Rhode Island Alliance for Retired Americans ©

RI ARA

Affiliated with the Rhode Island AFL-CIO

"Fighting for the future of our members."

"NOW, more than ever!!!"

August 6, 2017 E-Newsletter

Publication 2017/ Issue 30
Published in house by the
RI ARA

5 Ways White House Can Use Its Muscle To Undercut Obamacare

About an hour after the Senate's dramatic third attempt to repeal Obamacare fell short — and after almost eight months of repeated congressional attempts to dismantle it — President Donald Trump **tweeted** that it was only a matter of time before the law fell apart on its own.

"As I said from the beginning, let ObamaCare implode, then deal. Watch!" the president wrote.

Independent analyses have concluded that such spontaneous disintegration isn't happening. But the White House has the power to make it so. In a number of ways, the Trump administration's policies are already pushing Obamacare into the vortex.

Reports from Standard & Poor's, the Congressional Budget Office and the **Kaiser Family Foundation** all suggest that the exchanges — where people can shop for coverage, often with the help of a government subsidy — are stabilizing. (Kaiser Health News is an editorially independent program of the foundation.)

But Obamacare faces a difficult political reality: Its marketplaces require active maintenance and federal support.

The White House can take a number of behind-the-scenes steps to sabotage the exchanges and hasten their undoing. It has been deploying some of those tactics for weeks now — even prompting a **review from the Government Accountability Office** to see if these actions are legal.

Meanwhile, in a statement issued after Friday's early-morning vote, Health and Human Services Secretary Tom Price **reiterated** the administration's commitment to "provide relief to Americans who are reeling from the status quo.

This will be an area to watch.

"The administration has a lot of power to undermine the markets and make them dysfunctional," said Sabrina Corlette, a research professor at Georgetown University's Center on Health Insurance Reforms, who specializes in private insurance markets.

Here's a look at five ways the White House is working to weaken the health law, and what that means for consumers.

'Cost-Sharing Reductions'

Under the ACA, when someone's income falls between 100 and 250 percent of the federal poverty level — up to about $29,000 for an individual or around $61,000 for a family of four — marketplace carriers must offer a plan with "cost-sharing reductions" (CSRs) that reduce consumers' out-of-pocket expenses.

...**Read More**

Even Without Congress, Trump Can Still Cut Medicaid Enrollment

After the Senate fell short in its effort to repeal the Affordable Care Act, the Trump administration is poised to use its regulatory powers to accomplish what lawmakers could not: shrink Medicaid.

President Donald Trump's top health officials could engineer lower enrollment in the state-federal health insurance program by approving applications from several GOP-controlled states eager to control fast-rising Medicaid budgets.

Indiana, Arkansas, Kentucky, Arizona and Wisconsin are seeking the administration's permission to require adult enrollees to work, submit to drug testing and demand that some of their poorest recipients pay monthly premiums or get barred from the program.

Maine plans to apply Tuesday. Other states would likely follow if the first ones get the go-ahead.

Josh Archambault, senior fellow for the conservative Foundation for Government Accountability, said absent congressional action on the health bill "the administration may be even more proactive in engaging with states on waivers outside of those that are already planning to do so."

The hope, he added, is that fewer individuals will be on the program as states figure out ways "to transition able-bodied enrollees into new jobs, or higher-paying jobs." States need to shore up the program to be able to keep meeting demands for the "truly needy," such as children and the disabled, he added.

To Medicaid's staunchest supporters and most vocal critics alike, the waiver requests are a way to rein in the $500 billion program that has undergone unprecedented growth the past four years and now covers 75 million people.

Waivers have often been granted in the past to broaden coverage and test new ways to deliver Medicaid care, such as through private managed-care organizations.

But critics of the new requests, which could be approved within weeks, said they could hurt those who are most in need.

The National Health Law Program "is assessing the legality of work requirements and drug testing and all avenues for challenging them, including litigation," said Jane Perkins, the group's legal director.…**Read More**

House Passes Budget Resolution That Would Radically Transform the Medicare Program

This week, the House Budget Committee approved a 2018 budget resolution that would end Medicare's guarantee of health coverage by converting the program to a premium support system. It would cut Medicare spending by $487 billion, largely by shifting more health care costs to beneficiaries. This is in contrast to President Trump's budget, which spares Medicare from cuts.

The Budget Committee's **description** proposes the following changes in Medicare:

♦**Premium support.** The House plan would replace Medicare's guarantee of health coverage with a flat premium-support payment, or voucher, that beneficiaries would use to help buy either private health insurance or a form Medicare. Premium support would apply to all new beneficiaries starting in 2024 and to any other beneficiaries choosing to participate.

♦**Higher income-related premiums**. Most Medicare beneficiaries now pay premiums for Parts B and D (which cover physician services and prescription drugs, respectively) that represent about one-quarter of program costs. Beneficiaries with incomes above $85,000 (twice that amount for couples) pay higher amounts. The House plan would increase these income-related premiums.

