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RI ARA

Affiliated with the Rhode Island AFL-CIO
"Fighting for the future of our members."
"NOW, more than ever!!!"

Publication 2019 Issue 48
Published in house by the
RI ARA

December 1, 2019 E-Newsletter

Protect and expand our earned benefits

When so many seniors are struggling to make ends meet, it's wrong to propose cutting earned Social Security and Medicare benefits.

Hiding behind closed doors to get it done faster is outrageous and undemocratic.

Please sign our petition and tell Congress to protect and expand our earned benefits, not create a secret plan to cut them.

But a secret, backroom process is exactly what Senator Mitt Romney of Utah is trying to make happen. He has introduced a dangerous bill, S. 2733, misleadingly called the TRUST ACT. That legislation would create a panel that would meet outside of public view and create "fast-track" plans to make changes to Social Security and Medicare.

Mitt Romney

We need to stop this idea before it goes any further.

Social Security and Medicare benefits are critical to all Americans. We paid for them our entire life. And we need to fight anyone whose goal is to cut them or put Wall Street in charge of the system.

Please take a minute and sign the petition. We must send a clear message to Congress now - and tell them you will not stand for any secret deal to fast track cuts to Social Security and Medicare.

Rich Fiesta

Thank you for taking action to defend our earned benefits. It is critical that Congress hear from you today.

Sincerely,
Rich Fiesta,
Executive Director
Alliance for Retired Americans

Social Security Lifts More Americans Above Poverty Than Any Other Program

Social Security benefits play a vital role in reducing poverty in every state, and they lift more Americans above the poverty line than any other program. Without Social Security, 22.1 million more Americans would be poor, according to analysis using the March 2018 Current Population Survey. Although most of those whom Social Security keeps out of poverty are elderly, 6.7 million are under age 65, including 1.1 million children. (See Table 1.) Social Security is particularly important for elderly women and people of color, who have fewer retirement resources outside of Social Security. Depending on their design, reductions in Social Security benefits could significantly increase poverty, particularly among the elderly.

Social Security Lifts 15 Million Elderly Americans Out of Poverty

Most people aged 65 and older receive the majority of their income from Social Security.[1] Without Social Security benefits, 39.2 percent of elderly Americans would have incomes below the official poverty line, all else being equal; with Social Security benefits, only 9.2 percent do. (See Figure 1.) These benefits lift 15.3 million elderly Americans above the poverty line, these estimates show.

Center on Budget and Policy Priorities

A recent study that matches Census survey data to administrative records suggests that the official estimates overstate elderly reliance on Social Security but confirmed that Social Security lifts millions of elderly Americans out of poverty and dramatically reduces the elderly poverty rate.

Protect and expand our EARNED BENEFITS

Effect of Social Security on Poverty (Official Poverty Measure), 2017

	Percent in Poverty		
Age Group	Excluding Social Security	Including Social Security	Number Lifted Above the Poverty Line by Social Security
Children Under 18	19.0%	17.5%	1,106,000
Adults Ages 18-64	14.1%	11.2%	5,629,000
Elderly Age 65 and Over	39.2%	9.2%	15,333,000
Total, All Ages	**19.1%**	**12.3%**	**22,068,000**

Medicare Part D: A First Look at Prescription Drug Plans in 2020

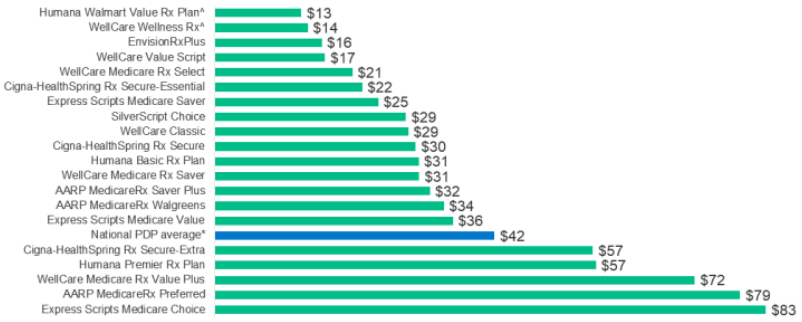
During the Medicare open enrollment period from October 15 to December 7 each year, beneficiaries can enroll in a plan that provides Part D drug coverage, either a stand-alone prescription drug plan (PDP) as a supplement to traditional Medicare, or a Medicare Advantage prescription drug plan (MA-PD), which covers all Medicare benefits, including drugs. Among the **45 million Part D enrollees in 2019**, 20.6 million (46%) are in PDPs (excluding employer-only group PDPs). This issue brief provides an overview of PDPs that will be available in 2020 and highlights key changes from prior years.

Key Findings

- The average Medicare beneficiary will have a choice of 28 PDPs in 2020, one more PDP option than in 2019, and six more than in 2017, a 29% increase. A total of 948 PDPs will be offered in the 34 PDP regions in 2020 (plus another 11 PDPs in the territories), an increase of 202 PDPs since 2017.
- PDP premiums will vary widely across plans in 2020, as in previous years (Figure 1). Among the 20 PDPs available nationwide, average premiums will range sixfold from a low of $13 per month for Humana Walmart Value Rx Plan to a high of $83 per month for Express Scripts Medicare Choice.
- Two-thirds of Part D enrollees without low-income subsidies (9.0 million enrollees) will see their monthly premium increase in 2020 if they stay in their same plan, while one-third (4.3 million) face premium decreases. As an example, the 1.9 million enrollees without low-income subsidies in the Humana Walmart Rx Plan, the third most popular PDP in 2019, will see their monthly premium double in 2020, from $28 to $57, unless they switch plans. This is due to plan changes and consolidations, with Humana consolidating two of its PDPs (Humana Walmart Rx and Humana Enhanced) into one PDP for 2020 and renaming it Humana Premier Rx, with a $57 monthly premium.
- The estimated national average monthly PDP premium for 2020 is projected to increase by 7% to $42.05, weighted by September 2019 enrollment. The actual average premium in 2020 may be lower if current enrollees switch to, and new enrollees choose, lower-premium plans during open enrollment.
- In 2020, all PDPs will have a benefit design with five or six tiers for covered generic, brand-name, and specialty drugs, and cost sharing other than the standard 25% coinsurance, similar to 2019. More than eight in 10 PDPs (86%) will charge a deductible, with most PDPs charging the standard deductible of $435 in 2020.
- Among all PDPs, median cost sharing is $0 for preferred generics and just $3 for generics, but $42 for preferred brands and 38% coinsurance for non-preferred drugs (the maximum allowed is 50%), plus 25% for specialty drugs (the maximum allowed is 33%).
- Medicare beneficiaries receiving the Low-Income Subsidy (LIS) will have a choice of seven premium-free PDPs in 2020, on average, one more than in 2019. In 2020, nearly 20% of all LIS PDP enrollees who are eligible for premium-free Part D coverage (1.3 million LIS enrollees) will pay Part D premiums averaging $18 per month unless they switch or are reassigned by CMS to premium-free plans.

