1,100, up from $258 for the average patient," says **Dr. Elisabeth Rosenthal**. "Insulin and insulin pump costs, and blood sugar test strips, these costs are persistent, and they're for life. Imagine if your rent suddenly went up $600 a month. It's really unfair to people who have type 1 diabetes."

But rationing insulin is not a safe practice for anyone with insulin-dependent diabetes and has resulted in many severe health crises and deaths in the last few years.

"For people with type 1 diabetes, insulin is a lifesaving drug. Without it, people can die within days," said the study's lead author, **Dr. Kasia Lipska**, an assistant professor of medicine at the Yale School of Medicine. "About 1 in 5 people with type 2 need insulin to prevent short-term and long-term complications, like blindness, kidney failure and dialysis, and heart disease."

Sadly, 26 percent may not even be the maximum percentage of U.S. patients rationing insulin. The American Diabetes Association (ADA) also conducted a study last year that found 27 percent of people with diabetes had changed how much insulin they purchased and used because of increased prices, and that number doesn't show any sign of decreasing anytime soon. These people all take less than the recommended dose, skip doses, or have switched the type of insulin they use in an attempt to cut down on cost.

"People are struggling to afford insulin, and it truly is a life-and-death situation," says **Dr. LaShawn McIver**, senior vice president of government affairs and advocacy for the ADA.

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Vagus nerve stimulation may reduce the symptoms of rheumatoid arthritis

Electrostimulation of the vagus nerve may be key to reducing the symptoms of rheumatoid arthritis, according to findings that scientists presented at the Annual European Congress of Rheumatology in Madrid, Spain.

This research gives hope that there may be a new way to help treat this autoimmune condition.

The vagus nerve, which is a very long nerve that runs between the brain and the neck, chest, and abdomen, is a complex structure.

Previous research has found an inflammatory reflex in the vagus nerve that reduces the production of cytokines, including certain molecules that are a component of autoimmune conditions. These molecules are called tumornecrosis factor (TNF).

The immune systems of healthy people block TNF, but in those with certain autoimmune conditions, excess TNF makes its way into the bloodstream and causes **inflammation** and a higher rate of symptoms associated with the conditions.

TNF is a target in many **rheumatoid arthritis** (RA) drugs, such as **infliximab** (Remicade) or **etanercept**(Enbrel). Many people call these drugs TNF-blockers.

The **researchers thought** that if they could boost this naturally occurring reflex in the vagus nerve, it might have a similar result — or one that was even better, as drugs that aim for TNF also suppress the immune system and have other unwelcome side effects.

"This is a really exciting development," says Prof. Thomas Dörner, Chairperson of the Scientific Programme Committee at the **Annual European Congress of Rheumatology,** which this year takes place in Madrid, Spain.

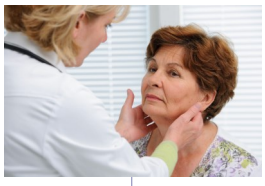
"For many [people living with] RA, current treatments don't work, or aren't tolerated. These results open the door to a novel approach to treating not only RA but other chronic inflammatory diseases. This is certainly an area for further study," adds Prof. Dörner. ...**Read More**

Hypothyroidism symptoms and signs in an older person

Some people over age 60 have few, if any, classic hypothyroidism symptoms, while others experience the same symptoms younger people do. Still others have hypothyroidism symptoms that are not typical at all, making the diagnosis even more difficult. Any of the following signs and symptoms can indicate hypothyroidism in an older person.

Unexplained high cholesterol. High cholesterol is sometimes the only evidence of an underactive thyroid in an older person. The problem might be diagnosed as a cholesterol disorder rather than hypothyroidism. Because this sign may stand alone, high cholesterol warrants a thyroid evaluation.

Heart failure. Reduced blood volume, weaker contractions of the heart muscle, and a slower heart rate—all caused by low thyroid hormone levels—can contribute to heart failure, a serious condition that occurs when your heart can't pump out enough blood to meet the needs of your body. The ineffective pumping also causes blood to back up in the veins that return blood to the heart. Blood backs up all the way into the lungs, which causes them to become congested with fluid. Symptoms of heart failure include breathlessness, swelling in the ankles, weakness, and fatigue.