♦**Limits on malpractice awards**. The House plan would limit medical malpractice litigation by capping awards and attorney fees, reducing the time for filing claims, and making other changes.

♦The Budget Committee staff have also stated that the resolution assumes further Medicare cuts in the form of:

♦**Raising the eligibility age**. The House resolution would gradually raise Medicare's eligibility age from 65 to 67. At the same time, it assumes enactment of the House-passed bill repealing the Affordable Care Act (ACA), which would **eliminate or weaken** the ACA's coverage expansions through Medicaid and the health insurance marketplaces. As a result, 65- and 66-year-olds would have to buy coverage in the individual insurance market, where they would face extremely high premiums and deductibles.

♦**Increasing cost sharing**. The resolution would add an annual limit on out-of-pocket spending to traditional Medicare, thereby filling the program's largest coverage gap. But it would increase Medicare cost sharing by establishing a single unified deductible for Parts A and B, imposing uniform 20 percent coinsurance for all covered services, and putting limits on Medicare supplemental insurance ("Medigap") policies.

Graduate medical education. The resolution assumes reductions in Medicare payments to teaching hospitals for the costs of medical education.

Read more from the Center on Budget and Policy Priorities.

Counting On Medicaid To Avoid Life In A Nursing Home? That's Now Up To Congress.

Ten years ago, a driver ran a stop sign as Jim McIlroy rode into the intersection on his motorcycle. Serious injuries left McIlroy paralyzed from the chest down. But, after spending some time in a nursing home, he returned to his home near Bethel, Maine.

McIlroy does most of his own cooking since Maine's Medicaid program paid for a stovetop that he can roll his wheelchair underneath to reach the food-prep area. His new kitchen sink has the same feature. Wheelchair-friendly wood flooring has replaced McIlroy's wall-to-wall carpeting.

The alterations plus a personal care aide — all paid for by Medicaid — enable McIlroy to stay in his house that he and his wife, who has since died, "worked really hard to own," he said. The arrangement also saves Medicaid roughly two-thirds of what it would cost if he lived in a nursing home.

McIlroy depends on the federal-state program's growing support of home-based care services — along with 2 million elderly or disabled Americans who rely on them to live at home for as long as possible.

However, that crucial help could face severe cuts if congressional Republicans eventually succeed in their push to sharply reduce federal Medicaid funds to states.

States can choose whether to offer Medicaid services at home, but nursing home coverage, which is more expensive, is a required benefit. Optional benefits like home services would likely be first to go if states face budget troubles, the Center on Budget and Policy Priorities (CBPP) warned in an analysis in May.

Children with special health needs, older adults and people with disabilities greatly value home- and community-based assistance, said Sen. Susan Collins (R-Maine), who chairs the Senate Select Committee on Aging.

"That's why I am deeply concerned with proposals that would significantly cut Medicaid, forcing governors and state legislators to confront difficult budget choices, including how to maintain these critical, but optional, services," said Collins, one of three Republicans whose votes early Friday helped defeat the Senate's "skinny repeal" measure that would have scuttled the Affordable Care Act.

While home services are not a required part of Medicaid, they represent a large share of Medicaid spending. Medicaid expenses for long-term care consumed a third of the Medicaid budget nationwide in 2015, and more than half of that amount went to optional home-based care, according to a government **report**. Nursing homes got the rest. ...**Read More**

Centrist lawmakers plot bipartisan health care stabilization bill

A coalition of roughly 40 House Republicans and Democrats plan to unveil a slate of Obamacare fixes Monday they hope will gain traction after the Senate's effort to repeal the law imploded.

The Problem Solvers caucus, led by Tom Reed (R-N.Y.) and Josh Gottheimer (D-N.J.), is fronting the effort to stabilize the ACA markets, according to multiple sources. But other centrist members, including Rep. Kurt Schrader (D-Ore.), and several other lawmakers from the New Democrat Coalition and the GOP's moderate Tuesday Group are also involved.

Their plan focuses on immediately stabilizing the insurance market and then pushing for Obamacare changes that have received bipartisan backing in the past.

The most significant proposal is funding for Obamacare's cost-sharing subsidies. Insurers rely on these payments – estimated to be $7 billion this year — to reduce out-of-pocket costs for their poorest Obamacare customers.

President Donald Trump has repeatedly threatened to cut off the payments, deriding them as a "bailout" for insurance companies. White House counselor Kelly Conway said on Sunday that Trump will decide "this week" whether to scrap the subsidies — which could make the markets implode.

The bipartisan working group also wants to change Obamacare's employer mandate so that it applies only to companies with more than 500 workers. Currently companies with at least 50 workers can be hit with a tax penalty if they don't provide coverage to their workers.