Figure 1

Average Monthly Premiums for the 20 National Part D Stand-alone PDPs Are Projected to Range Sixfold from $13 to $83 in 2020



NOTES: PDP is prescription drug plan. Estimates are weighted by September 2019 enrollment; assume current PDP enrollees remain in their same plan; and make no assumptions about plan choices by new enrollees for 2020. ^Reflects unweighted median because PDP is new for 2020. *National average includes premiums for basic and enhanced PDPs.

SOURCE: KFF analysis of Centers for Medicare & Medicaid Services 2019-2020 Part D plan files.

KFF HENRY J. KAISER FAMILY FOUNDATION

Top Democratic presidential candidates support strengthening Social Security

The top four Democratic presidential candidates may be split on health care reform, two favor the public option and two favor Medicare for All. But, Nancy Altman writes in **Forbes** that all four top candidates, Bernie Sanders, Elizabeth Warren, Joe Biden and Pete Buttigieg, support strengthening and expanding Social Security. No matter who becomes the Democratic candidate, if you support expanding Social Security, it will be critical to vote.

Social Security is a national treasure that virtually all Democratic members of Congress support expanding. In fact, nine out of ten members of the House of Representatives support Congressman John Larson's **Social Security 2100 Act**. If enacted, Social Security benefits would rise, and its Trust Fund would be strong for many many decades.

Increasing Social Security benefits would help older Americans in retirement. Today, a large portion of older adults struggle to afford their basic needs. Few people can rely on pensions or retirement savings. **Many rely almost exclusively or heavily on Social Security** for their income. Social Security income is guaranteed and cost-effective, unlike Wall Street stock investments and **401(k) plans**.

Most Republicans in Congress would like to cut Social Security benefits even though their constituents overwhelmingly support Social Security..

Social Security is an earned benefit, unlike other federal and state social programs that are for particular populations in need. For our personal and collective security, we must ensure its continued well-being.

Without adequate Social Security benefits, young Americans would be left worrying even more about their parents' financial well-being

Update on lowing drug price Legislation

Wve reported in previous weeks about H.R. 3, the legislation in the House of Representatives being referred to as the 'Pelosi bill.' It is the top bill in the House, authored by House Speaker Nancy Pelosi (D-Calif.), that would allow Medicare to negotiated drug prices in order to bring the costs down. Speaker Pelosi had been hoping that President Trump might support her bill because he has said one of his top goals is to reduce the cost of prescription drugs.

There were even indications that the House would vote on the Pelosi bill this week and then send it to the Senate for action, even though Senate Majority Leader Mitch McConnell (R-Ky.) is opposed to the bill and has said he would not bring it up in the Senate.

Much to Speaker Pelosi's disappointment, the President indicated this week that he will not support the Pelosi bill but instead will support a bi-partisan bill in the Senate co-authored by Senate Finance Committee Chairman Chuck Grassley (R-Iowa) and Senator Ron Wyden (D-Ore.)

The name of the Grassley-Wyden bill is the Prescription Drug Pricing Reduction Act of 2019 (S.2543). It's purpose is to lower prescription drug prices in the Medicare and Medicaid programs, improve transparency related to pharmaceutical prices and transactions, lower patients' out-of-pocket costs, and ensure accountability to taxpayers, and for other purposes.

Unfortunately, earlier this week Sen. John Thune (R-S.D.), the Senate's No. 2 Republican, said that it is unlikely the Senate will pass legislation to lower drug prices before the end of the year.

Then just yesterday Senator Grassley announced in a speech that the Senate is short of the 60 votes it will need to pass a prescription drug pricing bill even though the bill is the only one in Congress that enjoys bipartisan support.

When they announced their bill this past July, the Senators said "The cost of many prescription drugs is too high. Without action, we're on an unsustainable path for taxpayers, seniors and all Americans. A working class family shouldn't have to pick between making their rent or mortgage payment and being able to afford their kids' medications. A single mother with diabetes shouldn't have to pick between groceries and insulin. A senior citizen who's paid into the system their entire life shouldn't have to cut pills in half to be able to make it to the next refill. The time to act on prescription drug prices is now.

"We've been working on a bipartisan basis for more than six months to craft legislation that begins to address the broken prescription drug supply chain. Pharmaceutical companies play a vital role in creating new and innovative medicines that save and improve the quality of millions of American lives, but that doesn't help Americans who can't afford them. Similarly, pharmacy benefit managers and insurance companies have the opportunity to negotiate lower prices, but the American people don't know how much these middlemen pocket for themselves. This legislation shows that no industry is above accountability. Passing these reforms, especially those that will affect some of the most entrenched interests in Washington, is never easy. But Americans are demanding action and reform is long overdue. We're looking forward to working with our colleagues on the Finance Committee and with other committees in Congress to pass this prescription drug pricing overhaul very soon."...**Read More**

U.S. prosecutors open criminal probe of opioid makers, distributors

Federal prosecutors are investigating six pharmaceutical companies for potential criminal charges in connection with shipping big quantities of opioid painkillers that contributed to a healthcare crisis, according to regulatory filings.