Bowel movement changes. An older person with hypothyroidism might have constipation because stool moves more slowly through the bowels. A less common hypothyroidism symptom is frequent bouts of diarrhea—a problem more typically associated with hyperthyroidism. Some people with an autoimmune thyroid disease such as Hashimoto's also have celiac disease, another autoimmune condition that can cause diarrhea.

Joint or muscle pain. Vague joint pain is a classic hypothyroidism symptom. It sometimes is the only symptom of hypothyroidism in an older person. Many people experience general muscle aches, particularly in large muscle groups like those in the legs.

Psychiatric problems. Clinical depression—a common symptom in younger people with hypothyroidism—can also affect older people with the condition. The difference is that in older people it can be the only hypothyroidism symptom. Some older adults also develop psychosis with delusional behavior or hallucinations.

Dementia. Debilitating memory loss that is often, but not always, accompanied by depression or psychosis can also be the lone symptom of hypothyroidism. If you or a loved one is being evaluated for dementia, make sure that a thyroid test is part of the evaluation.

Balance problems. Hypothyroidism can lead to abnormalities in the cerebellum (a region at the back of the brain that's involved in motor control). This may cause problems with walking in older people.

To learn more about diseases and conditions of the thyroid, read the Special Health Report, ***Thyroid Disease*** from Harvard Medical School.

Hypertension treatment may slow down Alzheimer's progression

Researchers have found that nilvadipine, a drug that doctors regularly use to treat hypertension, may help people with Alzheimer's disease by increasing blood flow to the brain.

Alzheimer's disease is the most common form of **dementia**. This progressive disorder causes the degeneration and, ultimately, the death of brain cells.

People with dementia experience cognitive decline, and have issues making judgments and performing everyday tasks.

Dementia affects millions of people worldwide. According to Alzheimer's Disease International, the number of people with dementia was close to **50 million n 2017**, and the organization say this number will almost double every 20 years, reaching 75 million people by 2030.

In the United States, Alzheimer's disease is the **sixth leading cause of death**.

Researchers have been looking for treatments to slow the progression of the disorder and recently found that the **hypertension** drug nilvadipine may have positive effects on the cerebral blood flow of those with Alzheimer's disease. The results appear in the journal *Hypertension*.

How nilvadipine affects cerebral blood flow

Nilvadipine is a **calcium** channel blocker that leads to vascular relaxation and lowers **blood pressure**, and people often use it to treat hypertension. The objective of the latest study, which included 44 participants with mild to moderate Alzheimer's disease, was to find out whether nilvadipine could slow the progression of the disorder.

"Even though no medical treatment is without risk, getting treatment for high blood pressure could be important to maintain brain health in patients with Alzheimer's disease," says Dr. Jurgen Claassen, Ph.D., associate professor at Radboud University Medical Center in Nijmegen, the Netherlands, and lead author of the study.

The researchers randomly gave nilvadipine or a **placebo** to the participants and asked them to continue the treatment for 6 months. They measured the blood flow to specific areas of the brain, using a unique **MRI** technique, at the beginning of the study and after 6 months.

The findings showed a 20% increase in blood flow to the hippocampus, the brain area linked to memory and learning, among the group who took nilvadipine in comparison to the placebo group. The treatment did not have any effects on the blood flow to other regions on the brain.

"This high blood pressure treatment holds promise as it doesn't appear to decrease blood flow to the brain, which could cause more harm than benefit," adds Dr. Claassen.

"In the future, we need to find out whether the improvement in blood flow, especially in the hippocampus, can be used as a supportive treatment to slow down progression of Alzheimer's disease, especially in earlier stages of [the] disease."

Dr. Jurgen Claassen...Read More

Homecare for a Loved One With Alzheimer's or Dementia

Caring for a loved one with dementia requires a little more effort than regular home care but can be done.

FOR MOST OLDER ADULTS, the idea of aging in place and staying at home for as long as possible is an attractive one. But the simple proposition of living at home can be made much more complicated when your loved one has been diagnosed with Alzheimer's or another form or dementia.

Alzheimer's and dementia are progressive neurological diseases that slowly rob people of their ability to care for themselves. What may start as forgetfulness or being occasionally tongue-tied can progress to a potentially dangerous situation where the person needs round-the-clock care.