The group also wants to create a federal stability fund – dollar amount unspecified -- that states can tap to reduce premiums and other costs for people with extremely expensive medical needs. Both the Senate and House repeal packages contained similar pots of money.

The bipartisan proposal also calls for scrapping Obamacare's medical-device tax, an idea that has received bipartisan support in the past….**Read More**

In Strong-Arm Tactic, Trump Puts Congressional Health Benefits Into Play

President Donald Trump, who appears increasingly frustrated by congressional Republicans' inability to "repeal and replace" the Affordable Care Act, has led — since before he took office — the ballyhoo to let the law fail.

Over the weekend, he upped the political ante by taking aim at a new target: health coverage for members of Congress and some of their staffers.

"If a new HealthCare Bill is not approved quickly, BAILOUTS for Insurance Companies and BAILOUTS for Members of Congress will end very soon!" he **tweeted** Saturday.

The administration has been threatening for months to stop **payments to health insurers** for reimbursement of discounts they are required to provide to lower-income customers to offset deductibles and other cost-sharing. Now the president appears ready to take up an old fight over the payments provided to Congress and its staff.

The threat is rooted in a change in congressional health coverage that was ordered during the initial consideration of the ACA in 2010.

In an effort to embarrass Democrats — then in the majority — Republicans successfully pushed an amendment to the ACA bill that required members of Congress and their staffs to drop out of the federal employee health insurance program that has traditionally provided coverage to the denizens of Capitol Hill. Instead, under this GOP revision, lawmakers and some staffers would have to buy — and now do — their insurance through the measure's health exchanges. ...**Read More**

Little-Known Middlemen Save Money On Medicines — But Maybe Not For You

For the past seven months, the GOP push to replace the Affordable Care Act has consumed Washington. All the while, many consumers continue to be focused on the rising costs of prescription drugs.

Pharmacy benefit managers — companies that are often unnoticed and even less understood by most consumers — hold an important place in the prescription drug-pricing pipeline. In this video, Kaiser Health News details the emergence of these multimillion-dollar corporations and the impact they have on medication costs and patients' access to these treatments.

For more information on drug pricing issues, check out this chart and these videos:

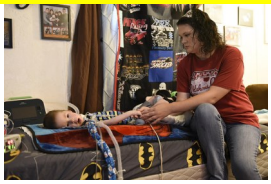
- **Tracking Who Makes Money On A Brand-Name Drug**
- **Sounds Like A Good Idea? Regulating Drug Prices**
- **The Orphan Drug Machine**

KHN also offers other videos examining hot topics such as **selling insurance across state lines**, **high-risk insurance pools**, **Medicare's observation care status** and how the health law could be disassembled through the **congressional budget reconciliation process**.

KHN's coverage of prescription drug development, costs and pricing is supported in part by the **Laura and John Arnold Foundation** and its coverage in California is funded in part by **Blue Shield of California Foundation.**

RI ARA HealthLink Wellness News

Drug Puts A $750,000 'Price Tag On Life'



Jana Gundy and Amanda Chaffin live within two hours of each other in Oklahoma. Each has a child with the same devastating disease, one that robs them of muscle strength, affecting their ability to sit, stand or even breathe.

So both families were ecstatic when the Food and Drug Administration approved the first treatment for the genetic condition — known as spinal muscular atrophy (SMA) — two days before Christmas 2016. It seemed the gift they had been waiting for — a chance to slow the heartbreaking decline of their young sons.

But that common hope has taken them down different paths: In April, Gundy's child, who is on private insurance, began getting the drug Spinraza, which costs $750,000 for the initial year of treatment. Chaffin's child — a Medicaid enrollee — was not receiving the drug, as his state regulators debated whether to offer it to children like him who use ventilators to breathe.

Across the country, similar stories are playing out as private insurers and already-squeezed state Medicaid programs wrestle with what, if any, limits to place on patients' access to break-the-bank drugs, weighing the needs of the ill against budget realities.

At the same time, policymakers and physicians increasingly demand to understand why drug manufacturers affix price tags that have risen to once unimaginable levels.

"It looks like a drug that works for a tragic condition that afflicts children and cripples and kills them. That's the good news," Jerry Avorn, a professor at Harvard Medical School, said of Spinraza. But "how in the world did the price of $750,000 a year get chosen?"

Biogen, the maker of Spinraza, defends its price. "We compared industry norms for other drugs in rare disease. We looked at the efficacy and safety profile of the drug itself," said Wildon Farwell, senior medical director of clinical development at Biogen, which covers the cost of the drug for patients who are denied by their insurers…. **Read More**

When Wounds Won't Heal, Therapies Spread — To The Tune Of $5 Billion

Carol Emanuele beat cancer. But for the past two years, she has been fighting her toughest battle yet. She has an open wound on the bottom of her foot that leaves her unable to walk and prone to deadly infection.