Five companies have received subpoenas from the U.S. Attorney's office in the Eastern District of New York as part of the investigation: drugmakers Teva Pharmaceutical Industries Ltd, Mallinckrodt Plc, Johnson & Johnson and Amneal Pharmaceuticals Inc, and distributor McKesson Corp, regulatory filings showed.

The Wall Street Journal first reported the investigation on Tuesday. The newspaper said the probe was in the early stages and prosecutors were expected to subpoena other companies in the coming months, citing a source.

A spokesman for the U.S. Attorney's office for the Eastern District of New York declined to comment.

The WSJ also said distributor AmerisourceBergen Corp had received a subpoena as part of the investigation. The company said in regulatory filings that it has received subpoenas from multiple U.S. attorneys including the Eastern District of New York, but unlike the other companies, AmerisourceBergen did not specify the nature of the probe.

Shares of AmerisourceBergen, Amneal, Teva, Mallinckrodt and McKesson ended down 3% to 9%, while J&J shares were down marginally following the report. J&J's disclosure of the investigation was reported by Reuters in October.

Teva said it was confident in its monitoring practices, which it said were designed to ensure medicines were delivered appropriately.

McKesson referred to recent regulatory filings while the other companies did not immediately respond to requests for comment.

Opioid manufacturers, distributors and pharmacy chains have been defending themselves against thousands of lawsuits by state attorneys general, local governments and class actions accusing them of fueling an addiction crisis.

Opioids have contributed to more than 400,000 deaths since 1997.

Some of the companies' filings described the subpoenas as part of an industry-wide probe into anti-diversion policies and distribution of opioid medications under the Controlled Substances Act (CSA).

Several companies said they received grand jury subpoenas, indicating a criminal investigation.

The CSA requires companies to report orders of controlled substances such as opioids that are unusually large or unusually frequent, or that substantially deviate from norm.

In July, federal prosecutors charged an Ohio drug distributor, Miami-Luken Inc, for shipping millions of opioid pills to rural Appalachia, ground zero for the epidemic.

Poll Finds Many Americans Worried about Health Care Costs and Struggle to Afford Care

.A **recent poll and study by Gallup and West Health** found that most Americans are worried about rising health care costs, and many are also concerned about bankruptcy from major health events. Older adults have somewhat more confidence about their access to quality care than younger people, but they still experience difficulty with affordability, especially when it comes to paying for prescription drugs. These findings and more are an important indicator that more must be done to bring down health care costs.

The poll of over 3,000 adults, bolstered by interviews with individual households and health care industry experts, shows widespread anxiety about the future of health care affordability in the United States. This includes fears that health care costs will have a negative impact on the U.S. economy (77%) in addition to more personal fears about the effects on household budgets and individual health. For example, 45% are concerned a major health event will leave them bankrupt.

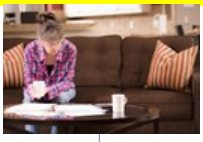
High health care and prescription drug costs can lead to delays in care, often with serious consequences. Over one-quarter of Americans have gone without needed care in the past 12 months due to its cost. And 19% reported that they have deferred purchasing prescription drugs due to costs, even though a significant portion of these respondents have conditions they characterized as "very serious." According to the poll, more than **13%** of adults—or about 34 million people—know of at least one friend or family member who died in the past five years after not receiving needed medical treatment because they couldn't afford it.

Older adults are less pessimistic about the health care system, but 10% of people 65 and older reported that they did not seek needed treatment in the past 12 months. This number increased for drug affordability, as 14% reported that they were unable to pay for a needed drug in the past year, with this number reaching 20% for those with household incomes under $60,000. This is significant because currently, **half of all Medicare beneficiaries live on $26,200 or less per year**, while one-quarter have incomes below $15,250 and less than $14,550 in savings.

At Medicare Rights, we know that Medicare improves access to high-quality care, but only if this coverage is affordable. More must be done to ensure that older adults and people with disabilities can obtain the care they need. This is especially apparent with prescription drugs where we support efforts to reduce drug prices and lower costs for people with Medicare and the program. This will improve access and adherence to prescriptions and boost the health and well-being of current and future beneficiaries.

Read the poll and study results.
Read about recent drug legislation in the **House** and **Senate.**

Older Americans Face Greatest Economic Insecurity in Northeast



Seniors who live alone are significantly more likely to be financially insecure, according to a new study.

More than 60% of seniors living alone in the Bay State can't meet their basic, necessary expenses, according to a new report.

SENIORS LIVING IN Northeastern states are among the most likely to lack sufficient financial resources to cover their day-to-day needs, according to a new **report**. Half of America's senior population that lives alone – and nearly a quarter of those living in two-person households – struggle to make ends meet.

The study, conducted by researchers from the University of Massachusetts—Boston's Center for Social and Demographic Research on Aging, suggests **Vermont**, **New York** and **Massachusetts** have the largest percentages of seniors at least 65 years of age who don't have enough income to cover their basic needs – defined by their ability to cover necessary expenses such as housing, food, transportation and health care without government support programs, loans or gifts.

In Massachusetts, nearly 62% of seniors living alone, and nearly 30% of seniors in two-person households, are considered to be economically insecure. In Vermont, more than 57% of senior singles and nearly 35% of couples are similarly vulnerable. Nationally, an average of 50.3% of singles and 22.9% of couples struggle with basic living expenses.

"Many older adults who live independently do not have the means to live with economic security," according to the report, which also notes "a large proportion of every state's independent older adults lack incomes that would allow them to escape the threat of poverty, to remain independent, and to age in their own homes."

When state rankings for singles and couples are averaged, half of the worst states for senior financial security are in the geographic Northeast: Vermont, New York, Massachusetts, **Maine** and **New Hampshire**. Southern states **Arkansas**, **Louisiana** and **Mississippi** are joined by **California** and **Hawaii** to complete the bottom 10.