But Alzheimer's and dementia don't worsen overnight, and many seniors can look forward to at least a few years before they need to consider making a move to an assisted living communityor long-term care facility. During that time, most people say they'd like to remain in their own home for as long as possible. AARP reports that nearly 90% of seniors want to "age in place," or stay in their homes for as long as possible as they age. And a Pew Research Center report found that 61% of adults aged 65 and older say they would stay in their home but have someone care for them if they could no longer live on their own. For seniors with dementia, finding the balance between safety and support at home can be a more challenging prospect than for people who don't have cognitive deficits.

The good news is, though, that according to United Health Foundation's 2019 America's Health Rankings Senior Report – an annual report that looks at the state of certain health measures related to senior health in America – the options for getting the right in-home care have improved in many parts of the country.

The 2019 edition found that across the board, "seniors have increasing access to **home-based care** and support services that may help them continue to live at home," in part because of an increase of 550,000 home health care workers between 2017 and 2018. That 21% rate increase per 1,000 adults age 75 and older means that there should be more options available locally, although not every state saw the same rate of increase.

"Minnesota leads the way with 264 home health care workers for every 1,000 adults over age 75," says Dr. Rhonda L. Randall, executive vice president and chief medical officer of UnitedHealthcare National Markets. That measure stands in stark contrast to Florida's 32 licensed home care workers for every 1,000 adults over age 75, she says. "There's a really significant difference depending on the state, even though we've seen improvements across the board."...**Read More**

Your brain might be taking tiny naps, which can lead to disaster

- "Microsleep" involves brief, intermittent moments of sleep throughout the day, sometimes without you noticing it.
- You can have episodes of microsleep when you're feeling drowsy and performing daily tasks such as reading or driving.
- Microsleep is caused by sleep deprivation, so the best remedy is to get a good night's rest.

If you've ever felt your eyelids droop for just a fraction of a second during some mundane task - like staring at a computer screen or driving down the highway - you've experienced a phenomenon known as "microsleep."

Discover Magazine's blog The Crux recently spotlighted the experience, which happens when key parts of the brain switch off for a few seconds at a time. This means that, while you're not quite asleep, you're certainly not awake either.

"It's sort of like being a zombie for a few brief moments - sans the whole 'eating human flesh' part," Megan Schmidt wrote for the blog. "And usually, people don't realize it's happening to them."

And while this can happen to anyone, the sleep-deprived are consistently most at risk.

Neuroscientist and sleep expert Matthew Walker previously told Business Insider that "the shorter your sleep, the shorter your life."

According to the AAA Foundation for Traffic Safety, a traffic research and safety organization, around 16.5% of fatal car crashes in the U.S. are caused by microsleep. One of the biggest disasters involving microsleep, reports Discover Magazine, is the 2009 crash of AirFrance Flight 447 that resulted in 228 deaths. Once investigators listened to recordings from the plane, they found the captain complaining that he was running on just an hour of sleep.

According to Walker, even losing a single hour of sleep could be harmful. "There is a global experiment that is performed on 1.6 billion people twice a year and it's called daylight saving time," he said. "And we know that in the spring, when we lose one hour of sleep, we see a subsequent 24% increase in heart attacks the following day."

In a **2012 experiment**, subjects were asked to play a 50-minute computer game in which they followed a dot around the screen using a joystick. During that time, researchers monitored eye movement and brain activity, looking for signs of drowsiness. According to the report, subjects experienced an average of 79 episodes of microsleep, with some episodes lasting a full six seconds.

The research found that during microsleep, certain parts of our brain "try to restore responsiveness" in the ones shutting off, perhaps triggering the sudden involuntary jolt you feel when your head starts to drop down.

How can microsleep be prevented?

A 2012 study by the Centre for Accident Research and Road Safety in Australia found that in drowsy drivers, pulling over at the first signs of sleepiness makes a big difference. The tired drivers (operating a computer-simulated car, of course) who didn't pull over were 15 times more likely to crash.

In a report by **Queensland University of Technology**, the study's lead investigator, Chris Watling, said, "The most important thing is if you notice signs of sleepiness you should stop straight away. Trying to push through is not a good idea."

Some products are designed to shock drivers back into consciousness, but so far there are only a **few on the market**, like a bracelet called **Steer** that monitors your pulse and sends an electric shock whenever it senses you dozing off.

It seems, however, that the best solution to microsleep is to get an adequate amount of sleep.