In an effort to treat her diabetic wound, doctors at a Philadelphia clinic have prescribed a dizzying array of treatments. Freeze-dried placenta. Penis foreskin cells. High doses of pressurized oxygen. And those are just a few of the treatment options patients face.

"I do everything, but nothing seems to work," said Emanuele, 59, who survived stage 4 melanoma in her 30s. "I beat cancer, but this is worse."

The doctors who care for the 6.5 million patients with chronic wounds know the depths of their struggles. Their open, festering wounds don't heal for months and sometimes years, leaving bare bones and tendons that evoke disgust even among their closest relatives.
Many patients end up immobilized, unable to work and dependent on Medicare and Medicaid. In their quest to heal, they turn to expensive and sometimes painful procedures, and products that often don't work**.**

According to some estimates, Medicare alone spends at least $25 billion a year treating these wounds. But many widely used treatments aren't supported by credible research. The $5 billion-a-year wound care business booms while some products might prove little more effective than the proverbial snake oil. The vast majority of the studies are funded or conducted by companies who manufacture these products. At the same time, independent academic research is scant for a growing problem…. **Read More**

Is It Too Good To Be True???

I have severe COPD and find it hard to walk for long distances. I saw an ad on television that says some company can get me a scooter paid by Medicare. The ad says if Medicare does not pay for it, it is free. This sounds a little too good to be true. What do you think?

Answer:

The short answer to your question is that it is too good to be true! What these ads actually say is that if you are approved by Medicare and your claim is later denied, you pay nothing for the scooter. The reality is that Medicare does not pay for mobility scooters. Medicare will at times pay for a motorized wheel chair to allow you some degree of mobility in your own home, but in order to qualify your ability to walk must be severely compromised.

There is a big difference between a motorized wheelchair and a mobility scooter. Mobility scooters are designed for outdoor use, are generally lighter in weight, easier to transport and have longer battery life. The design of the mobility scooter allows it to operate over a variety of terrain. Motorized wheelchairs are primarily designed to operate indoors. They tend to be quite heavy. In order to use a motorized wheelchair indoors, your house must have wide enough doorways to get from room to room. Motorized wheelchairs are not really useful in two story houses…. **Read More**

Many Still Sidestep End-Of-Life Care Planning, Study Finds

Before being deployed overseas for the Iraq War in 2003, Army reservist Don Morrison filled out military forms that gave instructions about where to send his body and possessions if he were killed.

"I thought, wow, this is mortality right in your face," Morrison, now 70, recalled.

With his attention keenly focused on how things might end badly, Morrison asked his lawyer to draw up an "advance directive" to describe what medical care he did and did not want if he were unable to make his own decisions.

One document, typically called a living will, spelled out Morrison's preferences for life-sustaining medical treatment, such as ventilators and feeding tubes. The other, called a health care proxy or health care power of attorney, named a friend to make treatment decisions for him if he were to become incapacitated.

Not everyone is as motivated to **tackle these issues**. Even though advance directives have been promoted for nearly 50 years, only about a third of U.S. adults have them, according to a recent **study.** People with chronic illnesses were only slightly more likely than healthy individuals to document their wishes. For the analysis, published in the July issue of Health Affairs, researchers reviewed 150 studies published from 2011 to 2016 that reported on the proportion of adults who completed advance directives, focusing on living wills and health care power-of-attorney documents.

Of nearly 800,000 people on whom the studies reported, 36.7 percent completed some kind of advance directive. Of those, 29.3 percent completed living wills, 33.4 percent health care proxies and 32.2 percent were "undefined," meaning the type of advance directive wasn't specified or combined the two.

People older than 65 were significantly more likely to complete any type of advance directive than younger ones, 45.6 percent vs. 31.6 percent. But the difference between people who were healthy and those who were sick was much smaller, 32.7 percent compared with 38.2 percent.

The Medicare program began reimbursing physicians in January 2016 for counseling beneficiaries about advance-care planning….**Read More**

Click on the links below from ELDERIMPACT for some great information

- **Medication Safety For The Elderly: A Guide For Patients And Caregivers**
- **Overdose Response Guide: Awareness, Prevention, And Preparedness For Caregivers Of Addicts**
- **The Ultimate Guide To Senior Nutrition**
- **The Benefits Of Cooking With Alzheimer's: A Caregiver's Guide**
- **Health: What To Expect In Your 70s And Beyond**
- **A Guide To Downsizing For Seniors And Their Loved Ones**
- **Is My Elderly Parent Incompetent? What To Do If You're Worried**
- **Senior-Friendly Remodeling**
- **12 Ways To Help Seniors Avoid Social Isolation**
- **Caretakers' Guide To Moving Seniors Into A Facility**

For more information visit http://elderimpact.org/