Highest Rates of Senior Economic Insecurity

- Vermont
- New York
- Massachusetts
- Mississippi
- Maine
- California
- Louisiana
- Hawaii
- Arkansas
- New Hampshire

The report suggests the Northeast's overrepresentation in the bottom 10 is a factor of high living expenses making it difficult for seniors without sufficient or predictable incomes to get by – dynamics that also place high-cost states such as California and Hawaii in the bottom 10.

And although the report notes living expenses are more modest in states such as Mississippi and Louisiana, it also suggests they placed among the 10 worst states "due to low incomes among residents."

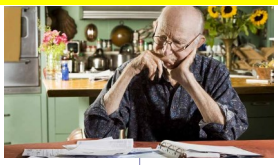
Several lower-cost Southwestern, Midwestern and Mountain states, such as **Nevada**, **Utah**, **Ohio, ,** Indian a**, Arizona**, **Kansas** and Colorado were found to hold the lowest percentages of financially vulnerable seniors. In **Alaska,** just 15 of older couples are considered economically insecure, well shy of the national average….**Read More**

Economic Security for Older Americans – by State

Recent Changes Add Complexity to Medicare's Fall Open Enrollment Period

Medicare's Fall Open Enrollment Period (OEP) is a busy time for beneficiaries and those who help them evaluate their health care and prescription drug coverage options. From October 15 to December 7 each year, people with Medicare can make changes to their coverage, such as switching Part D prescription drug plans, or switching between Original Medicare and Medicare Advantage. This annual decision-making process can be complex, and several changes this year are making it even more so.

First, people with Medicare must compare more plans than ever before. A new **analysis** from the Kaiser Family Foundation (KFF) finds the average Medicare beneficiary will have a choice of 28 prescription drug plans (PDPs) in 2020, a 29% increase from just three years ago. And these decisions aren't getting any easier, as plan premiums continue to vary widely. Among the 20 PDPs available nationwide, average premiums range from $13 to $83 per month.



Second, an unprecedented number of beneficiaries are facing premium increases if they don't change plans by December 7. According to KFF, two-thirds of Part D enrollees without low-income subsidies—9 million enrollees—will see their monthly premium increase in 2020 if they maintain current coverage. This is largely due to plan changes and consolidations. For example, Humana recently consolidated two of its PDPs (Humana Walmart Rx and Humana Enhanced) into one new plan, Humana Premier Rx, which will carry a $57 monthly premium in 2020. As a result, unless they switch plans, 1.9 million enrollees without low-income subsidies in the Humana Walmart Rx Plan—the third most popular PDP in 2019—will see their monthly premium double in 2020, from $28 to $57.

Third, for this year's OEP, the Centers for Medicare & Medicaid Services (CMS) redesigned the Medicare Plan Finder (MPF) tool on which millions rely for accurate plan information. Medicare Rights appreciates CMS's work to modernize MPF; many of the changes are significant improvements. However, we **remain concerned** that this well-intended revamp may further complicate the plan comparison process for some looking to make plan changes this fall. Specifically, that issues with the new tool's roll out, content, and functionality could cause beneficiaries to make sub-optimal coverage decisions for 2020, errors they may not discover until well into next year. A recent Health Affairs **article** underscores this concern, noting that many of the MPF revisions will make the tool more user-friendly—while others may undermine plan selection efforts, including by steering beneficiaries away from lower-cost options.

To mitigate these potential hardships and improve MPF ongoingly, Medicare Rights is working with CMS and other stakeholders to address problems with the tool; we applaud the agency's responsiveness in quickly adopting many of our **initial recommendations**. We are also urging CMS to take steps to prevent beneficiaries from experiencing any MPF-related enrollment complications in 2020. We look forward to continuing to work to strengthen this important resource in ways that empower people with Medicare to make informed decisions about their care.

Additionally, amid these trends and changes, Medicare Rights is helping people with Medicare weigh their options. **Read more** about the services and resources we provide during Fall Open Enrollment, including Medicare Plan Finder appointments, and call our National Consumer Helpline (800-333-4114) today with any questions. We also offer a **free, downloadable Fall Open Enrollment guide** to connect beneficiaries with accurate, unbiased Medicare information, as well as **this online resource** to help people get started with the new MPF.

Last-Minute Loophole Could Undermine Texas Law Against Surprise Medical Bills

Texas' bipartisan effort to shield patients from surprise medical bills could be weaker than lawmakers intended when it takes effect Jan. 1.

Earlier this year, lawmakers from both parties came together on legislation to protect people in state-regulated health plans from getting outrageous bills for out-of-network care. The new law, known as Senate Bill 1264, creates an arbitration process for insurers and providers to negotiate fair prices in those cases. The intention of the law is to establish those fair prices without ever involving patients.

But that protection is at risk of becoming "irrelevant," consumer advocates in Texas say.

"The financial struggle that legislators were trying to remove us from — trying to protect us from — patients might be right back in the middle of that situation," said **Stacey Pogue**, a senior policy analyst with the Center for Public Policy Priorities.

State agencies are writing the rules to implement and enforce the new law. Some of those rules, which will be discussed publicly in early December, will let hospitals and other care providers send patients bills in nonemergency situations, such as scheduled surgeries.

One state agency hashing out how the law will work is the Texas Medical Board, which is run by physicians and regulates other doctors in the state. Pogue said the board has proposed a rule that would expand the use of a narrow exception in the law. SB1264 created an exception for patients who knowingly want to receive nonemergency care from a doctor who is out of their health plan's network. In those cases, patients would sign a waiver with the expectation of paying those out-of-network costs.

The board's proposed rule takes that narrow exemption — intended to be used only when patients want a particular out-of-network doctor — and instead would require all out-of-network providers in nonemergency situations to give patients that waiver.

In practice, advocates say, the rule could essentially require out-of-network providers — like anesthesiologists and pathologists — to give patients a confusing form that waives their right to the new law's protection. The form would allow the patients to be balance-billed.

"Now it's a loophole," Pogue said. "It's a loophole in the [law] where legislators wanted to give a protection — a win-win. And now some patients are going to get a lose-lose." ...**Read More**

How to Spot Elder Abuse from Afar: Signs and Solutions for Long-Distance Caregivers

From a distance, it can be hard to assess the quality of your family member's caregivers. Ideally, if there is a primary caregiver on the scene, he or she can keep tabs on how things are going.

Perhaps you have already identified friends or neighbors who can stop in unannounced to be your eyes and ears. Sometimes, a geriatric care manager can help.

You can stay in touch with your family member by phone and take note of any comments or mood changes that might indicate neglect or mistreatment. These can happen in any setting, at any socioeconomic level. Abuse can take many forms, including domestic violence, emotional abuse, financial abuse, theft, and neglect.

Sometimes the abuser is a hired caregiver, but he or she can also be someone familiar. Stress can take a toll when adult children are caring for aging parents, or when an older person is caring for an aging spouse or sibling. In some families, abuse continues a long-standing family pattern. In others, the older adult's need for constant care can cause a caregiver to lash out verbally or physically. In some cases, especially in the middle to late stages of Alzheimer's disease, the older adult may become difficult to manage and physically aggressive, causing harm to the caregiver. This might cause a caregiver to respond angrily.

But no matter who is the abuser or what is the cause, abuse and neglect are never acceptable responses. If you feel that your family member is in physical danger, contact the authorities right away. If you suspect abuse, but do not feel there is an immediate risk, talk to someone who can act on your behalf: your parent's doctor, for instance, or your contact at a home health agency. Suspected abuse must be reported to adult protective services.

Elder Abuse:

- **Types of Abuse**
- **Money Matters**
- **Who Is Being Abused?**
- **What Are Signs of Abuse?**
- **Who Can Help?**
- **Caregiver Stress—You're Not Alone**
- **What Is the Long-Term Effect of Abuse?**

For More Information About Elder Abuse

- **Eldercare Locator**
  1-800-677-1116 (toll-free)
  eldercarelocator@n4a.org
  https://eldercare.acl.gov
- **National Committee for the Prevention of Elder Abuse**
  info@preventelderabuse.org
  www.preventelderabuse.org
- **National Center on Elder Abuse**
  1-855-500-3537 (toll-free)
  ncea-info@aoa.hhs.gov
  https://ncea.acl.gov

Two Medicaid-Related Initiatives That Help set to expire

Two initiatives that for years have helped shift Medicaid enrollees away from nursing homes in favor of long-term care at home and in the community face year-end deadlines that could undercut that trend, according to two new KFF issue briefs. While there does not appear to be substantive disagreement over the initiatives like there is with many other federal health programs, their expiration is coming at a time when Congress is engaged in a contentious budget debate with other competing demands.

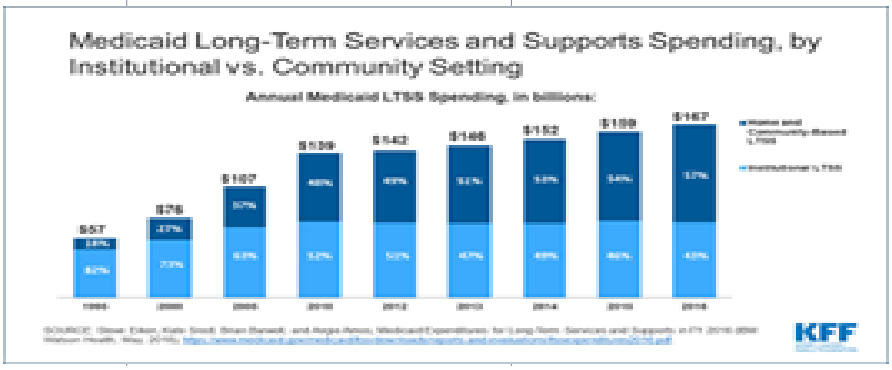
Funding for Medicaid's Money Follows the Person (MFP) demonstration, which has served more than 90,000 people in 44 states since 2007, is set to expire on December 31. The program provides states with enhanced federal matching funds for services and supports needed to help seniors and people with disabilities transition from institutional care to community-based care.

Absent a reauthorization by Congress, KFF surveys show that nine of the 44 states will have exhausted their current funds by the end of this year, and the vast majority of the remaining states expect to run out of money for the program during 2020. Fifteen states report a range of services, activities and staff positions that they expect to discontinue, including services such as community case management, housing relocation assistance and family caregiver training.

The second brief examines the implications of a pending change to "spousal impoverishment" rules in Medicaid that allow married couples to protect a portion of their income and assets should one spouse seek Medicaid coverage for long-term care, so that the other spouse still has adequate resources to meet their needs. A provision of the Affordable Care Act that requires state Medicaid programs to apply such rules to home and community-based long-term care is set to expire at the end of December.

That could tip the balance of financial incentives toward institutional care, to which the rules would still apply, and affect the efforts that states have made through waivers to expand access to home and community-based services (HCBS), the brief explains. Following a decades-long shift, the majority of Medicaid long-term services and supports spending now goes toward HCBS instead of institutional care. Medicaid spent $167 billion on long-term services and supports in 2016, with 57 percent on HCBS.

If Congress does not extend the ACA provision, states would still have the option to continue applying the spousal impoverishment rule to at least some enrollees in HCBS. However, a KFF survey finds that at least 14 states expect the expiration of the ACA provision to have an effect on Medicaid enrollees who are receiving such services.



RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Emerging cardio-oncology field fights heart disease in breast cancer patients

Four months into her fight against stage 2 **breast cancer**, Andrea Cianfrani learned she had a new health challenge to conquer. After recovering from a mastectomy, she received chemotherapy to attack the cancer, not knowing that it was also attacking her heart.

The 40-year-old had heart disease, the #1 cause of death for breast cancer survivors and women overall. More than 3.8 million breast cancer survivors live in the United States, and in about 10% of breast cancer patients, chemotherapy and radiation can damage the heart. It can happen during treatment, or the issue may develop years afterward, reports CBS News medical contributor Dr. Tara Narula, who is a cardiologist.

"It really did feel like another punch … where you've been punched a couple of times," Cianfrani said. "It was a little bit of a surprise especially because … I wasn't feeling anything."

An emerging field called cardio-oncology has developed to protect the hearts of cancer patients both during and after treatment.

"During treatment we actually can see a cardiac dysfunction, namely heart failure, for some of our patients," said Dr. Chau Dang, Cianfrani's oncologist at Memorial Sloan Kettering Cancer Center. Dr. Dang teamed up with a cardiologist, prescribing medication to protect Cianfrani's heart, so she would be strong enough to finish chemotherapy.

"Cardio-oncology is a field that is growing," Dang said. "We're all working very well together to take care of our patients not only to improve their cancer outcomes as they survive but to improve their cardiovascular outcomes as they age."

Breast cancer treatment puts the heart at risk in several ways. Chemotherapy can damage the heart muscle that pumps blood, leading to heart failure. Radiation can disrupt normal heart rhythm, and damage both the lining around the heart and the heart valves. The biggest risk from radiation is the development of early and accelerated coronary artery disease, which raises the **risk of heart attack.**

While some women, like Cianfrani, have no **symptoms**, others experience shortness of breath, chest pain or decreased ability to exercise.

"What we should *not* be telling our patients is, don't get the very treatments that make you beat the cancer in the first place," said Dr. Javid Moslehi, who directs the cardio-oncology program at Vanderbilt University in Tennessee. "The treatments are effective … but now the issue is, how do we give the drugs more safely? … How do we prevent heart disease?"

Breast cancer survivors could be at risk of heart disease years to even a decade after completion of treatment, Moslehi said. "It is this part that I think we as a medical community need to raise more awareness and do a better job of screening for," he said.

Three years after completing her treatment, Cianfrani's heart is strong again, but she will be monitored for any lingering effects of the chemotherapy for the rest of her life.

After treatment, cancer patients should ask doctors to give them a detailed record of their chemo and radiation dosages to discuss with their primary care doctor or cardiologist. They should also speak to them about how to recognize symptoms of heart disease and take preventive measures to lower their risk.

Click on picture below to Watch Video

Here's Why Heart Attacks Are More Common in the Winter

The winter might bring about the happiness of the holidays and hot chocolate galore, but the season also comes with a scary statistic: increased heart attacks. For a 2018 study published in JAMA Cardiology, researchers looked at weather data points corresponding with hundreds of thousands of heart attacks in Sweden; they concluded that days with below-freezing temperatures had the highest heart attack rates. So, why are heart attacks more common in winter?

It's because of what the weather does to your body internally that ultimately makes a difference. "**Heart attacks** are more common in winter because … cold temperatures can constrict heart vessels," explains **Sanjiv Patel**, MD, a cardiologist at MemorialCare Heart&Vascular Institute in Fountain Valley, California. When your heart vessels constrict, there's reduced blood flow to the organ, which **increases the risk of a heart attack**.

But it's not just heart vessels: Cold weather causes *all* blood vessels to tighten in order to preserve core body temperature. That forces **your blood pressure** to rise, putting even more strain on your heart.

Another reason **why heart attacks are more common in the winter** is because of the rise in upper respiratory infections. As Patel explains, these illnesses "lead to more inflammation in the body, which then can destabilize existing buildup in the arteries or make the buildup worse."

The last thing you probably want to think about during what should be the most cheerful time of year is a heart **attack**, but it's important to consider these added risk factors as the temperature dips. After all, sadly, the day you're at the highest risk for a heart attack, according to a 2018 *BMJ* study, is Christmas Eve. And for the heart attack symptoms to be aware of, **These Are the Heart Attack Warning Signs Hiding in Plain Sight.**

An often-missed form of dementia that's treatable

As Trish Bogucki walked from her office to her car, she often felt unsteady, tripping and stumbling. She expected it: She had a bunion and a hammer toe that probably needed surgical repair. Finally, the then-66-year-old visited a podiatrist, who surprised her with a very different cause of her condition.

"He said 'Yep, you have a bunion. Yep, you have a hammer toe. But what's your problem with walking,?" Bogucki, 70, of Mahwah, New Jersey, told TODAY.

The podiatrist believed something else caused her shuffling gait.

"He asked me lots of insightful questions," she said. "He said, 'You need surgery but I would hate to operate on you and not get at the root cause of the walking problem.'"

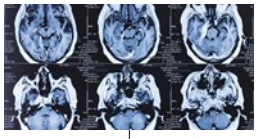
He called her general practitioner and explained that he thought Bogucki's walking issues were neurological. Her doctor then performed two tests: The first was for **Parkinson's disease,** which she did not have. The second was for normal pressure hydrocephalus, something she had never heard of before.

Yet, she had it.

"I had all the symptoms. I didn't realize it," Bogucki said.

Normal pressure hydrocephalus

NPH is a lesser known and often misdiagnosed form of dementia. It occurs when too much cerebrospinal fluid accumulates in the brain and spinal cord.



"In elderly patients that have a chronic form it likely evolves over time," Dr. Mark Luciano, director of the Cerebral Fluid Center, and professor of neurosurgery at Johns Hopkins University, told TODAY.

About 700,000 people have NPH in the United States, according to the **Hydrocephalus Association** but the group estimates that only 20% of people receive the correct diagnosis. Experts think that NPH is under-diagnosed because its symptoms resemble changes associated with aging, Parkinson's or dementia, including:

- Shuffling, unsteady gait
- Bladder incontinence
- Memory problems

People do not have to have all three symptoms for an NPH diagnosis, though.

"There is some short-term memory loss. It also involves decreases in complex (tasks), like executive functioning and communication," Luciano said."Those symptoms are a little different than Alzheimer's."

Experts are unsure what causes NPH though doctors sometimes observe a former brain injury, such as a concussion, or a blockage that causes the fluid to build up, for example. They also don't know if it runs in families.

"There isn't really an exact genetic marker so far," Luciano said. "There is a greater proportion where it is spontaneous."

While Bogucki sought help because of her impaired walking, she also realized she could no longer multitask. She once enjoyed riding a recumbent stationary bike and solving Sudoku puzzles at the gym but she suddenly couldn't.

"I could either do the puzzle or move the peddles. I couldn't do both at the same time," she said. "You have trouble with processing multiple problems, with decision making … short term memory."

If doctors suspect NPH, patients undergo an MRI to examine the brain. The next step is to find out if a patient has enlarged ventricles in the brain caused by fluid accumulation, Luciano said.

A proper diagnosis of the disease makes a huge difference for patients — it's the one form of dementia that can be halted and even reversed in some cases.

Treating NPH

If doctors notice abnormal amounts of fluid, they can perform a lumbar puncture, also known as a spinal tap, to drain some of the fluid. Almost immediately NPH patients, who relied on canes, walkers or wheelchairs, regain the ability to move more independently.

Bogucki couldn't believe the difference.

"I got relief that night," she explained. "Once I got the spinal tap I remembered 'This is what life used to be like," and I didn't have to hold onto a wall or a cane or a husband (to walk)."

She knew if she improved from that procedure she could undergo brain surgery where her doctor would insert a stent in her brain, which would continuously drain the excess fluid from her brain. The stent helps patients regain their physical abilities and memory long term.

Although she was nervous about brain surgery, she wanted to walk again without help, take step exercise classes and be able to stand during choir performances.

She received a brain stent and then attended physical and cognitive therapy. Since surgery four years ago, she's taken up line dancing and volunteers as a peer mentor and educator with the Hydrocephalus Association.

"I can multitask again. I can do Sudoku on the recumbent bike," she said.

Luciano said such impressive results are common.

"Patients show improvements and doctors see people coming out of nursing homes and walking independently," Luciano said.

Bogucki wants to raise awareness of NPH so that others can receive proper diagnosis and treatment.

"The dementia that comes with NPH is reversible," she said. "I am not perfect, but I wasn't perfect before anyway."

Health Tip: Five Common First-Aid Myths

First-aid myths may do more harm than good, these examples of first-aid folklore, and what to do instead:

- Putting hot water on frozen skin can cause serious damage. Slowly thaw skin with warm water instead.
- Rubbing alcohol does not bring down a fever. Use ibuprofen or acetaminophen instead.
- Putting coffee grounds on a cut to stop bleeding can cause infection. Apply pressure with sterile gauze instead.
- Rubbing butter on a burn can actually keep the heat in. Run cool water over the area to ease pain instead.
- Using ipecac syrup to induce vomiting can be dangerous. Call poison control immediately instead.

IF YOU'RE 65+, THE FLU CAN BE MORE DANGEROUS FOR YOU

Chronic conditions increase the risk for serious complications

Learn how a Senior Flu Shot can help protect you against the FLU

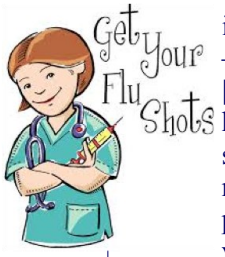
How Long Does the Flu Shot Last? Here's What Experts Say

If you find yourself with those typical flu-like symptoms — fever, chills, nasal congestion, the works — you might start worrying that you've come down with the flu (yep, **even in August)**.

But wait...didn't you get the flu shot last year? And if that's the case, how long does a flu shot last, exactly — and are you still covered? To help you figure things out, *Health* spoke with a few infectious disease experts (you know, doctors that actually specialize in diseases like the flu) to find out how long you're covered with a flu shot, and what that means for when you should get your next one.

All right, how long does the flu shot last?

The short answer: six months. But the long answer is a little bit more complicated, in part because every body is different. As a general rule "the flu shot is most effective in the first three months, [but] people still have protection after six months," Vanessa Raabe, MD, pediatric infectious disease specialist at NYU Langone Health, tells *Health*.



Knowing how long the flu shot lasts plays a pretty important part in determining when to get your flu shot each year. That part requires a little bit of math (luckily, these doctors are here to do the dirty work for you). Flu season, in general, lasts from October to May, according to **the Centers for Disease Control and Prevention** (CDC). But flu season actually *peaks* sometime between December and March, Frank Esper, MD, pediatric infectious disease specialist at Cleveland Clinic tells *Health*.

That means you should definitely get the flu shot before flu season peaks. You should get it "at least two weeks — but preferably four [beforehand] — to have full immunity," says Dr. Esper. "You need a little pre-planning time to get your shot, to have that shot develop its effectiveness," he adds. That means you should plan on getting a new flu shot in September or October, Dr. Esper says. **The CDC also recommends** getting a flu shot by the end of October.

So, unfortunately, if you got your flu shot at the correct time last year, you're not currently covered (and yes, that can matter, since flu technically exists year round and only *peaks* during flu season). And if you got one later in the season last year, say, in March? Unfortunately, you're still not covered right now, even if you're within the six-month range. That's because the flu strains differ from year to year. The shot you got last year "was for last season's strains, and the strains coming up this season may be different," Dr. Esper says.

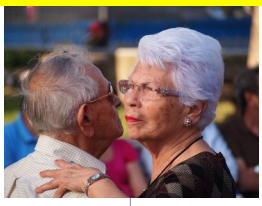
In fact, Dr. Raabe adds, the two A strains of flu (there are three types that affect humans: A, B, and C viruses), which are the most common, are expected to be different this flu season. For that reason, the flu shot from last year was "tweaked" to better protect people from those strains, Dr. Raabe says.

Basically, you need to get the flu shot every year — no exceptions, unless you're severely allergic to the vaccine or are six months of age or younger. And yes, while the flu shot isn't 100% effective, it can prevent the flu from becoming fatal. "The flu shot is not 100%, [but] it's there to make sure you don't die from the flu [or] get hospitalized," Dr. Esper says.

Older adults with cancer do better with care tailored to their needs

Standard treatment for cancer, including multiple rounds of radiation, may help lots of patients. But, older adults with cancer may do better with different care, tailored to their needs. Cheryl Platzman Weinstock reports for **NPR** that certain cancer treatments may leave older patients weaker.

Older patients with cancer may benefit from a geriatric assessment to help doctors understand their overall health status before their cancer treatment plan is established. The assessment evaluates people's mental and physical conditions as well as their functional capacity, social lives and preferences. If a patient is not active physically or has lost significant cognitive function, aggressive treatment may not be in the patient's best interest.



More than six in ten people with cancer are 65 or older and that percentage is expected to rise in the coming years. It's not easy to know whether someone will survive cancer treatment or how much longer a patient will live after treatment. Geriatric assessments help doctors understand the likelihood of side effects from treatment.

Some evidence suggests that geriatric assessments may improve cancer care for older patients. Doctors are often inclined to try to cure patients regardless of the risks. But, intensive treatments on older patients with multiple conditions may actually accelerate their death.

Sometimes, less is more. With cancer treatment, a prescription drug could keep the cancer from growing. And, the drug, unlike radiation treatment, could allow patients who are already weak or suffering from multiple health conditions a better quality of life in their remaining years.

With a geriatric assessment, patients are more likely to learn about the benefits of less intensive treatment or comfort care. Some prefer these options to preserve their quality of life longer.

In fact, **Cochrane** analyzed 27 studies of geriatric assessments of older patients. It found that they had a greater chance of living at home one year afterwards than older patients who received chemotherapy or radiation treatment.

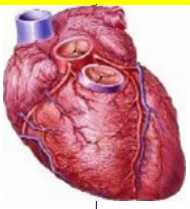
If someone you love is diagnosed with cancer, consider asking for a geriatric assessment, especially in situations in which the person with cancer has another serious health condition or functional limitations. Geriatric assessments are not commonplace yet, but they can be enormously helpful.

CARDIOVASCULAR HEALTH INFORMATION

Cardiovascular problems, or problems that affect the heart and blood vessels, are some of the greatest overall health problems in the United States and worldwide. Overall, heart disease, sometimes called coronary artery disease, is the No. 1 killer of both men and women in the United States. Heart attack, when the heart suddenly stops working, is another major problem related to cardiovascular health. And there are many more conditions that can affect the heart or blood vessels and impact cardiovascular health.

Specific Cardiovascular Problems

Heart disease is a general term that refers to blood circulation problems in the heart. It is the result of atherosclerosis, or the narrowing of the arteries caused by plaque buildup. When a person has heart disease, it increases the risk for other cardiovascular problems occurring, such as heart attack or stroke. A stroke can occur if a blood vessel is blocked by a dislodged piece of plaque of if it suddenly bursts.



Other problems related to cardiovascular health can also develop. For example, some people have an irregular heartbeat that comes and goes, which is known as arrhythmia. When a heart valve is not opening or closing properly, this can cause heart and blood flow problems as well. Heart failure is often a complication of heart disease, and this occurs when the heart cannot keep up with the blood flow that the body needs. In addition, health conditions such as high blood pressure, high blood cholesterol and diabetes can all increase the risk for future cardiovascular problems.

Maintaining Cardiovascular Health

A number of risk factors increase the chances of developing cardiovascular problems later in life. Some, such as age or a family history of the problem, are out of an individual's control. But in other cases, people can take steps to reduce their risk for cardiovascular problems with simple lifestyle changes. For example, maintaining a healthy weight, eating a healthy diet, exercising regularly and quitting smoking can all reduce the likelihood of developing cardiovascular problems. Other health problems such as diabetes and high blood pressure increase the risk for heart disease so it's also important to manage these conditions if they develop. Being under the care of a trusted doctor is critical, too. This ensures regular heart health checkups and careful monitoring and treatment of any cardiovascular problems that may occur.

DISEASES AND CONDITIONS INFORMATION

Diseases and conditions are any form of illness that disrupts normal bodily functions and leaves a person feeling impaired in some way. There are thousands of different kinds of diseases and conditions, and they can range in severity from a mild cold to a life-threatening heart condition. Sometimes they are caused by an outside organism like a virus or bacteria. Other times, the body attacks itself in the form of an autoimmune disorder. Many diseases and conditions have a cause that is not known or is poorly understood.

Types of Diseases

Some diseases and conditions are defined as acute. This essentially means that they are short-term diseases or conditions that only last a few days or a few weeks. Sometimes acute conditions can be treated with medication, while others will subside on their own over time.

The more concerning types of diseases and conditions are generally chronic illnesses. These are diseases and conditions that last a long time, and they often have no cure.

According to the U.S. Centers for Disease Control and Prevention, seven out of every 10 deaths in the United States is due to a chronic disease. The most common chronic diseases are heart disease, cancer and stroke. Together, these three chronic diseases account for about half of all deaths in the United States. Diabetes and arthritis are other common chronic health conditions. Many of these are preventable with healthy lifestyle choices, and they can often be managed after they occur even if there is no cure.

The Changing Definition of Disease

Disease definitions tend to change through the years. For example, the bone condition osteoporosis was not formally identified as a disease until 1994. The definition of what is a disease or a condition continues to evolve along with the general understanding of medicine and health….**Click here for more information on Diseases And Conditions Topics In The News**

SENIOR CITIZEN INFORMATION

Senior citizens have a variety of concerns when it comes to health and well-being. As people grow older, many health problems become more likely to occur, including problems that affect the body and mind. And though some of these problems are unavoidable, becoming a senior citizen does not doom someone to a life of health problems. A number of steps can be taken to help preserve good health well into the golden years.

Common Senior Citizen Health Problems

As adults grow older, their risk for a number of chronic health problems begins to rise. Heart disease, diabetes and cancer are all conditions that become increasingly likely as people age. Other problems related to aging include the weakening of the bones known as osteoporosis, as well as hearing and vision problems. Injuries caused by falls also increase, sometimes as a result of osteoporosis but also because of balance problems that are more common in older people.

Mental health problems also become more prevalent as people grow older. Perhaps the most well-known is Alzheimer's disease, a condition that causes declining mental function and other debilitating behaviors in older adults. In addition, a common but under-treated mental health condition in senior citizens is depression. Often, older adults develop depression in concurrence with another debilitating health condition like heart disease or cancer...**Click here for Senior Citizen Topics In The News**